RUPTURE RESOLUTION RATING SYSTEM (3RS): MANUAL

Technical Report · January 2015

DOI: 10.13140/2.1.1666.8488

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January 2015

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Table of Contents

Introduction

Our view of the therapeutic alliance draws on Bordin's (1979) three-part conceptualization: the alliance is composed of 1) agreement between patient and therapist on the tasks of treatment; 2) agreement on the goals of treatment; and 3) a personal, affective bond between the patient and therapist. An alliance **rupture** is a deterioration in the alliance, manifested by a *lack of collaboration* between patient and therapist on tasks or goals, or a strain in the emotional bond.

Note that our definition of ruptures related to tasks and goals focuses on lack of *collaboration* rather than lack of *agreement*. This reflects our experience that not all disagreements between patients and therapists are ruptures. A patient can express disagreement with the therapist in an appropriate, collaborative way that does not constitute a rupture. An emphasis on collaboration over agreement is also helpful in instances when a patient has concerns about a task or goal, but expresses agreement with the therapist in an effort to appease the therapist or to avoid conflict. These surface-level agreements are actually examples of withdrawal ruptures (described below).

Ruptures are inevitable and occur in all therapies and with therapists of all skill levels. Ruptures can emerge when patients and therapists unwittingly become caught in vicious circles or enactments. A rupture may remain outside of the patient's and the therapist's conscious awareness, and it may not significantly obstruct therapeutic progress. In extreme cases, however, ruptures can lead to dropout or treatment failure.

Ruptures can be organized into two main subtypes: **withdrawal** and **confrontation** ruptures (Harper, 1989a, 1989b). In differentiating between these two subtypes, we draw on Horney's (1950) concept of responding to anxiety by moving away, toward, or against others. In withdrawal ruptures, the patient either moves *away* from the therapist (e.g., by avoiding the therapist's questions), or the patient may appear to move *toward* the therapist, but in a way that denies an aspect of the patient's experience (e.g., by being overly deferential and appeasing) and is therefore a withdrawal from the actual work of therapy. In confrontation ruptures, the patient moves *against* the therapist, either by expressing anger or dissatisfaction in a non-collaborative manner (e.g., hostile complaints about the therapist or the treatment) or by trying to pressure or control the therapist (e.g., making demands of the therapist). Ruptures can also include elements of both withdrawal and confrontation.

Although ruptures are a function of both patient and therapist contributions, this coding system focuses on *patient behaviors* as indicators or markers of ruptures. In our experience, even if a therapist behavior precipitates an alliance rupture (e.g., the therapist is critical or condescending), the patient usually responds by withdrawing or confronting the therapist; thus, we are usually still able to capture the rupture with this coding system. However, if coders feel that a therapist is playing a large role in causing or exacerbating ruptures, the coders should indicate that on the final item on the scoresheet.

The process by which a rupture is repaired is referred to as a **resolution process**. A resolution process enables the patient and therapist to renew or strengthen their emotional bond, and to begin or resume collaborating on the tasks and goals of therapy. The resolution process may also serve as a corrective emotional experience for the patient. Therapists may attempt to initiate resolution processes by employing **resolution strategies**, such as changing

the task, or disclosing the therapist's internal experience of the rupture. The 3RS tracks resolution strategies over the course of the session as *potential* markers of resolution processes. After viewing the entire session, the coder determines the extent to which the resolution strategies were successful in actually bringing about a resolution to the rupture or ruptures in the session.

Coding Procedures

Unit of coding: This coding system can be applied to different amounts of clinical material. The following suggestions are based on our experience:

- Coding the entire session as one unit: We have found that it is difficult to capture the many changes that can occur in one session with just one score. Also, it is harder to reach reliability.
- Coding speech turn by speech turn: This kind of coding is possible, but requires transcripts. Also, it is sometimes unclear within one speech turn whether or not a rupture is occurring—more speech turns may be needed to clarify what is transpiring.
- Coding in 5 minute segments: This is the approach we are currently using. We find that 5 minutes usually gives us enough material to identify ruptures, but not so much that we cannot reach agreement on what we are seeing. However, 5 minutes is somewhat arbitrary. Other researchers may prefer longer (e.g., 10 minutes) or shorter (e.g., 1 or 2 minute) time bins.

Using video: Transcripts can be used in addition to video, but transcripts cannot replace video because nonverbals are important for detecting ruptures and resolution events. You can stop, rewind, and review the video whenever necessary to complete the ratings.

Good process: Ruptures occur often, but in most cases, they are not occurring every minute of the session. It is important to be clear on what process looks like when there are no ruptures, before trying to identify ruptures. When there are no ruptures, the process will be marked by the following characteristics:

- Patient and therapist are attuned to each other. They are on the same page.
- Patient and therapist are both actively engaged in the work of therapy.
- Patient and therapist either agree on the tasks and goals of treatment, or they are actively and collaboratively working to reach clarification and agreement on the tasks and goals of treatment.
- Patient and therapist trust and respect each other and are comfortable with each other, to an extent that is appropriate for the stage of therapy (i.e., there will be more trust and comfort in the fifteenth session than in the first).

Note that a lack of ruptures is not necessarily the same as effective therapy. A patient and therapist could be in agreement and be working together very smoothly, but pursuing goals and tasks that are not the best choice for the patient's situation. When coding ruptures, the focus is on the quality of the collaboration and bond between the patient and therapist—not the quality of the therapist's case conceptualization, choice of treatment approach, or adherence or competence.

Observing a rupture: A rupture is a deterioration in the alliance between patient and therapist, manifested by a lack of collaboration on tasks or goals or a strain in the emotional bond. In a rupture, the patient either moves *away* from the therapist or the work of therapy (withdrawal), moves *toward* the therapist in a way that denies the patient's own experience and thereby

contributes to a movement away from the work of therapy (also withdrawal), or the patient moves *against* the therapist or the work of therapy (confrontation).

The word "rupture" may call to mind a major argument or conflict in a session. However, with this coding system, we are coding minor tensions and strains as well as major disagreements. Even good sessions with skillful therapists may contain some degree of tension or strain. That being said, you will likely find sessions that do not contain any ruptures. As beginning coders are often eager to find ruptures, and may be tempted to overcode, we suggest this rule of thumb: *when in doubt, wait and watch*. If a rupture is developing, it will likely become clear as you continue to watch the session.

The following are some indications of a rupture:

- Patient and therapist are *not* working together collaboratively and productively. They are "not on the same page."
- There is strain, tension, or awkwardness between patient and therapist.
- Patient and therapist are misaligned or misattuned.
- Patient and therapist seem distant from each other.
- Patient and therapist are working at cross purposes.
- Patient and therapist are acting friendly, but you sense tension or disagreement beneath the surface, such that the friendliness seems to be a pseudoalliance.
- Patient and therapist seem to be caught in a vicious cycle or enactment.
- You feel very bored while watching a session. This *might* be a sign that a withdrawal rupture is occurring and the patient is avoiding talking about genuine feelings and concerns.

Deciding type of rupture:

- Withdrawal: patient is moving *away* from the therapist or the work of therapy.
- Confrontation: patient is moving *against* the therapist or the work of therapy.
- Both withdrawal and confrontation: patient is simultaneously moving away and against. For example, the patient may criticize the therapist (confrontation) while smiling and laughing nervously (withdrawal). Patients who are dissatisfied with some aspect of therapy, but at the same time want to avoid conflict with the therapist, are particularly likely to exhibit mixtures of confrontation and withdrawal.

Choosing category of rupture marker: Once you decide on the type of rupture (withdrawal or confrontation), then select the rupture marker within that category that best describes what is happening. (See the category definitions and examples on pp. 10-27 for descriptions of the rupture markers.)

Withdrawal rupture markers:

- Denial
- Minimal response
- Abstract communication
- Avoidant storytelling and/or shifting topic
- Deferential and appeasing

- Content/affect split
- Self-criticism and/or hopelessness

Confrontation rupture markers:

- Complaints/concerns about the therapist
- Patient rejects therapist intervention
- Complaints/concerns about the activities of therapy
- Complaints/concerns about the parameters of therapy
- Complaints/concerns about progress in therapy
- Patient defends self against therapist
- Efforts to control/pressure therapist

Coding is not limited by speech turns: a single speech turn can contain multiple rupture markers. For example:

> Patient: *I don't like this ridiculous homework, and I don't like the way you keep nagging me to do it.*

This one speech turn contains two rupture markers and should receive two confrontation codes (complaint about activities and complaint about therapist).

Rating the clarity of the rupture marker: When you see an example of a rupture marker, put a check on the scoresheet. If it is unclear whether the behavior you observed meets full criteria for a particular rupture, you can rate it with a check minus.

- ✓ Meets criteria for rupture marker
- ✓- Unclear whether it meets criteria for rupture marker

Resolution

Observing resolution: When a rupture is repaired or resolved, there is a shift in a positive direction. Whereas the patient and therapist had seemed stuck, or locked in a vicious cycle, drifting apart, or working against one another, now they begin to come together, to understand each other, and to work collaboratively.

In order for an event to constitute a resolution marker, *it must be in the context of a rupture*. Usually, that will mean that a rupture occurred prior to the resolution attempt. In some cases, a therapist may refer to a rupture from a prior session or from earlier in the same session, and then commence a resolution attempt. When you are coding multiple sessions from the same dyad, you may be able to detect very subtle references to prior ruptures. For example, a therapist may try to "preempt" a rupture by employing resolution strategies because he/she anticipates that something he/she is about to say or do may precipitate a rupture. If you are able to make a link between the resolution strategy and a past rupture, current rupture, or rupture that is anticipated based on past ruptures, then you can code a resolution strategy. If there is no connection to a rupture, then the behavior cannot be considered a resolution strategy, even if it otherwise is topographically similar to one of the resolution strategies. For example, a therapist may decide to change tasks for many reasons. Only if the change in tasks is related to a rupture can it be coded as a resolution strategy.

While resolutions will usually occur following a rupture, they may not correspond one to one. In other words, there may not be a resolution for every rupture. Also, resolutions may not follow directly after ruptures—there can be a rupture at the beginning of the session, and a resolution for that rupture may come at the end of the session. Or one resolution event may address a series of ruptures. For these reasons, we have found it easier to track *attempts* to resolve ruptures as we watch the session by coding therapists' use of resolution strategies. Only after watching the entire session do we make global ratings of the extent to which the resolution attempts succeeded in resolving ruptures.

Choosing category of resolution strategy:
Select the resolution strategy that best describes what the therapist is doing to address the rupture. (See the category definitions and examples on pp. 28-37 for descriptions of the strategies.)
Resolution strategies:

- Therapist clarifies a misunderstanding.
- Therapist changes tasks or goals.
- Therapist illustrates tasks or provides a rationale for treatment.
- Therapist invites the patient to discuss thoughts or feelings with respect to the therapist or some aspect of therapy.
- Therapist acknowledges his/her contribution to a rupture.
- Therapist discloses his/her internal experience of the patient-therapist interaction.
- Therapist links the rupture to larger interpersonal patterns between the patient and the therapist.
- Therapist links the rupture to larger interpersonal patterns in the patient's other relationships.
- Therapist validates the patient's defensive posture.
- Therapist responds to a rupture by redirecting or refocusing the patient.

As with the rupture markers, coding is not limited by speech turn. For example:

> Therapist: *It makes sense that you are frustrated with me right now. I think I haven't been sensitive enough to your concerns about the homework.*

The therapist's response is one speech turn that contains two resolution markers (validating the patient's defensive posture and acknowledging contribution to a rupture).

