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Therapeutic Alliance Ruptures and Resolution in

Cognitive Behaviour Therapy with

Patients with Borderline Personality Disorder

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Doctorate of Clinical Psychology

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Declaration

It is confirmed that the work contained in this thesis has not been submitted for any other degree, or to any other institution.

Report Structure

This thesis has been prepared according to guidance set out by the following journals:

Literature Review: Clinical Psychology Review

Research Report: Psychotherapy Research

Appendix A includes copies of the guidance for authors, and a letter of University approval of journal choice.

Word Counts

Section	Word Count
Literature Review excluding References	7,981
Research Report excluding References	11,994
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Abstract

This research thesis consists of three sections; a literature review, the research report, and appendices.

Literature Review: Aims: 1) to investigate, beyond recent reviews of the literature, the theoretical developments for how ruptures in the therapeutic alliance are resolved; 2) to identify whether there is empirical evidence supporting these ideas.

Research Report: Aims: 1) to investigate how therapists deal with alliance ruptures in cognitive behaviour therapy (CBT) with good outcome clients with borderline personality disorder (BPD); 2) to identify whether a CBT model of rupture resolution (Aspland, Llewelyn, Hardy, Barkham & Stiles, 2008) could be validated with BPD clients. This study focused on data collected from participants in the Sheffield Personality Disorders (SPeDi) Trial who had received CBT. A rupture and repair session for two good outcome clients (totalling four sessions) were the focus of qualitative task analysis. Systematic analysis of 41 rupture resolution attempts suggested progress toward resolution took place when therapists changed their approach to explore the salient issue for the client. The final rupture resolution model shared similarities with Aspland et al. (2008). However, additional components included the 'external observer', which encompassed bringing the client's attention back to salient issues, therapists' acknowledgement of their own limitations, and therapist emotional self-disclosure. Focus on affective experience appeared to be important for rupture resolution in BPD clients, and is suggested as a future research area. Clinical implications of results are discussed.

Appendices: Relevant documentary evidence for the study is presented and additional

data supplementing the research report provided.

Keywords: rupture resolution; therapeutic alliance; borderline personality disorder;

cognitive behaviour therapy.

Acknowledgements

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SECTION 1: Literature Review

The Resolution of Ruptures in the Therapeutic Alliance:

A Review of the Literature.

Abstract

A good therapeutic alliance is critical for treatment outcome, and therefore research on how to resolve alliance ruptures is important. The current review focused on 21 articles not included in previous reviews, and aimed to address two questions. First, beyond recent reviews of the literature, what have been the theoretical developments for how alliance ruptures are resolved? Second, is there empirical evidence supporting these ideas? The first question was discussed in relation to: acknowledgement of the rupture; use of countertransference versus interpretation; and the use of images and specific therapeutic models applied to rupture resolution. Reviewed literature included articles that applied task analysis to building models of rupture resolution. Issues related to study design, measurement, sampling and analysis were discussed. Despite methodological limitations across studies, rupture resolution models derived from a range of therapeutic orientations shared commonalities. A degree of rupture recognition, whether explicit or internally by the therapist, was advocated. Negotiation and exploration or linking with other experiences was proposed, as was identification of alternative behaviours. All models advocated for rupture resolution as a collaborative process. Recommendations for future research and implications for clinical practice are discussed.

Keywords: rupture resolution; therapeutic alliance; psychotherapeutic process; process research.

1. Introduction

1.1 The Therapeutic Alliance

The therapeutic alliance, which refers to the relationship between the therapist and client, has long been acknowledged to be the most consistent predictor of outcome in psychotherapy (Horvath & Symonds, 1991; Martin, Garkse, & Davis, 2000). The concept of the therapeutic alliance originated in the psychoanalytic literature (Freud, 1913), and described a positive transference from patient to therapist. Contemporary understandings of the therapeutic alliance emphasise a conscious and active collaboration between both parties. Most conceptualisations are based on Bordin's (1979) transtheoretical reformulation of the alliance, which highlights three interdependent components: the bond, agreement on tasks, and agreement on goals. Collaboration between therapist and client is seen as central to the therapeutic alliance. The tasks and goals of therapy vary according to the treatment approach, whilst the bond (the affective quality of the relationship between therapist and client), reflects the agreement between both parties on the nature of the tasks and goals.

1.2 Alliance Ruptures

Given that the therapeutic alliance consistently predicts outcome, it is recognised as an important variable for understanding psychotherapy process. Specifically, researchers need to identify processes involved in the development and maintenance of the therapeutic alliance (Safran, 1993a). Therapists must therefore recognise and manage negative process, or ruptures in the alliance (Binder & Strupp, 1997).

Safran and Muran (2000a) suggested the negotiation of alliance ruptures is at the heart of the therapeutic change process. Ruptures were defined as "deteriorations in the relationship between therapist and patient" that are "patient behaviours or markers indicating critical points in therapy for exploration" (Safran & Muran, 1996, p.447).

Alliance ruptures vary in frequency, severity, intensity and duration (Safran & Muran, 1996). They range from subtle miscommunications to overt misunderstandings, and may lead to premature termination of treatment (Rhodes, Hill, Thompson, & Elliott, 1994). Two major subtypes of ruptures have been identified: In confrontation ruptures, the client directly expresses anger or dissatisfaction; in withdrawal ruptures, the client emotionally or cognitively disengages from some aspect of the therapy (Harper, 1989a, 1989b; Safran, 1993a, 1993b).

Ruptures provide opportunities for collaborative exploration around exactly what was happening for the client during the rupture (Safran & Muran, 1996). In line with developmental theorists (Bowlby, 1969, 1973, 1980), our early interactions with important attachment figures lead to the development of schematic representations of self and other interactions, known as 'relational schemas' (Safran, 1998; Safran & Muran, 2000a; Safran & Segal, 1996). Alliance ruptures occur when a maladaptive relational schema is triggered (Safran, 1993a, 1993b; Young, Klosko, & Weishaar, 2003). Both client and therapist become involved in negative complementary reactions (Binder & Strupp, 1997). Safran and Muran (1996) stated, "by systematically exploring, understanding, and resolving alliance ruptures, the therapist can provide the patient with a new constructive interpersonal experience that will modify their maladaptive interpersonal schemas" (p. 447). Ruptures can provide important corrective emotional experiences (Safran & Muran, 1996), whilst resolving ruptures predicts significant symptomatic improvement, and reduces drop-out (Muran, Safran, Samstag, & Winston, 2005; Strauss et al., 2006).

1.3 A Model of Rupture Resolution

Safran and Muran (1996) employed the task-analytic paradigm (Greenberg, 1984) to examine resolution of withdrawal ruptures during integrative psychotherapy.

Task analysis is a qualitative research strategy that involves the detailed study of processes used to perform tasks; explanatory models of processes involved in task resolution are built (Greenberg & Foerster, 1996). Safran and Muran (1996) selected sessions for analysis based on fluctuations in patient and therapist ratings on the Working Alliance Inventory (Horvath & Greenberg, 1989), and developed a change process model. Three therapist interventions that facilitated resolution were identified: attending to the rupture marker, followed by either exploration of rupture experience or exploration of avoidance, and self-assertion. In their later model (Katzow & Safran, 2007; Safran & Muran, 2000a), an additional stage was added after attending to the rupture marker. This involved recognising the cognitive-interpersonal cycle evident in the relationship, and finding a way to disengage from this.

1.4 Current Review and Rationale

Safran, Muran, Samstag and Stevens (2001) provided a brief review of the empirical literature on rupture resolution. Provisional practice implications for rupture-repair were presented, which suggested that therapists be more attentive to ruptures, explore patient negative feelings about therapy, and respond to those feelings in an open, non-defensive fashion. Ackerman and Hilsenroth (2003) focused on therapist characteristics and techniques which positively impact the therapeutic alliance. Findings supported Safran et al.'s (2001) conclusions; therapist behaviours such as exploration, depth, interest, affirmation, and understanding may contribute to the development of a stronger alliance. Such qualities and techniques enable the identification or repair of alliance ruptures.

Since Safran et al.'s (2001) article, no reviews of the rupture resolution process have been conducted. The current literature review aimed to address two questions:

1. Beyond the 2001 literature review, what have been the theoretical developments for how alliance ruptures are resolved?

2. Is there empirical evidence supporting these ideas?

A literature search was conducted through OvidSP, selecting Medline (1950-2009) and PsychInfo (1985-2009) databases. Using the Advanced Search and mapping search terms to subject headings, 'psychotherapeutic processes' and 'therapeutic alliance' were exploded, and combined to identify articles. This search resulted in a total of 2089 articles. The title and abstract of each article was then reviewed according to the inclusion and exclusion criteria.

Inclusion criteria specified that each article focused on how alliance ruptures are resolved, with reference to any therapeutic model, and working with individuals with any disorder. Only articles that focused on adults, and were written in the English language in peer-reviewed journals were considered. In light of Safran et al. (2001), the current review focused on literature published since 2001, or not referenced in Safran et al. (2001). All articles that did not meet this criterion were excluded. The full texts of 17 applicable studies were retrieved. References of all applicable studies were subsequently reviewed, which yielded an additional article.

This review is structured into two parts. First, articles which using a non-experimental design with the aim of contributing towards theory development were reviewed, and evaluated (see Table 1). The first question is discussed in relation to: acknowledgement of the rupture; use of countertransference versus interpretation; and the use of images and specific therapeutic models applied to rupture resolution. In order to answer the second question, experimental studies which aimed to empirically test the theoretical ideas were reviewed, and evaluated. These included studies which aimed to build rupture resolution models (see Table 2).

Table 1. Non-Experimental Studies Contributing to Theory Development.

Study	Definition	Method/Participants	Disorder(s) Studied	Therapy; Stage and Duration	Findings and Main Conclusions
King Keenan et al. (2005).	Rupture; withdrawal and confrontation.	Ruptures related to cross-cultural issues between white therapists and clients of other ethnicities were presented. Suggestions for resolution were supported by multiple clinical case vignettes (n=9).	Depression, anxiety.	Beginning phase of Psychotherapy.	Safran & Muran's (2000b) framework of direct and indirect responses to the resolution of ruptures was applied, and seen as a useful model.
Frankel (2006).	Disjunction: blocks to progress.	Case study (n=1).	Anxiety and feelings of unrealness.	Psychoanalysis.	Disjunctions seen as inevitable. Resolution is a collaborative process; each person much recognise their contribution to resolve the analytic block, which results in unity of purpose called 'therapeutic conjunction'.
Watson & Greenberg (2000).	Rupture.	Case illustrations (n=3).	Not always specified but included depression.	Early and middle stages of Experiential Therapy.	Metacommunication & specific tasks to facilitate clients turning inwards to access inner experience. Therapist must be empathic, validating, responsive, use reflection, and encourage expression rather than continuing to implement intervention. Acknowledge own contribution. Emotional self-disclosure.

Table 1. Continued.

Study	Definition	Method/Participants	Disorder(s) Studied	Therapy; Stage and Duration	Findings and Main Conclusions
Babiak (2005).	Therapeutic impasse.	Case study (n=1).	Severe depressive illness.	Sixteen year Psychoanalytic Psychotherapy.	Analyst reaffirmed the frame and recovered own disrupted composure and reflectiveness, whilst maintaining a compassionate and caring attitude toward patient.
Ringstrom (2005).	Distinguished between enactment and impasse.	Discussion in response to Babiak (2005).			Enactments can be prevented from devolving into impenetrable impasses. Enactments viewed as an inevitable part of therapeutic process.
Strean (1999).	Impasse.	Case vignettes (n=5).	Interpersonal difficulties.	Psychoanalytic Psychotherapy.	Therapist used disclosure of countertransference to resolve therapeutic impasses. This provided a corrective emotional experience.
Newirth (2000).	Impasse.	Case examples (n=3); two from Winnicott (1971; 1977).	Narcissistic and schizoid individuals.	Psychoanalytic approach; relational model (Greenberg & Mitchell, 1983).	Resolution through corrective emotional experience; therapist helped client engage in therapeutic "play", in which transitional experience was created that challenged client's conceptions of what was real and unreal. Use of emotional self-disclosure was illustrated.

Table 1. Continued.

Study	Definition	Method/Participants	Disorder(s) Studied	Therapy; Stage and Duration	Findings and Main Conclusions
Omer (2000).	Impasse.	Case illustrations (n=3).	Varied, including drug use and interpersonal difficulties.	Unspecified.	Described "three major roads to impasse". Pluralist model for resolution; rather than exploring the rupture with the client, the therapist received help from a consultation group to develop intervention. This incorporated empathic characterisation of the client.
Arnkoff (2000).	Strains/ruptures.	Case examples (n=2).	Varied, including interpersonal problems.	Integrative cognitive therapy.	In one case, direct discussion of the therapeutic strain was useful. In the other, the author did not discuss the strain directly. The author conceptualised the stance taken drawing on attachment theory.
Nafisi & Stanley (2007).	Ruptures.	Examples from the authors' clinical cases were discussed (n=4).	Self-injuring patients.	Not specified; reference made to brief relational therapy.	Repairing ruptured alliance was identified as a method for maintaining relationship; therapist must first notice damaged alliance. Drew on Safran et al. (2005); in brief relational therapy ruptures are healed by focusing on process rather than content. Ruptures seen as an opportunity to understand patterns of interaction.

Table 1. Continued.

Study	Definition	Method/Participants	Disorder(s) Studied	Therapy; Stage and Duration	Findings and Main Conclusions
Holtforth & Castonguay (2005).	Ruptures.	The use of motivational attunement to resolve ruptures was discussed (n=0).	Unspecified; clients for whom cognitive-behavioural therapy was used.	Cognitive-behavioural therapy.	Fostering the quality of the alliance is a legitimate goal in cognitive-behavioural therapy. Motivational attunement was considered a "meta-technique". It is possible to tailor the technique used to the client's motivational goals.
Klagsburn & Brown (1984).	Therapeutic impasse.	Case illustrations (n=5).	Varied, including mood disorders.	Unspecified although the authors used the language of psychoanalytic theory.	Paper addressed the efficacy of using imagery instructions instead of verbalisations to elucidate the patient-therapist interaction in clinical practice or supervision. Saw the impasse in a new light; provided clarification.

2. Beyond the 2001 Literature Review, What Have Been the Theoretical Developments for How Alliance Ruptures are Resolved?

2.1. Acknowledgement of the Rupture vs. Non-Acknowledgement

In their experiential therapy approach, Watson and Greenberg (2000) drew on Bordin's (1979) conceptualisation of the alliance to outline interventions for working with therapeutic impasses or ruptures. Ruptures were defined as "breakdowns in the agreement between clients and therapists as to the goals and tasks of therapy" (Watson & Greenberg, pp. 175). Interventions included metacommunication, which involved therapists commenting on the therapeutic process to repair a breakdown in collaboration. This could involve clarification of the rationale of therapy, or the implementation of specific therapeutic tasks to help the client develop a better understanding of the therapeutic change process.

Watson and Greenberg (2000) stated that when the therapist perceives an alliance rupture, not only is it important to be empathic, validating and responsive, but also to acknowledge what is happening in the relationship, to use metaphor, reflection, and to encourage the client to express their concerns, rather than the therapist continuing to implement the therapeutic intervention. Acknowledgement and validation of the client's feelings was proposed to help the client attend to their subjective experience. Conditions of safety are enhanced if the client perceives the therapist as having treated their feelings as valid (Watson & Greenberg, 2000).

Watson and Greenberg (2000) encouraged therapists to inquire whether there was anything in their own behaviour that contributed to the client's feelings in-session. Therapists therefore sought to understand their own contribution to the alliance breakdown, to accept responsibility for their role and to acknowledge the client's feelings. Frankel (2006) supported the notion of the therapist accepting responsibility for their own role in the rupture. From a psychoanalytic perspective, Frankel (2006)

used the term disjunctions; "subtle blocks to therapeutic progress." (p. 56). Disjunctions were viewed as a common reality of dynamic therapy, with the process of resolution a collaborative task to acknowledge and understand the failure of interpersonal engagement. The resolution of the analytic block resulted in a unity of purpose; the 'therapeutic conjunction' (Frankel, 2006, p. 57).

From the perspective of the dynamic therapies, both these articles viewed ruptures as integral to the therapeutic change process. Both presented a clear rationale for acknowledging alliance ruptures, and utilised extracts from case studies of clients with depression and anxiety to illustrate the resolution process. In recognising the rupture, the therapist requires the ability to respond non-defensively, recognising their own mistakes. However, it is important to recognise differences between studies in rupture definition. Furthermore, whilst case studies were illustrative, the limited number and type restricted the extent to which conclusions could be generalised.

Arnkoff (2000) provided two case examples to illustrate methods for working with ruptures in integrative cognitive therapy. In contrast to psychodynamic psychotherapy, when a rupture is noticed, Arnkoff (2000) stated it is not always necessary to discuss it directly with the client. Arnkoff (2000) advocated for thinking about how the client's attachment style (Bowlby, 1969, 1973, 1980) is reflected in the alliance. In one case, the client's insecure attachment style led to a rupture when she thought the therapist was suggesting treatment termination. Therapist and client acknowledged the rupture, and worked collaboratively towards resolution, as the rupture was reflective of problems on which the client wanted to work.

In the second case the rupture was not discussed. Arnkoff (2000) discussed reactance (Brehm & Brehm, 1981) to explain this. Individuals high in reactance place high value on their personal freedom, and therefore resist attempts of others to influence them (Arnkoff, 2000). Directive techniques can evoke resistance in highly reactive

clients so although the therapist might internally acknowledge a rupture, it would not necessarily be discussed. These clients like to feel new concepts come from themselves. Arnkoff (2000) concluded that the alliance rupture should only be explicitly acknowledged when the client sees that this will facilitate them attaining their therapeutic goals.

Using a pluralistic approach, Omer (2000) suggested rather than explicitly acknowledging and exploring the rupture, the therapist receives help from a consultation group in developing a strategy. The therapist then attempts to create an empathic characterisation of the client, and a mutually endorsed therapeutic contract. Omer (2000) presented a clear, rational argument for not acknowledging the rupture, supported by clinical material, but concluded that no single resolution strategy is right in all cases.

Non-experimental literature in this area did not reach consensus. However, articles from the perspective of the dynamic therapies advocated for acknowledgement, and working through of the rupture. Other theorists argued that whether the rupture is acknowledged depends on the individual case (Arnkoff, 2000; Omer, 2000). The quality of each of these papers was good; authors presented a clear rationale for their argument, embedded in psychological theory, and included illustrative case studies. Overall, conclusions supported Omer's (2000) argument, that no single resolution strategy is right in all cases.

2.2. Use of Countertransference Reactions vs. Use of Interpretation

Newirth (2000) suggested from a psychoanalytic perspective that rather than resolving ruptures through a rational or linear attempt to understand what is happening, impasses are best resolved through corrective emotional experience. Newirth (2000) drew on Winnicott's (1971) concept of the transitional experience, and illustrated points

with case examples from narcissistic and schizoid individuals. Impasses were proposed to result from the client's inability to participate in their own experience in a subjectively meaningful way. Impasses "are not seen as a function of resistance or a lack of cooperation, but rather as an enactment of the client's experience of self as an object, which is central to the early failures in the development of self" (2000, p. 226). Treatment aimed to help the client work towards developing the subjective self. The therapist encouraged the client to engage in a therapeutic 'play' where the client related to what was happening in a more affectively engaged fashion. This challenged the client's perception of what was real and unreal (Newirth, 2000).

This psychoanalytic view focused on affective experience as a means of resolution, rather than the spoken interpretative word. The therapist's countertransference, assumed to reflect an "affective representation of a disowned part of the client's experience" (p. 227) is communicated to the therapist through 'projective identification'. When the therapist disclosed their own emotional experience in the relationship, this facilitated the client in integrating disowned parts of the subjective self (Newirth, 2000).

Newirth (2000) outlined a comprehensive viewpoint, embedded in psychoanalytic theory. Furthermore, illustrative clinical examples from a selection of complex cases were used. The idea of therapist emotional self-disclosure was supported by other articles. Watson and Greenberg (2000) stated that the therapist's appropriate self-disclosure of feelings of concern towards the client can aid resolution. Furthermore, also drawing on the psychoanalytic literature, Strean (1999) suggested that impasses are resolved through a corrective emotional experience, and advocated for disclosure of countertransference to facilitate resolution.

All articles that advocated for rupture resolution through corrective emotional experience, and proposed the use of countertransference as opposed to rational

interpretation formulated their viewpoint on a comprehensive psychoanalytic base. However, it is important to recognise that again differences existed in alliance rupture definition whilst the reliance on individual case studies to illustrate points made, made it difficult to compare conclusions across studies. Articles represented the viewpoint of authors although the nature of the case study means exceptions can always be found (Omer, 2000).

2.3. Use of Images

Klagsburn and Brown (1984) also advocated for rupture resolution through corrective emotional experience, as there are occasions when what needs to be said cannot be verbalised. Images and metaphors are said to make what is implicit explicit, and what is preconscious conscious (Pollio, Barlow, Fine, & Pollio, 1977). They can therefore be used to uncover what is happening during the therapeutic impasse. This article outlined with reference to psychoanalytic theory, the advantages of using imagery, including their use in clarification, integration, creativity, and for evoking emotion. Points were illustrated with reference to only one case vignette, and represented the authors' opinions. However, a strength of this article was that having reviewed past research on using imagery, its limitations were presented, thus providing an overall balanced viewpoint.

Newirth (2000) described a case study to illustrate the use of countertransferential fantasies, and the development of a transitional experience to resolve an impasse. Using countertransferential fantasy involved moving from an interpretive to an experiential form of expression. The client responded with his own fantasy, which facilitated resolution. This paper supported the use of imagery for rupture resolution, and provided a detailed case example to evidence points made.

However, as previously acknowledged, the nature of the case study meant the extent to which conclusions could be generalised was limited.

2.4. The Use of Specific Therapeutic Models

Babiak (2005) presented extracts from a 16 year analytic treatment of a client with a severe depressive illness. An impasse occurred when the patient requested that the analyst participate in a sexualised enactment. Resolution was demonstrated by the analyst reaffirming the therapeutic frame and maintaining a reflective stance, whilst retaining a compassionate response toward the patient. A detailed account of Babiak's (2005) work was provided, including transcripts of sessions. However, the exact definition of the impasse was unclear.

