APPROVAL

Name: Jacqueline Kate Gruter-Andrew
Degree: Master of Arts
Title of Thesis: Identifying Working Alliance Ruptures in Couples Therapy: A Quantitative and Qualitative Analysis

Examining Committee:

Chair: Patrice Keats, Assistant Professor, Faculty of Education

__________________________
Adam Horvath, Professor Emeritus, Faculty of Education
Senior Supervisor

__________________________
Grace Iarocci, Associate Professor, Department of Psychology
Committee Member

__________________________
Laurie Heatherington, Professor and Chair, Department of Psychology, Williams College
External Examiner

Date Defended/Approved: December 16, 2007
Declaration of Partial Copyright Licence

The author, whose copyright is declared on the title page of this work, has granted to Simon Fraser University the right to lend this thesis, project or extended essay to users of the Simon Fraser University Library, and to make partial or single copies only for such users or in response to a request from the library of any other university, or other educational institution, on its own behalf or for one of its users.

The author has further granted permission to Simon Fraser University to keep or make a digital copy for use in its circulating collection (currently available to the public at the “Institutional Repository” link of the SFU Library website <www.lib.sfu.ca> at: <http://ir.lib.sfu.ca/handle/1892/112>) and, without changing the content, to translate the thesis/project or extended essays, if technically possible, to any medium or format for the purpose of preservation of the digital work.

The author has further agreed that permission for multiple copying of this work for scholarly purposes may be granted by either the author or the Dean of Graduate Studies.

It is understood that copying or publication of this work for financial gain shall not be allowed without the author’s written permission.

Permission for public performance, or limited permission for private scholarly use, of any multimedia materials forming part of this work, may have been granted by the author. This information may be found on the separately catalogued multimedia material and in the signed Partial Copyright Licence.

While licensing SFU to permit the above uses, the author retains copyright in the thesis, project or extended essays, including the right to change the work for subsequent purposes, including editing and publishing the work in whole or in part, and licensing other parties, as the author may desire.

The original Partial Copyright Licence attesting to these terms, and signed by this author, may be found in the original bound copy of this work, retained in the Simon Fraser University Archive.

Simon Fraser University Library
Burnaby, BC, Canada

Revised: Fall 2007
STATEMENT OF ETHICS APPROVAL

The author, whose name appears on the title page of this work, has obtained, for the research described in this work, either:

(a) Human research ethics approval from the Simon Fraser University Office of Research Ethics,

or

(b) Advance approval of the animal care protocol from the University Animal Care Committee of Simon Fraser University;

or has conducted the research

(c) as a co-investigator, in a research project approved in advance,

or

(d) as a member of a course approved in advance for minimal risk human research, by the Office of Research Ethics.

A copy of the approval letter has been filed at the Theses Office of the University Library at the time of submission of this thesis or project.

The original application for approval and letter of approval are filed with the relevant offices. Inquiries may be directed to those authorities.

Bennett Library
Simon Fraser University
Burnaby, BC, Canada
ABSTRACT

It has been suggested that effective therapeutic treatment consists of a pattern of tears and repairs in the working alliance (Horvath, 1995). Ruptures have been investigated in single client therapeutic relationships, with few studies on couple therapy ruptures. This pilot study sought to ascertain whether the Structural Analysis of Social Behaviour (SASB) method or the Rupture Resolution Scale (RRS) identified ruptures in 47 couples' brief therapy sessions. Expert Raters (ERs) completed a questionnaire about the videotaped segments and identified ruptures. ERs observations' were juxtaposed upon SASB and RRS findings.

Results found RRS identified ruptures (RIRs) matched all ER identified ruptures, suggesting that the RRS is accurate at detecting ruptures in couple therapy. The SASB method was less accurate than the RRS. There were indications of differences between the threshold the RRS and ERs had for ruptures. What RIRs represent in couple therapy is discussed. No couple subsystem ruptures were identified.
DEDICATION

This thesis is dedicated with gratefulness, affection and admiration to my long suffering husband Oliver. At times he has been a single parent to our delightful, but energetic, children, Cory and Ash, as I struggled to find the perfect words. I cannot begin to thank him enough for his unwavering support, cups of tea, love – and remarkable parenting skills.
ACKNOWLEDGEMENTS

I have many people to thank for the existence of this dissertation. First and foremost is my mentor Adam Horvath who supported my exploration of ideas, encouraged me, insisted I be realistic, and inspired me to continue even when it was difficult. Thank you for your kindness and patience with my quest for a thesis I could be proud of.