Rating the clarity of the resolution marker: When you see an example of a resolution strategy, put a check on the scoresheet. If it is unclear whether the behavior you observed meets full criteria for a particular strategy, you can rate it with a check minus.

- ✓ Meets criteria for resolution strategy
- ✓- Unclear whether it meets criteria for resolution strategy

Global Ratings

These ratings are made after watching and coding the entire session in 5-minute segments. They should be based on the entire session.

Significance ratings: Rate the significance of each type of rupture marker (e.g., denial, minimal response) and each resolution strategy (e.g., clarify misunderstanding, change tasks/goals). Use the following scale:

Rating	Significance	
1	No significance	No rupture markers/resolution strategies, or only very minor ones that did not appear to impact the alliance. It is possible for a session to include a few minor ruptures (e.g., patient tells a somewhat avoidant story) and resolution strategies (e.g., therapist redirects patient) that have ***no visible or lasting impact*** on the bond or on collaboration on tasks and goals. Such very minor ruptures and resolution strategies can be coded here.
2	Minor significance	Rupture markers/resolution strategies have ***a minor impact*** on the alliance***.***
3	Some significance	Rupture markers/resolution strategies have ***some impact*** on the alliance.
4	Moderate significance	Rupture markers/resolution strategies have a ***moderate impact*** on the alliance. Probably the easiest way to gauge "moderate" is to use this category for markers/strategies that seem greater than 3, but not significant enough to be rated a 5.
5	High significance	Rupture markers/resolution strategies have a ***noteworthy impact*** on the alliance.

- Please note that you are rating significance, not frequency or duration. Numerous minor ruptures may be less significant for the alliance than one large rupture.
- **Overall Withdrawal and Confrontation:** After rating each rupture marker, rate the significance of all the withdrawal markers as a group, and all the confrontation markers as a group, using the Significance scale above.
    - Once you have made the Overall Withdrawal and Confrontation ratings, compare them and make certain that the difference between them reflects your overall sense of the session. For example, if the session was marked more by withdrawal than confrontation in terms of significance for the alliance, then your overall Withdrawal score should be higher than your overall Confrontation score.

Overall Resolution Rating: This rating is your global assessment of the extent to which resolution actually occurred across all the ruptures in the session. *This may differ from your significance ratings for the individual resolution strategies.* A session may include numerous, significant attempts to resolve ruptures (many high Significance ratings), but those attempts may not be completely successful (low or moderate Overall Resolution). Sessions may include some ruptures that are resolved and some that are not; pick the rating that best captures your global sense of the session.

Start by anchoring at 3, and then move up or down based on the extent of resolution in the session. Three is "average." In this context, "average" is meant to convey the idea of typical, commonplace, baseline. It is not meant to indicate the statistical average (mean) in your sample. For example, your sample may include only highly skilled therapists who are all excellent at repairing ruptures. In that case, you could give them all high ratings.

Overall Resolution Rating	Degree to which ruptures were resolved.
1	**Poor resolution**/worse alliance—Major ruptures were not resolved. Either the ruptures were not addressed, so they continued, or attempts to resolve ruptures were unsuccessful. If attempts to resolve ruptures of any kind—major or minor—made the alliance worse, then code that here.
2	**Below average resolution**/no improvement in alliance—Minor ruptures were not resolved, or major ruptures were only slightly resolved. Resolution strategies neither improved nor harmed the alliance.
3	**OK/average resolution**/OK alliance—Ruptures were at least partly addressed and resolved. By the end of the session, patient and therapist have some bond and are generally able to collaborate on most therapy tasks and goals. Sessions with no ruptures or only very minor ruptures that have no significant impact on the work of therapy should be coded here.
4	**Good, above average resolution**/somewhat improved alliance—Ruptures were generally resolved well. Some ruptures may have been resolved very well and others only moderately well, but overall, problems with the bond and/or collaboration on tasks and goals were addressed with some success. If very minor ruptures were resolved very well, code that here.
5	**Very good resolution**/improved alliance—Ruptures were more than minor, and they were resolved very well. The resolution process seems to have improved the alliance—strengthened the bond between patient and therapist, and/or facilitated greater collaboration between patient and therapist on the tasks and goals of therapy.

Therapist Contribution Rating: The last item on the scoresheet asks coders to rate the extent to which the therapist caused or exacerbated ruptures in the session. We regard ruptures as relational phenomena that always involve both members of the dyad, so therapists are always contributing to ruptures in some fashion. The focus of this item is the extent to which the therapist is playing a "larger than average" role by actually initiating or exacerbating the rupture. The therapist might be actively engaging in negative interpersonal behaviors such as criticism, or the therapist might be unusually passive and seem to ignore prominent rupture markers. If you feel that the therapist is exhibiting markers of withdrawal and/or confrontation that cause or exacerbate patient rupture markers in the session, use this code to capture the therapist's behavior.

Withdrawal Rupture Markers

In a withdrawal, the patient is moving *away* from the therapist and/or the work of therapy. Below are descriptions and examples of markers of withdrawal ruptures.

Denial

The denial marker overlaps with, but is not necessarily synonymous with denial as a defense mechanism. The patient withdraws from the therapist and/or the work of therapy by denying a feeling state that is *manifestly* evident, or denying the importance of interpersonal relationships or events that seem important and relevant to the work of therapy. The patient's denial functions to shut down or move away from the current topic or activity, thereby hindering the work of therapy.

The patient may be aware that he/she is denying his/her true feelings in order to avoid discussing them. Or, he/she may not be aware—he/she may be disconnected from his/her own internal state. In other words, the patient may be withdrawn from him/herself. This constitutes a withdrawal rupture because it functions to create or exacerbate withdrawal from the therapist and the work of therapy.

T: You look upset.
P: I'll be fine. Don't worry about me.

T: According to what it says here, it looks like you could have died too.
P: Yeah. That would have solved a lot of problems
T: What would it solve?
P: Nothing. I didn't mean anything by it.

T: It's interesting that you compare this mission with the death of your mother.
P: My mother's death was the most traumatic event of my life so far. That mission was just another mission.

Check minus rating: Patient's denial is unclear. You suspect that the patient might be trying to move away from the therapist, but it is also possible that the patient is collaborating by openly, honestly, and accurately reporting how he or she feels or thinks.

T: You look upset.
P: *(calmly)* I don't think I'm actually upset right now, I think I'm just really tired.

Minimal Response

Patient withdraws from the therapist by going silent or by giving minimal responses to questions or statements that are intended to initiate or continue discussion. The patient's minimal responses function to shut down the therapist's attempts to engage the patient in the work of therapy.

Walking out: An extreme example of a minimal response is walking out of the session.

Nonverbals: When a patient's speech does not meet criteria for a withdrawal marker, but the patient's nonverbal behaviors indicate that the patient is withdrawing (e.g., patient slumps down, sinks into his/her chair, avoids eye contact), this code can be used.

Cell phone: The patient stopping the work of therapy to answer or check his/her cell phone can also constitute a minimal response. (Note that if the patient does this in a way that reveals hostility or contempt for the therapist, then it should also receive a confrontation code. If there is a compelling, external reason why the patient is answering the phone in the middle of a session—e.g., a parent taking an emergency call from the nurse at a child's school—then do not code it as a rupture.)

Overly talkative therapists: When a therapist dominates the session by talking a great deal, coders may feel that the patient has no choice but to give minimal responses because the therapist does not give the patient an opportunity to speak. Pay close attention to the patient's body language. If the patient appears to be actively listening and is engaged by what the therapist is saying, then the patient is not withdrawing. However, if the patient seems bored or disengaged, then minimal response is an appropriate code even if the therapist is not pausing to let the patient speak.

T: That sounds like it was very difficult. How did it make you feel?
P: *(Shrugs.)*

T: So is it upsetting to even talk about it right now?
P: Sort of.

T: What type of cancer is it?
P: You know what? I don't want to talk about it.

Check minus rating: Patient gives a short response or goes silent for a few moments, and it is unclear whether the patient is withdrawing from the therapist or is engaging in the work of therapy by quietly processing what the therapist just said. What a patient says *after* a long pause may help to clarify whether a short reply or silence was a minimal response or not. A pause followed by a thoughtful answer suggests that the patient is engaged in the therapy process. A pause followed by a terse response or a change in topic suggests that the patient's silence was part of a withdrawal.

Abstract Communication

Patient avoids the work of therapy by using vague or abstract language. The patient's use of abstract language functions to keep the therapist at a distance from the patient's true feelings, concerns, or issues.

Intellectualization: The patient may intellectualize by focusing on rational concepts and complex terminology.

T: Did it bother you when I said that?

P: I was confused, but I think it's OK for things to be confusing a little every once in a while. It makes you think about it more and you can learn from it.

Global statements: The patient may make global statements that allude to an issue that is relevant to the treatment, rather than directly stating his/her true thoughts or feelings.

Vague and confusing: The patient may rely on abstract and/or vague language to such an extent that the therapist (and the coder) may become confused and have difficulty following what the patient is saying.

P: But I mean, you know, I was thinking that maybe what I would do is just not let that happen, and just say, well, you know, maybe I don't even have to understand why that happened, maybe if I just don't let that happen, that I would just be in a better place to work on things.

Differentiating between collaboration and collusion: Sometimes therapists join patients in the use of abstract language, and both engage in an intellectualized discussion. To determine whether or not this constitutes collaboration (no rupture), or collusion (a withdrawal rupture), consider the following:

- Does the intellectualization function to strengthen the bond between the patient and therapist?
- Do they agree that this intellectual discussion is an appropriate therapy task for this moment in this session?
- Do they agree that this intellectual discussion is consistent with or in support of their agreed-upon treatment goals?

If so, then this is not a withdrawal rupture.

- If the intellectual discussion is a way of avoiding the work of therapy and/or is harming their bond, then it is a form of withdrawal.

Check minus rating: Patient is using abstract language, but it is unclear whether this is contributing to a withdrawal from the therapist and/or the work of therapy.

Note: some patients have an intellectualized style of speaking. If this is the way the patient generally speaks, and it does not seem to interfere with the work of therapy, then it is not a withdrawal rupture.

Avoidant Storytelling and/or Shifting Topic

Patient tells stories and/or shifts the topic in a manner that functions to avoid the work of therapy. It is not uncommon for the patient to do both simultaneously—to shift the topic by launching into an avoidant story.

Avoidant stories: These stories are often long and tangential or circumstantial, but they can also be brief or even entertaining and may foster the sense of a "pseudoalliance." The key is that the stories function to move away from the therapist and/or the work. They may shut the therapist out, as if the patient were not even aware that the therapist is there.

Talking about someone else's reactions in an effort to avoid talking about oneself should also be coded here; for example, a patient who has been laid off talks about his co-workers' stress and anxiety rather than his own. (If the patient were to talk about the difficulties "many people are facing in this economy," then abstract communication would be the appropriate code.)

Stories that are efforts to engage in the work with the therapist by communicating something that the patient believes is important and relevant should not be coded as withdrawal ruptures. If the patient and the therapist chat a little at the very beginning or end of the session as a way of "warming up" or "cooling down," do not code that as avoidant storytelling unless you have a *strong* sense that they are avoiding the work of therapy in an important way.

Shifting topic: A good indication that the patient is withdrawing by shifting the topic is if he/she changes the topic from a "heavy" subject to a "light" one.

If the patient shifts the topic not to avoid, but rather to enhance the work of therapy, this would not be coded as a withdrawal (e.g., "I know that we were talking about my job, but I just remembered something that happened with my boyfriend that I really want to discuss with you…").