In response to Babiak (2005), Ringstrom (2005) discussed the terms impasse and enactment. Enactments were described as an inevitable aspect of therapeutic process, resulting from an interaction between the characters of both therapist and patient. Enactments provide opportunities for reflection, frequently give rise to reparative transference experiences, and have the potential to develop into impasses. Impasses were not viewed as inevitable, do not yield easily, and were described as a 'double bind' whereby therapist and client feel they are "damned if they do and damned if they don't" (Ringstrom, 2005, p. 156). Ringstrom (2005) supported the notion of maintaining the therapeutic frame as a means for resolution, although stated a series of powerful enactments, rather than an impasse were illustrated in Babiak's (2005) examples. This highlighted the lack of consensus around definition.

Other therapeutic models used to inform the rupture resolution process included Safran and Muran's (2000b) organising framework of direct and indirect techniques. King Keenan, Tsang, Bogo and George (2005) applied this model, as seen in figure 1 to rupture resolution in cross-cultural psychotherapy. Nafisi and Stanley (2007) applied

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Safran, Muran, Samstag, and Winston's (2005) brief relational therapy as a means of resolving alliance ruptures with self-injuring patients, whilst Holtforth and Castonguay (2005) discussed the application of motivational attunement to rupture resolution in cognitive behaviour therapy (CBT).

Figure 1. Safran & Muran's (2000b) Interventions to Address Ruptures in the Therapeutic Alliance.

Safran & Muran's (2000b) direct and indirect interventions have been removed.

As shown in figure 1, Safran and Muran (2000b) proposed that within both direct and indirect interventions, strategies that addressed the bond, task and goal components of the alliance were identified. This framework was based on Safran and Muran's (1996, 2000a) research programme on alliance ruptures, and included interventions such as providing a rationale for tasks within therapy, and exploring core interpersonal themes. The application of such evidence-based techniques to the discussion of rupture resolution was a strength of these articles (Holtforth & Castonguay, 2005; King et al., 2005; Nafisi & Stanley, 2007). However, what was missing was an empirical foundation regarding the application of these techniques with a specified population. Only with empirical investigation can the authors' theoretical ideas be validated. Empirical studies which empirically test theoretical ideas now become the focus of the current review.

Table 2. Summary of the Empirical Studies on Rupture Resolution.

Study	Definition	Method/Participants	Disorder(s) Studied	Therapy; Stage and Duration	Findings and Main Conclusions
Dalenberg (2004).	Patient anger that disrupts treatment alliance. Also, breakdowns in alliance as a result of countertransference reactions.	132 interview participants completed long-term trauma therapies & rated efficacy of therapists' responses	Trauma.	Trauma therapies; cognitive-behavioural, analytic, humanistic.	Greater satisfaction when therapist was emotionally disclosing after angry episode. Also, when therapist took partial responsibility for the disagreement. Satisfaction was poor when therapist was a "blank screen" in the face of anger.
Hill et al. (2003).	Hostile & suspected-unasserted anger events.	Qualitative study of 13 therapists' recollections of such events. Consensual qualitative research (CQR).	Mixture of depression, anxiety, personality disorder diagnosis.	Mixed orientation of therapists.	-Factors associated with resolution of hostile anger events: lack of problematic client behaviours; therapists turning negative feelings outwards; goal of connecting with clients; exploring anger and explaining behaviour; conceptualising anger as due to problems in the alliance rather than personality problems. -Resolution of suspected-unasserted anger: good therapeutic relationship; helping client gain insight; and exploring anger.
Dimaggio et al. (2006).	Threats to the alliance.	Exploratory Single Case; 4 audiotaped sessions analysed. Dialogical Self Theory to explore transference and influence on alliance	Narcissistic Personality traits.	Psychotherapy – psychoanalytic language.	-At the point at which the patient withdrew (rupture), stabilising of alliance was promoted by working through transference patterns. Therapist used confrontational interpretation action.

Table 2. Continued.

Study	Definition	Method/Participants	Disorder(s) Studied	Therapy; Stage and Duration	Findings and Main Conclusions
Dimaggio et al. (2006) continued					-Need early recognition of countertransference reaction to help therapist disengage from relationship patterns typical of personality disorder.
Agnew et al. (1994).	Rupture.	Single case; ARM[1]; quantitative & qualitative methods; task analysis.	Depression and anxiety.	Psychodynamic interpersonal psychotherapy.	Six stages of rupture-repair: acknowledgement; negotiation; exploration; consensus & renegotiation; enhanced exploration; new styles of testing.
Bennett et al. (2006).	Alliance-threatening transference enactments.	4 good outcome & 2 poor outcome cases; TEQ[2]; discovery oriented phases of task analysis.	Borderline Personality Disorder.	Cognitive Analytic Therapy.	- Good outcome: recognised and focused on enactment. Poor outcome: failed to notice rupture and did not adhere to model. - Nine stage model: acknowledgement; exploration; linking & exploration; negotiation; consensus; getting in touch with 'role positions'; further explanation; development of 'exits' or aims; closure.
Aspland et al. (2008).	Rupture.	2 good outcome cases: 2 sessions each; ARM; task analysis.	Depression.	Cognitive-Behaviour Therapy.	-Seven stages of rupture resolution: internal rupture recognition; addressing empathic failure; restoring collaborative relationship; linking; revising approach; negotiation; pursuit of revised task.

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[1] Agnew Relationship Measure.
[2] Therapy Experience Questionnaire.

3. Is There Empirical Evidence Supporting These Ideas?

3.1. Acknowledgement of the Rupture vs. Non-Acknowledgement

Hill et al. (2003) hypothesised that client anger toward therapists threatens the alliance. Thirteen therapists across a range of theoretical models, who had volunteered to provide recollections of 12 hostile and 13 suspected-unasserted client anger events, were interviewed. Client diagnoses included anxiety, depression and personality disorder. The trigger for all anger events was a disliked therapist action or inaction. Consensual qualitative research (Hill, Thompson & Williams, 1997) was used to analyse interview data. Hostile anger events were resolved most often when therapist intervention went beyond just acknowledging the anger, to talking about it and providing explanation of the behaviours. Furthermore, conceptualising the anger as due to problems in the alliance, rather than client personality problems was associated with the resolution of hostile anger events. This suggested that the therapist exploring their own role in the rupture and taking responsibility for this is, as a means of resolution. Factors associated with resolution in suspected-unasserted anger included therapists helping clients to gain insight and explore the anger.

A limitation of this research included that data was collected only from therapists, and therefore could not generalise to client perceptions of anger events. Data was based on therapist recollections so there was no objective record of anger events as they occurred. Furthermore, there may have been some bias regarding therapists who volunteered to participate as these therapists may have felt more comfortable with client anger. This influenced the extent to which conclusions could be generalised.

3.2. Use of Countertransference Reactions vs. Use of Interpretation

Hill et al. (2003) found that resolution of hostile anger events included therapists turning negative feelings outward, not inward. In practice, this looked like feeling

annoyed and frustrated with the client instead of anxious or incompetent. Results suggested a degree of therapist emotional self-disclosure might be beneficial for resolution.

Dalenberg (2004) researched the management of anger when working with trauma survivors. Traumatised patients often have high levels of anger which tend to hinder treatment both from cognitive-behavioural and psychodynamic perspectives (Foa & Roathbaum, 1997; Strupp, 1977). Dalenberg (2004) focused on reports of 132 interview participants who had completed long-term trauma therapies within cognitive-behavioural, analytic and humanistic models. Participants were asked to complete several questions, which included asking patients to classify their therapist as disclosing or non-disclosing, and to rate the efficacy of the therapist's response to anger. Overall, patients reported greater satisfaction with therapists who were emotionally disclosing after angry episodes, and took partial responsibility for therapeutic disagreements. Satisfaction was poor if therapists were "blank screens" (p. 438), thus supporting the idea that therapists must be responsive to patients' feelings when faced with a rupture.

The finding that patients reported greater satisfaction with therapists who were emotionally disclosing following angry episodes supported the use of countertransference for rupture resolution. However, it is important to outline that patients were asked to rate therapists as generally emotionally disclosing or not. This question was vague and subjective, and therefore somewhat unreliable. Also, whilst the study focused on clients' reports, instead of relying on therapist self-report, both measures were likely to have been influenced by distorted recollection of events, and may not have been a reliable account of what actually happened.

With regards to using interpretation, Dimaggio et al. (2006) focused on clients with narcissistic personality traits. The hypothesis that alliance threats emerge from patients' maladaptive patterns of behaviour and from therapists being affected by these

patterns was explored. Transcripts from the first four sessions of psychotherapy were qualitatively analysed; dialogical relationship patterns were examined through identification of narrative episodes (Semerari et al., 2003). When the patient withdrew from the relationship, stabilising the alliance was promoted by working through transference patterns. The therapist took confrontational interpretation action, which although momentarily broke the alliance, had an overall positive effect as the client recognised the therapist taking an accepting position (Dimaggio et al., 2006). However, this study focused only on withdrawal ruptures, and it is likely that resolution strategies vary depending on the individual case.

3.3 Empirical Models of Rupture Resolution

Theoretical ideas regarding rupture resolution were further tested through experimental research which focused on building models to aid this process. Such research recognised the issue of acknowledgement. Agnew, Harper, Shapiro and Barkham (1994) combined quantitative and qualitative methods to identify change processes in rupture resolution in a good outcome case in psychodynamic interpersonal therapy for depression. Data on core battery outcome measures were used to select a case which met criteria for reliable and clinically significant change (Jacobson & Traux, 1991). The Agnew Relationship Measure (ARM: Agnew & Shapiro, 1989), completed at the end of each session by client and therapist, was used to identify sessions with markers of challenges and their resolution. Task analysis (Greenberg, 1992) was then applied to session transcripts to build a rational-empirical model of successful resolution. The final model identified six stages of rupture-repair, illustrated in figure 2.

Figure 2. Rational-Empirical Model of Rupture Resolution (Agnew et al., 1994).

Agnew et al.'s (1994) Rational-Empirical Model has been removed.

Acknowledgement of the rupture was the first stage of resolution. Focusing on psychodynamic interpersonal therapy, results of this empirical research were consistent with conclusions of the aforementioned non-experimental studies in this area (Frankel, 2006; Watson & Greenberg, 2000), and suggestions of Hill et al. (2003), which were based on empirical investigation.

Bennett, Parry and Ryle (2006) employed task analysis to explore the resolution of alliance threats in cognitive analytic therapy (CAT; Ryle & Kerr, 2002), with clients with borderline personality disorder (BPD). This study focused on 107 enactments from 66 sessions in four good outcome cases compared with 35 enactments from 16 sessions in two poor outcome cases. As seen in table 2, rupture resolution stages included acknowledgement of the rupture, and shared similarities with Agnew et al.'s (1994) findings; negotiation; exploration; consensus; and seeking to identify alternative ways of responding. Bennett et al. (2006) found that in good outcome cases, therapists recognised and focused on the enactment, whilst in poor outcome cases therapists failed to notice the rupture, and did not adhere to the model.

Similarities between models are shared with findings of Aspland, Llewelyn, Hardy, Barkham and Stiles (2008). This model related to two good outcome cases in CBT for depression. However, in contrast to Safran and Muran (1996), Aspland et al.'s (2008) revised model did not include overt recognition or discussion of the rupture. Reasons for this were discussed including that recognition may have occurred silently in the therapist's own understanding of the case. Furthermore, the predominance of withdrawal, and therefore predominantly covert ruptures, might help to explain the lack of explicit discussion (Aspland et al., 2008).

Findings from studies that built rupture resolution models through application of task analysis (Greenberg, 1984, 1992, 2007) were not entirely consistent. However, results did advocate for a degree of acknowledgement, whether explicit or internally by the therapist. Exploration of ruptures was advocated across interpersonal psychodynamic therapy, CAT, and CBT (Agnew et al., 1994; Bennett et al., 2006; Aspland et al., 2008, respectively). However, each study had strengths and weaknesses whilst methodological differences made comparison of results difficult. Such issues are discussed here with reference to study design, measurement, sampling and analysis.

3.3.1. Study Design

Agnew et al. (1994) employed a single case methodology to build a rupture resolution model. Single case research designs are highly suited to illustrate the clinical utility of therapeutic methods (Kazdin, 1982). However, it was debatable whether results could be generalised to a wider population. The study needs to be extended to focus on more cases and those with less successful outcome, in order to validate the model. As acknowledged by Agnew et al. (1994), a single-case study is insufficient to demonstrate that events described within selected sessions caused the positive outcome

for the case. Results are useful for theory development, but need to be replicated through further research.

Aspland et al., (2008) and Bennett et al., (2006) included a larger number of cases, and focused on good and poor outcome cases. Differences in therapeutic modality, types of cases studied, and the different focus on good and poor outcome made comparisons between studies difficult but increased generalisability of findings. Bennett et al. (2006) recognised that BPD patients experience greater difficulty than most in maintaining a therapeutic alliance (Waldinger & Gunderson, 1984). This client group might therefore be an area of study in itself, for which specific rupture resolution models are developed and tested.

Finally, as previously identified, there was debate and inconsistency across the literature, including different therapeutic orientations of therapists as to how alliance ruptures are defined (Ringstrom, 2005). Bennett et al. (2006) described 'enactments', which in contrast to an alliance rupture is based on the concept of a reciprocal role enactment, whereby the therapist plays an active role and constitutes an alliance threat. Enactments were viewed as "re-enactments of dysfunctional interpersonal patterns" (p. 397), an inevitable part of therapy (Ringstrom, 2005). Aspland et al. (2008) based their rupture definition on Safran and Muran's (1996) work; "patient behaviours or communications that are interpersonal markers indicating critical points in therapy for exploration" (Safran & Muran, 1996, p. 447). The authors looked for rupture markers of confrontation, withdrawal or over-compliance in identified sessions using Harper's (1994) coding system. Differences in definition across the literature had implications for the identification and measurement of ruptures.

3.3.2. Measurement

A strength of studies which aimed to build empirical rupture resolution models was the use of quantitative measures to identify ruptures. For example, Aspland et al. (2008) selected events for analysis when the client's ARM (Agnew-Davies, Stiles, Hardy, Barkham & Shapiro, 1998) scores contained rupture-repair sequences as identified by Stiles et al. (2004). This method recommended that a rupture occurred when the client's mean score dropped two standard deviations below the value predicted from a regression curve fitted to the data. Such quantitative criterion removed subjectivity from the identification of ruptures, thus improving the extent to which results could be generalised, and the methodology of the study replicated (Agnew et al., 1994).

Whilst two studies utilised ARM scores to identify rupture-repair sessions for analysis (Agnew at al., 1994; Aspland et al., 2008), the other study (Bennett et al., 2006) utilised scores on the Therapy Experience Questionnaire (TEQ), a self-report measure, which focused on the client's experience of the alliance. The TEQ is sensitive to alliance changes over the course of therapy (Ryle, 1995), whilst evidence of the internal consistency and validity of the ARM has been reported (Agnew-Davies et al., 1998; Stiles et al., 2002). However, such methodological differences between studies made comparison of results problematic.

Agnew et al. (1994) looked for markers of confrontation challenges in identified sessions, employing coders trained in the use of Harper's (1994) coding manual. Aspland et al. (2008) used confrontation, withdrawal and over-compliance as rupture markers (Harper, 1994; Safran & Muran, 2000a), consensually identified by two of the authors. In contrast, Bennett et al. (2006) asked judges to identify enactments using Ryle's (1992) coding method. Although methodological differences made comparison between results difficult, the use of coders trained in the identification of ruptures was

considered a strength of these studies; this ensured as much as possible the objective identification of events for analysis.

3.3.3. Sampling

Empirical studies have focused variously on clients with symptoms of depression and anxiety (Agnew et al., 1994; Aspland et al., 2008) and BPD (Bennett et al., 2006). As previously mentioned, due to the nature of the BPD client's difficulties, it is suggested that it might be necessary for specific rupture resolution models to be applied to this client group. Furthermore, the generalisability of each model across client type and therapeutic modality needs further empirical investigation.

A strength of these studies was that cases were selected on the basis of results of validated outcome measures. Aspland et al. (2008) chose clients because they experienced good outcomes as defined by changes on the Beck Depression Inventory (BDI: Beck, Ward, Mendelson, Mock & Erbaugh, 1961). Agnew et al. (1994) employed the Symptom Checklist-90R (SCL-90R: Derogatis, 1983) and the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureno & Villasenor, 1988), whilst Bennett et al. (2006) utilised the BDI, SCLR-90R (Derogatis, Lipman, & Covi, 1973), and the IIP (Horowitz et al., 1988). Despite differences in measures used, good and poor outcome cases were defined on the basis of whether they met criteria for statistically reliable and clinically significant change (Jacobson & Truax, 1991), and who were representative of a clinical population.

3.3.4. Analysis

Studies which aimed to build rupture resolution models employed complementary methodologies (Horowitz, 1982) as a means of identifying and describing key change processes. As recognised by Agnew et al. (1994), combining

quantitative and qualitative methods, in line with methodological pluralism in psychotherapy research (Shapiro, 1990), is a systematic and replicable research strategy. Confidence in qualitative data can be increased as cases for analysis were selected on quantitative grounds.

Task analysis (Greenberg, 2007), a tool for capturing moment-by-moment events in psychotherapy, was considered an appropriate analytic strategy for researching the rupture resolution process. However, it is unlikely, due to the focus on a limited number and type of cases, that all manner of rupture resolution strategies were sampled. Rupture-repair may take other forms in other dyads across other therapies. Another limitation of these studies was the focus on good and/or poor outcome cases. For example, by focusing on two cases, both of which had successful outcomes, Aspland et al. (2008) noted that comparisons with rupture-repair sequences in poor outcome cases were not achieved. Further research which validates specific models, through comparison with such cases would be useful. Furthermore, the results of these studies represented only initial attempts at building rupture resolution models, employing various phases of the task analytic process. Refinements based on further cases would increase confidence in the model. Similarly, testing the models in other clinical samples, to check which stages of the model could be reliably identified would be helpful (Safran, Greenberg & Rice, 1988).

Despite the aforementioned limitations, proposed models derived within CBT (Aspland et al., 2008), psychodynamic psychotherapy (Agnew et al., 1994), CAT (Bennett et al., 2006) and integrative therapy (Safran & Muran, 1996) did appear to share common aspects of rupture-repair. A degree of rupture recognition was advocated, whether through explicit discussion or internal acknowledgement on the part of the therapist, whilst exploration or linking with other experiences was also proposed. Furthermore, across all studies, results were presented with reference to extracts from

transcripts to illustrate conclusions drawn. Authors acknowledged the reflexive nature of the task-analytic process, and attempted to increase validity by ensuring consensus between external coders (Agnew et al., 1994; Bennett et al., 2006) and authors (Aspland et al., 2008) when ruptures were identified.

4. Summary and Conclusions

Safran and Muran (2000b) noted the diversity of approaches for resolving alliance ruptures within and between orientations. Focusing on articles published since 2001, or not included in Safran et al. (2001), this review aimed to address two research questions. First, beyond the 2001 literature review, what have been the theoretical developments for how alliance ruptures are resolved? Second, is there empirical evidence supporting these ideas?

Within the non-experimental literature there were differing viewpoints across different therapeutic orientations regarding acknowledgement of the rupture. From the perspective of the dynamic therapies, ruptures were viewed as integral to the therapeutic change process and acknowledgement advocated (Frankel, 2006; Watson & Greenberg, 2000). Rather than continuing to implement therapeutic techniques, therapists should encourage the client to express their negative feelings about the therapy, and the therapist should respond non-defensively. Furthermore, when reflecting on what is happening at the time of the rupture, therapists inquiring about their own contribution to the rupture and accepting responsibility for this was regarded as facilitating resolution (Frankel, 2006; Watson & Greenberg, 2000).

In contrast, Arnkoff (2000) described from a cognitive-behavioural perspective that acknowledgment was not always seen as appropriate. Explicitly acknowledging the strain in alliance was advocated only when the client could see that this would

contribute to them reaching their therapeutic goals. It was suggested that no single resolution strategy is right in all cases (Omer, 2000).

Experimental research provided support for rupture acknowledgement and exploration, for the therapist exploring their own role in the rupture and taking responsibility for this (Hill et al., 2003). However, in contrast to those articles that suggested seeking to understand what was happening during the rupture through a rational and linear attempt of acknowledgement and exploration, within non-experimental research, some psychoanalytic theorists suggested ruptures are resolved through corrective emotional experience (Newirth, 2000). Using countertransference and emotional self-disclosure on the part of the therapist was suggested (Newirth, 2000; Strean, 1999; Watson & Greenberg, 2000), and supported by experimental research in this area (Hill et al., 2003; Dalenberg, 2004).

Experimental research provided support for using confrontational interpretation (Dimaggio et al., 2006). Non-experimental research suggested the use of images and countertransferential fantasies in therapy to help the client engage in a more affective experience towards resolution (Klagsburn & Brown, 1984; Newirth, 2000). However, insufficient empirical investigation in this area meant such suggestions were unsubstantiated. Similarly, therapeutic models used to inform the rupture resolution process included Safran and Muran's (2000b) organising framework of direct and indirect techniques for rupture-repair (King Keenan et al., 2005), application of Safran et al.'s (2005) brief relational therapy (Nafisi & Stanley, 2007), and the use of motivational attunement in CBT (Holtforth & Castonguay, 2005). Empirical research into the application of such models for rupture resolution is still needed.

Proposed rupture resolution models derived within CBT (Aspland et al., 2008), psychodynamic psychotherapy (Agnew et al., 1994), CAT (Bennett et al., 2006) and integrative therapy (Safran & Muran, 1996) shared some common aspects. A degree of

rupture recognition was advocated, whether through explicit discussion or internal acknowledgement on the part of the therapist. Negotiation and exploration or linking with other experiences was proposed, as was identification of alternative behaviours. Consistent with Safran and Muran (1996), models advocated for rupture resolution as a collaborative process.

5. Recommendations for Future Research

As those studies which aimed to build rupture resolution models focused on a limited number of cases, these models need to be refined and validated based on analysis of further cases. This will increase confidence in the models and the extent to which results can be generalised to a wider population. Furthermore, as recognised by Aspland et al. (2008), future research might involve operationalising stages of the models and testing them against other clinical samples. A model of successful rupture resolution needs to be validated against both good and poor outcome cases within specific therapeutic modalities, and at specified stages of therapy.