I would also like to thank my committee; Grace Iarocci who patiently read my various thesis proposals, made many useful suggestions, and took precious time to help me, and Patrice Keats and Laurie Heatherington who asked several challenging and thoughtful questions. Thank you!

I would also like to thank Lisa Samstag, who always made me feel welcomed into the academic community, Laura Benjamin who graciously answered my many detailed questions, and Micki Friedlander who was always enthusiastic about my research.

There are not enough words to thank the volunteers who devoted so much time to the extensive coding needs of this study. They include Eun Jung Lee, Rajeewa Wijesinghe and Krista Schultz. Your generosity, dedication and hard work has been invaluable. Thank you so much for your amazing efforts, many meetings, and desire to help this project be finished.

I would also like to thank the other people who freely gave this study the benefit of their expert knowledge – Pauline Barrett, Terry Parsons, Cathy Trudeau and Bev Redekop. Without you donation of time this project would not have happened. Diane Symonds not only volunteered her expert time, but also let me access her data – thanks Diane.
Finally I would like to thank my friends and family who have always had unwavering, optimistic confidence that I could do anything.

Thanks to you all, you have all been so generous and supportive.
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approval</td>
<td>ii</td>
</tr>
<tr>
<td>Abstract</td>
<td>iii</td>
</tr>
<tr>
<td>Dedication</td>
<td>iv</td>
</tr>
<tr>
<td>Acknowledgements</td>
<td>v</td>
</tr>
<tr>
<td>Table of Contents</td>
<td>vii</td>
</tr>
<tr>
<td>List of Figures</td>
<td>ix</td>
</tr>
<tr>
<td>List of Tables</td>
<td>x</td>
</tr>
<tr>
<td>Chapter I INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>Research and exploratory questions</td>
<td>6</td>
</tr>
<tr>
<td>Research Question 1</td>
<td>6</td>
</tr>
<tr>
<td>Research Question 2</td>
<td>7</td>
</tr>
<tr>
<td>Research Question 3</td>
<td>7</td>
</tr>
<tr>
<td>Research Question 4</td>
<td>7</td>
</tr>
<tr>
<td>Research Question 5</td>
<td>8</td>
</tr>
<tr>
<td>Research Question 6</td>
<td>8</td>
</tr>
<tr>
<td>Chapter II LITERATURE REVIEW</td>
<td>9</td>
</tr>
<tr>
<td>The Working Alliance: History and Definition</td>
<td>9</td>
</tr>
<tr>
<td>Measures of the Working Alliance</td>
<td>12</td>
</tr>
<tr>
<td>The Working Alliance in Couples and Family Therapy</td>
<td>13</td>
</tr>
<tr>
<td>Measures of the Working Alliance in Couples Therapy</td>
<td>15</td>
</tr>
<tr>
<td>Strains and Ruptures in the Working Alliance</td>
<td>16</td>
</tr>
<tr>
<td>Ruptures and Alliance Development Patterns</td>
<td>19</td>
</tr>
<tr>
<td>Detecting ruptures in the working alliance</td>
<td>20</td>
</tr>
<tr>
<td>Rupture and Rupture Resolution Model</td>
<td>21</td>
</tr>
<tr>
<td>Measure of Ruptures in the Working Alliance</td>
<td>23</td>
</tr>
<tr>
<td>Ruptures in Couple Therapy</td>
<td>25</td>
</tr>
<tr>
<td>Measures of Ruptures in Couple Therapy</td>
<td>29</td>
</tr>
<tr>
<td>Summary</td>
<td>29</td>
</tr>
<tr>
<td>Chapter III METHODOLOGY</td>
<td>30</td>
</tr>
<tr>
<td>Design</td>
<td>30</td>
</tr>
<tr>
<td>Methods</td>
<td>31</td>
</tr>
<tr>
<td>Participants</td>
<td>31</td>
</tr>
<tr>
<td>Measures</td>
<td>31</td>
</tr>
<tr>
<td>Selection of Events and the Coding Process</td>
<td>39</td>
</tr>
<tr>
<td>Procedure</td>
<td>46</td>
</tr>
<tr>
<td>Segment Selection Process</td>
<td>46</td>
</tr>
<tr>
<td>Rupture Detection Process</td>
<td>50</td>
</tr>
<tr>
<td>Analyses of the Data</td>
<td>51</td>
</tr>
<tr>
<td>Chapter IV Results</td>
<td>52</td>
</tr>
<tr>
<td>Section</td>
<td>Page</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Introduction</td>
<td>52</td>
</tr>
<tr>
<td>Descriptive Statistics</td>
<td>52</td>
</tr>
<tr>
<td>SASB Descriptive Data</td>
<td>52</td>
</tr>
<tr>
<td>RRS Descriptive Data</td>
<td>53</td>
</tr>
<tr>
<td>ER Questionnaire Descriptive Data</td>
<td>54</td>
</tr>
<tr>
<td>Comparative Analysis</td>
<td>55</td>
</tr>
<tr>
<td>Research Question 1</td>
<td>57</td>
</tr>
<tr>
<td>Research Question 2</td>
<td>58</td>
</tr>
<tr>
<td>Research Question 3</td>
<td>59</td>
</tr>
<tr>
<td>Research Question 4</td>
<td>60</td>
</tr>
<tr>
<td>Research Question 5</td>
<td>61</td>
</tr>
<tr>
<td>Research Question 6</td>
<td>62</td>
</tr>
<tr>
<td>Further Analysis</td>
<td>62</td>
</tr>
<tr>
<td>Chapter V Conclusions</td>
<td>64</td>
</tr>
<tr>
<td>Limitations of this study and future directions</td>
<td>71</td>
</tr>
<tr>
<td>Appendices</td>
<td>75</td>
</tr>
<tr>
<td>Appendix A</td>
<td>76</td>
</tr>
<tr>
<td>Appendix B</td>
<td>79</td>
</tr>
<tr>
<td>Appendix C</td>
<td>81</td>
</tr>
<tr>
<td>Appendix D</td>
<td>83</td>
</tr>
<tr>
<td>Appendix E</td>
<td>86</td>
</tr>
<tr>
<td>Appendix F</td>
<td>100</td>
</tr>
<tr>
<td>Appendix G</td>
<td>102</td>
</tr>
<tr>
<td>Appendix H</td>
<td>104</td>
</tr>
<tr>
<td>Appendix I</td>
<td>106</td>
</tr>
<tr>
<td>Appendix J</td>
<td>108</td>
</tr>
<tr>
<td>Appendix K</td>
<td>111</td>
</tr>
<tr>
<td>Bibliography</td>
<td>116</td>
</tr>
</tbody>
</table>
LIST OF FIGURES