T: How do you think things are going so far in our work together?
P: That sounds like a performance review question. I had a performance review at work last week, and it was so stressful…

T: Are you experiencing me as angry right now?
P: No, no. I feel, um, actually, um, very safe talking to you. And it's not that I don't worry-- I don't feel-- I can say to my boyfriend…

Collaboration vs. collusion: The patient may tell an avoidant-sounding story or make a sudden topic shift, and the therapist may go along and even encourage the story or the new topic by asking questions or making encouraging comments. To determine whether this constitutes a withdrawal rupture, consider the following questions:

- Does the story/topic shift function to strengthen the bond between the patient and therapist?
- Do they agree that this story/new topic is an appropriate therapy task for this moment in this session?

- Do they agree that this story/new topic is consistent with or in support of their agreed-upon treatment goals?

If so, then this is not a withdrawal rupture.

- If the story/topic shift is a way of avoiding the work of therapy and/or is harming their bond, then it is a form of withdrawal.

Check minus rating: Patient tells a story or shifts the topic, but it is unclear whether this functions to avoid the work of therapy. The story or new topic may be somewhat relevant, but still has an avoidant quality (e.g., somehow shutting out the therapist). Or the therapist goes along with the story or topic shift, and it is unclear whether the patient and therapist are colluding in a withdrawal or collaborating.

Deferential and Appeasing

Patient withdraws from the therapist and/or the work of therapy by being overly compliant and submitting to the therapist in a deferential manner. The patient's deferential behavior functions to avoid conflict with the therapist, and/or makes it harder for the therapist to know how the patient really feels or what the patient really thinks. Code deferential for patients who "yes" the therapist—who seem superficially engaged and smile and say "yes" to everything the therapist says, even when they do not really agree.

T: How was the homework?
P: Oh, it was so helpful. You give such wonderful advice.

T: It's a process, but I think we can both agree it's nice to have that support. What I'm hearing, and you can tell me if it's different, is that there isn't so much of that right now.
P: Yeah, totally.
T: It can be challenging and can increase the feelings of sadness.
P: Yeah.
T: That's what it sounds like.
P: I think that's absolutely right. I totally agree. I 100% agree.

Collaboration vs. deference: Not every positive comment a patient makes is deferential. Patients can genuinely feel and honestly express positive feelings about the therapist and the work of therapy. In order to determine whether a patient's positive comments constitute a withdrawal rupture, consider the following questions:

- Does the patient seem genuine, honest, and engaged? (Note body language as well as tone of voice.) Then do not code a withdrawal rupture.
- Does the patient seem insincere? Does it feel like the patient is trying to smooth things over, to avoid conflict, to win over the therapist? Then do code a withdrawal rupture.

Check minus rating: Patient is agreeing with or praising the therapist or the therapy, and it is unclear whether the patient is being overly deferential or sincere.

P: Did you do it all yourself, or did you use an interior decorator? So this is all you? I'm impressed.

Content/Affect Split

The patient withdraws from the therapist and/or the work of therapy by exhibiting affect that does not match the content of his/her narrative. For example, the patient is describing an upsetting event, but his/her affect is too positive (smiling, nervous laugh) or is very matter-of-fact.

Patient looks tearful.
T: It's hard for you to tell me about those sad feelings.
P: *(A bright, forced smile).* Yes, it is. It's not easy to talk about.

Content/affect splits are particularly noteworthy when the patient uses positive affect to soften or withdraw from a complaint or concern about the therapist or the therapy.

T: What just happened? You did not like that question?
P: Well, I just felt like things were moving forward *(chuckling),* that question took me back a couple of steps.

P: So, first, I wanted *(chuckle)*, after the last session, I felt like, I don't know if that was the intention or not but I felt like you were trying to tell me that I need to take more responsibility. *(Smiling).* That's the impression I left with. Maybe I wasn't doing my homework, so I wasn't taking it seriously, me coming here, and that I wasn't challenging myself. Like, I was just coming in here and it became like a routine. So I took that as you want me to do my homework and I need to work on things and put more effort into this because I'm not here because someone made me, I'm here because I wanted to, so to get benefit out of it, I needed to be more proactive. *(Laughs.)*

Content/affect split vs. humor: Do not code every time a patient laughs or smiles or makes a sarcastic joke. Upsetting events can contain within them aspects that are funny or ironic, and a patient's comfort with laughing with his/her therapist could be a marker of a strong alliance rather than a rupture. To determine whether a content/affect split constitutes a withdrawal rupture, consider the following questions:

- Does the split between the patient's content and his/her affect cause or reveal weakness in the bond with the therapist? Does the patient seem uneasy or uncomfortable? Do you have the sense that the patient does not trust the therapist enough to reveal his/her true feelings?
- Does the content/affect split hinder the work of therapy by making it harder for the therapist to know how the patient really feels or what the patient really thinks?
- Is the patient using overly positive affect in an effort to avoid conflict with the therapist by "softening the blow" of a complaint or concern?

If yes, then code a withdrawal rupture.

Check minus rating: When the content and affect seem discrepant, but you are not sure if the patient is withdrawing from the therapist.

Self-criticism and/or hopelessness

The patient withdraws from the therapist and the work of therapy by becoming absorbed in a depressive process of self-criticism and/or hopelessness that seems to shut out the therapist and to close off any possibility that the therapist or the treatment can help the patient. The patient may make self-denigrating and self-minimizing statements. The patient may engage in this process as a means of avoiding conflict with the therapist.

T: That sounds important. Can you tell me more about that?
P: *(Sighs).* What's the point? It's not going to make me feel better.

T: It's hard for you to tell me "no."
P: Now you see why it's impossible for me to get a job.

Patient and therapist discussing patient's sense of loneliness. Patient mentions several friends and acquaintances, but for each one, provides a reason that she cannot turn to them for support.
T: Are there other people in your life that we can get you connected with?
P: Um…*(long pause)*---it's hard because the friends I've made here, they're not people that I really want to open up to. They're not people I think would give good advice. It's more of an informal, social friendship than in my proper friends back home. I haven't found, you know, really good friends here yet.

Help-rejecting patients like this can present with a combination of self-critical/hopeless and reject intervention. The therapist keeps trying to get patient to identify someone she can talk to, and the patient rejects the idea that such a person exists in her life—because she is hopeless that her situation can be improved.

Note that patients can be self-critical or hopeless about some aspects of their situation, but still be engaged with the therapist and the work of therapy, and can explore these feelings with the therapist in a collaborative way, as in the example below:

P: I doubted my intelligence. Like, maybe I'm just stupid because I'm having all these problems. So am I really a thinking type? Maybe I'm sensing. I don't think things through. Because I always test as thinking, but then I thought, well these tests are subjective. So maybe I don't know who I am.
Patient is not withdrawing—she is sharing her self-critical thoughts in an open and direct way. This is not a rupture.

Check minus rating: The patient is making self-critical and/or hopeless statements, and it is unclear whether this constitutes a withdrawal from the therapist and/or the work of therapy.

Confrontation Rupture Markers

In a confrontation, the patient is moving *against* the therapist and/or the work of therapy. Below are descriptions and examples of markers of confrontation ruptures.

Complaints/concerns about the therapist

Patient expresses negative feelings about the therapist. Patient may feel angry, impatient, distrustful, manipulated, hurt, judged, controlled, rejected, or may feel that therapist has failed to support, encourage, or respect him/her. The patient may criticize the therapist's interpersonal style, or express doubts about the therapist's competence. If the patient says or implies that the therapist does not understand the patient, or is ineffective as a therapist, then code it here.

For most patients, it is very difficult to criticize a therapist directly. If you get any sense of a hint of negative feelings for the therapist, code it.

P: I was thinking about some of the things that you said last week. I wasn't very happy about them. Not so much what you said, actually, more the way you said them. You were pushing me into a corner. I wouldn't have thought that was the way to go about helping people.

P: I feel like you are opening me up and exploring every inch of my insides. It's really, really, really uncomfortable.

T: And the air force?
P: *(testily)* The *navy*, doctor, *listen*.

P: I can see I'm not gonna get anything useful out of you.

P: This is not for me. All this "what do you feel, what do you think?" I asked you something. I came to you to consult about something very clear and specific.

P: I can't communicate with you.

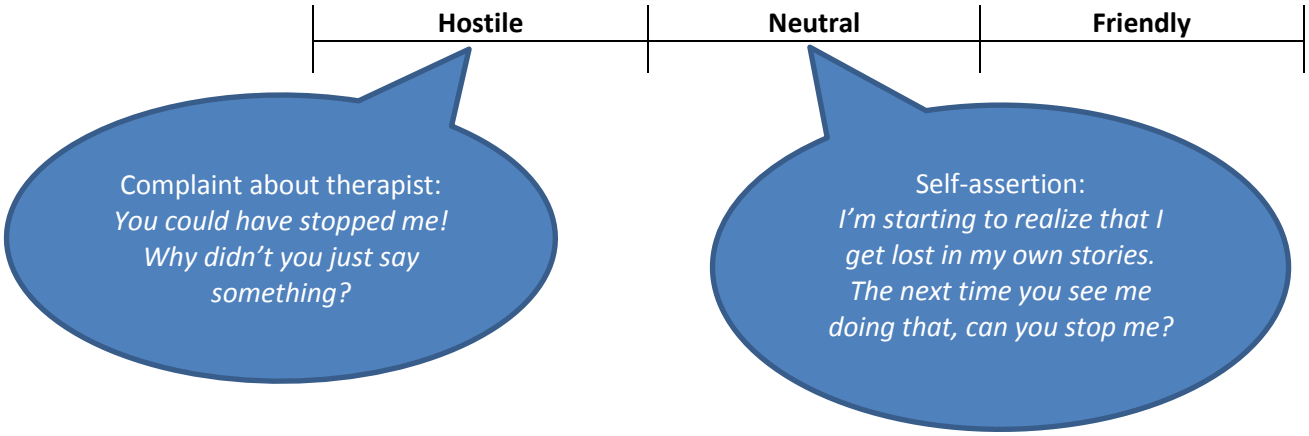
P: I just kind of resented, you know, when you came at me like that. Why didn't you just stop me?

Complaint/concern about therapist with "nice" patients: Complaints/concerns about the therapist are often expressed in a hostile manner, but hostility is not necessary for this code. Complaints/concerns can also be expressed in a subtle, polite way by "nice" patients. They may appear in conjunction with a withdrawal rupture (e.g., concern expressed with a smile, so that it is both complaint/concern therapist and content/affect split). These **mixed codes** (withdrawal and confrontation) should be captured by coding both confrontation and withdrawal markers in the same time segment.

P: So, first, I wanted *(chuckle),* after the last session, I felt like, I don't know if that was the intention or not, but I felt like you were trying to tell me that I need to take more responsibility. *(smiling).*
Content/affect split, complaint therapist—the patient is telling the therapist "You made

me feel criticized."

Complaint/concern about therapist vs. self-assertion: Helping patients to express concerns about the therapist and/or the work of therapy can be a step toward healthy self-assertion and part of the process of repairing an alliance rupture. When this is happening, it is important to distinguish between markers of confrontation ruptures and self-assertion. Pay attention to the degree of hostility. Thinking about how affiliation is rated on the SASB (e.g., Benjamin, 1974[1]) can be helpful. On the SASB, affiliation is conceptualized as a dimension with poles of hostility/hate at one end and friendliness/love at the opposite end. At the midpoint of this dimension is a point of neutrality. When the patient's concern is expressed with hostility, it is a confrontation rupture. Generally speaking, a healthy self-assertion will be expressed in a more neutral way.



Check minus rating: It is unclear whether the patient is expressing negative feelings about the therapist.