Future research requires a clear definition and operationalisation of the types of ruptures studied. Furthermore, building more comprehensive theoretical models of rupture resolution for working with specific client groups would be a useful clinical tool. Individuals with BPD demonstrate a pervasive pattern of unstable and intense interpersonal relationships (DSM-IV-TR; APA, 2000). Such clients experience greater difficulty than most in forming and maintaining a therapeutic alliance (Waldinger & Gunderson, 1984). As previously noted, this client group might be an area of study in itself to which specific rupture resolution models be applied. This could be addressed in future research. For example, Bennett et al. (2006) studied how therapists resolve alliance threats with clients with BPD in CAT. However, the resolution of ruptures in the alliance in CBT with such clients has never been studied. Future research might

validate and extend the model proposed by Aspland et al. (2008) model, through verification with BPD clients.

As noted by Safran et al. (2001), research on the relevance of rupture resolution for therapeutic outcome is a developing literature. Addressing and resolving ruptures has been shown to predict significant symptomatic improvement and reduce drop-out (Muran et al., 2005; Strauss et al., 2006). Future research might focus on testing rupture resolution models experimentally, considering what psychological processes within the client allow progression through specific stages of the model, and identifying the implications of rupture resolution for outcome (Safran & Muran, 2000b).

6. Implications for Clinical Practice

As previously noted, as the therapeutic alliance has consistently been shown to predict treatment outcome, it is important that therapists recognise and manage alliance ruptures (Binder & Strupp, 1997). Safran and Muran (2000a) stated that negotiation of alliance ruptures is at the heart of the process of psychotherapeutic change. Failure to recognise markers of ruptures may result in the therapist unknowingly perpetuating the client's distress and not addressing significant interpersonal issues, which in turn might maintain a cycle in which the rupture remains unresolved (Ackerman & Hilsenroth, 2003; Binder & Strupp, 1997).

Safran et al. (2001) concluded that therapists need to be attentive to ruptures, explore patient negative feelings about therapy, and respond to those feelings in an open and non-defensive fashion. Overall, such conclusions were supported by the current review. Ruptures need to be acknowledged, either explicitly or in the mind of the therapist. Instead of continuing to implement therapeutic techniques, clients need to be encouraged to express their negative feelings, and when reflecting on what is happening during the rupture, therapists need to inquire about their own role in this and accept

responsibility (Frankel, 2006; Hill et al., 2003; Watson & Greenberg, 2000). Furthermore, conceptualising the process of rupture resolution as a corrective emotional experience, the use of countertransference and emotional self-disclosure was highlighted (Dalenberg, 2004; Hill et al., 2003; Newirth, 2000; Strean, 1999; Watson & Greenberg, 2000).

This review also has implications for training and supervision. Competence in the task of resolving alliance threats and ruptures is key to helping clients toward successful therapeutic outcome. Models of rupture resolution might inform supervision and training on the management of psychotherapeutic process, particularly in notoriously more difficult to engage clients including individuals with BPD.

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SECTION 2: Research Report

Therapeutic Alliance Ruptures and Resolution in

Cognitive Behaviour Therapy with

Patients with Borderline Personality Disorder.

Abstract

Qualitative task analysis methods were used to investigate the process of rupture resolution in cognitive behaviour therapy (CBT) with good outcome clients with borderline personality disorder (BPD). This study investigated whether a CBT model of rupture resolution (Aspland, Llewelyn, Hardy, Barkham & Stiles, 2008) could be validated with BPD clients. Quantitative analyses identified rupture-repair sequences. Audiotapes of a rupture and repair session for two good outcome BPD clients were transcribed (totalling four sessions). Systematic analysis of 41 rupture resolution attempts suggested progress toward resolution took place when the therapist changed their approach to explore the salient issue for the client, and acknowledged the client's emotions. The final rupture resolution model, developed through an iterative model-building procedure, shared similarities with Aspland et al. (2008). However, additional components included 'external observer', which encompassed bringing the client's attention back to salient issues, therapists' acknowledgement of their own limitations, and therapist emotional self-disclosure. Focus on affective experience appeared to be important for rupture resolution in BPD clients, and is suggested as an area for future research. Clinical implications for the identification and management of alliance ruptures with BPD clients are discussed.

Introduction

Psychotherapy Process Research

Psychotherapy process research focuses on interactions between clients and therapists to identify processes of change, test theoretical ideas, and develop treatment models (Toukmanian & Rennie, 1992). Such research can be applied to specific therapeutic dilemmas. For example, when faced with negative process or a rupture in the therapeutic alliance, process research can address the question as to how this should be managed, and the alliance repaired (Katzow & Safran, 2007).

Alliance Ruptures

The therapeutic alliance is the relationship between therapist and client and has long been evidenced to be most consistent predictor of therapeutic outcome, irrespective of treatment model (Horvath & Symonds, 1991; Martin, Garkse, & Davis, 2000). A positive alliance is therefore central to facilitating therapeutic change processes (Safran & Muran, 2000a). In fact, contemporary cognitive behaviour therapy (CBT) conceptualises the alliance as an integral aspect of treatment, used in combination with therapeutic techniques to promote recovery (Leahy, 1993; Safran & Segal, 1996; Young, Klosko & Weishaar, 2003).

Safran and Muran (1996) defined ruptures as "deteriorations in the relationship between therapist and patient." (p. 447). Ruptures have been conceptualised in various ways: strains (Bordin, 1994); impasses (Elkind, 1992); resistance (Leahy, 1993); and weakening and repairs (Lansford, 1986). Two rupture subtypes have been identified: confrontation ruptures, in which clients directly express anger or dissatisfaction; and withdrawal ruptures, in which clients emotionally or cognitively withdraw (Harper, 1989a, 1989b; Safran, 1993a, 1993b).

Ruptures are "patient behaviours or communications that are interpersonal markers indicating critical points in therapy for exploration" (Safran & Muran, 1996, p. 447). Early childhood experiences result in schematic representations of self and other interactions known as 'relational schemas' (Bowlby, 1969, 1973, 1980; Safran, 1998; Safran & Muran, 2000a; Safran & Segal, 1996). Alliance ruptures often occur when a maladaptive 'relational' schema is triggered, due to an interactive process between therapist and client (Safran, 1993a, 1993b; Young et al., 2003). Ruptures provide opportunities for exploring and clarifying the client's patterns of relating across relationships (Safran & Segal, 1996). The occurrence of mainly confrontation ruptures has been shown to be associated with the emergence of schematic 'core conflictual relational themes' (Sommerfield, Orbach, Zim & Mikulincer, 2008).

Resolution of alliance ruptures can provide important corrective emotional experiences. Safran and Muran (1996) stated, "by systematically exploring, understanding, and resolving alliance ruptures, the therapist can provide the patients with a new constructive interpersonal experience that will modify their maladaptive interpersonal schemas" (p. 447). Psychoanalytic research emphasises affective experience as a means of resolution. For example, the therapist may facilitate rupture resolution through emotional self-disclosure (Strean, 1999; Watson & Greenberg, 2000). The therapist's countertransference, assumed to reflect an "affective representation of a disowned part of the client's experience" (Newirth, p. 227) is communicated to the therapist through 'projective identification'. When the therapist discloses their own emotional experience, this facilitates the client in integrating disowned parts of the subjective self (Newirth, 2000).

In CBT, it is recognised that alliance ruptures may threaten the client's therapeutic progress, but may also offer opportunities for therapeutic gains (Aspland, Llewelyn, Hardy, Barkham & Stiles, 2008; Leiper, 2000; Waddington, 2002).

Castonguay, Goldfried, Wiser, Raue and Hughes (1996) found ruptures in CBT occurred when therapists responded by continuing to apply therapeutic technique, rather than exploring the client's emotional experience. Furthermore, attending to the rupture had a positive impact on outcome.

Data drawn from a clinical trial of brief psychotherapies for depression identified that clients who experienced rupture-repair sequences made greater treatment gains than other clients (Stiles et al., 2004). However, unsuccessful rupture resolution can lead to premature treatment termination (Rhodes, Hill, Thompson & Elliott, 1994). Therapists must therefore be competent in recognising and managing alliance ruptures (Binder & Strupp, 1997; Safran, 1993a).

The Study of Rupture Resolution: Task Analysis

Greenberg (1984) developed the use of task analysis; a qualitative process research strategy, which involves the detailed study of processes individuals use to perform tasks. It aims to understand the process of task solution, and build explanatory models of resolution processes (Greenberg & Foerster, 1996).

Greenberg and Foerster (1996) described the process of task analysis of therapeutic change. First, a specific problem-solving task such as the resolution of therapeutic conflict (Greenberg, 1984), is selected for study. Second, in-session markers of the problem are described, and measures of these and therapist interventions believed to facilitate task resolution constructed. Third, a **rational task analysis** in which a rationally derived range of possible strategies to solve the problem is proposed; this "thought experiment" (Greenberg & Foerster, 1996, p. 439) highlights ways in which the problem might be solved.

Fourth, an empirical study of actual problem-solving, the **empirical task analysis** is carried out. Progressively correcting the rational model using empirical data

to form a **rational-empirical model** leads to a model of strategies used to solve the problem. This can be tested and refined by comparing successful and unsuccessful resolutions of problems, and relating specific types of task performances to therapeutic outcome (Greenberg & Foerster, 1996).

A Model of Rupture Resolution

Safran and Muran's (1996) seminal work on rupture resolution employed the task-analytic paradigm (Greenberg, 1984), to examine resolution of withdrawal ruptures during integrative psychotherapy. Sessions were selected for analysis based on patient and therapist ratings on the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989). A change process model of rupture resolution was developed and evaluated, which identified three therapist interventions for resolution: attending to the rupture marker, followed by exploration of the rupture experience or exploration of avoidance, and self-assertion. An additional stage was added to their later model (Katzow & Safran, 2007; Safran & Muran, 2000b) after attending to the rupture marker; the therapist identified the cognitive-interpersonal cycle evident with the patient, to disengage from this relational pattern.

A CBT Model of Rupture Resolution

Aspland et al. (2008) applied task analysis (Greenberg, 1984; Greenberg & Foerster, 1996) to construct a rupture resolution model in two good outcome cases in CBT for depression. Two sessions per client were selected for analysis; the rupture session, indicated by a drop in the client's score on the Agnew Relationship Measure (ARM: Agnew-Davies, Stiles, Hardy, Barkham & Shapiro, 1998), and the repair session, when the ARM score recovered. A rational rupture-repair model, based on consultation with CBT experts was built and subsequently refined based on empirical

data from the two cases. Stages of the final model and conclusions made are listed in figure 1. In support of Castonguay et al. (1996), ruptures arose from inattention to salient issues for the client, and persisting with therapeutic technique.

Figure 1: CBT Model of Rupture Resolution (Aspland et al., 2008).

Rupture Resolution Stages:
- Internal Rupture Recognition
- Change in Approach to Address Empathic Failure – Exploration of Client's Experience
- Restoring Collaborative Relationship
- Linking Patterns of Interaction to Formulation
- Revising Approach Accordingly
- Negotiation of New/Revised Task
- Collaborative Pursuit of Task

- Ruptures arose from:
  - unvoiced disagreements about the tasks and goals of therapy, which negatively affected the alliance.
  - therapists initially appearing inattentive to the client's experience or to the significance of an issue for them.

- Ruptures occurred in clients seeking to avoid tasks or becoming unresponsive to therapist intervention.

- Resolution was facilitated only by therapists changing their behaviour to focus on salient issues for the client.

- Being more collaborative avoided perpetuating the rupture.

- Results supported the suggestion that ruptures arise from therapists persisting with therapeutic technique, irrespective of client concern.

- Consistent with Safran & Muran's (1996) model; results suggested rupture-repair can be affected if the recurrence of repetitive relational patterns are addressed.

- In contrast to Safran & Muran's (1996) model, the final model did not include overt recognition or discussion of the rupture.

- Summarising, exploring and validating facilitated rupture resolution.

- A concentration on task rather than process perpetuated the rupture.

Borderline Personality Disorder

People with borderline personality disorder (BPD) demonstrate a pervasive pattern of unstable and intense interpersonal relationships (DSM-IV-TR; APA, 2000). Such clients therefore experience greater difficulty than most forming and maintaining a therapeutic alliance (Waldinger & Gunderson, 1984). Alliance ruptures can prevent progress and, if unresolved can lead to premature treatment termination (Rhodes et al., 1994). Whilst between 42% and 67% of BPD patients drop out of treatment prematurely (Gunderson et al., 1989; Skodol, Buckley & Charles, 1990), many cognitive-behavioural approaches now explicitly explore the client's experience of schema activation during therapy (Safran & Segal, 1996; Young et al., 2003). Resolving ruptures in cognitive therapy for BPD predicts significant symptomatic improvement, and reduces drop-out (Muran, Safran, Samstag & Winston, 2005; Strauss et al., 2006). However, failure to recognise ruptures may result in an increase in client distress, and continuation of problematic interpersonal procedures (Ackerman & Hilsenroth, 2001; Binder & Strupp, 1997).

A Rupture Resolution Model for Clients with BPD

Bennett, Parry and Ryle (2006) applied task analysis (Greenberg, 1984; Greenberg & Foerster, 1996) to successful rupture resolution with BPD clients during cognitive analytic therapy (CAT; Ryle & Kerr, 2002). Task analysis of 107 enactments in four good outcome cases were compared with 35 enactments in two poor outcome cases. This compared a rational process model with empirically coded transcripts of therapy sessions. The refined rupture resolution model broadly comprised stages of: acknowledgement; exploration; linking and explanation; negotiation; consensus; getting in touch with 'role positions'; further explanation and development of 'exits' or aims;

and closure. As therapist and client progressed through differing levels of understanding, the model was not linear (Bennett et al., 2006).

In contrast to poor outcome cases, therapists in good outcome cases recognised the majority of enactments and focused attention to them, whilst adhering to the model. Successful resolution involved facilitating the client to process previously avoided feelings and memories; getting in touch with 'role positions' (Bennett et al., 2006). This key component of resolution involved understanding and assimilating core feelings activated. Facilitating the client in experiencing was acknowledged by Bennett et al. (2006) as a component of many psychotherapies and a common change mechanism (Greenberg & Safran, 1987; Stiles et al., 1990).

Comparing Two Models

As previously mentioned, CBT alliance ruptures often occur when a maladaptive 'relational' schema is activated, and therapy involves exploring the client's experience of this (Safran, 1993a, 1993b; Young et al., 2003). Both Aspland et al. (2008) and Bennett et al. (2006) included exploration in their respective models, although the latter emphasised focusing on the therapeutic relationship. However, a key component of Bennett et al.'s (2006) model emphasised the affective experience; facilitating the client in experiencing core feelings activated in-session. Such an affective component was not included in Aspland et al.'s (2008) CBT model. Finally, Aspland et al. (2008) specified internal recognition of the rupture, rather than explicit acknowledgement. These differences will be considered in the current study.

The Current Study

Bennett et al. (2006) studied how alliance threats with BPD clients were resolved, although the research was limited to CAT. The current study investigated how

alliance ruptures in CBT are resolved with clients with BPD. Employing a task-analytic approach (Greenberg, 1984; Greenberg & Foerster, 1996), Aspland et al.'s (2008) CBT rupture resolution model was compared with rupture-repair sequences in cases of CBT with good outcome BPD clients.

This study aimed to address two questions:

1. How do therapists deal with ruptures in CBT with clients with BPD?

2. Can Aspland et al.'s (2008) CBT model be validated with clients with BPD?

Method

Design

Quantitative data analysis was used to identify rupture sessions. Qualitative task-analytic methods (Greenberg, 1984; Greenberg & Foerster, 1996) were then employed to investigate the rupture resolution process. This involved comparing Aspland et al.'s (2008) CBT rupture resolution model with clients who were depressed, with rupture-repair sequences in cases of CBT (Davidson, 2008) with good outcome BPD clients.

The SPeDi Trial

The current study focused on data collected in the Sheffield Personality Disorders Trial (SPeDi Trial); a randomised controlled exploratory trial of psychotherapy for adults with BPD. The SPeDi Trial compared psychologically informed standard care in a Community Mental Health Team (CMHT), with cognitive therapy; either CBT or CAT.

Inclusion criteria for SPeDi Trial participants were:

1. A BPD diagnosis (APA; DSM-IV, 1994) with at least one Axis I disorder. Diagnosis was based on results of the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First, Gibbon, Spitzer, Williams & Benjamin, 1997) and the Screen Patient Questionnaire (SSPQ; First, Gibbon, Spitzer, Williams & Benjamin, 1999).

2. Mental health service history greater than one year.

3. On the caseload of a Sheffield Adult CMHT.

4. Willingness to engage in psychological therapy.

Exclusion criteria were:

1. Current severe and problematic substance dependence, meeting SCID-II criteria for substance misuse.

2. A serious organic condition.

3. Diagnosis of schizophrenia or bipolar disorder.

4. Actively suicidal at the time of referral, beyond the point where CMHT treatment is clinically safe.

Participants

All eight participants who had so far received CBT in the SPeDi Trial were included in quantitative analyses. Demographic data is shown in table 1. Participants included four women and four men, aged from 27 to 44 ($M = 34.37$, $SD = 9.19$). Five participants were single; two separated/divorced; and one was married. All participants were White/British. Four participants were on sick leave from work, two unemployed; one in full time employment; and one was a part time student. Five participants lived alone; and one participant fell into each of the following categories: lives with relatives/friends; caring for children more than five years old; and lives with partner and cares for children less than five years old.

Sessions from two of the eight participants (participants 2 and 7) became the focus of the task-analytic approach. Participants were selected because they demonstrated rupture-repair sequences that satisfied a specified definition (Stiles et al., 2004), and good therapeutic outcomes (see Procedure). Participants 2 and 7 are referred to as John and Simon, respectively. John (39 years old) and Simon (33 years old) were both single men who lived alone. John was unemployed, and Simon a part-time student.

Therapists were two (one male and one female) qualified CBT therapists, as approved by the British Association for Behavioural and Cognitive Psychotherapies

(BABCP), with a background in mental health nursing. Therapists had also received

additional training from Kate Davidson for working within the specified CBT model

(Davidson, 2008).

Table 1. Demographic Data of all CBT Clients.

Client	Gender	Age	Relationship Status	Ethnicity	Employment Status	Living Arrangements	Session Total
1	Female	27	Single	White/ British	Sick Leave	With Relatives/ Friends	22
2	Male	39	Single	White/ British	Unemployed	Lives Alone	21
3	Female	30	Single	White/ British	Full Time Paid	Cares for Children > 5	24
4	Male	44	Separated/ Divorced	White/ British	Sick Leave	Lives Alone	8
5	Female	34	Single	White/ British	Unemployed	Lives Alone	16
6	Female	28	Married/ Cohabiting	White/ British	Sick Leave	With Partner/ Cares for Children < 5	27
7	Male	33	Single	White/ British	Part Time Student	Lives Alone	23
8	Male	40	Separated/ Divorced	White/ British	Sick Leave	Lives Alone	7

Therapeutic Model

Participants had received cognitive therapy for the treatment of personality disorder (Davidson, 2008). This was a structured therapy based on individual formulation, which aimed to challenge core beliefs and associated behaviours often experienced by individuals with personality disorder. As shown in table 1, participants received between 7 and 27 sessions ($M = 18.5$, $SD = 7.46$), as dictated by the individual case.

Ethics

All SPeDi Trial participants consented to data being used for research. The current study's research protocol was approved via the University of Sheffield's Doctorate in Clinical Psychology course's ethical approval procedures. The SPeDi Trial was given research governance approval, in which the current study was included. Appendix B includes all confirmatory documentation, and a letter outlining that the University of Sheffield was the study's research governance sponsor.

Measures

Treatment Outcome

Outcomes were measured using the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-OM; Appendix C; Barkham et al., 2001; Evans et al., 2002). This is a 34-item self-rating questionnaire designed as a global outcome measure of psychological distress. The CORE-OM is a reliable and valid instrument with good sensitivity to change (Barkham et al., 2001; Evans et al., 2002).

Client and therapist independently completed the ARM (Agnew-Davies et al., 1998; Appendix C) following each therapy session. The ARM is a 26-item self-report questionnaire which provides a measure of the therapeutic relationship, with parallel versions for client and therapist. The internal consistency and validity of this measure has been evidenced (Agnew-Davies et al., 1998). The ARM, as completed by the participant, was used to identify rupture sessions.

Procedure

Quantitative Data Analysis: Selection of Sessions for Qualitative Task Analysis

Identification of rupture-repair sequences was based on Stile et al.'s (2004) criterion, using the regression curve of participant's ARM ratings. Rupture-repair sequences demonstrated a drop in the alliance (**rupture session**), followed by a subsequent recovery (**repair session**).

Stiles et al. (2004) specified that participants for whom the overall slope in ARM ratings across therapy was negative, should be excluded. This eliminated participants whose ruptures were not fully repaired, but reflected a generally deteriorating alliance. Each participant's ARM scores were plotted on graphs to allow visual data inspection (Appendix D). All participants demonstrated an overall nonnegative slope across therapy.

Stiles et al.'s (2004) criterion was adopted with one modification. The criterion was based on four parameters drawn from a regression analysis of the client's ARM ratings; the mean, the linear slope, the quadratic curve and variability around the curve. Ruptures were defined as **an alliance score two standard deviations below a fitted quadratic trend line in a non-descending profile.** The quadratic trend was identified using:

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$$ARM < y' - 2 \text{ (RMSE)}$$

Where

y' = predictions from the intercept (mid-treatment level of the alliance),

the slope (change across sessions or linear coefficient), and curve (quadratic

coefficient) parameters

And

RMSE = variability parameter i.e. the residual, or distance, of raw scores

from the fitted curve or Root Mean Square Error

This study adopted the criterion of 1.645 standard deviations instead of 2. As only one

end of the distribution was the focus (ruptures), a more liberal criterion could therefore

be applied. Stiles et al. (2004) excluded ruptures in the first or last sessions since

rupture-repair sequences require at least one higher alliance score preceding, and one

succeeding the rupture. This was employed in the current study. Regression curves for

all eight participants are included in Appendix D. Ruptures were identified for

participants 2, 3, 5, and 7 (encircled in Appendix D). Table 2 summarises the results,

including details of therapeutic outcome. As audiotapes of identified sessions were only

available for participants 2 and 7, sessions for these participants became the focus of

qualitative analyses.