Figure 1. Alliances that could be effected by ruptures in couple therapy .................. 2
Figure 2. The theoretical structure of the integrative psychotherapy alliance 
(Pinsof, 1994) ........................................................................................................ 14
Figure 3. Stage-Process model III of rupture resolution (Safran, Muran, Samstag 
& Stevens, 2002) .................................................................................................. 23
Figure 4. Surface 1 (focus on other) and Surface 2 (focus on self) of the SASB 
model cluster version (Benjamin, 1999) ................................................................. 35
Figure 5. Event selection decision tree ...................................................................... 48
Figure 6. Overlap between RIRs and SIRs within T1 and T2 ................................. 61
LIST OF TABLES

Table 1: Level of agreement between two SASS coders about whether utterances could be coded .................................................. 42
Table 2: Kappa weighted inter-rater reliability of two SASS coders ......................... 43
Table 3: Pearson correlation of RRS inter-rater reliability for two raters .................. 44
Table 4: Frequency and mean of significant interactions, negative interactions, and negative shifts in the relationship between client and therapist observed by ERs in Rupture and Non-rupture groups ........................................ 55
Table 5: Overall comparison of ERIRs, RIRS, SIRS for Rupture group and Non-rupture group in each time period .................................................. 56
CHAPTER I
INTRODUCTION

One of the most fundamental questions that psychotherapy researchers address is what enhances treatment outcome. The therapeutic relationship has come under increasing scrutiny in this regard with two important research findings. First, that different therapies have similar levels of effectiveness (Luborsky, Singer & Luborsky, 1975) implying that factors common to all therapies have an effect on outcome. One of the factors common to all forms of psychotherapy is the presence of a purposeful therapeutic relationship between client and therapist. Secondly, the therapeutic alliance has consistently been shown as a robust predictor of treatment success or failure, irrespective of treatment model (Horvath & Symond, 1991, Martin, Garske & Davis, 2000, Orlinsky, Grawe, & Parks, 1994). What comprises the therapeutic alliance, moderates the quality of the therapeutic alliance, and how the alliance is linked to therapeutic efficacy has become a focus of researchers.