[1] Benjamin, L.S. (1974). Structural analysis of social behavior. *Psychological Review, 81,* 392– 425.

Patient rejects therapist intervention

Patient rejects or dismisses the therapist's intervention. The patient may reject the therapist's view or interpretation of the patient and/or the patient's situation, or the patient rejects or dismisses the therapist's efforts to intervene (e.g., therapist tries to offer support and patient rebuffs therapist in a hostile manner). The patient is attacking and shutting down something that the therapist is trying to bring to the table. Rejecting a therapist's question as irrelevant or inappropriate should be coded here.

If the patient disagrees with, dismisses or rejects a task—an activity that the therapist wishes the patient to participate in, such as completing a thought record or doing a two-chair exercise—then rate Complaint/concern about activities.

T: It sounds like you are concerned about him.
P: *(hostile tone)* No, that is not it at all.

T: When did your insomnia begin?
P: What difference does that make?

T: I thought we could focus some more on your anxiety…That's the thought I had. I don't know if there's anything in particular that you want to make sure we get to today?
P: *(Frowning.)* Yeah, I don't know if it's anxiety.

Collaboration vs. confrontation: Not every disagreement is a rupture. A patient may disagree with a therapist's idea in the context of a collaborative exploration of an issue, as in the following example:

T: You've been under a lot of pressure at work lately. Is there something at work that is contributing to how you are feeling today?
P: Work was stressing me out a lot last week, but today, no, I don't think it's work that is causing my anxiety. I think maybe it's more about what's going on with my girlfriend…

Note that in the above example, the patient and therapist are working together to identify the source of the patient's anxiety. The patient is actively engaged, really considering the therapist's idea and taking the therapist's contribution seriously. If the patient said "no" to everything the therapist suggested, and you had the feeling that the patient was resisting the therapist's efforts, then you would code reject intervention.

In order to determine whether a disagreement is a confrontation rupture, consider the following questions:

- Is the patient engaging with the therapist in the work of therapy (vs. resisting the work of therapy)?
- Are the patient and the therapist on the same page? (If the therapist appears frustrated or defeated, that is a good sign that a rupture is occurring.)
- Does the patient respect the therapist's ideas and suggestions?

Check minus rating: If it is unclear if the patient is rejecting the therapist's intervention, or is thoughtfully considering it. There might be a subtle sense of pushback.

Complaints/concerns about the activities of therapy

Patient expresses dissatisfaction, discomfort, or disagreement with specific tasks of therapy such as homework assignments or in-session tasks such as empty chair or imaginal exposure. Patients may directly complain about an activity, or they may express their concerns in a more subtle way by expressing some doubts about the effectiveness of a particular task.

P: I really don't understand what you're asking me to do on these thought records. I don't see the point of them at all.

P: What is this? Why are we doing this exercise? I feel really uncomfortable right now.

T: That's the kind of pressure you're putting on yourself, the kind of stuff you wouldn't want your boss to do to you.

P: Yeah. That's true. *(Pause).* Do you think this, doing this exercise is going to actually help with that? *(sounds skeptical)*.

Homework: When a patient reports that he/she did not do the homework, code complaint/concern about activity. The fact that the patient did not do the homework indicates a problem in the collaboration between the patient and therapist on the tasks of therapy: the patient may not agree with the homework, the patient may lack motivation to do the homework, or the homework may be problematic (e.g., too difficult) for the patient.
The only exception would be the rare instance when the patient agreed with the homework, was motivated to do the homework, tried to do the homework, but encountered obstacles that could not have been foreseen (e.g., homework was to practice assertion by speaking up in class and class was cancelled that week).

Check minus rating: It is unclear whether the patient is expressing concerns/complaints about activities of therapy.

Complaints/concerns about the parameters of therapy

Patient expresses concerns or complaints about the parameters of treatment, such as the therapy schedule (e.g., appointment times, session length, number and frequency of sessions) or the research contract (e.g., completing questionnaires, being videotaped).

P: Once a week is not enough. It's not enough time to address all my problems!

P: I don't see the point of these questionnaires I have to fill out every week. What do these questions have to do with me?

P: I can never forget that the camera is there.

Collaboration vs. confrontation: When patients and therapists are trying to schedule a session, the patient may express concerns about specific dates or times. This may be part of a collaborative scheduling process in which both parties are comfortable being honest and clear about what they realistically can do. To determine whether a patient's concern about certain dates or times is part of collaborative discussion or is a complaint/concern about parameters, consider the following questions:

- Is the patient not really trying to find a time to meet?
- Is the patient putting up roadblocks to every suggestion the therapist makes?
- Is the patient inflexible?
- Does the patient seem not to want to meet with the frequency the therapist thinks is appropriate?

If yes, then code complaint/concern about parameters.

Check minus rating: It is unclear whether the patient is expressing concerns/complaints about the parameters of treatment.

Complaints/concerns about progress in therapy

Patient expresses complaints, concerns, or doubts about the progress that can be made or has been made in therapy.

P: I've been coming here for four weeks now, and I really can't think of anything that has changed. Maybe this has all been a waste of time.

P: As I told you, I have the feeling we are going in circles.

P: I think I want to quit.

P: Yeah. *(Sounds a little unsure).* I think I've made some progress.

In the example above, the patient's tone and affect revealed her doubts about her progress. This example should be coded as a **combination of confrontation** (complaint about progress) **and withdrawal** (deferential) because the patient is dissatisfied with her progress, but reluctant to clearly state that for fear of upsetting the therapist. If the patient's tone and affect had been less clear, this could be coded as a check minus. Alternatively, if the patient said this in a straightforward way and was communicating that she really felt that she *had* made some progress and was pleased, then this would not be a rupture.

Check minus rating: It is unclear whether the patient is expressing complaints/concerns/doubts about his/her progress in therapy.

Patient defends self against therapist

Patient defends his/her thoughts, feelings, or behavior against what he/she ***perceives*** to be the ***therapist's*** criticism or judgment of the patient. The patient makes a case to support, validate, and defend his/her behavior, beliefs, feelings, decisions, etc. Note that the therapist does not have to actually criticize the patient for the patient to anticipate or perceive criticism and become defensive. Also, what patients regard as critical can be idiosyncratic. One patient may regard being called "career-focused" a compliment, while another patient becomes defensive because he/she regards it as criticism.

Patients who insist that they do not meet criteria for diagnoses or that they do not need treatment are usually defending themselves against a perceived criticism or judgment.

T: That makes a lot of sense.
P: Of course it does! I'm not an idiot!

P: But I think it's normal for people to change. I'm going through a transitional period. So I have new ideas about what would help me get through this situation. It doesn't necessarily mean that I am unstable.

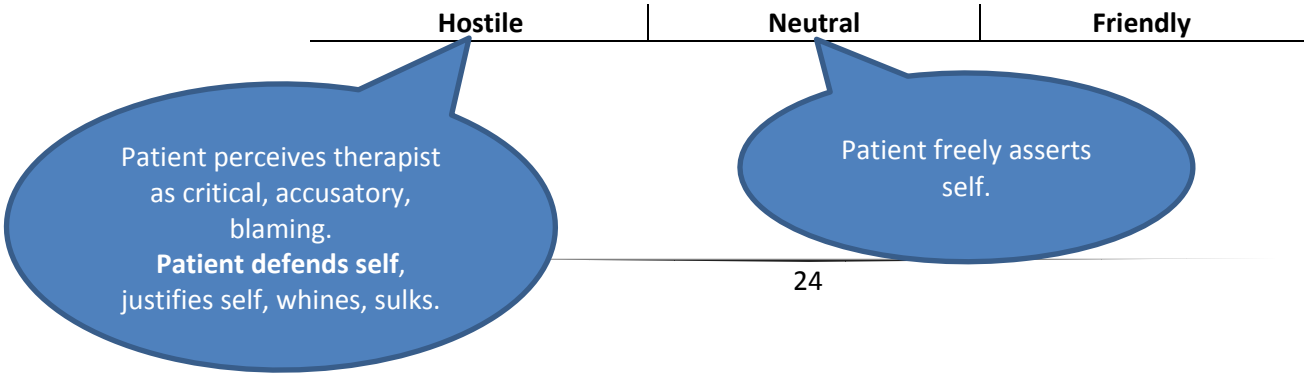
T: That's the interesting thing, you always come in and you tell me that you're always listening and you always follow me.
P: And I do exactly what you suggest all the time.
T: That's the funny thing, because you do lots of things that I never suggested.
P: My life is more complex. I did exactly what you suggested. Taking a look back, I did everything that you suggested, but it didn't help our relationship.

There are instances when a patient sounds very defensive, but it is unclear against whom the patient is defending him or herself. In the following example, the patient gets very animated talking about her boyfriend:

P: It was like he didn't understand…I had to keep up my separate household. How do you do that? How do you do that? I can't do this stuff during the day….

If the coder believes that this patient is not only defending herself against her boyfriend, but is also trying to make her case to the therapist because she thinks he might share the boyfriend's views, then code Patient defends self. If it seems likely that the patient is only defending herself against her boyfriend, or her own inner critic, but there is a small possibility that she is in some ways trying to defend herself against the therapist, then code check minus.

The SASB coding system can be a helpful guide here as well. Patient defends self is trying to capture behaviors that are toward the hostile end of the affiliation dimension, as opposed to the neutral point of the dimension, which is more likely a healthy place of self-assertion.



Check minus rating: It is unclear whether the patient is defending him/herself against the therapist. If the patient is highly defensive, even if the defensiveness seems to be directed toward someone other than the therapist, give at least a check minus—most likely on some level, the patient's defense is partly aimed at the therapist.

Efforts to control/pressure the therapist

Patient attempts to control the therapist and/or the session (e.g., patient tells the therapist what to do or what not to do), or the patient puts pressure on the therapist to fix the patient's problems quickly. Trying to push or provoke the therapist should be coded here. While watching a segment, if you can imagine feeling very pressured if you were the therapist, then consider this code.

T: And you do need to tell your parents.
P: Just stop it.
T: Your cancer is at stage three.
P: Stop it, stop it, stop it!

P: Tell me what my problem is and what I need to do.

T: So why have you come to see me?
P: Whoa, we'll get to that. Now, you're probably thinking… [Patient goes on to dominate the discussion and makes no space for the therapist to participate.]

P: I'm tired of wasting time. I want to know how this therapy works. Tell me how it's going to help me with my problems. And none of that fancy therapist talk; I want a direct answer.

A long-time patient (who is himself a therapist, and who often engages in power struggles with his therapist) arrives at the session and sits in the therapist's chair.
T: That's where I sit.
P: Oh, yes, of course. *Patient gets up and moves to the other chair.*

The session of Gloria with Rogers is a good example of a more subtle form of control/pressure. The excerpt below is one of many times Gloria asks Rogers for an answer. She is never completely direct—she hedges a little ("almost") and smiles in a forced way. There is a sense of desperation and pleading, which puts pressure on the therapist.
P: And I want—I almost want an answer from you. I want you to tell me if it would affect her wrong if I told her the truth, or what.

Control/pressure can also take the form of sexually charged, flirtatious patient behaviors that feel intrusive and demanding to the therapist. Do not automatically code all flirtatious behavior or all examples of erotic transference. The key for this code is the patient's effort to put pressure on or exert power over the therapist. For example, if a patient says the following to a female therapist:

P: That's a really pretty skirt you have on today.

The above statement may feel like a friendly, well-meaning compliment from a grandmotherly patient, but may feel intrusive and intimidating from a domineering male patient who often makes sexually inappropriate comments about his female employees. The latter would constitute an example of control/pressure.