Therapeutic Outcome

Outcome was determined on the basis of pre- and post-therapy CORE-OM

scores, completed by the participant at screening/assessment for therapy, and at 6 month

follow-up (18 months after the first therapy session). 'Good outcome' cases met criteria

for statistically reliable and clinically significant improvement (Jacobson, 1988). As

shown in table 2, participants 2, 3 and 7, each of whom demonstrated rupture-repair

sequences, were identified as 'good outcome' cases. 'No improvement' cases failed to

meet this criterion, although their score did not show a reliable and clinically significant deterioration to meet the 'poor outcome' criterion (Jacobson, 1988). Participants 1, 5, and 6 were identified as 'no improvement' cases, of which participant 5 demonstrated a rupture-repair sequence. None of the participants were defined as 'poor outcome' cases. It was not possible to determine outcome for participants 4 and 8, due to missing CORE-OM scores.

Table 2. Identified Ruptures and Therapeutic Outcome.

Client	Identified Ruptures	Outcome		
		CORE-OM: pre; post	RCI: z score	Outcome (significance)
1	None	1.94; 1.65	0.86	No improvement
2	1; Sessions 16 (rupture), and 17 (repair)	2.29; 1.59	2.09	Good (p< .5)
3	1; Sessions 21 (rupture), and 22 (repair)	1.50; 0.82	2.02	Good (p< .5)
4	None	Missing	N/A	N/A
5	1; Sessions 10 (rupture), and 11 (repair)	2.35; 2.41	0.18	No improvement
6	None	1.74; 1.53	0.63	No improvement
7	1; Sessions 12 (rupture), and 13 (repair)	2.44; 1.12	3.94	Good (p< .001)
8	None	Missing	N/A	N/A

Qualitative Data Analysis: Task-Analytic Procedure

Rupture and repair sessions for participants 2 and 7 were the focus of qualitative task analysis (Greenberg, 1984; Greenberg & Foerster, 1996). Harper (1994) outlined that the change process in psychotherapy research is continuous and cumulative. Therefore, each rupture resolution attempt might only reflect a 'partial task solution' (Greenberg, 1984), and cumulative resolution of the rupture is needed. Without a

cumulative resolution of the rupture, the rupture will reoccur until a more complete resolution strategy is achieved (Greenberg, 1984). Therefore, as identified by Aspland et al. (2008), it was necessary to follow the longitudinal process through, by analysing rupture resolution attempts within individual cases, rather than selecting a number of attempts from numerous participants.

Each participant's rupture and repair session was transcribed (Appendix E; Guidelines and Confidentiality/Consent Form). Task analysis studied the moment-by-moment rupture resolution performances within each therapist-client dyad. The following steps were taken to address research questions:

1. How Do Therapists Deal with Ruptures in CBT with Good Outcome Clients with BPD?

Stage 1.   The Empirical Task Analysis

1. *Markers of Rupture and Repair:* Transcripts of sessions for both clients were read and all potential rupture and repair markers identified and classified by the researcher and two independent supervisors. Rupture and repair markers were discussed until consensus reached.

Aspland et al, (2008) used confrontation, withdrawal and over-compliance as rupture markers (Harper, 1994; Safran & Muran, 2000a), with re-engagement (Rhodes et al., 1994) as the repair marker. Samstag, Muran and Safran's (2003) list of rupture marker behaviours was also used to inform identification of ruptures. All of the above markers were used in the current study. Appendix F lists the in-session behavioural indicators of ruptures used, in addition to an extract from an analysed transcript.

2. Focusing first on client 7, each consensually identified rupture resolution attempt was analysed for its characteristics, including duration, therapist and client response, and subsequent engagement. As outlined by Aspland et al. (2008), processes

that led from the rupture marker to re-engagement were highlighted; points at which the client's state changed in productive ways were identified and used as 'anchor points' for understanding the change process.

3. Throughout empirical analysis, a diagram which incorporated major components of the rupture resolution process was sketched. This **empirical model** represented an iterative process, based on the analysis of all rupture resolution attempts for client 7, until saturation of the data was reached. Results of the analysis of rupture resolution attempts were compared with results from previous analyses to identify common resolution components. The resulting model, produced by the researcher in conjunction with independent supervisors whilst working to consensus, described possible patterns and generated hypotheses for subsequent testing.

Quality Control

The researcher read every transcription whilst listening to audiotapes to ensure accurate transcription. Markers of ruptures and repair were consensually identified by the researcher and independent supervisors. Furthermore, the researcher kept a reflective diary throughout the task-analytic process, including reflections on how the researcher's own theoretical perspective might have influenced analysis.

2. Can Aspland et al.'s (2008) Model of Rupture Resolution in CBT be Applied to Good Outcome Clients with BPD?

The empirical rupture resolution model was compared with Aspland et al.'s (2008; Appendix G) model. Stage 2 of the task-analytic approach was followed:

Stage 2.   *Synthesising a Rational-Empirical Model*

1. Changes were made to Aspland et al.'s (2008) model to reflect actual resolution performance; a synthesised sketch of resolution performance, which incorporated the rational model (Aspland et al., 2008) and the empirical model developed in this study, was constructed. This synthesis, the first **rational-empirical model** constituted a discovery-oriented result, and an empirically grounded hypothesis to be developed through subsequent analyses (Greenberg & Foerster, 1996).

2. As part of the iterative model-building procedure, resolution events from sessions for client 2 were now observed. Observations of client 2's actual in-session activity were then compared with the rational-empirical model and changes made to accurately reflect resolution, thus looping between stages 1 and 2. This served to test generated hypotheses.

3. The model was progressively refined until examination of more in-session performances yielded no further discoveries, signifying saturation. This resulted in the final **rational-empirical model.**

Researcher's Perspective

In qualitative research, the researcher is an active participant, who attempts to understand the observed therapist-client interaction within their own own context, and influenced by their internal beliefs (Aspland et al., 2008). The researcher held an interest in psychodynamic psychotherapy (Malan, 2007), a model which at the time of analysis informed the researcher's clinical work. Psychodynamic psychotherapy emphasises the therapeutic alliance, which is often the focus in therapy as a means of reflecting on interpersonal patterns. Supervisors held similar interests, and also cognitive approaches including CAT.

Results

1. How Do Therapists Deal with Ruptures in CBT with Good Outcome Clients with BPD?

Twenty-one rupture resolution attempts were identified in Simon's sessions (13 in session 12, and 8 in session 13), and 20 in John's sessions (12 in session 16, and 8 in session 17). All 41 rupture resolution attempts were systematically analysed. As it is not possible to document the analysis of 41 rupture-repair sequences here, a sample, which illustrates the analysis for each client and highlights the variation in types of ruptures identified, is presented. Examples represent the cumulative nature of the rupture resolution process across the two sessions for each client.

A descriptive account of each selected rupture-repair sequence is provided and grounded in extracts from the data, allowing the reader to follow the process of hypothesis generation and interpretation. All extracts have been allocated numbers to elucidate an 'audit trail' ('T' represents the therapist and 'P' the participant, both of which are followed by a transcript line number). This allows the reader to place extracts within a time frame.

Detailed Qualitative Task Analysis

Stage 1.   Empirical Task Analysis

Empirical results from Simon's sessions are presented. Rupture markers (Appendix F) are highlighted by an underline, and the therapist's attempts at resolution indicated in bold.

Simon's Sessions

Rupture Session

Rupture Resolution Attempt 4, Session 12

Simon had talked at length about a relationship difficulty with a female friend, about which he felt angry and upset. Simon believed this friend had spoken badly of him behind his back. He described her as "two faced", as she had been pleasant to his face.

A rupture occured when the therapist did not respond to the difficulties Simon described, but drew Simon's attention to a therapeutic letter. This letter from the therapist outlined Simon's difficulties. His withdrawal, marked by a <u>minimal response,</u> represented the rupture marker:

T71: *'I will be understanding about why you are upset and everything and wonder how we deal with this. One of the things that is going through my mind is, you know we talked about looking at a letter, I wonder if we can, I mean is this an example of things that happen in your life?'*

P75: *'Yes.'*

The therapist did initially acknowledge the emotional impact of the interpersonal difficulty (T71), although then focused on the letter and emphasised its importance:

T76: *'I will begin to see the wider picture rather than concentrate on this specific incident. I don't know how that feels?'*

This appeared to perpetuate the rupture. Simon <u>disregarded the therapist's </u>question, and came back to the interpersonal event, <u>talking incessantly</u> about the subject:

P78: *'I am not saying that over the years of friendship with (friend) there hasn't been like crap between us...'*

The rupture appeared unresolved, as the therapist failed to engage in conversation about this interpersonal issue, and gave no acknowledgement or summary of what Simon had said. When the therapist instead explained that she wanted to read the letter, the rupture perpetuated further; he continued to <u>disregard</u> the therapist, again <u>talking incessantly</u> about the interpersonal difficulty:

P106: *'... I am trying to compare stuff that I may have done wrong but yet everything that I do is like... getting thrown back in your face... what pisses me off more than anything is that you are the people that were so insistent that I needed help, and now that I am getting help, you don't want to know me... If you actually saw, you know, talked to me for more than five seconds you may realise that I have changed...'*

T121: *'And I wonder if this is the first step. If you want to read this first and then we can discuss it.'*

The initial rupture perpetuated into a confrontation rupture, as the interpersonal difficulty and associated feelings remained unacknowledged. Simon expressed anger towards his friend, but was also <u>critical of the therapist</u>; his angry accusations (e.g. 'you were the people...' and 'if you actually... talked to me for more than five seconds'), were evidence of his dissatisfaction with the therapeutic relationship, although the therapist made no reference to this and the rupture continued.

Re-engagement occurred when Simon was **asked for his contributions to the formulation**. Simon was asked what stood out for him as accurate. The therapist took a

reflective stance and **explored** Simon's difficulties with reference to the past. This appeared to encourage Simon to think about his patterns of relating. He talked at length about how his interpersonal patterns manifested in his past and present relationships:

P128: *'...Yes, I do believe that a lot of arguments... I was about sixteen at the time... I realise with the bullying with (name), he didn't have to get in trouble by kicking the shit out of me because he would just wind me up that I would do it myself... and I do act in a way that pushes people away...'*

Rupture Resolution Attempt 9, Session 12

Simon was asked about the feelings he had whilst reading the letter. The therapist maintained a **reflective stance**. Simon had felt parts were 'scarily accurate' (185), and when **asked to contribute** by giving examples of these, Simon appeared engaged:

T186: *'Were there particular bits that were scary?'*
P187: *'This thing with people I can't trust and starting to believe that I am not a good person and that I deserve what's happening to me... I did used to self harm to try and raise my emotions...'*
T192: *'It is that kind of relationship; emotions, behaviour, thinking... it is a vicious circle and you really have captured that.'*

This appeared to lead to a withdrawal rupture, marked by Simon <u>disregarding the therapist's</u> comment, and <u>continuing to talk</u> about the interpersonal difficulty:

P194: *'At the minute I have just got a really bad trust issue with people...'*

T200:   'Which, thinking about all those core beliefs that I have written down, which

        core beliefs hang around for you at the moment?'

P202:   'Difficulty with personal relationships...break down in relationships and beliefs

        that you are weak and useless...It is true but I don't like not trusting people but if

        you trust people too much then you'll get screwed.'

The therapist subsequently **acknowledged the core difficulty** of not trusting others, and re-engagement occurred. The therapist **validated** the client's feelings, and **responded empathically** (T212). Re-engagement was marked by Simon's emphatic agreement, and he subsequently expanded on his answer:

T212:   'I guess it is understandable because of what has happened to you in your life

        and I guess it is hard to trust people.'

P214:   'It is, yes definitely. I want to because I am a very loving person.'

Rupture Resolution Attempt 13, Session 12

      Alliance ruptures were infrequently fully resolved, despite intermittent periods of re-engagement. Simon was asked whether there were things in the letter on which he wanted to work; he identified feelings of uselessness and his fear of being rejected. The therapist somewhat acknowledged these feelings, but then proceeded to set homework. This resulted in a rupture, marked by <u>disregard of the therapist</u>:

T389:   'I guess it is about having a think around this useless stuff... What does it stop

        you from doing?... All these things that we are talking about have a link

        between thinking and doing and I just wondered if you could have a think about

        it for next week, along with that we're doing two experiments... One is about

planning and that is about eating... increasing that self nurturing... reducing

cannabis... Alongside that, every time you back, "I am useless".... make a note

of what it stops you doing... '

P402: *'I was just thinking, I don't think about the situation rationally... I am getting*

into that bad frame of mind... and any sort of idea or plan, whatever now is just

going to be completely useless...'

T406: *'We need to think about change... So we have got these experiments that we are*

going to be looking at for next time...'

Simon did not acknowledge the proposed homework tasks. He did not appear engaged in the conversation, as his <u>disregard</u> of the therapist's comments suggested he was thinking about something else. The therapist made no inquiry about Simon's comment (point P402), but emphasised the importance of the experiments.

Simon's next comment further indicated a rupture. Simon withdrew, marked by a <u>minimal response</u>, and now appeared to demonstrate over-compliance; he demonstrated <u>overly ingratiating comments</u>, and made no further attempts to discuss what was important to him:

P412: *'Yes'*

T413: *'Is there anything else... that you want to finish with today?'*

P414: *'No. You have given me a lot of things to think about for the next week.'*

T415: *'What will be particularly helpful?'*

P416: *'This has really helped... I think you have done a very, very good job of*

capturing what I was trying to get across to you, which I know sometimes with

me is quite difficult.'

Re-engagement attempts were not evident and at the end of the session, Simon returned to the interpersonal issue about which he had talked at the start, indicating that the rupture remained unresolved:

T422: '... Has anything not been helpful today?'

P424: 'No, not at all as per usual and just being able to (pause) as I said like that incident this morning, I was fuming about it...'

Repair Session

Rupture Resolution Attempt 1, Session 13

Simon started the session talking about another interpersonal difficulty. A friend had not contacted him on the day on which they had arranged to meet. Simon identified his core beliefs and automatic thoughts, and the therapist asked questions to **explore** and **clarify**. The therapist also **inquired** about Simon's behaviour:

T61: '...What was happening with your behaviour? Were you feeling useless? Strong beliefs about that for you?

P63: 'Yes. Very erratic, self harming, generally getting myself wound up...'

T64: 'And were you getting out and about? Isolating yourself?

P65: 'Yes... It was bothering me...'

In contrast to the rupture session, the therapist appeared interested in Simon's experience, and **acknowledged his feelings**. Simon engaged in conversation, and appeared to think about questions asked. He subsequently talked at length about his emotional difficulties and associated behaviours, including self-harm. The therapist in turn asked about Simon's past, and in the same sentence about self-harm:

T78:   *'Let's think about your past. You pointed out that you started self-harming. So what happened there?*

A rupture occurred, marked by Simon <u>shifting the topic</u>; he returned to his difficulty trusting people, which had been a key theme throughout the preceding session:

P80:   *'I don't know. I am having a big problem with trust issues all the time... I mean even with my really close friends... people that I can normally rely on have let me down... It is almost like I am on guard again.'*

T86:   *'Is that something that we need to put on the agenda for today? What do you think?'*

The therapist made no reference to the alliance, but asked about the agenda. The rupture appeared to continue, marked by Simon <u>disregarding</u> the therapist's comment. Re-engagement occurred only when the therapist **acknowledged the feeling** of being let down (T92). Simon then expanded on his answer and revealed more of his associated thought processes:

P87:   *'I think it is just me... blowing it out of proportion... it is like a nasty side and ordinarily I won't let it pass because other people have let me down.'*

T92:   *'That is a big thing for you, being let down, isn't it?'*

P93:   *'Yes. If it is people I expect to let me down, then I am not bothered but with people that I don't think will let me down it makes me feel "what's next then?"'.*

Rupture Resolution Attempt 4, Session 13

Simon appeared despondent, and his contributions reduced. A rupture occurred, marked by Simon's <u>minimal response</u>. He also demonstrated over-compliance; he took a seemingly passive and <u>helpless</u> role in therapy, and handed responsibility for the session to the therapist:

T104: *'Is that what you want to put on the agenda for today?... So, we have got looking at homework... What do you think about the timings of homework... about fifteen minutes?'*

P108: *'I will take it at your pace.'*

Simon and the therapist started to look at the previous week's homework task, which included keeping a food diary. Simon said the task had been useful, and the therapist **inquired** about what he had written to **clarify** and understand. Re-engagement then appeared to occur (P141); the therapist took a **reflective stance**, and encouraged Simon to think about his behavioural patterns with reference to the diary:

T140: *'In here, tell me a bit about things like when you are eating.'*

P141: *'When I feel hungry, that's really crap. I got shouted at the other day as a friend of mine said, "you have lost another half a stone"... He said I was wearing a shirt, a t-shirt and "you have got them both tucked in and a belt on and those trousers are still loose on you."'*

T146: *'Let's think about how much, if this was somebody else to whom you were responsible and they weren't eating very much and were losing weight. What would you say to them?'*

P149: 'I would be having a go. Well, I wouldn't be having a go at him, I would be telling him he is not looking after himself.'

Asking Simon to think about this from someone else's perspective seemed to help him gain some emotional distance from the situation and to reflect:

T151: 'What would you advise him to do?'

P152: 'I would be telling him to use that diary. I am very good at looking after others.'

T153: 'I know you are.'

P154: 'And getting other people to listen to me.'

T155: 'Absolutely. Now let's think about how we could transfer that, that caring of other people into yourself. Fantastic that! (Refers to diary).'

P157: 'That's because I care about other people. I am bothered about me... I see me, like a good person if I am helping someone out. Do you know what I mean?'

T160: 'I can feel that.'

The therapist's responses (153; 155; 160) appeared very powerful in the resolution process. Simon's contributions were **validated**, and the therapist conveyed an understanding and knowledge of Simon, which made him feel understood. By **affirming the client's contributions** ('Fantastic that!'), the therapist emphasised Simon's **role in the therapy as important**.

Rupture Resolution Attempt 5, Session 13

Simon and the therapist talked about how Simon could feel better about himself, including reducing self-destructive behaviours. Simon was reluctant to acknowledge the negative effects of his cannabis use, and a rupture appeared to occur when the therapist

proposed change. This conversation seemed difficult for Simon; he <u>shifted the topic</u> of conversation, and <u>talked incessantly</u>:

T182:   *'I wonder whether together we could see about reducing all those things that keep you feeling bad?'*

P184:   *'That is kind of like, when I am helping other people, that is my way of feeling good about myself... It is not like, "oh, look at me, I am fantastic", it is just silly stuff like me and my friend... because I used to work at the cinema... and I can still get free tickets. She adores me for that... it is doing something for somebody I like...'*

T194:   *'But what you do, you see, it makes you feel better about yourself.'*

P195:   *'It does, yes.'*

T196:   *'...So we are taking time to think about how we feel about ourselves.'*

The therapist **tentatively brought the conversation back** to talking about Simon feeling good about himself (194). Simon's response appeared minimal (195), but indicated agreement despite apparent ambivalence. Simon seemed now to be starting to re-engage. Throughout this rupture resolution attempt, the therapist's language **emphasised collaboration** (182; 196), and although the topic was difficult for Simon to stay with, the therapist's **empathic responses** indicated support. Simon's next comment suggested he was now actively thinking about change:

P198:   *'I am keen to get into the drug and alcohol thing, volunteer work.'*

T199:   *'And we have discussed how that could support you towards making a positive change. It could strengthen the way you feel about yourself... all the things we have been talking about; you wanting to help others, but also your responsibility*

toward helping yourself... That's one of the ways you show you can help

yourself.'

P207: *'It's something else I'd be doing for me.'*

The therapist **emphasised collaboration**, by talking about 'we' rather than 'you'. Furthermore, the therapist **emphasised the client's role in the therapy**, **validated** Simon's contributions, and **emphasised the client's responsibility** to help himself. Simon appeared to re-engage, indicated by his apparent reflection on what was said, and subsequent agreement (207). The therapist subsequently acknowledged that they had not managed the timing of the session:

T353: *'...I know I haven't managed the time very well, but we need to think about...*

needing reassurance, and that sounds like it was very relevant for you in the last

few weeks.'

P356: *'It is like I need constant reassuring.'*

The therapist showed humility and **acknowledged their own limitations**. Simon's feelings were **validated**, and Simon appeared engaged.

Empirical Model

Based on analyses, the empirical model is shown in figure 2; hypotheses to be tested by further analysis are highlighted in italics.

Upon recognition of an alliance rupture, the first stage involved acknowledging the feeling or a problem troubling the client. Resolution appeared to only occur when the therapist explicitly acknowledged this event and associated feeling. This feeling or

problem was typically triggered by an interpersonal event outside of therapy (Rupture Resolution Attempt 1, Session 13).