Several conceptualizations of the therapeutic alliance have been put forward since Freud (1912) first wrote about “unobjectionable positive transference” and the need to engage the client as a collaborator. The most widely accepted pantheoretical model is the working alliance (Bordin, 1979). The working alliance between client and therapist is comprised of the affective bond, agreement on therapeutic goals, and collaboration on tasks that the therapist and client undertake together to reach the goals. The need for mutual collaboration and trust, and the ongoing negotiation of goals and tasks between the therapist and client are key components of this model. It has been proposed that the working alliance itself may be a vehicle of change.
Only recently has empirical evidence begun to emerge suggesting that the alliance is a predictor of couple and family outcome (Rait, 2000). This lag in research compared to individual therapy could be due to the difficulties in analyzing and formulating therapeutic process events when there are multiple clients (Bennun, 1989). At present the most encompassing formulation of the working alliance in couple and family therapy is offered by Pinsof and Catherall (1986) who amplified Bordin's (1979) definition. They contend the working alliance is the “aspect of the relationship between the therapist system and patient system that pertains to their capacity to mutually invest in, and collaborate on, the therapy” (p. 139). In addition, Symonds and Horvath (2004) suggest that when the couple agree about the strength of the alliance, there is a robust correlation between alliance and outcome.

Couple therapy differs from dyadic therapy in several ways. One difference is that the working alliance must be developed between each client system and the therapist system simultaneously, and between the couple subsystem and therapist system (Figure 1).

Figure 1. Alliances that could be effected by ruptures in couple therapy
How the working alliance in individual therapy develops over time, and what effects the development, is still not well understood. Some specific factors such as pre-existing client characteristics (e.g. O'Malley, Suh & Strupp, 1983) and client's parental bond and level of social support (Mallinckrodt, 1992) have been shown to influence the development of the working alliance. However the processes by which the working alliance develops and changes over time is still under investigation. One process in the development of the working alliance was brought to light by Bordin (1980), who claimed that effective therapeutic treatment consists of a pattern of tears (ruptures) and repairs in the working alliance. A rupture can be defined as a “deterioration in the quality of the relationship between patient and therapist” (Safran & Muran, 1996, p. 447) and many theorists (Safran, Crocker, McMain & Murray, 1990; Horvath, 1995; Safran, Muran & Samstag, 1994) consider the occurrence of ruptures inevitable in a strong working alliance. Rupture events expose patients' core issues and offer the opportunity to correct maladaptive interpersonal schemas (Muran 2002). This conceptualisation of the change process is similar to Stiles (2002) assimilation model. Stiles suggested that therapeutic progress occurs as problematic experiences are acknowledged, understood, and integrated by a client. Unassimilated client problems appear similar to ruptures markers indicative of fear or avoidance. However this study will focus on the concept of identifying ruptures, as defined by Safran and Muran (1996) in the working alliance.

An indication of the importance of ruptures is a recent study by Stiles, Glick, Osatuke, Hardy, Shapiro, Agnew-Davies, Rees and Barkham (2004) who reported a subset of clients, with a clear rupture-repair cycle present, were associated with significantly greater positive treatment outcome compared to clients without a rupture-repair profile. What is quite clear, both empirically and in clinical practice, is that unresolved ruptures and a weak working alliance are associated with poor outcome and early treatment drop out. Goldfried (1982) compares a strong alliance to an anesthetic
that enables the client to engage in therapeutic techniques to their benefit. There are indications that a strong working alliance can be beneficial for therapeutic progress.

Given the role of rupture resolution in maintaining and developing the working alliance, therapists would benefit from recognizing and managing this process. If a therapist is unaware of a rupture, he or she may behave in a manner that increases the frequency or magnitude of ruptures. For example, a therapist who rigidly adheres to an unsuccessful therapeutic approach may not attend to markers of client distress. Even experienced therapists report a lack of awareness of “conflictual interpersonal processes” such as subtle blaming of the client by the therapist (Strupp, 1993).