Collaboration vs. confrontation: Patients can directly tell therapists what they need from them in a collaborative way. In order to distinguish between frank collaboration and control/pressure, consider the following questions:

- Is the patient expressing his/her needs to the therapist in a sincere, direct way, or is the patient trying to compel (e.g., with hostile force or fawning flattery) the therapist to do what the patient wants?
- Does the patient legitimate the therapist's freedom to decline the patient's request?
- Does the patient seem so intimidating or so desperate that the therapist will have a hard time saying no?

If yes, code control/pressure.

Check minus rating: It is unclear whether the patient is pressuring or attempting to control the therapist.

Resolution Strategies

Resolutions strategies are therapists' attempts to repair a rupture. Below are descriptions and examples of resolution strategies.

Therapist clarifies a misunderstanding

Therapist responds to a rupture by attempting to clarify a misunderstanding. Generally, the resolution effort stops here; the therapist does not go on to explore the underlying significance of the misunderstanding or to try to link it to the patient's core themes.

T: You seem a little distant right now.
P: Well, I guess I was a little bothered about what you said about how I should apologize to my sister.
T: No, no, I said that I think your sister should apologize to you.
P: Oh *(smiling)*. I must have misheard you…

P: *(nervously)* I guess I can try reaching out to them.
T: It's worth trying out, to see how it makes you feel to share more with them. I don't want you to misunderstand and think that I'm saying call them and just pour it out and say, this is what's going on in my life!

T: It sounds like you clicked with CBT
P: No! I was assigned to CBT, that's totally different.
T: What I'm saying by "you click with it" is that you seem to like it.

Check minus rating: It is unclear whether or not the therapist is trying to resolve a rupture by clarifying a misunderstanding. For example, the therapist may be clarifying something, but it is unclear whether or not this explanation is in response to a rupture.

Therapist changes tasks or goals

The therapist changes the tasks or goals of therapy in response to a rupture. The therapist may change the task/goal in order to address the concerns of a patient who is complaining (confrontation rupture). Or the therapist may change the task/goal in an effort to engage a withdrawn patient. Changing the task can include *modifying* the task in order to make it more palatable for the patient.

P: We're getting off track again. I don't think this is getting us anywhere.
T: I'm willing to follow your lead right now. What direction would you like to go in?

P: It's hard to talk about my mom. *(Patient goes quiet.)*
T: So how are things at work? You were going to meet with your boss to ask about a raise, right?

T: Today's our 15th session, so we're about the middle of our treatment. So today I was interested in reflecting back on your main concerns, the things you wanted to work on when you first came in, see how things are going so far, and also planning what we're going to do moving forward. And then I'd like to hear about how the homeworks went. Does that sound good? Do you have anything else you want to add to the agenda?
P: *(Tight smile)*. I have a whole list of things. So much happened since last time. I wrote it down and I wanted to talk to you about. *Content/affect split and check minus reject intervention—patient is subtly telling the therapist "no"*
T: OK, so we can do two things. We can either assess the midphase today, or we can put that off until next week and work mostly on this stuff if there's a lot of stuff going on.
P: That sounds good.
T: OK, so then next week we'll talk about where we've come.

P: I don't relate to it. It just doesn't seem the kind of thing that's useful to me, that even relates to me. *Complaint activity*
T: So what do you feel like doesn't relate to you? *Invite thoughts/feelings*
P: Well, *(looks at thought record)* distressing physical sensations, I've never had that.
T: OK, that doesn't need to apply.
P: Thoughts and images through my mind—I'm not the kind of person who thinks in images –I don't know.
T: OK, that's also something that can be sort of removed from this. Maybe it's easier to just cross those things out.

Check minus rating: It is unclear whether or not the therapist is changing the task/goal in response to a rupture, or if the therapist is simply doing therapy (e.g., therapist is unaware of a rupture and is moving on to the next item on the agenda).

P: It's hard to talk about my mom *(goes quiet)*.
T: *(Nods)*. Well, I think we're done setting the agenda, should we review the homework?

Therapist illustrates tasks or provides a rationale for treatment

The therapist responds to a rupture by illustrating, explaining, or providing a rationale for a therapy task or goal. The therapist may share his/her reasons for pursuing a particular therapy task, in an effort to engage the patient or to alleviate the patient's concerns. Sometimes this may be in the form of reframing the meaning of tasks or goals in a way that is more appealing to the patient.

Do not code if the therapist is simply explaining a task as part of the regular process of treatment—for example, if the therapist is introducing a thought record for the first time and is explaining how to do it and why it would be helpful. If it is not clear whether or not the therapist is responding to a rupture or "just doing therapy", follow this guideline: the first time the therapist explains a task, it is most likely "just therapy." If the therapist explains the task a second time, or keeps expanding on his/her original explanation, that increases the likelihood that the therapist is responding to a rupture of some kind (e.g., a sense that the patient is not agreeing with the task).

T: I'd like to spend some time trying to understand what's going on between us right now. My hope is that this type of exploration may provide us with some clues as to what may go on for you in your relationship with other people.

A patient is reluctant to complete a homework assignment that involves increasing social contact because he fears rejection. The therapist reframes the assignment as "putting yourself into the anxiety-provoking situation in order to self-monitor your cognitive processes."

T: I'd be interested in exploring it because I learn as much as you do too. It helps me understand what's happening between us.

P: I just felt like, is that an issue? Is it?
T: I guess I did see it as an issue that we could explore. Maybe you like to see me as older, maybe that is comforting to you? That's kind of where I was going with that.

T: It may be frustrating to have to carry these thought records around with you, but it may be really helpful to just have them in moments when you're so overwhelmed.

T: I do think that you are suffering from some kind of anxiety. And the only way I know to alleviate your symptoms is to figure out what's causing that anxiety. And the only way I know how to do that is to talk.

T: You see, one thing that concerns me is, uh…It's no good you doing something that you haven't really chosen to do. That's why I am trying to help you find out what your own inner choices are.

Check minus rating: If it is unclear whether the therapist is illustrating a task/providing a rationale in response to a rupture, or is simply doing therapy.

The therapist invites the patient to discuss thoughts or feelings about the therapist or some aspect of therapy

The therapist responds to a rupture by inviting the patient to express negative or vulnerable thoughts or feelings about the therapist and/or the tasks or goals of therapy. For example, the therapist may encourage a confrontational patient to expand upon his/her negative feelings about a therapy task, or the therapist may observe that a patient is quiet and withdrawn and may ask him/her to voice his/her concerns directly.

This code really involves two parts: the therapist recognizes that a rupture is occurring, and then tries to initiate some exploration of the rupture with the patient.

Do not code every time the therapist asks the patient what he/she is thinking or feeling. Just checking in to make sure the patient is still in agreement is not acknowledging and exploring a rupture. For example, do not code if the therapist is simply following CBT protocol and asking for feedback at the end of the session. Do code if the therapist is asking for feedback in the context of a rupture (e.g., "We had a challenging session today. We didn't really agree about the thought record. How are you feeling about it now?")

P: I'm feeling a little irritated, but it's not a big deal.
T: I understand that you're uncertain about how important your concerns are. But if you're willing to go into it, I'd be interested in hearing more.

T: I'd like to talk about the thoughts you are having about it, specifically, this isn't going to work…?

T: So are you feeling in general frustrated with this whole thing, the thought record?
P: Yeah *(slight smile) Minimal response and check minus content/affect split*
T: So, can you say more about that? What is frustrating about it?

T: Are you experiencing me as angry right now?

T: So did you feel that we weren't communicating with each other?

Therapists often invite thoughts/feelings by asking questions. However, they can also invite making observations that function to encourage the patient to elaborate about his/her concerns about the therapist or the therapy. For example:

T: It almost sounds like maybe you felt like you were in trouble, maybe you weren't doing things right.
P: Yeah.
T: Like I was disappointed.
P: Yeah. I was in trouble. That was the feeling.

Check minus rating: It is unclear whether or not the therapist is inviting the patient to express negative or vulnerable thoughts/feelings about the therapist and/or the therapy. The therapist may be simply acknowledging that the patient has negative thoughts or feelings, not clearly inviting and encouraging the patient to explore them. Or it may not be clear that the patient's concerns are related to the therapist and/or the therapy.

The therapist acknowledges his/her contribution to a rupture

The therapist acknowledges his/her contribution to a rupture. For example, the therapist acknowledges the ways in which he/she may be frustrating, confusing, or upsetting the patient and thereby harming their bond or hindering their work together. The therapist may acknowledge how he/she contributed to a rupture earlier in the session or in a prior session, how he/she is contributing to a rupture that is occurring right now, or the therapist may predict, based on past ruptures, that his/her next response will contribute to a new rupture.

T: I could see how this could be frustrating for you. You're asking me for a direct answer and I keep putting the ball back in your court

T: OK, I want to stay with this for a moment because it's possible maybe I was unclear, or without realizing it, gave you certain signals or messages.

T: I have to admit, in this moment, I feel a little accusatory…

T: I'm sure this will sound evasive to you.

T: You know, I've been thinking about it a lot, what happened last time, I have two thoughts about it, see what you think. One is that I need to take some responsibility for not making your environment here safe, that things got farther and more emotional and more painful, um, then they needed to be and that, um, there were some mistakes that I made.

Check minus rating: It is unclear whether or not the therapist is acknowledging his/her contribution to a rupture.

The therapist discloses his/her internal experience of the patient-therapist interaction

In the context of a rupture, the therapist discloses his/her internal experience of the patient-therapist interaction.

Do not code every time a therapist shares what he/she thinks or feels. Many therapists are in the habit of prefacing many statements with phrases like "I am wondering…" or "I feel like…" Only code when the therapist is sharing his/her thoughts or feelings about the patient-therapist interaction when the patient is confronting or withdrawing. The therapist may share his/her perception of their interaction (e.g., "I feel like we are caught in a power struggle"). The therapist may share negative feelings, like frustration or anxiety. Or the therapist may reassure an anxious patient by disclosing his/her positive feelings.

T: I'm trying to answer your question, but I get the sense that nothing I say to you will be satisfying right now. I'm concerned I will antagonize you further if I continue to try.

T: I feel like walking on ice here…

T: Yeah, so, I think just as it was difficult--You felt like I didn't understand you, I felt like, you know, every time, not every time, but sometimes when I brought certain things up and made some suggestions or maybe asked, you know like I said, presented a different point of view from the point of view that you had, oftentimes you were not really absorbing, taking in what I was saying.

T: I have to be honest with you. I'm a little angry with you. As a therapist that's not something that's comfortable to feel.

T: But I also had a feeling that there may have been a reason that you were saying, you know, so much and maybe keeping me away because if we picked at something, you were going to go to an emotional place.

P: Yeah. I was in trouble. That was the feeling. A lot of times with people I feel like I did something wrong.

T: Well I'm really glad that you were able to bring that up, that's awesome, that's total assertiveness right there. The other thing is, I'm *not* disappointed. So I just want to put that out there. I don't think you're doing a bad job or being lazy. I think you're doing a great job on homework. I feel like you're really taking this seriously.

Check minus rating: It is unclear whether or not the therapist is disclosing his/her internal experience in the context of a rupture. It may be unclear that the therapist is responding to a rupture. Or the therapist may not be clearly revealing his/her internal experience, but rather only hinting at it.

T: I'm getting the sense from you that there's a lot that you're holding onto, and it sounds like there's no way to bounce it off of anyone. *Therapist is aware that the patient is holding things in and is reluctant to share. However, the therapist does not clearly disclose her experience—she does not say, for example, "there's a lot you're holding back from me."*

Therapist links the rupture to larger interpersonal patterns between the patient and the therapist

Therapist links a rupture to larger interpersonal patterns between the patient and the therapist. With this strategy, the therapist notes how the rupture that is occurring now is similar to other ruptures that have occurred in this dyad (e.g., "I think we're doing it again").