Continuing to implement therapeutic technique appeared to perpetuate the rupture. Stage B proposed a change in approach, to exploring exactly what happened during the interpersonal event. This was hypothesised to involve identifying whether difficulties outside of therapy were relevant to the alliance, as when the therapist failed to do this, the rupture continued (Rupture Resolution Attempt 4, Session 12).
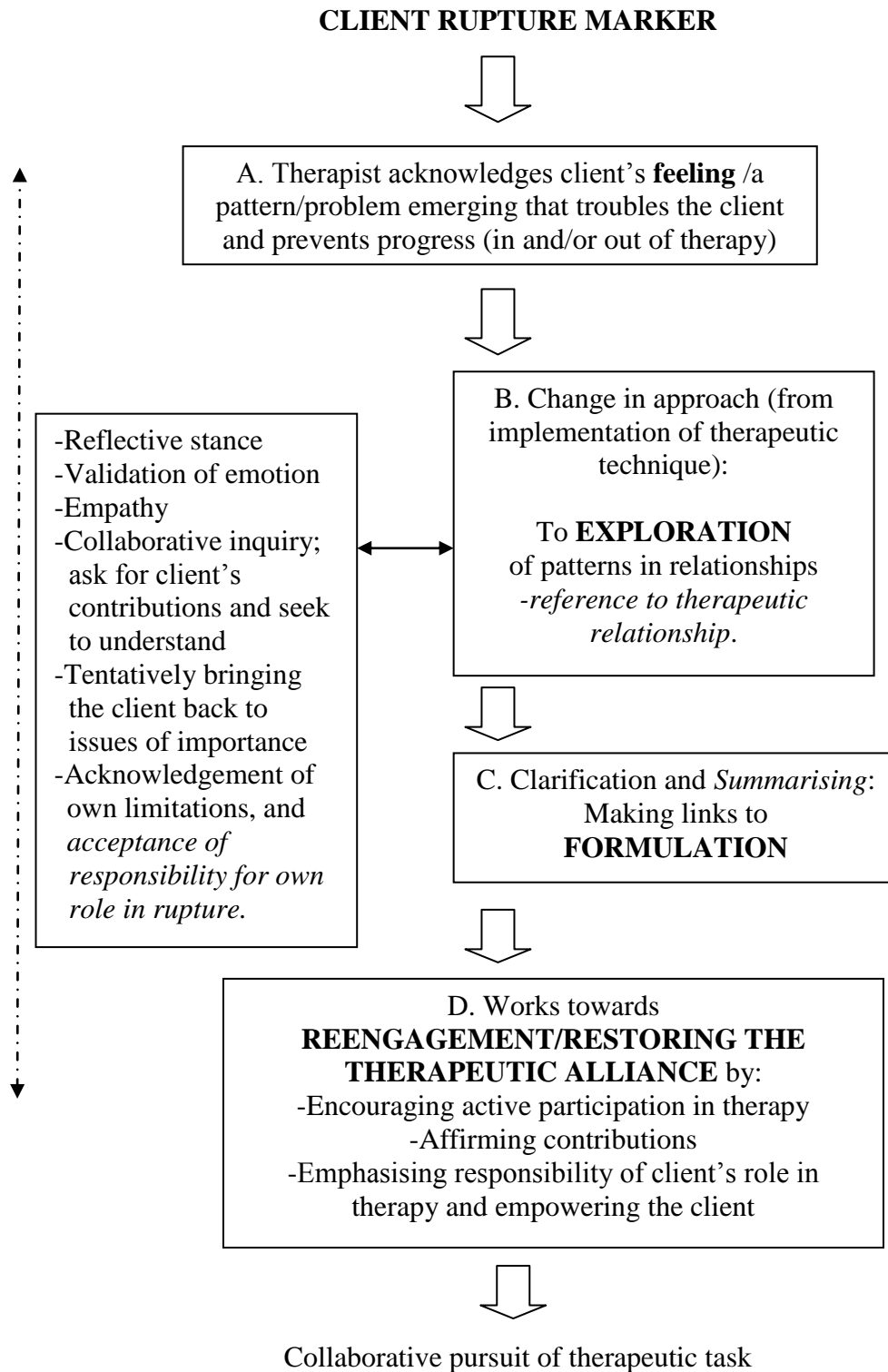
The box to the left of stage B, which ran parallel to this stage, specified that the therapist also maintain a reflective stance, showing interest in the event, and maintaining a position of collaborative inquiry (Rupture Resolution Attempt 1, Session 13). The client's feelings were validated, the therapist responses empathic, whilst acknowledging their limitations (Rupture Resolution Attempt 5, Session 13).

Despite the finding that when the therapist suggested areas of change about which the client appeared ambivalent perpetuated the rupture; tentatively bringing the client's attention back, contributed towards resolution (Rupture Resolution Attempt 5, Session 13). The therapist's 'acceptance of responsibility for their own role in the rupture' was also hypothesised; although the therapist had not explicitly acknowledged alliance ruptures, this component was based on the result that when the therapist acknowledged their own limitations, resolution was facilitated.

Stage C involved clarification of what was happening for the client at the time of the interpersonal event (e.g. Rupture Resolution Attempt 1, Session 13), and links to the formulation were made (Rupture Resolution Attempt 4, Session 12). Analyses also suggested that the therapist's failure to summarise salient issues for the client perpetuated the rupture (e.g. Rupture and Resolution Attempt 4, Session 12); summarising was therefore included as a hypothesised component.

Stage D specified restoration of the therapeutic alliance was achieved by encouraging the client's active participation in the therapy, affirming the client's contributions, and emphasising the client's role in therapy as important (Rupture Resolution Attempt 4, Session 13). The dyad could then pursue the therapeutic task.

Figure 2. Empirical Rupture Resolution Model.

CLIENT RUPTURE MARKER

⇩

A. Therapist acknowledges client's **feeling** /a
pattern/problem emerging that troubles the client
and prevents progress (in and/or out of therapy)

⇩

B. Change in approach (from
implementation of therapeutic
technique):

To **EXPLORATION**
of patterns in relationships
*-reference to therapeutic
relationship*.

-Reflective stance
-Validation of emotion
-Empathy
-Collaborative inquiry;
 ask for client's
 contributions and seek
 to understand
-Tentatively bringing
 the client back to
 issues of importance
-Acknowledgement of
 own limitations, and
 *acceptance of
 responsibility for own
 role in rupture.*

⇩

C. Clarification and *Summarising*:
Making links to
FORMULATION

⇩

D. Works towards
**REENGAGEMENT/RESTORING THE
THERAPEUTIC ALLIANCE** by:
-Encouraging active participation in therapy
-Affirming contributions
-Emphasising responsibility of client's role in
therapy and empowering the client

⇩

Collaborative pursuit of therapeutic task

2. Can Aspland et al.'s (2008) CBT Model of Rupture Resolution be Applied to Good Outcome Clients with Borderline Personality Disorder?

Stage 2.   Synthesising a Rational-Empirical Model

The empirical model was compared with Aspland et al.'s (2008; Appendix G) model and changes made to reflect resolution. This synthesised rational-empirical model is shown in figure 3.

Stage A was an additional component which incorporated the first stage of Aspland et al.'s (2008) model. Empirical analysis highlighted that re-engagement appeared to occur when the interpersonal difficulty outside of therapy was acknowledged. Explicit reference to the relevance of this rupture to the alliance was not made. However, in light of Aspland et al.'s (2008) model, it was hypothesised that internal consideration of this by the therapist may have occurred. As this component was not possible to assess, it is highlighted in a broken text box. This preceded the stage included as a result of empirical analyses; now stage B; acknowledging the client's feeling.

Stage C specified a change in approach; a common component in both models. Exploring interpersonal patterns with regards to past relationships and current relationships outside of therapy, contributed towards resolution. Exploring such patterns with regards to the therapeutic alliance was a hypothesis based on empirical analyses, which remained to be tested. Aspland et al. (2008) incorporated summarising and validating. Based on empirical results, validating was included in the box parallel to box C; 'external observer'; this term emphasised the importance of the therapist's reflective stance, and included components based on previously described empirical analyses, and hypotheses which remained to be tested.
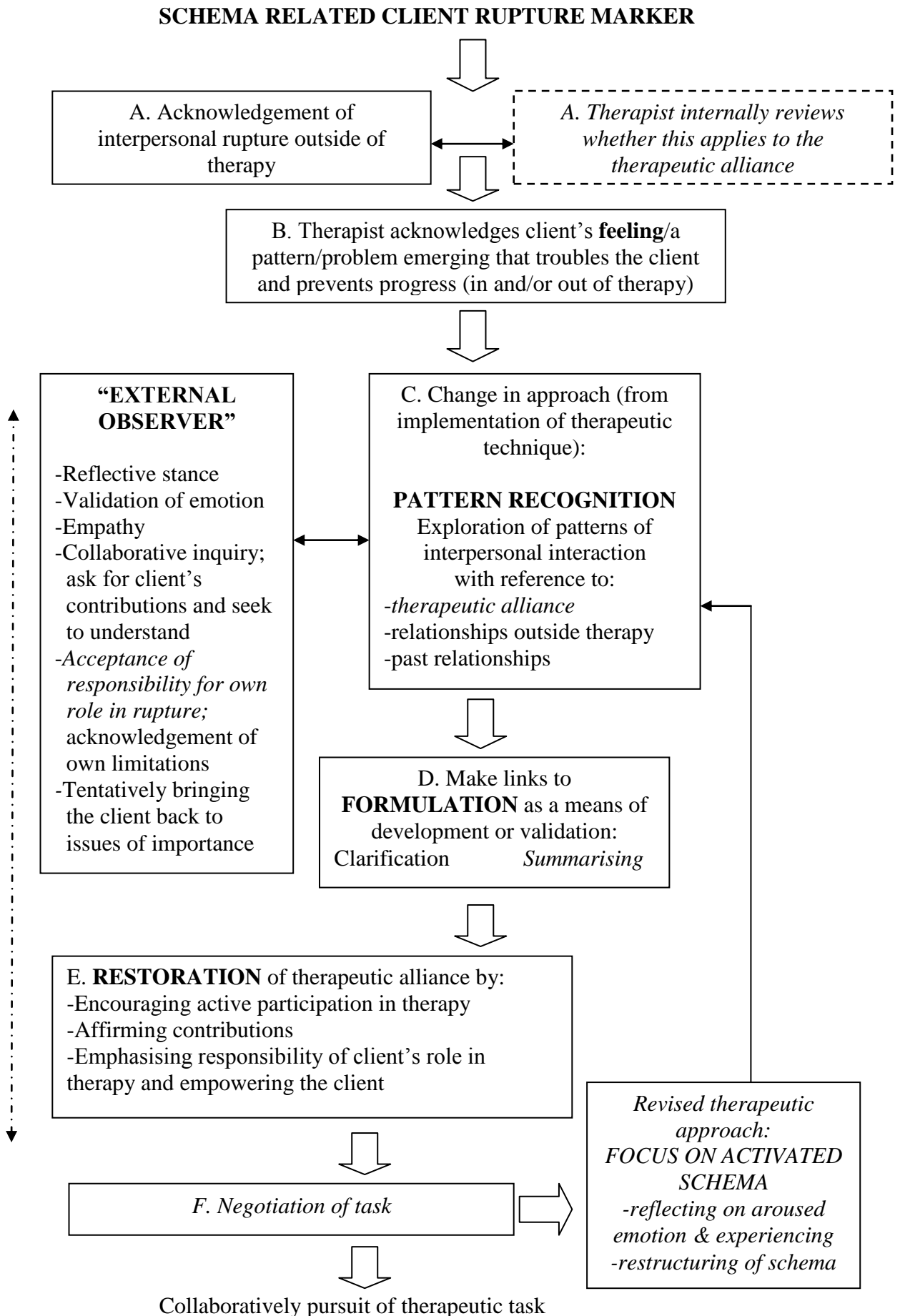
Stage D specified making links to the formulation; a result of empirical analyses, also supported by Aspland et al. (2008; stage D). Clarification was included, and summarising as a previously discussed hypothesised component.

'Restoration' overlapped with Aspland et al.'s (2008) stage C; encouraging the client's active participation in therapy and affirming the client's contributions were evident in analyses, and supported by Aspland et al. (2008). Emphasising responsibility of the client's role in therapy was also included.

Stage F was incorporated from Aspland et al.'s (2008) model; negotiation of the therapeutic task, and a hypothesis to be tested. Aspland et al.'s (2008) model specified revising the therapeutic approach at various points (E and F). As continuing to implement therapeutic technique often perpetuated ruptures, the apparent importance of responsivity to the client was emphasised.

With regards to revising the therapeutic approach, the activation of schemas, triggered by interpersonal events outside of therapy, contribute to alliance ruptures (Young et al., 2003). Bennett et al.'s (2006) model emphasised the affective experience as a means of resolution whilst working with clients with BPD. The revised therapeutic approach was therefore hypothesised to involve focusing on the activated schema, facilitating the client to experience core feelings activated in-session.

Figure 3. The First Rational-Empirical Model.

SCHEMA RELATED CLIENT RUPTURE MARKER

A. Acknowledgement of interpersonal rupture outside of therapy

A. Therapist internally reviews whether this applies to the therapeutic alliance

B. Therapist acknowledges client's **feeling**/a pattern/problem emerging that troubles the client and prevents progress (in and/or out of therapy)

"EXTERNAL OBSERVER"

-Reflective stance
-Validation of emotion
-Empathy
-Collaborative inquiry; ask for client's contributions and seek to understand
-*Acceptance of responsibility for own role in rupture;* acknowledgement of own limitations
-Tentatively bringing the client back to issues of importance

C. Change in approach (from implementation of therapeutic technique):

PATTERN RECOGNITION
Exploration of patterns of interpersonal interaction with reference to:
-*therapeutic alliance*
-relationships outside therapy
-past relationships

D. Make links to **FORMULATION** as a means of development or validation:
Clarification   *Summarising*

E. **RESTORATION** of therapeutic alliance by:
-Encouraging active participation in therapy
-Affirming contributions
-Emphasising responsibility of client's role in therapy and empowering the client

Revised therapeutic approach:
FOCUS ON ACTIVATED SCHEMA
-reflecting on aroused emotion & experiencing
-restructuring of schema

F. Negotiation of task

Collaboratively pursuit of therapeutic task

Empirical results from John's sessions were used to refine and validate the rational-empirical model.

John's Sessions

Rupture Session

Rupture Resolution Attempt 5, Session 16

Interactions throughout this session indicated that a rupture appeared unresolved. John and the therapist had recently recognised John's all-or-nothing thinking style. John had noticed a time when this was apparent in the preceding week, and had talked about it with another health professional, who had praised him for his recognition:

P120: '...When I told (name) about it she nearly jumped off her chair, she said that was like a Eureka moment, she was really, really pleased... she's known me for three years now and she knows what I am like...'

Shortly afterwards, talking about the preceding week's events, John stated:

P161: '... Another thing that struck me is, I have probably been coming here for what, four or five months now?... I don't know how you feel... whether you feel this is going slow... or that it's going well and there's some progress?...'

John had started the session talking about someone else, a marker of a withdrawal rupture. In light of him having described how this person had praised him, he sought the therapist's feedback. The therapist responded:

T168: '*It's difficult for me to judge where you are. We're in a situation where there is a time limit... you know we're a research study... My sense is you're probably somewhere in the middle... you're probably going to carry on doing it (CBT) up to the twelve month point...*'

The therapist's response was very long (T168-179) and somewhat vague, ignoring that John felt anxious about his progress. A confrontation rupture occurred; John became more challenging and <u>questioned the therapy contract</u>:

P180: '*A couple of things from what you've said. If we get to the end of this twelve months... if we're not as far down the road as we should be... what happens there?*'

T187: '*You get discharged.*'

P188: '*... Is there any danger that that it will leave me in a crisis situation?*'

Instead of changing the approach to respond to John's emotional needs, as suggested by the model, the therapist reaffirmed the boundaries of the therapy in a seemingly overly concrete manner (T187). The therapist subsequently talked at length (T190-T223) about the constraints of the therapy, whilst emphasising the research context. This perpetuated the rupture further, marked by John <u>questioning the rationale of therapy</u>:

P224: '*I think, obviously because I am aware that this is an experimental programme... it is not solely for my benefit...*'

The therapist eventually highlighted an item from the agenda to end this conversation, apparently leaving the rupture unresolved. John subsequently engaged in some topics of conversation, but continued to <u>talk about the other person's</u> praise.

Rupture Resolution Attempt 8, Session 16

John said he worried whether CBT worked, and asked the therapist to summarise the approach. A withdrawal rupture occurred (P311), marked by John's <u>minimal response</u>, when the therapist suggested drawing a picture to explain:

T309: *'Shall we do a picture, you like pictures? Do you want to do a picture rather than talking about it?'*

P311: *'Erm, yes, I don't mind.'*

Considering that John had asked for a summary, the therapist then talked at length (T312-T389) whilst sketching the theoretical basis of CBT. John continued to <u>talk about someone else</u>, and it was only when the therapist **acknowledged John's feeling** of anxiety that re-engagement seemed to occur. The therapist talked about John's anxiety in relation to the model. John described a 'general increase in anxiety' of late, including physical sensations. When the therapist took a reflective stance and showed an interest in this, asking questions to **clarify** John's experience, John appeared to re-engage, marked by an apparent increase in reflection and expanding on his answers:

T437: *'Are there particular behavioural or cognitive aspects... that go along with those physical symptoms?'*

P439: *'Yes. There's probably more obsessive behaviour... being more vigilant...'*

T445: *'... Are there aspects of your thinking... associated with symptoms as well?'*

P449: '*Yes, I am thinking a bit more about my health...*'

Rupture Resolution Attempt 12, Session 16

The therapist talked about homework tasks for the forthcoming week:

T533: '*So you have got stuff to do with anxiety... stuff to do with why change has been difficult... stuff to do with noticing and focusing... just jot it down.*'

P537: '*(Name) said that actually and I keep doing it.*'

Talking about someone else throughout the session marked the unresolved rupture. Furthermore, John felt overwhelmed at the end of the session:

T545: '*Anything you want to comment on on what we have done today?*'

P546: '*Just in general, sometimes after we've talked about these things... I can go away and my head like... there seems to be so many things to focus on... sometimes I feel a bit overwhelmed by it all.*'

T551: '*If that feels too much then we need to think about chunking it a bit more... Not next week but the week after we'll start to think about moving to fortnightly rather than weekly...*'

P558: '*I'm sure it will be a discussion rather than a...*'

T559: **TALKS OVER PARTICIPANT**

'*I'm raising it now so we can start to think about it together.*'

Instead of acknowledging that John felt overwhelmed, the therapist discussed reducing sessions. A confrontation rupture occurred, marked by John directing the therapist

(P558), as John emphasised the importance of collaboration. However, the therapist spoke over John, and the session ended.

Repair Session

Rupture Resolution Attempt 1, Session 17

John started the next session reiterating that he felt overwhelmed. Initially, this was not explicitly acknowledged and a rupture appeared to occur, marked by John <u>disregarding the therapist,</u> and continuing to talk about what was bothering him:

P7:   *'... I've had another one of those weeks... I've been getting a bit overwhelmed.'*

T11:   *'So we could look at the (CBT) approach in the context of what's happened in the week... and see what you managed to do... What else do we need to put on (the agenda)?'*

P15:   *'Well, I feel a little bit like I did a few weeks ago... I feel a bit lost in my own world, overwhelmed...'*

It was only when the therapist explicitly **acknowledged the feeling** of being overwhelmed, and asked questions to **clarify** John's experience that he seemed to re-engage, marked by John describing this further:

P23:   *'... I'm feeling very down and that's linking into behaviour... It's just an overwhelming feeling of what happens to me, dread. I feel that something really awful is going to happen to me.'*

T32:   *'... How long have you been feeling like that?'*

P34:   *'... for the last few weeks, certainly this last week it has felt worse.'*

Both parties collaboratively **explored** what had happened for John in the preceding week, which included an interpersonal rupture outside therapy. The therapist took a **reflective stance** and responded **empathically**; John appeared to gain emotional distance from the situation by thinking about how somebody else would feel:

T52:   '... This is clearly upsetting you quite strongly. Is it something you think other people would feel equally upset about in this situation?'

P55:   'Possibly. They may go about it in a different way but possibly...'

T57:   'It would be a difficult situation for anybody. I can feel how upset you are, I feel it, and I might feel the same. How would other people deal with the difficulties?'

The therapist **validated** John's feelings. Furthermore, **emotional self-disclosure** (T57) appeared powerful in conveying to John that he was not alone, and normalised his experience (T57).

Rupture Resolution Attempt 4, Session 17

In exploring what happened at time of the interpersonal difficulty outside of therapy, John struggled to recognise that his means of managing his feelings were problematic. When the therapist suggested this to him, a withdrawal rupture appeared to occur, marked by John's <u>minimal agreement</u>:

T91:   'So... you think it perfectly reasonable to be upset about the way people let you down and that will be the same response that everyone will have, but do you think other people manage it in the same terms as you do?'

P95:   'I suppose not. Probably not.'

The therapist maintained a **reflective stance**, and asked further questions. However, the rupture continued, marked by John's <u>refusal</u> to talk about how he thought about himself:

T96:   *'What do they do differently?'*

P97:   *'They probably just forget it... you know I get all these scenarios in my head... is it because they don't like me... I'm not going back to that stuff.'*

John did not want to talk about this, but the therapist **tentatively stayed with the topic**, and gave a clear but empathic **summary** of what John had said. Initially John reluctantly agreed, but subsequently said he did feel that way. This suggested that although difficult for him, John was engaged with the material:

T101: *'So we've almost got a two part reaction is what you're saying?... an initial reaction which is as anybody would... the second part... which is where you're looking for explanations... explanations to do with something about you as a person...'*

P109: *'I suppose I agree with you. I do feel like that.'*

The therapist then linked John's thoughts about himself and his ways of managing his feelings to his **formulation**:

T116: *'... in the past, you've reacted immediately, strongly to situations, or you've held back your feelings...'*

P129: *'I think there's something else wrapped up in all this as well... I'm just wondering if there's a bit of a throw back to when my mum died going on because every time I think about the situation, I feel really, really upset...'*

John contributed his own ideas about his experience, which marked his re-engagement.

The Final Rational-Empirical Model

The final rational-empirical model is included in Appendix H. Like Aspland et al.'s (2008) model, the final model did not describe a linear process, but rather one that involves cycling between and within stages; a cumulative process that gradually moves toward resolution.

Changes to first rational-empirical model included the addition of the therapist's emotional disclosure to the 'external observer' (Rupture Resolution Attempt 1, Session 17). The inclusion of 'summarising' was supported by analyses (Rupture Resolution Attempt 4, Session 17). However, as there was no explicit discussion of alliance ruptures, results did not confirm that patterns of interaction were explored with reference to the alliance or 'acceptance of responsibility for the therapist's own role in the rupture'. Furthermore, analyses did not support stage F, and the suggestion of focusing on the activated schema. Components which remained to be validated are indicated in italics.

Summary of Findings in Relation to Past Literature

This study shared similarities with Aspland et al.'s (2008) findings. Empirical analyses identified that ruptures arose from therapists' inattention to the client's experience or emotions. Being unresponsive to the client's emotional needs and continuing to implement therapeutic technique appeared to perpetuate ruptures. Furthermore, progress toward resolution typically occurred when therapists changed their approach to explore the salient issue for the client (Aspland et al., 2008; Castonguay et al., 1996).