The Brief Psychotherapy Program at the Beth Israel Medical Centre under the auspices of Jeremy Safran, Christopher Muran and Lisa Samstag Wallner has investigated the rupture resolution process in dyadic therapy. Their micro-analysis of in-session rupture events led to quantitative methods of identifying the presence of a rupture, a typology of ruptures, and a stage process model of the rupture repair process (Safran & Muran, 1996, Samstag, Safran, & Muran, 2000, 2006). Two methods of operationalising ruptures have been used to identify the presence of a rupture. The earlier version (Safran & Muran, 1996) used particular codes from the Structural Analysis of Social Behaviour (SASB, Benjamin, 1974) to identify two types of rupture – withdrawal and confrontation ruptures. The newly developed Rupture Resolution Scale - revised (RRS, Samstag, Safran, & Muran, 2000, 2006) detects three rupture types: where the client moves away from the therapist, towards the therapist in a hostile compliant and anxiously helpless manner, and when the therapist moves against the therapist. Both of the above rupture identification methods were developed for dyadic therapy. While Safran and Muran’s (1996) model have not been widely replicated, it provides the most rigorous and empirically validated rupture resolution process model available.
These rupture identification methods do not necessarily translate to a multi-client environment, such as couple therapy. Relationships between the clients and therapist are more complex than in dyadic therapy. There may be ruptures which are unique to couple therapy. For example, if a client has a strong alliance with the therapist, and the other client has a very weak alliance with the therapist, could this be considered a rupture between the client subsystem and therapist? Would rupture marker behaviours be similar, or different, to dyadic therapy rupture markers? Perhaps dyadic rupture identification methods can identify all ruptures observed in couple therapy. This study will explore whether the two rupture identification rubrics can be used to capture the start of a rupture in couple therapy, using both quantitative and qualitative methods.

According to Pinsof and Catherall’s (1986) reformulation of the working alliance, a rupture could occur between the partner and therapist or the couple subsystem and therapist (Figure 1). Pinsof (1994) describes as a “split alliance” as when a family member’s perception of the alliance is quite different from another family member’s perception. At this point a rupture between the client subsystem and the therapist takes place. The split alliance concept has been empirically supported (Heatherington & Friedlander, 1990). However, to date there has been only one couple therapy study (Tomcik, 2005) exploring other types of ruptures. Tomcik’s qualitative investigation found ruptures that appear unique to couple therapy, in addition to ruptures that could occur in both dyadic and couple therapy.

Given the differences between dyadic and couple therapy, the aim of this study is to ascertain whether the identification of ruptures, operationalised by Safran and Muran (1996) and developed further by Samstag et. al. (2000, 2006) captures ruptures in a multi-client environment, including those that may be unique to couple therapy. Ultimately it is hoped that increased clarity in detecting ruptures will enable therapists to
realise when to employ rupture resolution techniques, and encourage research into this complex area of study.

Research and exploratory questions

This pilot study explored whether ruptures in couple therapy can be detected using methods from dyadic therapy rupture studies. Can the two rupture identification methods used in dyadic therapy - the Structural Analysis of Social Behaviour (SASB, Benjamin 1974) method (Safran & Muran, 1996) and the recently developed Rupture Resolution Scale – Revised (RRS, Samstag et al., 2006) be used in the complex environment of couple therapy? The RRS was derived in part from the SASB method, however the RRS identifies more rupture types than the SASB method. In addition, Expert Raters (ERs) were asked to view the videotaped data given to SASB and RRS coders, and give their opinion about whether a rupture was present or not.

Below are the Research Questions this study seeks to answer, followed by the related hypothesis.

Research Question 1

Can the RRS identify the same ruptures observed by ERs? Do ERs or the RRS identify more ruptures? It is hypothesised that the RRS will identify at least some ER identified ruptures, however ERs will probably detect more ruptures than the RRS. If the RRS coding judgements match ER observed ruptures, this would suggest that the RRS can identify ruptures in couple therapy, assuming that ER judgements define when a rupture occurs in couple therapy. Because ERs judgements are informed by their clinical experience, and they are likely to be able to assess ruptures at different systemic levels, ERs will probably identify more ruptures than the RRS.
Research Question 2

Can the SASS method (Safran & Muran, 1996) detect ruptures observed by ERs? Do ERs or the SASS method identify more ruptures? It is anticipated that the SASS method will detect some ER identified ruptures, however ERs will identify more ruptures than the SASS method. Similarly to Research Question 1, if the SASS method of detecting ruptures match ER identified ruptures this would suggest that the SASS method can identify ruptures in couple therapy.