The patient has difficulty articulating what she wants to focus on in the session, and criticizes herself for being confused and disorganized. The therapist observes how the patient often blames herself for any misunderstandings that arise between them.

In some cases, the patient is the first one to observe such a pattern. If the therapist then picks up on the patient's idea and agrees with it or elaborates on it, then you can still code this strategy, as in the example below:

P: I've never gotten that kind of feedback from someone. It makes me think about other situations. Is that maybe how I'm skewing some other interactions with people?

T: You know, it's delicate, because I'm sure you're not always skewing everything and I don't want you to not trust your instincts. Lots of times our instincts are telling us useful information. But at times when you're feeling maybe not as confident, maybe a little more delicate, you may be more likely to pull for stuff like that.

Check minus rating: It is unclear whether or not the therapist is linking a rupture to larger interpersonal patterns between the patient and therapist.

Therapist links the rupture to larger interpersonal patterns in the patient's other relationships

Therapist links a rupture to larger interpersonal patterns in the patient's other relationships. This code will encompass many—but not all—transference interpretations in a psychodynamic therapy. This code may also be appropriate for some discussions of core beliefs in CBT. The link has to be made in the context of a rupture—the link functions to draw attention to and/or invite exploration of a rupture.

The therapist can start by acknowledging a rupture and then note a parallel with an outside relationship, or the therapist can start with an observation about an outside relationship and then draw a parallel with a rupture in therapy. The patient can be the first to make the link, as long as the therapist then agrees with or expands on what the patient said.

The patient has difficulty asking the therapist for a different session time. The therapist links this to the patient's lack of assertiveness in her relationships with her family and co-workers.

T: Well, speaking of what you were just saying about the reasons why you never developed some of these important, close friendships, around this idea of being understood, it sounds like some time in the process since we last saw each other, there was this question of how much *I* understood you.

P: And that problem came up when I was in physical therapy.
T: Is it coming up here with cognitive therapy?

Check minus rating: It is unclear whether or not the therapist is linking a rupture to larger interpersonal patterns in the patient's other relationships.

Therapist validates the patient's defensive posture

Therapist responds to a rupture by validating the patient's defensive posture. The therapist allies with the resistance: instead of challenging the patient's defensive behaviors, the therapist validates the ways in which they are understandable and adaptive. This is more than just reflecting back the patient's own explanations for his/her behavior—this involves communicating that the patient's position is legitimate and valid. The therapist may validate a patient's complaints or concerns, or a therapist may validate a patient's withdrawal, as in the following example:

A patient cries in session, and then becomes self-conscious and begins to speak in a distant, intellectualized fashion. The therapist observes that the patient now seems distant from her pain, and says, "Perhaps it's adaptive for you to have some distance from it right now."

P: *(critical tone)* You also seemed like really stressed about being late, and you know, that was something you know like that just didn't, just wasn't an issue for me. And I don't know, I don't know why that bothered you so much.
T: So you observing my emotion and commenting on it is exactly what we want to be doing for one thing. And you're right about everything you said.

P: You will never understand me. I cannot express myself so it's much better to quit.
T: Actually, I appreciate your honesty, and if you want to quit of course that's your choice.

T: And let me know if you have any other questions, too, like if it doesn't make sense. I'm glad that you came in and—some people might come in and say, 'oh yeah, I like the thought record' even though they hate it.
P*:* *(smiling)* Oh, OK, oh that's not my style.
T: No, it's great! I'm very happy that, you know, you're telling me exactly how it's going and what you think because there's no point if you don't like it.

Check minus rating: It is unclear whether or not the therapist is validating the patient's defensive posture. For example, the therapist validates the patient, but it is unclear whether or not this validation is in response to a rupture.

Therapist responds to a rupture by redirecting or refocusing the patient

When the patient moves away from the tasks of therapy, e.g., by telling avoidant stories, the therapist responds to the rupture by redirecting him/her back to the task at hand, or by refocusing him/her on the present moment.

[Session began with a focus on the patient's anxiety, which was one of his presenting problems. Patient began talking at length about going to clubs to hear music. Patient is not engaging with the therapist at all and seems to be avoiding the tasks of therapy—this is a withdrawal, Avoidant storytelling.]

P: It's really hard to find a club that has consistently good music without having to pay through the nose.

T: Yeah.

P: And not having to buy a drink, which sometimes I do and sometimes I don't. It's like, if I'm going to listen to this music, I'm going to have to get a pint of beer and I'm not in the mood for a pint of beer.

T: Right.

P: I'd rather leave my system alone.

T: Yeah, OK, I hate—not to change pace too much, but I know that the last time we met, you had a lot of doctor's appointments, a lot of health concerns. Is that contributing to your anxiety right now? *(The therapist attempts to stop the patient's avoidant storytelling by redirecting the patient back to the task of therapy, discussion of his anxiety.)*

P: They were huge for me, it was like he didn't understand. The thing is, we lived two doors apart, and that was like a big mistake so there was an expectation both on his part so really what it was doing was that we lived together but at the same time there was I had to keep up my separate household. How can you do that? How do you do that? Laundry, letters, I can't do this stuff during the day, you know, going out, buying cards. I'm a woman. It takes me an hour to get ready and I'm not even high maintenance. I was looking like a slob. I have a living animal in my house, you know, that I have to take care of. I take the responsibility of a pet seriously! I made a commitment to her, and it isn't like I put her before him—In reality, of course, I do. Does he have to know that? No—but she still has to get walked and taken care of…

T: So let's check in with how you're feeling right now. What are you feeling now?

In this vignette, the therapist is not trying to expand the discussion of the patient's feelings about a rupture (which would be an example of invite thoughts/feelings). Rather, the therapist is trying to rein the patient in and bring her focus back to the present moment.

Check minus: It is unclear whether or not the therapist is redirecting/refocusing the patient in response to a rupture, or whether the therapist is simply doing therapy.

Rupture/Resolution Marker Differential Diagnosis

Below are some guidelines for deciding between two or three rupture or resolution marker codes that coders sometimes have difficulty distinguishing between.

Deferential vs. minimal response

- If the patient is just being quiet and seems withdrawn—code ***minimal response***.
- If the patient is nodding, agreeing with the therapist, and seems at least superficially engaged, trying to be a good patient—then code ***deferential***.
- If the patient is giving very brief, minimal responses *and* behaving deferentially (e.g., quiet nods, smiles), then code ***both deferential and minimal response***.

Denial vs. deferential

- If the patient denies feeling upset at the therapist, when the patient seems to actually be upset (e.g., "I'm not upset!"), code ***denial***.
- If the same patient then goes on to say that he/she has very positive feelings toward the therapist or therapy (e.g., "I'm very happy with how therapy is going"), code ***deferential***.

Avoidant storytelling vs. abstract communication

- If the patient talks about the experiences of other people—specific people—in an effort to avoid talking about him/herself, code ***avoidant storytelling***.
- If the patient talks about the experiences of people in general—people in the abstract—in an effort to avoid talking about him/herself, code ***abstract communication***.

Denial vs. reject intervention

- If the patient's response is best characterized as an attempt to move away from the therapist or the task of therapy—to avoid something painful, to avoid conflict—then code ***denial***.
- If the patient's response is best characterized as an attempt to move against the therapist—to show the therapist that he/she is wrong, to put the therapist in his/her place, to assert the patient's independence from or superiority over the therapist by saying that the therapist's idea is wrong—then code ***reject intervention***.
- If the patient seems to be doing both—simultaneously trying to avoid *and* trying to move against the therapist—then code ***both denial and reject intervention***.

Reject intervention vs. Complaint/concern therapist vs. complaint activity

- If the patient's response is focused on the therapist's intervention—the interpretation is wrong, the assessment is inaccurate, the question is the wrong question to ask—then code ***reject intervention.***
- If the patient's response is focused on the person of the therapist—the therapist is incompetent or misguided or confused or confusing—then code ***complaint/concern therapist.***

- If the patient's response is focused on a specific activity—homework, an in-session exercise such as two-chair—then code ***complaint activity***.
- Note that the patient may do all of the above in a single time segment.

Patient defends self vs. reject intervention:

- If the patient's response is focused on making a case for him/herself—I didn't do anything wrong, it's not my fault, I did the best I could—then code ***patient defends self***.
- If the patient's response is focused on criticizing or dismissing or attacking the therapist's position—your idea is wrong—then code ***reject intervention***.

Reject intervention vs. denial vs. defends self

- You said that I have a problem with depression. That is not true. ***Reject intervention***
- I am not depressed. ***Denial***
- I am dealing with a lot at work, and anybody in this situation would feel stressed. ***Patient defends self***

Self-critical vs. reject intervention vs. concern/complaint therapist

- If the patient is giving up on the therapist or the therapy because the patient feels he/she cannot be helped—I'm too depressed, too lazy, too weak—then code ***self-critical***.
- If the patient says the therapist cannot help the patient because the therapist's intervention is flawed, insufficient, irrelevant—then code ***reject intervention***.
- Help-rejecting patients who reject the therapist's suggestions AND convey a sense of hopelessness, of giving up on the therapy can present with a combination of ***BOTH self-critical and reject intervention*** (mixed codes).
- If the patient says the therapist cannot help the patient because the therapist is incompetent, inexperienced, a poor match—then code ***concern/complaint therapist***.

Mixed codes—both confrontation and withdrawal

- Ruptures can include elements of both confrontation and withdrawal, and when this occurs, both should be coded.
- As noted above, help-rejecting patients may present with both ***reject formulation*** and ***self-critical/helpless*** markers.
- Patients who are uncomfortable criticizing the therapist may present with a confrontation marker (e.g., ***complaint therapist, complaint progress***) in combination with a withdrawal marker. For example, the patient may smile or laugh nervously (***content/affect split***) while voicing a complaint, or the patient may try to soften the complaint by expressing it in an indirect or veiled way in an effort to avoid conflict with the therapist (***deferential***).

Disclose internal experience vs. acknowledge contribution

- Whenever the therapist acknowledges how he/she may be contributing to a rupture, code ***acknowledge contribution***.

- If the therapist also shares how he/she experiences the rupture with the patient—his/her thoughts and feelings about their interaction, about how they work together—then also code ***disclose internal experience.***

Invite thoughts/feelings vs. Redirect/Refocus

- If the therapist is trying to explore the patient's feelings about a rupture—to expand the discussion—then code invite ***thoughts/feelings***.
- The therapist is trying to stop a patient who is withdrawing from the task of therapy, perhaps by telling avoidant stories—to rein in the discussion—code ***redirect/refocus***.

Coding Examples

The following examples, based on actual sessions with patients in our research program, as well as excerpts from episodes of the American HBO television show *In Treatment* and from the "Gloria" session with Carl Rogers (*Three Approaches to Psychotherapy*), may be helpful for reference and for training purposes.