Interestingly, Aspland et al. (2008) identified that ruptures arose from clients seeking to avoid tasks, or being unresponsive to therapist intervention. Empirical analyses supported this as staying with a difficult topic for the client, about which they felt ambivalent, momentarily perpetuated the rupture. However, tentatively bringing the client's attention back to the issue, a component included in the current study's model, actually facilitated resolution.

Both Aspland et al. (2008) and Bennett et al. (2006) specified exploration of the client's experience as one stage of their respective models, which was validated in the current study. However, as supported by Bennett et al. (2006), the current study's model hypothesised that ruptures are explored with reference to the alliance. This was not supported by analyses. Bennett et al. (2006) stated that in order for such exploration to take place, the therapist must first acknowledge the alliance rupture. In line with Aspland et al. (2008), this was not observed in the current study. Aspland et al. (2008) discussed in detail the absence of explicit acknowledgement and proposed several explanations, including that the therapist internally reviewed whether an alliance rupture

occurred. However, this was not possible to assess in the current study and remains to be tested.

As explicit acknowledgement of the rupture was absent, the hypothesised component of accepting responsibility for the therapist's own role in the rupture was not validated. Ruptures identified in the current study were predominantly withdrawal ruptures, which may explain the lack of explicit acknowledgement as these may be managed more covertly (Aspland et al., 2008). However, incomplete resolution of withdrawal ruptures meant they often perpetuated into confrontation ruptures or over-compliance. In contrast to Aspland et al. (2008), the final model advocated for the therapist acknowledging their own limitations in therapy. Also, analyses supported the notion of rupture resolution as a cumulative process, as suggested by Harper (1994), and that each resolution attempt might only reflect a 'partial task solution' (Greenberg, 1984).

Other components of the final model in common with Aspland et al.'s (2008) model included linking to the formulation, and restoration of the alliance. However, an important component of the current study's model was the 'external observer', which encompassed taking a reflective stance with an emphasis on collaborative inquiry. Furthermore, the final model in the current study included therapists' emotional self-disclosure. This supports the psychoanalytic literature which advocates for affective experience as a means of resolution (Newirth, 2000; Strean, 1999; Watson & Greenberg, 2000). Emotional self-disclosure is suggested to help clients incorporate difficult feelings which have been 'projected' into the therapist, thus facilitating a corrective emotional experience (Newirth, 2000).

A key component of Bennett et al.'s (2006) model, which applied to clients with BPD also emphasised affective experience. Specifically, facilitating the client in experiencing core feelings activated in-session; a component not included in Aspland et

al.'s (2008) model. Based on the inclusion of emotional self-disclosure in the current study, and the affective component in Bennett et al.'s (2006) model, it may be that when seeking to resolve alliance ruptures with clients with BPD, a focus on the affective experience is important.

'Negotiation of task' was another component of the final model not validated by analyses. Furthermore, the first rational-empirical model proposed 'revising the therapeutic approach'. This specified focusing on the schema activated in-session, and experiencing this emotion within therapy, thus facilitating schematic restructuring (Young et al., 2003). Empirical analyses did not confirm this affective component. However, based on previous discussion, if rupture resolution with BPD clients is achieved through affective experience, a schema approach is likely to be useful. The occurrence of alliance ruptures has been evidenced to be associated with the emergence of clients' schematic 'core conflictual relational themes' (Sommerfield et al., 2008). Furthermore, schema therapy (Young et al., 2003) is recognised as a treatment for BPD. Results emphasised the importance of being responsive to clients' emotional needs for rupture-repair. Schema therapy advocates for 'limited reparenting'; the notion that within the bounds of the therapeutic relationship, the therapist meets and responds to the client's emotional needs, which were denied in early childhood (Young et al., 2003). The notion of responsivity to clients' feelings is evident in this approach however, it is clear that the affective component of the model needs further testing.

Clinical Implications

The final theoretical rupture resolution model may be useful in supervision when working with BPD clients using CBT, during training, and for direct clinical work. With regards to the latter, it is important to respond to the client's emotional needs and acknowledge the client's feelings. This change in approach to attend to the client's

experience is advocated, as is exploring patterns of problematic interpersonal interaction, with reference to past and present relationships. It is then possible to make links to the client's formulation, using this as a tool for understanding. The notion of an 'external observer' suggests taking a reflective stance; for example, making attempts to gain emotional distance from the situation, and looking at events more objectively. Being empathic, validating the client's feelings, and maintaining a position of collaborative inquiry is advocated. The therapist may acknowledge their own limitations to facilitate rupture resolution, and a degree of emotional self-disclosure is identified as beneficial. Furthermore, encouraging the client's participation in therapy, emphasising their responsibility in this, and affirming their contributions are suggested.

Methodological Critique

As recognised by Aspland et al. (2008), the study of two therapeutic dyads is suitable for theory-building case study research (Rosenwald, 1998). It also allowed the researcher to follow through the cumulative rupture resolution process. However, rupture-repair sequences are likely to vary across other cases, which the small sample in the current study would not have captured. Furthermore, a related issue is that small sample sizes create potential biases in results. Not only this but some hypothesised components of the final model were not supported by empirical analyses, yet data from other cases might have validated these components.

Due to missing audiotapes, both selected cases in this study demonstrated good outcome. It was therefore not possible to compare the rupture resolution model with cases who demonstrated no improvement or poor outcome. Comparisons with these cases might have allowed further refinements to, and increased confidence in the final model. It was however possible to make comparisons with Aspland et al. (2008) and Bennett et al. (2006).

The identification of sessions for analysis was based on Stiles et al.'s (2004) quantitative criterion for the identification of rupture-repair sequences. This objective statistical criterion meant confidence in qualitative data was increased as sessions were selected on quantitative grounds (Agnew, Harper, Shapiro & Barkham, 1994). Furthermore, evidence of the internal consistency and validity of the ARM is reported (Agnew-Davies et al., 1998). However, whilst a reliance on the client's perspective of the alliance is viewed as valid (Waddington, 2002), using the therapists' ARM scores may have generated different examples of ruptures.

Obtaining qualitative data from therapists about the internal process of rupture resolution would have been helpful and added more detail to the model. This would have also allowed assessment of whether internal acknowledgement of the alliance rupture took place. Videotapes of sessions would also have been helpful to allow visual observations of alliance ruptures as they occurred.

The use of the CORE-OM to define therapeutic outcome was a strength of this study. This measure is a reliable and valid instrument with good sensitivity to change (Barkham et al., 2001; Evans et al., 2002). However, unfortunately missing data for two of the participants meant therapeutic outcome could not always be calculated.

Task analysis (Greenberg, 1984; Greenberg & Foerster, 1996) is a valuable research tool for understanding the processes involved in rupture resolution. In this study, 41 rupture resolution attempts were systematically analysed. Markers of rupture and repair were clearly defined, and identification guided by previously established behavioural indicators.

O'Connell and Kowal (1995) note that there are many possible transcripts of the same conversation. The transcriber was therefore given clear guidelines prior to transcription, and the researcher read every transcription whilst listening to audiotapes to ensure accurate interpretation. Furthermore, due to the reflexive nature of qualitative

research, credibility safeguards are needed to ensure validity and reliability of results (Elliott, Fischer & Rennie, 1999). Rupture and repair markers were consensually identified by both the researcher and independent supervisors, and the use of multiple qualitative analysts working to consensus aimed to ensure data credibility. The researcher kept a reflective diary throughout the task-analytic process. This included reflections on how the researcher's own theoretical perspective might have influenced analysis, discussed with supervisors throughout the task-analytic process.

Future Research

The current study represents an initial attempt at building a rupture resolution model when using CBT with BPD. Refinements to the model based on empirical analyses of further cases would increase confidence in the model and the extent to which it can be generalised. Comparing the model against data from no improvement and poor outcome cases is necessary. Future research might also consider therapist reports of ruptures and how these are managed. This would allow assessment of the therapist's internal processes, including whether the therapist internally reviewed whether an interpersonal rupture applied to the alliance.

A focus on more cases is likely to generate further hypotheses for testing, and would also allow investigation into whether components of the model which remain to be validated are important. Particularly, the suggestion that a focus on affective experience is important when seeking to resolve alliance ruptures with BPD clients needs further research. This may focus on whether the application of a schema approach, in which the client experiences feelings triggered in-session, is successful for rupture resolution.

Conclusions

- Ruptures arose from therapists not attending to the client's experience, or emotions associated with this.

- Continuing to implement therapeutic technique perpetuated the rupture.

- Progress toward resolution took place only when therapists changed their approach to explore the salient issue for the client.

- Ruptures arose from clients seeking to avoid tasks, or being unresponsive to therapist intervention. However, tentatively bringing the client's attention back to the salient issue facilitated resolution.

- Similarities were shared with Aspland et al.'s (2008) model: alliance ruptures were not explicitly acknowledged; exploration; linking to the formulation; restoration of the therapeutic alliance.

  - Additional components to the model included 'external observer', which encompassed tentatively bringing the client back to salient issues, acknowledgement of own limitations, and emotional self-disclosure.

- Focus on affective experience appears to be important when seeking to resolve alliance ruptures with BPD clients, although further research in this area is recommended.

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SECTION 3

Appendices

Appendix A: Formats

- Guidance for Authors for Clinical Psychology Review and

Psychotherapy Research Journals

-Letter of University Approval of Journal Choice

Appendix A: Guidance for Authors; Clinical Psychology Review Journal.

Guidance for authors has been removed.

Appendix A: Guidance for Authors; Clinical Psychology Review Journal, continued.

Guidance for authors has been removed.

Appendix A: Guidance for Authors; Clinical Psychology Review Journal, continued.

Guidance for authors has been removed.

Appendix A: Guidance for Authors; Clinical Psychology Review Journal, continued.

Guidance for authors has been removed.

Appendix A: Guidance for Authors; Clinical Psychology Review Journal, continued.

Guidance for authors has been removed.

Appendix A: Guidance for Authors; Clinical Psychology Review Journal, continued.

Guidance for authors has been removed.

Appendix A: Guidance for Authors; Clinical Psychology Review Journal, continued.

Guidance for authors has been removed.

Appendix A: Guidance for Authors; Psychotherapy Research Journal.

Guidance for authors has been removed.

Appendix A: Guidance for Authors; Psychotherapy Research Journal, continued.

Guidance for authors has been removed.

Appendix A: Guidance for Authors; Psychotherapy Research Journal, continued.

Guidance for authors has been removed.

Appendix A: Guidance for Authors; Psychotherapy Research Journal, continued.

Guidance for authors has been removed.

Appendix A: Guidance for Authors; Psychotherapy Research Journal, continued.

Guidance for authors has been removed.

Appendix A: Letter of University Approval of Journal Choice .

Letter of University Approval of Journal Choice has been removed.

Appendix B

Ethical Approvals

- Confirmation of Ethical Approval for the SPeDi Trial

- Letter of University Ethical/Protocol Approval

Governance Approvals

- Confirmation of Research Governance Approval for the

SPeDi Trial

- Letter of University Research Governance Approval

Appendix B: Confirmation of Ethical Approval for the SPeDi Trial.

Confirmation of Ethical Approval for the SPeDi Trial has been removed.

Appendix B: Confirmation of Ethical Approval for the SPeDi Trial, continued.

Confirmation of Ethical Approval for the SPeDi Trial has been removed.

Appendix B: Confirmation of Ethical Approval for the SPeDi Trial, continued.

Confirmation of Ethical Approval for the SPeDi Trial has been removed.

Appendix B: Confirmation of Ethical Approval for the SPeDi Trial, continued.

Confirmation of Ethical Approval for the SPeDi Trial has been removed.

Appendix B: Letter of University Protocol Approval.

Letter of University Protocol Approval has been removed.

Appendix B: Confirmation of Research Governance Approval for the SPeDi Trial.

Confirmation of Research Governance Approval for the SPeDi Trial has been removed.

Appendix B: Letter of University Research Governance Approval.

Letter of University Research Governance Approval.

Appendix C: Measures

Clinical Outcomes in Routine Evaluation – Outcome Measure
(CORE-OM: Barkham et al. 2001; Evans et al., 2002)

Agnew Relationship Measure
(ARM: Agnew-Davies et al., 1998)

Appendix C: CORE-OM: Barkham et al. (2001); Evans et al. (2002)

The CORE-OM has been removed.

Appendix C: CORE-OM: Barkham et al. (2001); Evans et al. (2002), continued.

The CORE-OM has been removed.

Appendix C: ARM: Agnew-Davies et al., (1998).

The ARM has been removed.

Appendix D

Graphs to Show Client-Rated ARM Scores Across Therapy

& Regression Curves

Appendix D: Client-Rated ARM Scores Across Therapy for Participant 1.
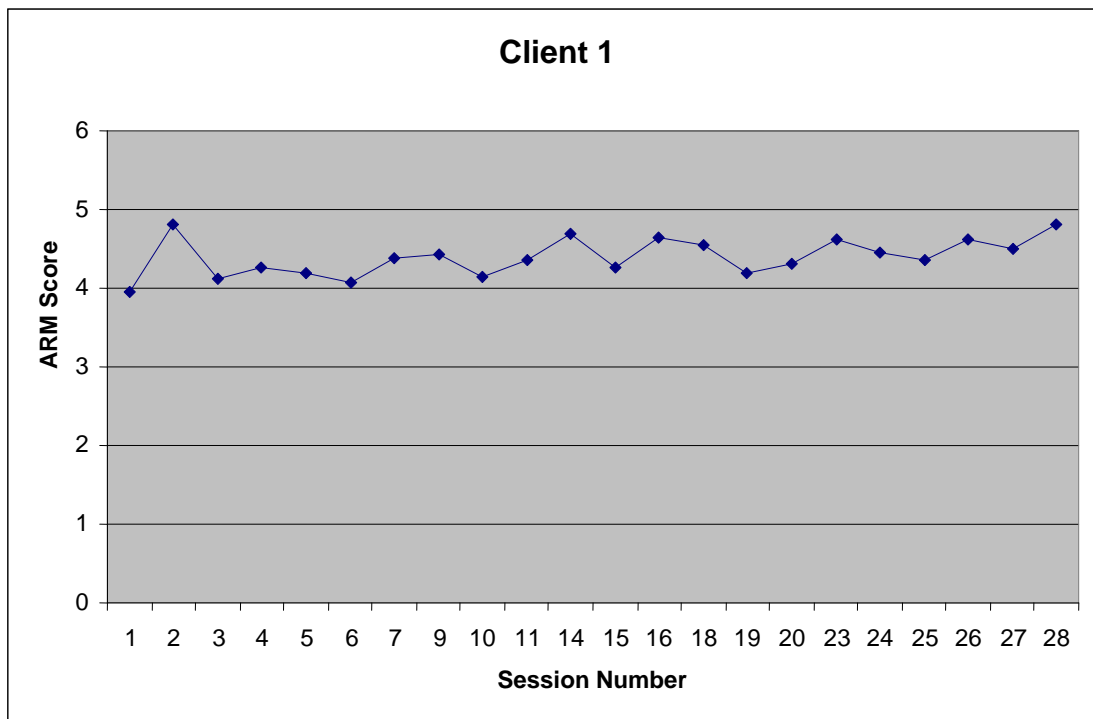
Appendix D: Client 1 Regression Curve
               No improvement client
               No ruptures identified
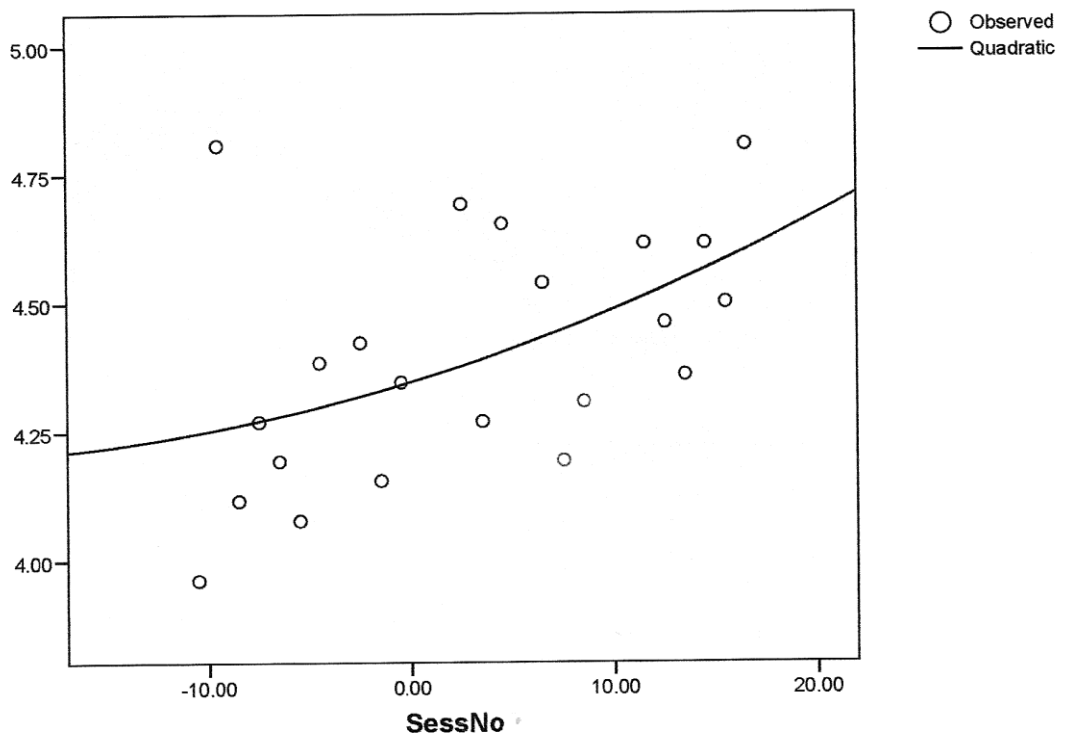
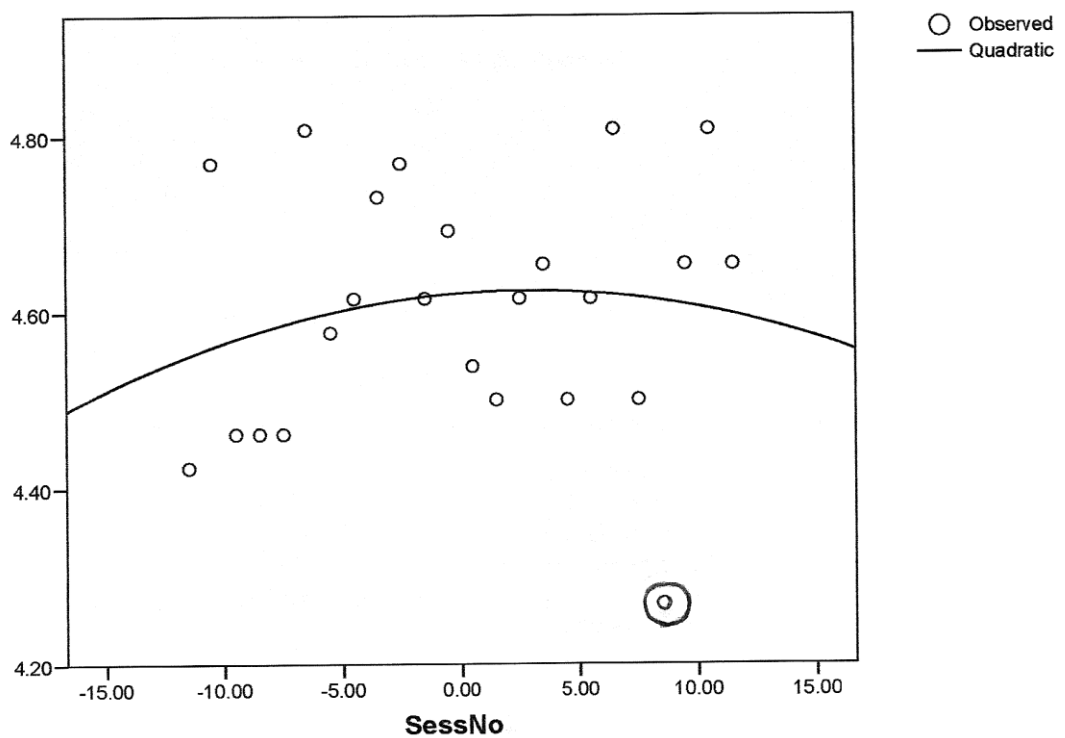Appendix D: Client-Rated ARM Scores Across Therapy for Participant 2.
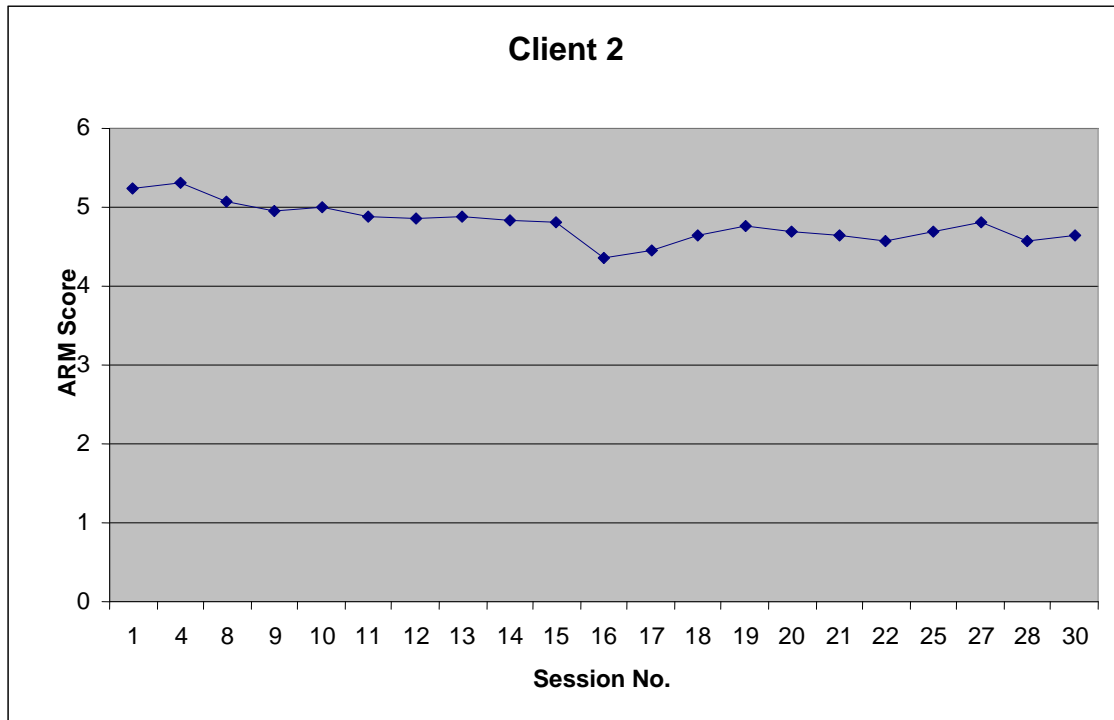
Client 2