Research Question 3

Is the SASS method or the RRS more accurate at detecting ruptures in couple therapy? Because the RRS was developed to identify more rupture types than the SASS method, it is hypothesised that the RRS will detect more ER identified ruptures than the SASS method. Whichever rupture identification method matches the most ER identified ruptures will be considered the most accurate method.

Research Question 4

Do the SASS rupture detection method and the RRS localise similar events as ruptures? Because the RRS is based in part on the SASS, it is anticipated that there would be some overlap between RRS and SASS method identified ruptures. However the RRS is likely to identify more ruptures than the SASS method because it identifies more types of ruptures. If some SASS identified ruptures match the RRS, and yet there are more RRS identified ruptures than SIRs, this hypothesis would be supported.
Research Question 5

Can the SASB rupture detection method or ERs identify couple subsystem ruptures? It is anticipated that ruptures between the couple subsystem and the therapist will be detected. The SASB method could identify a rupture between the couple referent and therapist, whereas ERIRs between the couple subsystem and therapist would occur when two or more ERs judge a rupture has occurred between the couple and therapist. The RRS is not able to detect ruptures because it was specifically designed to assess ruptures between a single client and the therapist.

Research Question 6

If there are ERIRs unmatched by either the SASB method or RRS, is there something unique or different about these ruptures compared to ruptures in dyadic therapy? Narratives provided by ERs relating to unmatched ERIRs will be explored for similar themes and ideas across rupture events.
CHAPTER II
LITERATURE REVIEW

The study of ruptures in couple and family therapy is fairly recent, and few studies are available that investigate this area. To date, ruptures in the working alliance have been studied almost exclusively within dyadic therapeutic relationships. Our understanding of the working alliance originated in dyadic therapy and has only more recently been adapted to couple and family therapy, therefore this literature review will focus on ruptures of the working alliance in dyadic therapy. The first section contains a brief discussion of the historical antecedents and current formulations of the working alliance in dyadic and couple therapy. The second section reflects on the study of ruptures in both dyadic and couple therapy.

The Working Alliance: History and Definition

Current conceptualisations of the relationship between the therapist and client stem from psychoanalytic theory. Freud wrote that "einfühlung" (empathy) was essential for establishing rapport between psychoanalyst and analysand before therapy could occur (Pigman, 1995, Shaughnessy, 1995). The "friendly and affectionate aspects of transference" (Freud, 1937c, p.233) were part of the success of treatment and are a strong motivation for patients to continue their therapeutic work.

Psychodynamic theorists have since proposed a number of different conceptualisations of the therapeutic relationship. Sterba (1934) used the term "ego alliance" to describe the need for an alliance between the working style of the therapist, and the mature or "analyzing" ego function of the patient. Therapeutic progress occurs
when the patient capacity to connect and work with therapist tasks increases. This is associated with the patient being able to shift between experiencing and observing their own transference reactions and defenses.

The expression “therapeutic alliance” was introduced by Zetzel (1956) as the alliance between the non-neurotic facet of the patient and the therapist, which allowed the patient to form a relationship that was not based on the fantasies and wishes of transference, but rather on what is actually present. It was defined as “a stable and positive relationship between the analyst and the patient which enables them to productively engage in the work of analysis” (Zetzel, 1973) and clearly separated transference from the working relationship. Zetzel contended that analysts might have to move from the neutral stance advocated by traditional psychoanalysis because some patients required warm and affirming interventions at critical moments in order to secure a sense of connection to the therapist, i.e., a therapeutic alliance, and become a collaborator. This connection was not in itself curative, but it is significant in facilitating therapeutic interaction.