In Treatment, Alex, Session 1

T:	It's interesting that you compare the death of your mother with this mission that you've just flown.	
P:	That's very clever of you.	*Complaint therapist*
	But there's no relation whatsoever.	*Reject intervention*
	My mother's death was the most traumatic event of my life so far.	
	That mission was just another mission for Alex.	*Denial*

In Treatment, Alex, Session 1

T:	Maybe I didn't make myself clear earlier on, when I was talking about the customer always being wrong.	*Acknowledge contribution*
	What I meant was that sometimes the patient hides things from his therapist, from himself.	*Clarify misunderstanding*
	And so part of our job is to uncover the things that we hide.	*Illustrate task/rationale*

In Treatment, Alex, Session 1

T:	And what does [your wife] think of all this?	
P:	What's *she* got to do with it?	*Reject intervention*
T:	Don't you talk things over with your wife?	
P:	You know what?	*Topic shift*
	This is not for me. All this "what do you feel, what do you think?" I asked you something. I came to you to consult about something very clear and specific.	*Reject intervention and Complaint therapist*

Gloria with Rogers, C15

P:	I have a feeling that you are just going to sit there and let me stew in it.	*Complaint therapist*
	(laughs)	*Content/affect split*

	and I-I want more. I want you to help me get rid of my guilty feeling.	*Control/pressure*
L 9, 0-5 minutes		
T:	I thought we could focus some more on your anxiety… That's the thought I had. I don't know if there's anything in particular that you want to make sure we get to today?	
P:	(Frowning.) Yeah I don't know if it's anxiety. I noticed some thought patterns that may be problematic.	*Reject intervention*
T:	OK, great.	
P:	I don't think I have an identity confusion. I think it's just I'm in a very extreme situation that—maybe my self-esteem is not as strong.	*Patient defends self*
T:	So let's talk about that. I'm curious hearing you say that. I don't know that I have a clear idea of what I was thinking in terms of talking about identity. I'm wondering what you thought I was saying about your identity.	*Invite thoughts/feelings* *Acknowledge contribution*
P:	Well, the fact that you asked me to do the wheel [exercise] obviously implies that I don't know myself or that I'm unclear about certain things, but that's untrue. I just can't even think about such things when I'm under such stress. I was just confused by the exercise and I don't know why I needed to do it.	*Patient defends self* *Complaint activities*
T:	So you felt that the exercise was—	*Invite thoughts/feelings*
P:	Well, I felt that you thought that I'm confused about who I am. Or I'm unclear, maybe have too much of a negative self-image. Which I don't think is true. Because I do see many positives in my situation and in myself. I think a lot of it is exacerbated by the situation.	*Patient defends self*
T:	So what thoughts came up when doing the exercise?	*Invite thoughts/feelings*

[Discuss patient's thoughts around exercise.]

P:	You assumed *(tone is critical)* that I've changed very quickly from last time to this time. But I think it's normal for people to change. I'm going through a transitional period. So I have new ideas about what would help me get through this situation. It doesn't necessarily mean that I am unstable.	*Complaint therapist* *Patient defends self*
T:	OK, I want to stay with this for a moment because it's possible maybe I was unclear, or without realizing it, gave you certain signals or messages. I just want to make sure I'm clear. So when you had this idea that I said that you had changed drastically, when was that?	*Acknowledge contribution* *Invite thoughts/feelings*

L 9, 10-15 minutes

P:	You mentioned that I'm career-focused, or that there's a lot of focus on success? And that's not—maybe it comes off this way, but I'm not focused—I don't want to be this brilliant inventor or anything like that.	*Reject intervention, check minus—patient is pushing back against therapist's view of her, but is also trying to help the therapist understand her better.*
	What I mean by success is that I need to be able to support myself, like some level of independence and some level of security. That's all. And it's perceived negatively by society that for two and a half years I've been looking for a job, even though the economy's bad—people who are working, they don't think this way.	*Patient defends self, check minus—patient perceives the therapist's description of her as "career-focused" as criticism, and she is defending herself against that. However, she is doing so in a somewhat collaborative way. Her comment about the bad economy is also somewhat defensive.*
	And I think it tags onto my core feelings about myself, like oh, I'm not going to be able to handle it. I notice now when I'm applying for positions that I still have that core feeling. Which is good because I'm now aware of it, when before I wasn't. So I definitely think	*Complaint activities, check minus—Patient is expressing negative feelings about an activity, but in an honest way that is moving in the direction*

	that I'm benefiting from this. But there were a lot of negative feelings around this exercise.	*of collaboration.*
T:	Yeah, which is really important. It seems like—	
P:	Maybe it was a good exercise (nervous laugh).	*Deferential, check minus, and content/affect split, check minus—patient believes, at least partly, that the exercise had some benefits. But she is also trying to back away from her criticism in order to mend things with the therapist.*
T:	Well, speaking of what you were just saying about the reasons why you never developed some of these important, close friendships, around this idea of being understood, it sounds like some time in the process since we last saw each other, there was this question of how much *I* understood you—	*Therapist links pattern in patient's other relationships to a rupture between them.*
	—and maybe I was a bit off or giving you an exercise that didn't make a lot of sense?	*Acknowledge contribution*
P:	Yeah, right.	
T:	So what actually came out of doing this exercise?	*Invite thoughts/feelings*

L 9, 15-20

P:	That's basically intelligence. And I attacked that part. I doubted my intelligence. Like, maybe I'm just stupid because I'm having all these problems. So am I really a thinking type? Maybe I'm sensing. I don't think things through. Because I always test as thinking, but then I thought, well these tests are subjective. So maybe I don't know who I am.	*Patient is not withdrawing—she is sharing her self-critical thoughts in an open and direct way. This is not a rupture.*
T:	So what were your thoughts around that?	*Therapist is not resolving anything—he is simply following CBT protocol.*
P:	That I'm really stupid, and I don't know why I thought that. I don't think anyone has ever questioned my	*Again, patient sharing her self-critical thoughts, not*

	intelligence. I always got everything very easily in school. Why do I doubt my intelligence? Maybe it's behavior, some behaviors that aren't intelligent.	*engaging in a self-critical withdrawal.*
T:	Right, so, let's think about this, what is the evidence that you are not intelligent?	*Therapist simply doing CBT, not resolving a rupture.*

L 10, 25-35

Patient and therapist discussing patient's sense of loneliness. Patient mentions several friends and acquaintances, but for each one, provides a reason why she cannot turn to them for support.

T:	Are there other people in your life that we can get you connected with?	
P:	Um…*(long pause)*---it's hard because the friends I've made here, they're not people that I really want to open up to. They're not people I think would give good advice. It's more of an informal, social friendship than in my proper friends back home. I haven't found, you know, really good friends here yet.	*Self-critical/hopeless and reject intervention. Help-rejecting patients like this can present with this combination. Therapist keeps trying to get patient to identify someone she can talk to, and patient rejects the idea that such a person exists in her life—because she is hopeless that her situation can be improved.*
T:	I'm getting the sense from you that there's a lot that you're holding onto, and it sounds like there's no way to bounce it off of anyone.	*Therapist is obliquely noting that she senses that the patient is rejecting of all of her suggestions. The therapist is aware that a rupture is occurring, and is sharing that awareness—albeit in a somewhat indirect way—with the patient. Disclose internal experience, check minus*
P:	Yeah, I think that's right.	
T:	And it can be hard to contain all of that inside, and at the same time, though, it could be challenging to	*Validate defensive posture*

share it with a lot of people

P: (weakly) Yeah, yeah. *Patient does not sound like she really agrees with the therapist. Deferential.*

T: I think it sounds like your husband is definitely there for you, but sometimes he's really preoccupied with work and busy. I think what we can think about together is who in your life can we maybe start to talk to a bit more, you know, be able to share feelings with or concerns. *Illustrate task/rationale*

P: Yeah….I think…I think this is the problem—because the friends I do have—I just I don't know…

T: What about them makes you not want to share things with them?

P: Well, one of my closest friends, she's a good friend, but she's consumed with trying to find a boyfriend, so she's well-meaning but not the best listener. But I think my other friend, maybe I—it sounds weird—I could try to get close to her.

T: It's a process, but I think we can both agree it's nice to have that support. What I'm hearing, and you can tell me if it's different, is that there isn't so much of that right now.

P: Yeah, totally.

T: It can be challenging and can increase the feelings of sadness.

P: Yeah.

T: That's what it sounds like.

P: I think that's absolutely right, I totally agree, I 100% agree. *Deferential*

T: How often do you speak to your in-laws?

P:	My husband has been saying I should talk to them more, and they do give good advice. It's sort of a bit daunting to just launch into my problems.	*Some push back to therapist's suggestion—check minus reject intervention*
T:	Well, I don't know that you should launch into your problems necessarily but, you know, building up a closer relationship because I've heard you talk positively about them.	*Illustrate task/rationale*
P:	Yeah. My husband has been saying for months I should talk to his mom more.	
T:	It's worth trying out, to see how it makes you feel. I don't want you to misunderstand and think that I'm saying call them and just pour it out and say, this is what's going on in my life! But building up that type of—	*Clarify misunderstanding*
P:	Yeah, yeah, ok.	*Patient seems to be agreeing in order to get therapist to stop talking about this. Deferential.*
T:	Because on those days when your husband isn't around and you find yourself feeling overwhelmed and a bit down, there is someone or several people you can choose from to pick up the phone and talk to.	*Illustrate task/rationale*
P:	Yeah, yeah, ok, yeah.	*Deferential.*
T:	So does that seem—	*Not enough of an invitation to really share thoughts and feelings—more just a check-in.*
P:	Yeah, I think that's definitely something I'm going to talk to my husband about and start reaching out to people.	*Patient's tone is not convincing. Deferential.*

1326, session 5, 35-40 min

T:	That's the kind of pressure you're putting on yourself, the kind of stuff you wouldn't want your boss to do to you.	
P:	Yeah. That's true. *(Pause).* Do you think this, doing this exercise is going to actually help with that? *(skeptical tone)*	*Complaint/concern activity*
T:	It doesn't sound like you're so sure.	*Invite thoughts/feelings*
P:	Yeah, I'm not so sure.	
T:	I mean, that's the thing is that, it's about changing the way you look at things, and getting used to being able to give these alternative responses to yourself. Do I think it works? I think it works really well. Especially if you can practice and get used to it. Because at first you don't even notice these thoughts. They're going on in the background, you're going about your day, and you don't even notice. But it sounds like you noticed, when the time was slow at work, you did start thinking about those things. So you're already, like, kind of picking up on having the thoughts, right? You're able to notice the thoughts, right?	*Illustrate task/rationale*
P:	Yeah. And especially last week when you said sometimes these thoughts can start in the morning and affect your whole day, I had a really good example of that the other day…[gives example]	
T:	And imagine how much it would change your day if at the beginning of the day, you started having these thoughts and you stopped yourself. And you thought, why am I getting so overwhelmed with trying to do X, Y, or Z? And you started having alternative responses to yourself, like that soothing voice that kind of reassures you and says that today is going to be fine, you're going to be able to get through it, you always get through it, you're stronger than you think, and you're going to be OK. I would imagine that you might feel a lot better going into your day, right? And it might make every reaction that you have to people, every interaction you have with each person feel	*Illustrate task/rationale*

differently.