Appendix D: Client 2 Regression Curve
                Good outcome client
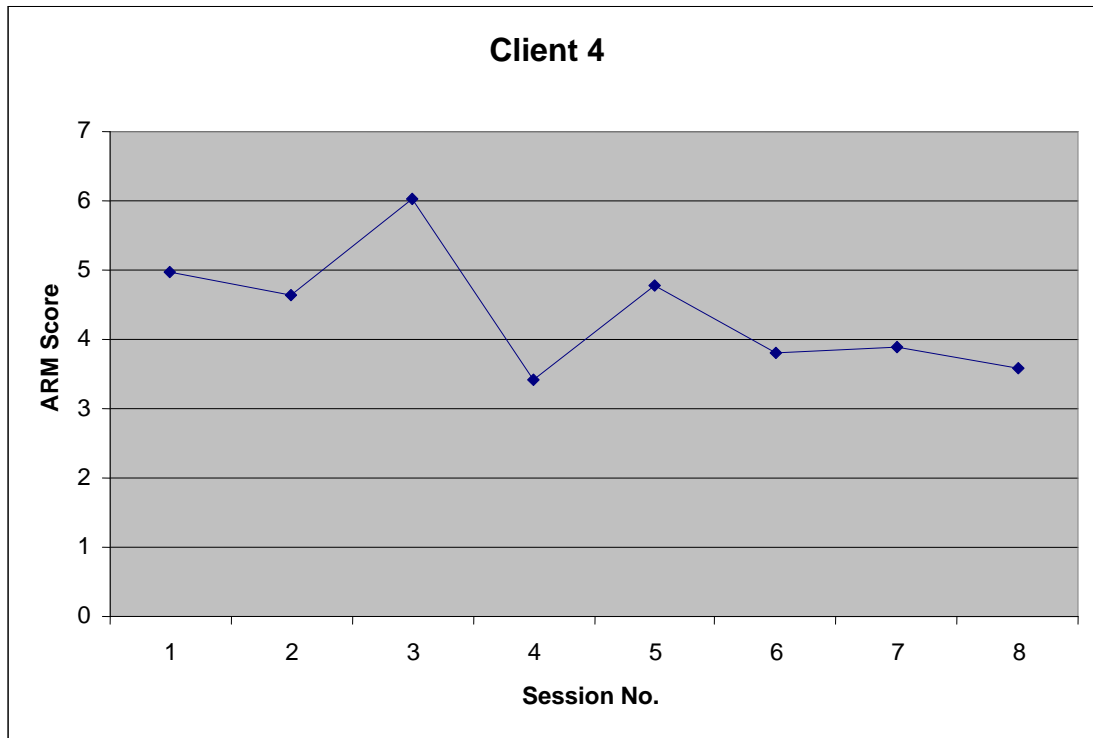   Rupture session is highlighted
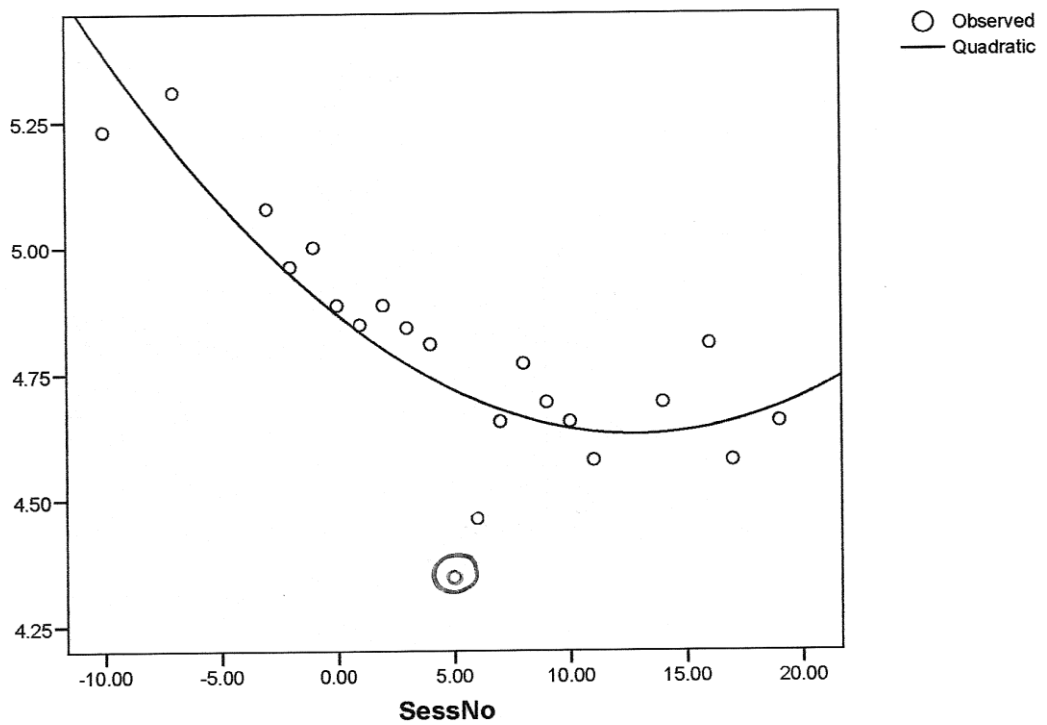
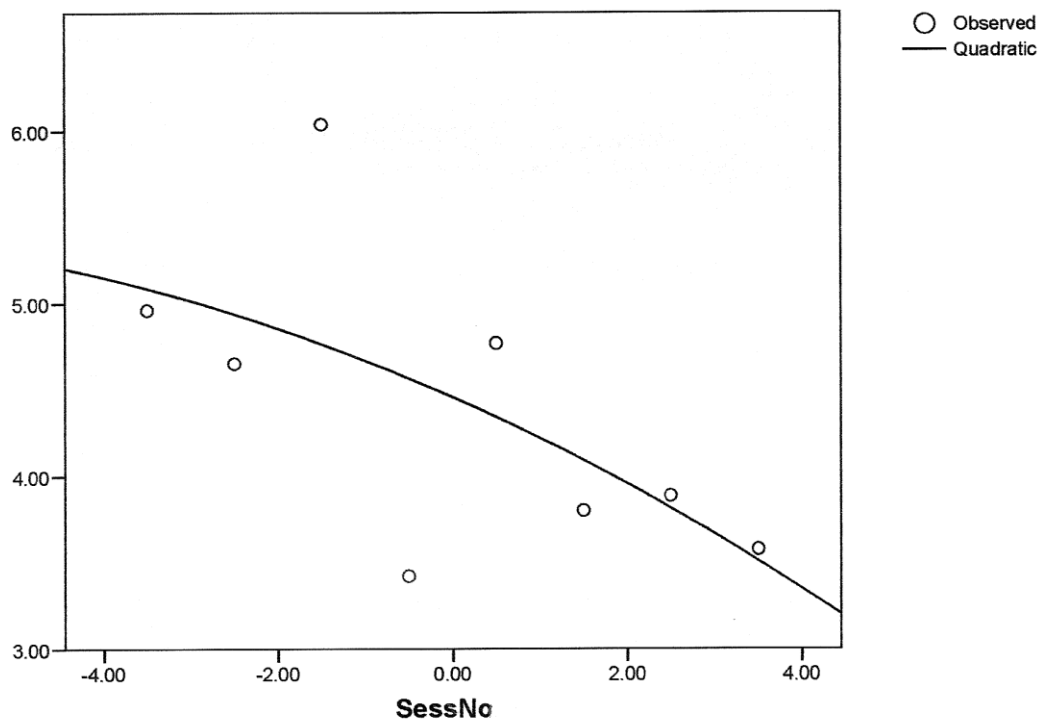Appendix D: Client-Rated ARM Scores Across Therapy for Participant 3.
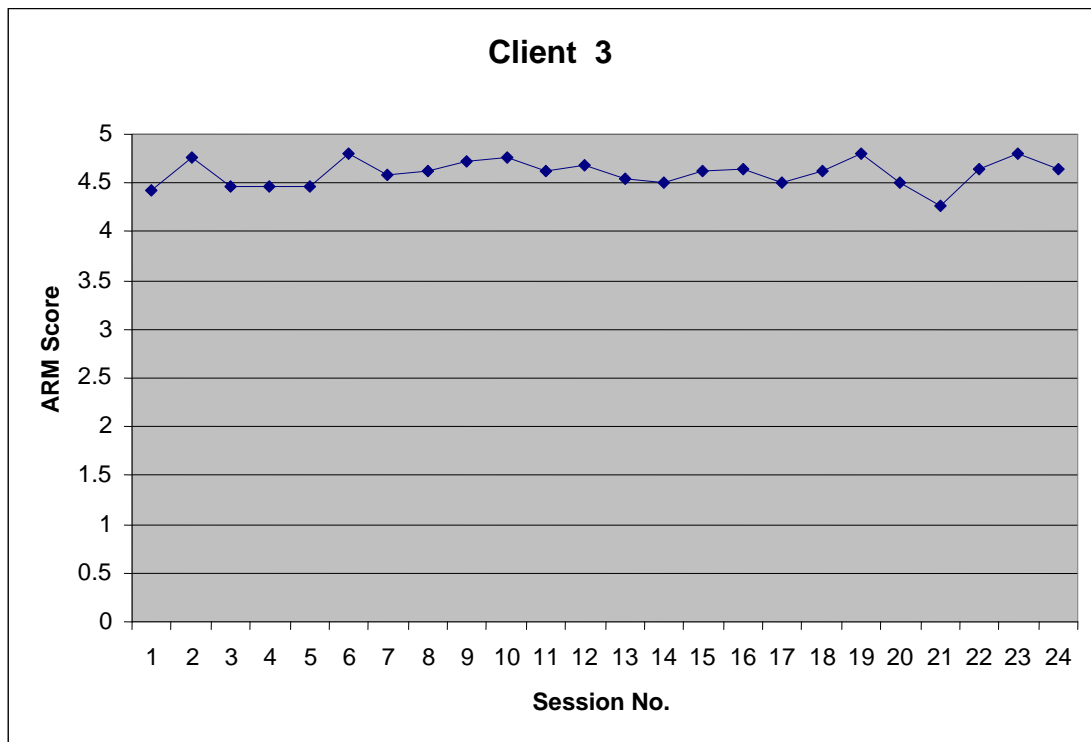
Client 3

Appendix D: Client 3 Regression Curve
               Good outcome client
               Rupture session is highlighted
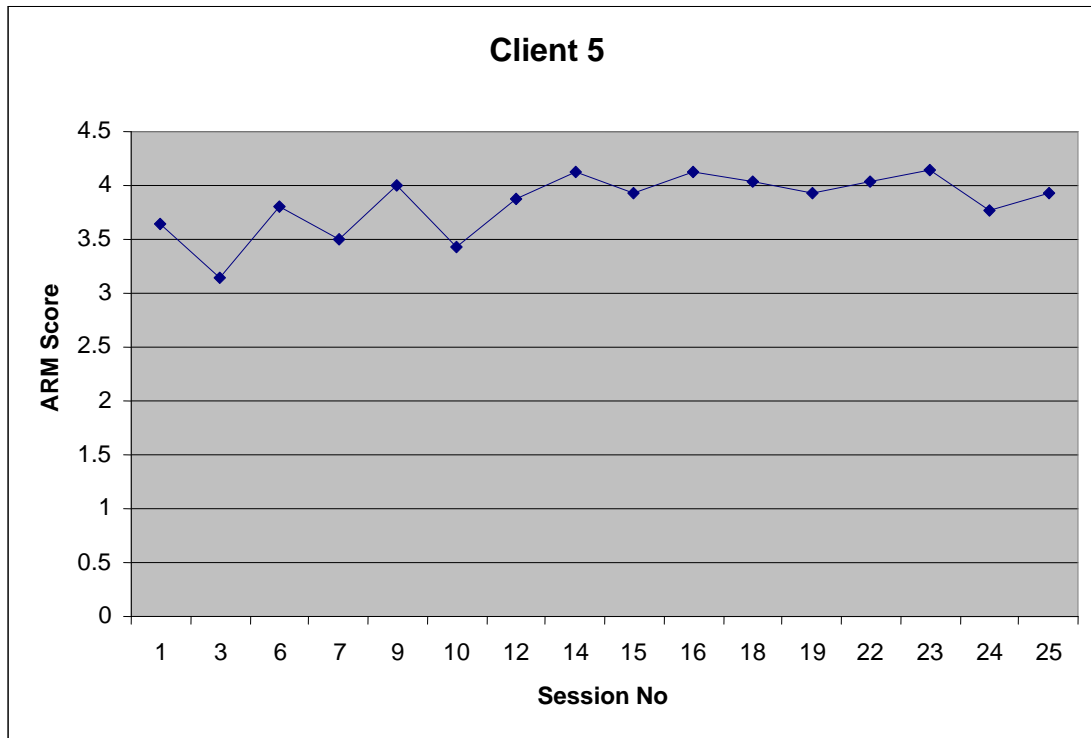
Appendix D: Client-Rated ARM Scores Across Therapy for Participant 4.
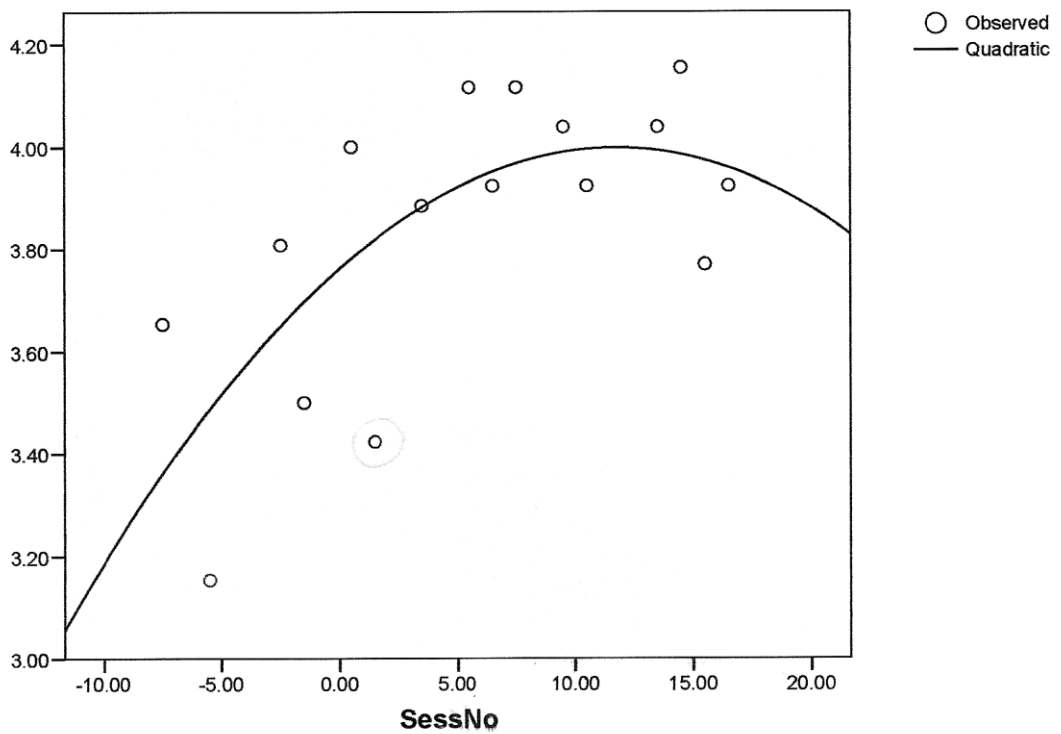

Appendix D: Client 4 Regression Curve
                No ruptures identified
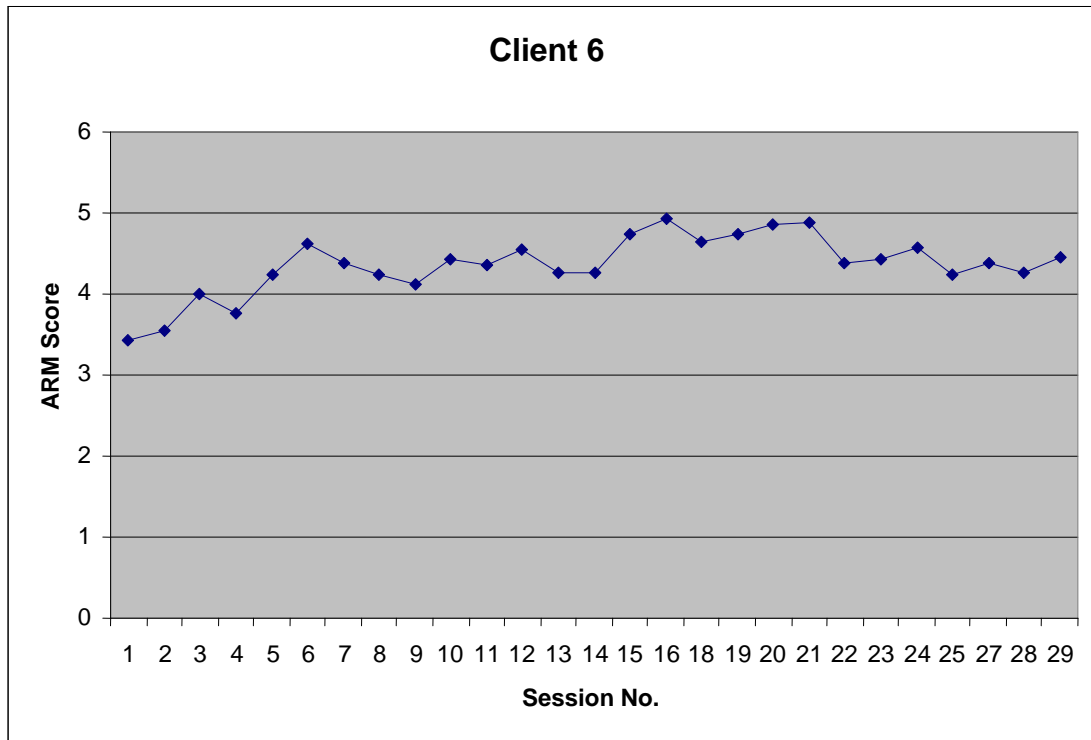
Appendix D: Client-Rated ARM Scores Across Therapy for Participant 5.
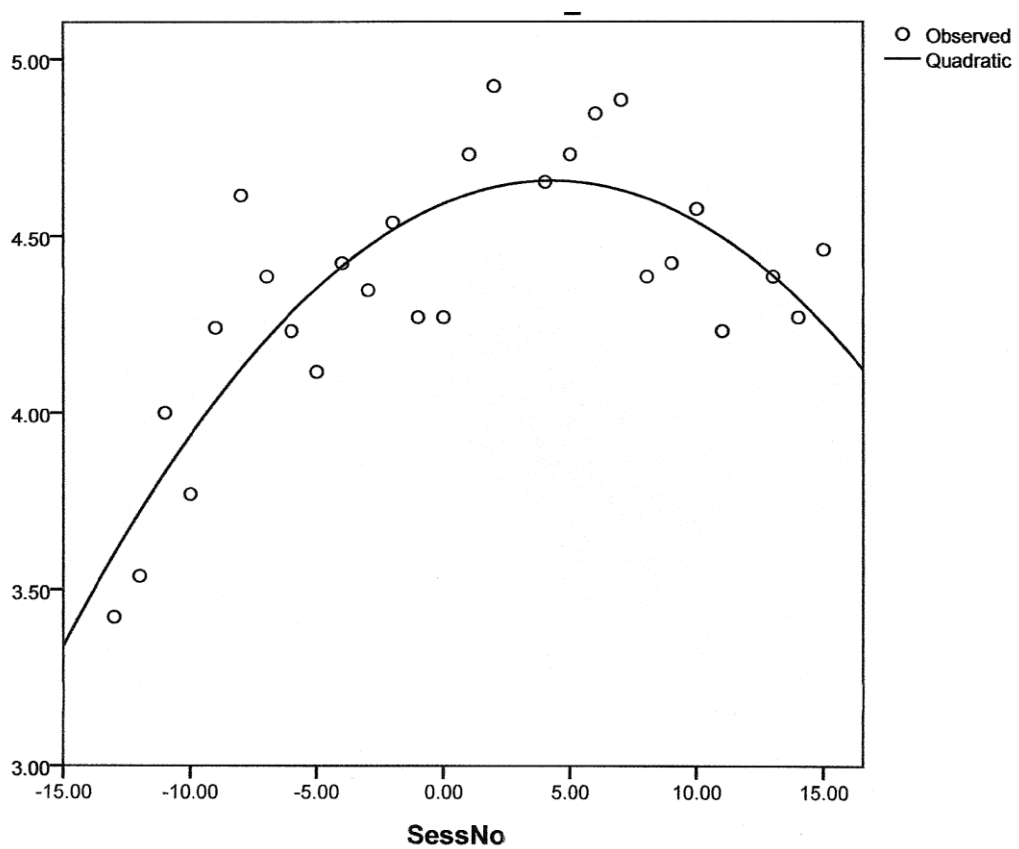

Appendix D: Client 5 Regression Curve
               No Improvement Client
               Rupture session is highlighted

Appendix D: Client-Rated ARM Scores Across Therapy for Participant 6.

Appendix D: Client 6 Regression Curve
                No improvement client
                No ruptures identified

Appendix D: Client-Rated ARM Scores Across Therapy for Participant 7.