P:	*(Pause.)* I think you're right.	*Deferential*
T:	I mean, it's hard, but I feel very confident that this is going to help you feel differently. You're already catching on so quickly. You're already identifying these thoughts, you can already reflect back on them when you think them. And over time, not only will you be able to spot those thoughts quickly, you'll be able to have an alternative response that you can think of that's actually very convincing. Not just, 'everything's going to be ok,' and you don't really believe it, but like, not only is everything going to be ok, but I'm going to give you some evidence to remind you why everything is going to be ok.	*Illustrate task/rationale*

1326, session 15, 0-10 minutes

T:	Today's our 15th session, so we're about the middle of our treatment. So today I was interested in reflecting back on your main concerns, the things you wanted to work on when you first came in, see how things are going so far, and also planning what we're going to do moving forward. And then I'd like to hear about how the homeworks went. Does that sound good? Do you have anything else you want to add to the agenda?	
P:	*(Tight smile)*. I have a whole list of things. So much happened since last time. I wrote it down and I wanted to talk to you about it.	*Content/affect split and check minus reject intervention—patient is subtly telling the therapist "no"*
T:	OK, so we can do two things. We can either assess the midphase today, or we can put that off until next week and work mostly on this stuff if there's a lot of stuff going on.	
P:	That sounds good.	
T:	OK, so then next week we'll talk about where we've come.	*Change task/goal.*

	So how's your mood today? On a scale from 1 to 10.	
P:	Today…7.	
T:	So what's been going on?	
P:	Um, a lot happened this week. Maybe I'll just give you a list of things and see what's the thing to talk about?	
T:	Sure	
P:	So, first, I wanted *(chuckle)*, after the last session, I felt like, I don't know if that was the intention or not, but I felt like you were trying to tell me that I need to take more responsibility *(smiling).* That's the impression I left with. Maybe I wasn't doing my homework, so I wasn't taking it seriously, me coming here, and that I wasn't challenging myself. Like, I was just coming in here and it became like a routine. So I took that as, you want me to do my homework and I need to work on things and put more effort into this because I'm not here because someone made me, I'm here because I wanted to, so to get benefit out of it, I needed to be more proactive. *(laughs)*	*Content/affect split, complaint therapist—the patient is telling the therapist "You made me feel criticized."*
T:	So a couple of things. First, I'm really glad you were able to say that, because it's really hard to say that.	*Disclose internal experience, validate defensive posture*
	It almost sounds like maybe you felt like you were in trouble, maybe you weren't doing things right.	*The therapist's take on this confirms that "complaint therapist" was the right code.*
P:	Yeah.	
T:	Like I was disappointed.	*Invite thoughts/feelings—the therapist is encouraging the patient to elaborate on her complaint/concern.*
P:	Yeah. I was in trouble. That was the feeling. A lot of times with people I feel like I did something wrong.	
T:	Well I'm really glad that you were able to bring that	*Disclose internal experience*

up, that's awesome, that's total assertiveness right there. That was a perfect example. The other thing is, I'm *not* disappointed. So I just want to put that out there. I don't think you're doing a bad job or being lazy. But I think it's really interesting that you're pulling that. You know, last week, I was thinking maybe we need to switch gears and just emphasize things on that thought record sheet because it seemed to be really useful to help you organize. I think that's why I was shifting gears toward that because I was realizing also that it really helps you, but I think you're doing a great job on homework. I feel like you're really taking this seriously. So it's interesting. It could be how I came across, it could be things that you pull from situations. You put a lot of pressure on yourself. What do you think?

Acknowledge contribution

P: Well, it's good to hear you say that, because I think that I was reading into that, that you were trying to send me a message, but it was really myself. So it's really interesting. I've never gotten that kind of feedback from someone. It makes me think about other situations. Is that maybe how I'm skewing some other interactions with people?

T: You know, it's delicate, because I'm sure you're not always skewing everything and I don't want you to not trust your instincts. Lots of times our instincts are telling us useful information. But at times when you're feeling maybe not as confident, maybe a little more delicate, you may be a more likely to pull for stuff like that. It kind of fits, you know how we talked about core beliefs at one point? There are these things that you believe, deep down inside about yourself. These are messages that were sent to you over and over through your lifetime and I think that at times of ambiguity, at times when you're not sure about how to read someone, it may bring up those things. And one of those things that you have at times, that you feel about yourself at times is that you're a failure, that you're not working hard enough, right?

Link to other relationships—the patient made the link, but then the therapist picked it up.

P: Yeah.

1326, session 19, 30-35 minutes

T:	It sounds like once you can get things down on a thought record, you're able to step away from them and do some work and it's not overwhelming and taking over your day.	
P:	Yeah *(nods).* Absolutely. Yeah, I can come back to it and it's more manageable, and I can have a conversation about it. I'm happy about that *(nervous smile)*. I'm happy that I'm able to get to that point, and that I'm getting these results.	*Content/affect split and deferential—patient seems ambivalent, simultaneously pleased and concerned.*
T:	You've made so much progress. We're only on session 19 and you've come so far. It may be frustrating to have to carry these kinds of things around with you, but it may be really helpful to just have them in moments when you're so overwhelmed.	*Illustrate task/rationale*
P:	*(Nods.)* Um hmm.	*Minimal response.*
T:	Or even just write on a piece of paper. You know the format by now. *(Pause)*. Do you feel like you've come far?	*Invite thoughts/feelings*
P:	Yeah. *(sounds a little unsure)*. I think I've made some progress *(smiles)*.	*Content/affect split, deferential, and complaint progress*
T:	Just some?	*Invite thoughts/feelings*
P:	Well *(sighs)*. I feel a huge relief. I just don't want to get too, like—I feel a sense of accomplishment, I'm very happy, but I don't want to feel like, oh yeah, everything's great now, I don't have to do all this *(gestures toward thought record)*, continue to be doing this writing. It's not always a pleasant thing, it's not always easy, but it gives me such relief that I hope that I keep doing it.	*Complaint activity*
T:	It sounds like you're really on guard. You're still vigilant. You think, yeah, I feel better, but I better keep up my defenses because it's still going to be hard	*Invite thoughts/feelings*

ahead. It's still going to be really rough.

P: Well, I know it will be an effort to do this, to maintain this, but I'm saying that because things that I'm constantly up against—it's still somewhat of a struggle. I'm just hoping to get to a place where it comes easier, more naturally to me. But I am happy with the result. It's a lot of hard work that's paid off.

Patient is now sharing her true feelings with the therapist in a straightforward, collaborative way—no longer a rupture.

1325, session 5, 15-20 minutes

T: So it sounds like this article you read for homework brought up again this schema of rebelling against the good little boy mentality that you've struggled with, and that's really at the core of a lot of these thoughts that are coming up.

P: Also doing things the way people tell me to. This is the right way, this is the way to do it. Something about that makes me stop cold.

Complaint therapist, check minus—not yet clear if patient is obliquely referring to therapist.

T: And challenge, or…?

P: Stop short.

T: Stop short. OK.

P: And that came up when I was in physical therapy.

T: Is it coming up here with cognitive therapy?

Link other relationships

P: It doesn't come up. I think of it, but I hope I'm not doing it.

T: I'd like to talk about the thoughts you are having about it, specifically, this isn't going to work…?

Invite thoughts/feelings

P: I think I'm open to it, I'm open to it. I've had problems in the past due to several reasons. One, that I was married to somebody who saw herself as a saint…and I had this therapist who was really bad for me and used it, as, uh…

T: Used what—cognitive therapy?

P:	Well he, uh…a lot of the stuff in here *(points at article)* reminds me of what he said.	*Complaint activity*
T:	What about the thought distortions? Getting on to the next topic, which was the four thoughts that you had.	*Possible change task/goal—unclear if therapist is moving away from article in response to rupture, or if therapist is simply moving on to next item on the agenda.*
P:	The thought distortions, well *(chuckle),* this reminds me of another old girlfriend…	*Avoidant storytelling/shift topic*

1325, session 15, 25-30 minutes

Patient has been talking at length about going to clubs to hear music. Patient is not engaging with the therapist at all—avoidant storytelling.

P:	It's really hard to find a club that has consistently good music without having to pay through the nose.	*Avoidant storytelling/shift topic*
T:	Yeah.	
P:	And not having to buy a drink, which sometimes I do and sometimes I don't. It's like, if I'm going to listen to this music, I'm going to have to get a pint of beer and I'm not in the mood for a pint of beer.	*Avoidant storytelling/shift topic*
T:	Right.	
P:	I'd rather leave my system alone.	
T:	Yeah, OK, I hate—not to change pace too much, but I know that the last time we met, you had a lot of doctor's appointments, a lot of health concerns. Now that your hearing has improved, how are other health-related things going? Is that contributing to your anxiety right now?	*Therapist redirects patient*
P:	At least I have my hearing back but I have to get my blood pressure checked every week…	

1329, session 6, 0-5 minutes

In the prior session, there was a rupture related to thought records.

T:	Just to set an agenda, we'll do a mood check, and then talk about the homework. And I just wanted to talk more about the thought record because I don't think I explained it very well—	*Acknowledge contribution*
P:	I'm just not relating to it.	*Complaint activity*
T:	So let's spend a little bit of time later going over that. Is there anything else you want to talk about?	

1329, session 6, 15-20 minutes

T:	So I'm wondering if when you were thinking you had to go home and be with your husband, that's true, but could you think, I have to go home and be with my husband, but I'm in the process of getting divorced, this won't last forever—do you sort of replace a thought with those thoughts?	
P:	No, because the immediate situation is often so toxic, or so upsetting because of his behavior. I can't escape his behavior, and knowing that I can in the future doesn't help.	*Reject intervention*
T:	It doesn't make you feel better to think about that?	
P:	No. *(a little teary)*	*Reject intervention and minimal response*
T:	So is it upsetting to even talk about it right now?	*Invite thoughts/feelings*
P:	Sort of.	*Minimal response*
T:	So are you feeling in general frustrated with this whole thing, the thought record?	*Invite thoughts/feelings*
P:	Yeah. *(slight smile)*	*Minimal response and check minus content/affect split*
T:	So, can you say more about that? What is frustrating about it?	*Invite thoughts/feelings*

P:	I don't relate to it. It just doesn't seem the kind of thing that's useful to me, that even relates to me.	*Complaint activity*
T:	So what do you feel like doesn't relate to you?	*Invite thoughts/feelings*
P:	Well, *(looks at thought record)* distressing physical sensations, I've never had that.	
T:	OK, that doesn't need to apply.	
P:	Thoughts and images through my mind—I'm not the kind of person who thinks in images–I don't know.	
T:	OK, that's also something that can be sort of removed from this. Maybe it's easier to just cross those things out.	*Change task/goal*

1329, Session 6, 45-50

T:	So do you have any feedback on how things are going so far?	*A standard check-in—not a resolution strategy.*
P:	Well, I think it's valuable. The true value will come when I've left my husband and I'm in my own place.	
T:	It's good that you're coming in now to build a relationship, that's good planning. And so the thought record, we're going to play around with it more, but you're not loving it.	*Invite thoughts/feelings*
P:	*(Smiling)* Right.	*Complaint activity*
T:	*(Laughs)*. Which is fine. Um, so I guess for this week, don't worry about the whole thing, just the part where it says situation and thought, that's the only thing to think about. You can cross off the last three columns…. *[go over thought record]*	*Change task/goal*
	And let me know if you have any other questions, too, like if it doesn't make sense. I'm glad that you came in and—some people might come in and say, 'oh yeah, I	*Disclose internal experience*

like the thought record' even though they hate it.

P: *(smiling)* Oh, OK, oh, that's not my style.

T: No, it's great! I'm very happy that, you know, you're telling me exactly how it's going and what you think because there's no point if you don't like it. *Disclose internal experience, Validate defensive posture*

P: Exactly.

T: So that is *very* helpful for me. Um, so I think that's it. Is there any other homework that you think would be helpful?

P: No.

T: OK, so I guess we'll just stick with that. So I never even did the mood check. How are you feeling?

P: Right now, terrible *(laughing*). *Content/affect split, Complaint activity*

T: *(Laughing)* This made you feel great!

P: But when I came in, I felt good.

Citation:
Eubanks, C.F., Muran, J.C., & Safran, J.D. (2015).
Rupture Resolution Rating System (3RS): Manual.
Unpublished manuscript, Mount Sinai-Beth Israel Medical Center, New York.

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January 2015