Client 7

Appendix D: Client 7 Regression Curve
                Good outcome client
                Rupture session is highlighted
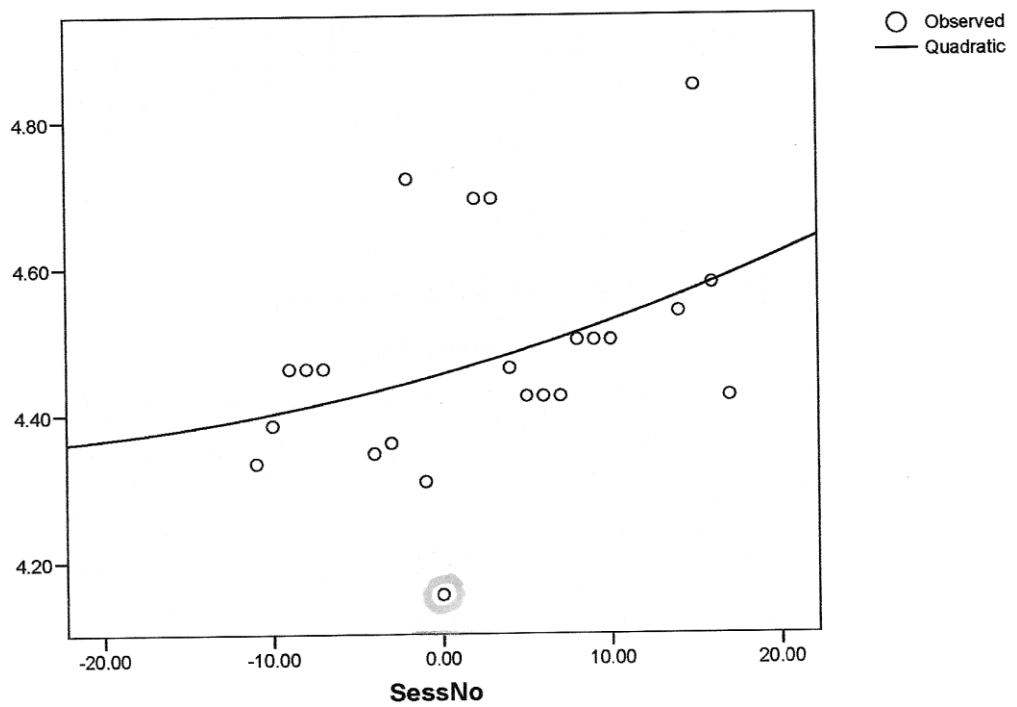
Appendix D: Client-Rated ARM Scores Across Therapy for Participant 8.

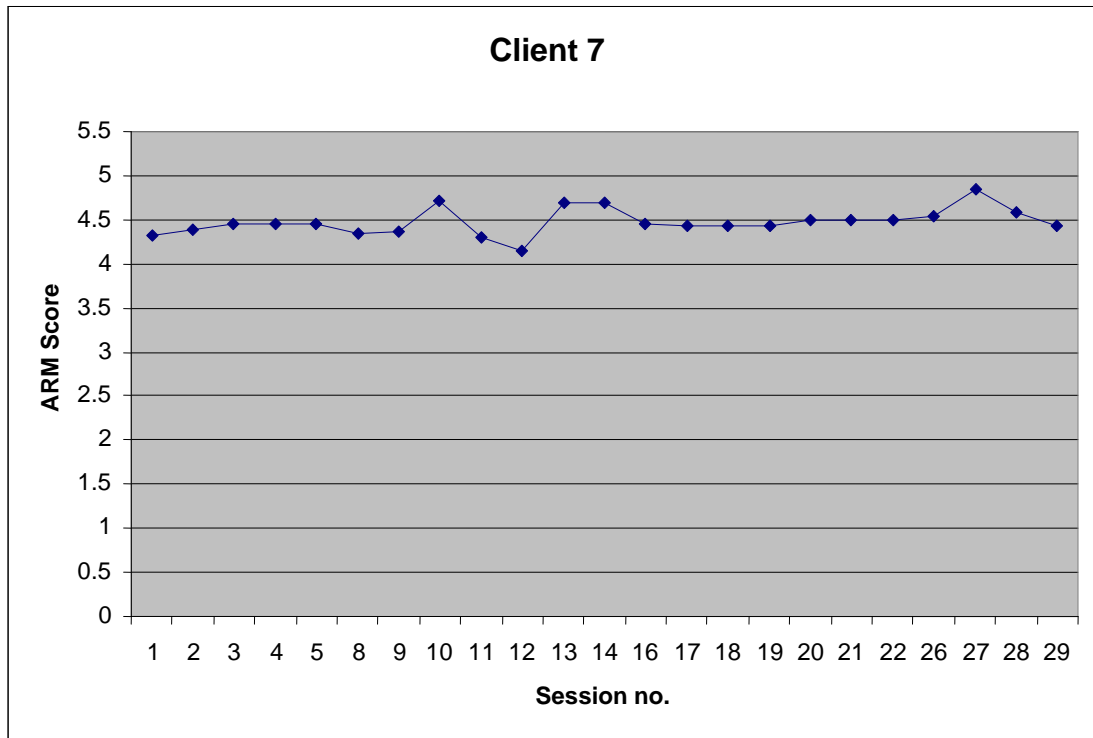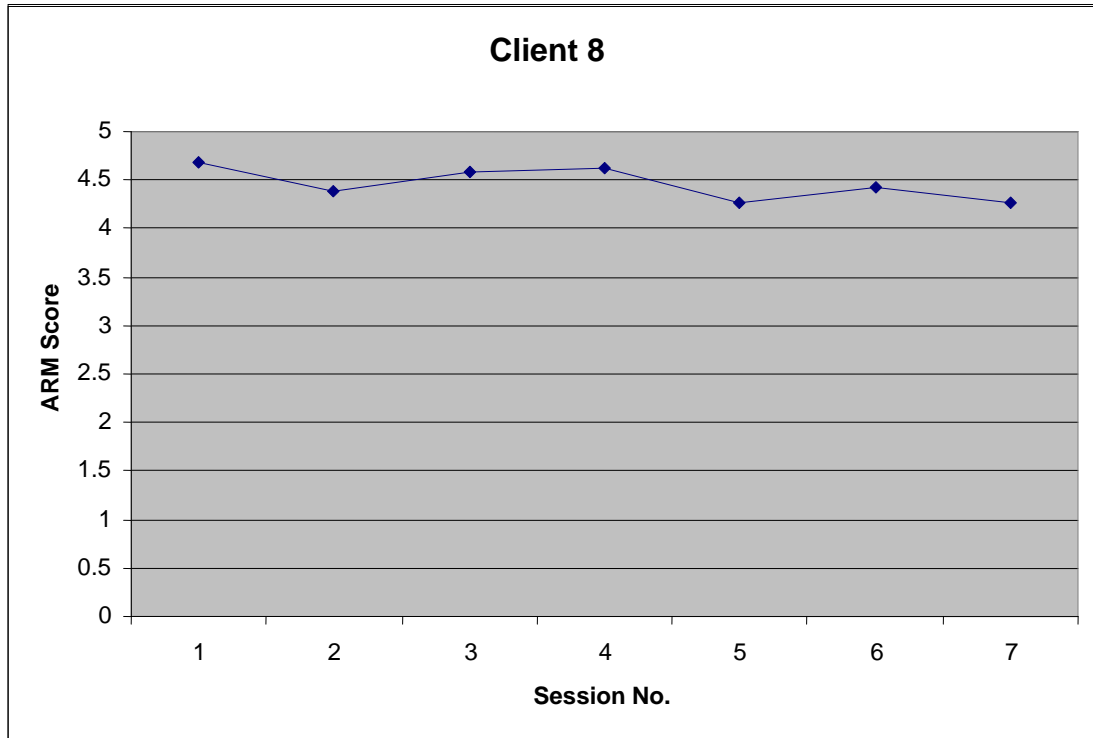Appendix D: Client 8 Regression Curve
                No ruptures identified
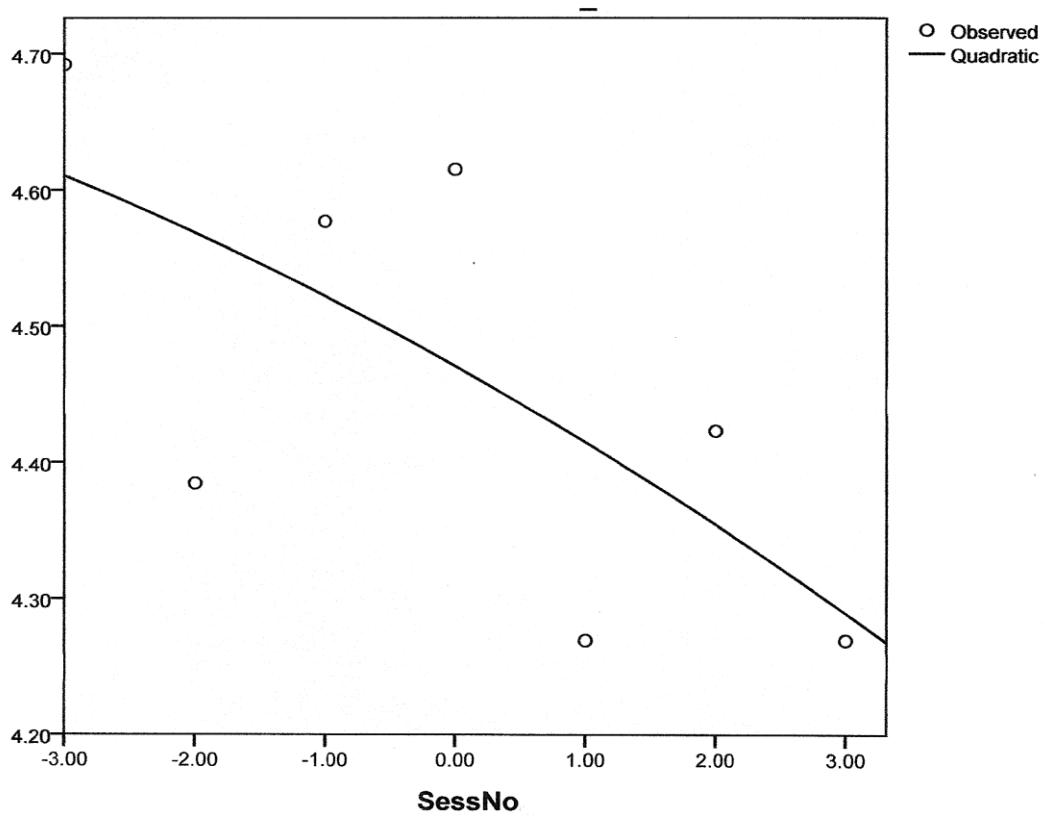
Appendix E

- Guidelines for Transcriber

- Confidentiality/Consent Form

Appendix E: Guidelines for Transcriber.

Transcription guidelines have been removed.

Appendix E: Confidentiality/Consent Form.

The confidentiality/consent form has been removed.

Appendix E: Confidentiality/Consent Form, continued.

The confidentiality/consent form has been removed.

Appendix F

In-Session Behavioural Indicators of Ruptures

(Harper, 2004; Samstag, Muran & Safran, 2003) &

Extract from Analysed Transcript: Exemplar

Appendix F: Harper (2004) Behavioural Indicators of Ruptures.

Harper's (2004) behavioural indicators of ruptures have been removed.

Appendix F: Harper (2004), continued.

Harper's (2004) behavioural indicators of ruptures have been removed.

Appendix F: Samstag, Muran & Safran (2003) List of Rupture Marker Behaviours

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The list of rupture marker behaviours (Samstag et al. 2003) has been removed.

Appendix F: Extract from Analysed Transcript: Exemplar

Client 7. Session 13.

Ruptures are indicated by an underline, and the therapist's attempts at resolution highlighted in bold. The researcher's notes are indicated by brackets.

T represents the therapist. P represents the patient.

T78   *Let's think about your past. You pointed out that you started self harming. So what happened there?* (Contradictory statement; the therapist asks about the past but in the same sentence about self-harm).

P80   *I don't know* (withdrawal; minimal response, and patient then shifts topic). *I am having a big problem with trust issues all the time.* (Trust issue was mentioned in previous session). *I am really not sure. I mean even with my really close friends, they don't do anything to make me suspicious or do things to make me think I can't trust them, it is just that recently, people that I can normally rely on have let me down and so, kind of like, I am wise of that with everybody no* (Does the patient feel this towards the therapist?). *It is almost like I am on guard again.*

T86   *Is that something that we need to put on the agenda for today?* (No reference to the alliance made; note the influence of researcher's own perspective, i.e., psychodynamic theory. Therapist does not acknowledge emotional content of what was said/trust issue, but continues to implement technique). *What do you think?*

P87   <u>*I think it is just me not taking things in the correct context of things and blowing it out of proportion and then getting stressed about it*</u> (withdrawal; patient disregards therapist's comment. Minimises significant of what was said. Patient continues to describe what is important to him). *I have been quite sarcastic to a*

few people this week and I have made sure that that they have known that I have not been joking, you know what I mean? It is like a nasty side and ordinarily I won't let it pass because other people have let me down.

T92   **That is a big thing for you being let down, isn't it (P)?** (Acknowledgement of being let down).

P93   *Yes* (Re-engagement; agreement, and patient expands on answer). *If it is people I expect to let me down, then I am not bothered but with people that I don't think will let me down it makes me feel "what's next then?"*

T95   *Let's have a think about how we can use today* (Again, no reference made to the alliance. Therapist returns to the agenda). *It is great to see you have got your homework. Let's look at that. Anything else we need to put on your agenda? We need to look at timing of the session.*

P98   <u>I don't know</u> (withdrawal; minimal response. Patient appears despondent as trust issue is not discussed further. Instead attention is brought back to the agenda). *PAUSE.*

I have been a bit obsessive recently about people and what they think about me (is this comment also relevant to the alliance?). *Most of the time it is like everyday people, I don't even want to talk to them but with people who I think that I know and think I can trust* (repetition of important issue for the client), *I don't know it is almost kind of like, because I am going through a bit of a slump, it is like I need that reassuring kind of thing* (does the patient need reassuring from the therapist?) *and it was a way of getting it to an extent. It did not turn me nasty but it put me really on guard* (this is the second time the patient said this).

Appendix F: Extract from Analysed Transcript: Exemplar, continued.

T104 *Is that what you want to put on the agenda for today?* (Therapist continues to refer to agenda; does not explore the relevance of what the client has said for the therapeutic alliance) *If I put it in the slump then we know what we mean about that, and reassurance. So, we have got looking at homework, plan a session, I guess that could come at the end and the slump. What do you think about the timings of homework and slump, about fifteen minutes?* (Therapist still does not acknowledge trust issue).

P108 <u>*I will take it at your pace.*</u> (Over-compliance; passive, helpless role in therapy. Patient hands responsibility for the session to the therapist).

T109 ***Remind me how I was asking you to do this?*** (Re-engagement effort: therapist asks questions; emphasis on the client's responsibility in the session).

P110 *To see how I used my days and nights to the best of my abilities without getting into, kind of like being in a rut still. I just put slump because it is just the same thing. It is really bad and there is only so much that I can do about it, and it is worrying me a bit as well because it is just like this, this and this, the same thing everyday and it is getting dull.*

T115 ***Your sleep is still poor isn't it?*** (Therapist continues to ask questions to explore and clarify).

P116 *Yes* (agreement; patient is on board with the conversation)*, I have talked to my doctor about that and again he has said to try and catch forty winks whenever because if you are feeling tired, just try and have forty winks, but you have got to try and catch your time up. It has not been very good, it is probably making me more erratic. If somebody says something to you and I take it out of context.*

Appendix F: Extract from Analysed Transcript: Exemplar, continued.

T121 **What do you think?** *Tell me a little bit about why you think you feel so much different.* (Re-engagement effort; therapist takes a position of collaborative inquiry. Therapist asks for contributions from the patient; emphasises patient view as important).

P122 *I just can't switch my brain off, it is full of crap. It is not even stuff, some of it is important and it is like, an example of a letter last week saying regardless of anything, pretty much, this charge against me that I didn't even know about for four and a half years, I only found that out when I applied for SHED and went through all the training and all that stuff and they said "you have got a criminal record" and I said "I'm sorry?" That was the first time I heard about it as well. Basically because of the line of work that I want to go into, drugs and alcohol counseling, that kind of thing and basically that is going to come up every time now and I was doing really well with the course and stuff and this is going to come up every time. The good thing is that now I can at least tell them up front from now on and explain about it.* (Patient is expanding on answers; suggests patient is starting to re-engage in the session)

T132 **Are those the sort of things that are keeping you awake?** (Therapist continues to ask questions to explore) *Not being able to switch off, that you keep dwelling on things? You have put here, 'Ritzville'?*

P134 *That was a polite word.*

T135 (Therapist does not ask the patient about what they mean) *The other thing I am looking at is helping you change some of your unhelpful behaviors and start behaviours that we call self nurturing really.*

Appendix F: Extract from Analysed Transcript: Exemplar, continued.

P137 *That's why this is good with these explanations in it really rather than just going – self harm* (Patient is finding the diary useful). *It is like this, I do try but nine times out of ten it doesn't work and then it just gets me more frustrated.*

T140 **In here, tell me a bit about things like when are you eating?** (Therapist continues to ask questions to explore and clarify contents of diary).

P141 (Re-engagement occurs; patient answers question asked, and expands on their answer). *When I feel hungry, that's really crap. I got shouted at the other day because a friend of mine said, "you have lost another half a stone". He only saw me about three weeks ago and basically I was getting more like a skeleton. He said I was wearing a shirt, a t-shirt and "you have got them both tucked in and a belt on and those trousers are still loose on you".*

T146 **Let's** (emphasis on collaboration) *think about how much, if this was somebody else to whom you were responsible and they weren't eating very much and were losing weight.* **What would you say to them?** (Re-engagement efforts continue: therapist takes a reflective stance; encourages client to reflect).

P149 *I would be having a go. Well I wouldn't be having a go at him, I would be telling him he is not looking after himself* (Therapist comment appears to have helped the patient gain emotional distance from the situation to be able to think about this situation; engagement continues).

T151 **What would you advise him to do?** (Therapist maintains reflective stance; asks further questions to help the client think about this).

P152 *I would be telling him to take that diary* (patient acknowledges usefulness of diary). *I am very good at looking after others.*

T153 **I know you are** (conveys that they understand the patient).

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P154   *And getting other people to listen to me* (patient remains engaged).

T155   **Absolutely** (Validation; affirms the patient).   *Now **let's*** (emphasis on collaboration) *think about how we could transfer that, that caring of other people, into yourself.* **Fantastic that!** *(Refers to the diary;* Therapist affirms the client's contributions. Also, emphasises the client's role in therapy).

P157   *That's because I care about other people. I am bothered about me but it is kind of like, the way I see me, like a good person, if I am helping someone out. Do you know what I mean?*

T160   **I can feel that** (Therapist validates the client, conveys understanding; therapist emphasises that they have really heard what the patient has said).

P161   (Engagement continues as the client continues to reflect on and talk about this topic) *It is like with the guy I sponsor, he cancelled his appointment with all the floods and that kind of stuff and he had to get down to London and there were no trains and no coaches and half the panel weren't going to be there anyway so there was no point. So he had it rescheduled for this Friday and I was speaking to him because he was getting quite nervous obviously, and I spent about half an hour on the phone to him, then he sent me a text yesterday morning saying "thanks for last night mate, I really, really needed that" and all that kind of stuff and that made me feel good. Unless I am doing something, I am very eager to do things for other people, but I am not very eager to do things…*

T170   **for you?** (Therapist indicates they have been listening by anticipating what the patient was about to say; clarifies and conveys understanding).

P171   *Yes* (patient feels understood).

Appendix F: Extract from Analysed Transcript: Exemplar, continued.

T172   *And again it is about trying to have some understanding, perhaps in relation to what we have been talking about, the way that you think about yourself, the words that you used about yourself like 'useless', 'shit', 'crap', all those words that you have used about yourself and about other people. Some people are unpredictable and can't be trusted* (summarises what the client has been saying; uses the client's words) *and all of those ways that you kind of see yourself, and in some ways it makes perfects sense because you feel so bad, and by doing things for others you feel better about yourself. I can understand that link* (validates the client's feelings/ways of seeing self and others)*, but I just wonder what the opposite link is, by you not caring for yourself and not nurturing yourself, what do you think that stems from?* (encourages client to reflect and participate; asks for their contributions).

P181   *All that tells me that I really believe in all that, that I do think that way about myself* (patient reaches their own conclusion)*.*

T182   **I wonder whether together** (tentative, and emphasis on collaboration) *we could see about reducing all those things that keep you feeling bad.*

P184   <u>*That is kind of like*</u> (withdrawal; shifts topic, and talks incessantly. The therapist had tentatively suggested thinking about change)*, when I am helping other people, that is my way about feeling…*

Appendix G

Aspland et al. (2008)
Rupture-Resolution Model in Cognitive Behaviour Therapy

Appendix G: Aspland et al. (2008). Rupture Resolution Model in Cognitive Behaviour
Therapy

The rupture resolution model (Aspland et al. 2008) has been removed.

Appendix H

The Final Rational-Empirical Model

Appendix H: The Final Rational-Empirical Model.

SCHEMA RELATED CLIENT RUPTURE MARKER

A. Acknowledgement of interpersonal rupture outside of therapy

A. Therapist internally reviews whether this applies to the therapeutic alliance

B. Therapist acknowledges client's **feeling**/a pattern/problem emerging that troubles the client and prevents progress (in and/or out of therapy)

"EXTERNAL OBSERVER"

-Reflective stance
-Validation of emotion
-Empathy
-Emotional disclosure
-Collaborative inquiry; ask for client's contributions and seek to understand
-*Acceptance of responsibility for own role in rupture;* acknowledgement of own limitations
-Tentatively bringing the client back to salient issues

C. Change in approach (from implementation of therapeutic technique):

PATTERN RECOGNITION
Exploration of patterns of interpersonal interaction with reference to:
-*therapeutic alliance*
-relationships outside therapy
-past relationships

D. Make links pertinent to client's **FORMULATION** as a means of development or validation:
Clarification   Summarising

E. **RESTORATION** of therapeutic alliance by:
-Encouraging client's active participation in therapy
-Affirming client's contributions
-Emphasising responsibility of client's role in therapy and empowering the client

Revised therapeutic approach:
FOCUS ON ACTIVATED SCHEMA
-*reflecting on aroused emotion & experiencing*
-*restructuring of schema*

F. Negotiation of task

Client and therapist collaboratively pursue therapeutic task