Similarly, Greenson depicted a “working alliance” (1965) as consisting of three components, the working alliance, the real relationship and transference. The client’s realistic, objective reactions to the therapist (the “real relationship”) was distinguished from transference stemming from fantasies and impulses derived from the client’s unconscious processes, and the working alliance which represents collaborative efforts between client and therapist to develop insight and change. Greenson considered the working alliance an important factor for successful therapeutic progress, and like Zetzel’s therapeutic alliance it was considered a pre-requisite for therapeutic interaction, rather than curative. Greenson and Zetzel both proposed that an empathic and caring attitude on the part of the analyst would encourage trust in the client, and
lessen the possibility of treatment impasses due to misunderstandings within the relationship (McEwan, 2005).

Zetzel and Greenson both emphasize that the alliance is collaborative, and intended to support therapeutic change. The work of these theorists and others (e.g. Ferenczi, 1955, Strachey, 1934, Friesyk, 1986) moved from an intrapsychic approach model of psychopathology proposed by Freud, to an approach that attends to the patient's relationships (interpsychic), particularly the relationship with the therapist (McEwan, 2004).

The working alliance (Bordin, 1979) is composed of three components. The bond component was described as the “human relationship between therapist and patient” (Bordin, 1979, p.254). It originates in the shared experience of joint activities between client and therapist, and is reflected in the growth of the therapist's and client's mutual liking, trust and respect. The bond is the context within which therapeutic tasks are agreed between client and therapist, and then implemented to achieve treatment goals.

The task and goal components of the working alliance are more cognitive than the bond component. The client and therapist cooperate or negotiate regarding therapeutic tasks offered by the therapist to reach mutually agreed upon change goals. Bordin (1979) noted that task and goal components are “intimately linked” to bond (p. 254).

The working alliance construct highlights “the more explicit negotiation of detailed aspects of goals and tasks as important steps in alliance building and attaining the strength to overcome strains and ruptures” (Bordin, 1994, p. 15). Similarly to object relations theory, Bordin acknowledged that clients attending psychotherapy bring a capacity to form both distorted relationships (transference) and undistorted relationships representing real events. The distortions can originate in childhood interactions, and
inform a person’s ability to participate in relationships. Bordin (p. 17) argues that bonds that are heavily laden with transference “provide weak therapeutic leverage” for a client and therapist to deal with strains and impasses “embedded in the pathological elements of transference”.

**Measures of the Working Alliance**

The tri-partite breakdown of this aspect of the therapeutic relationship enabled researchers to operationalise and measure the working alliance, and has influenced many psychotherapy researchers interested in assessing the therapeutic relationship. Horvath and Bedi (2002) noted there were 24 self-report and observer rated measures of the working alliance. Many of them have operationalised the working alliance in slightly different ways, however the most commonly used measures (Horvath & Bedi, 2002) in the literature appear to be the Working Alliance Inventory Horvath, 1981, Horvath & Greenberg, 1984), California Psychotherapy Alliance Scales (Marmar, Weiss & Gaston, 1989), Penn Helping Alliance Rating measure (Morgan, Luborsky, Crits-Christoph, & Solmon, 1982) and the Vanderbilt Therapeutic Alliance Scale (Hartley & Strupp, 1983). Meta-analyses of studies using these measures have consistently shown the working alliance as an important individual psychotherapy outcome predictor (Horvath & Symond, 1991, Martin, Garske & Davis, 2000, Orlinsky, Grawe, & Parks, 1994). The working alliance has proven fruitful in understanding “some of the important, clinically active, relational ingredients common to all forms of therapy” (Horvath, 2001, p. 370).
The Working Alliance in Couples and Family Therapy

The working alliance has been primarily studied in dyadic relationships with limited attention paid to its role in couples and family therapy (for exceptions see: Pinsof & Catherall 1986, Pinsof, 1994, Sexton, Robbins, Hollimon, Mease & Mayorga, 2003). Rait (1998, 2000) comments that the notion of the alliance has not been widely used in family therapy, despite the different models of family therapy highlighting the importance of establishing a positive relationship with families. Only recently has empirical evidence begun to emerge suggesting that the alliance is related to couples therapy (Johnson & Talitman, 1997, Reif, 1998, Symonds, 1999), couples group therapy (Brown & O'Leary, 2000, Bourgeois, Sabourin, & Wright, 1990), and family therapy outcome (Ettinger, 2000, Green & Herget, 1991, Quinn, Dotson, & Jordan, 1997). Rait (1998) comments that family therapy theories all advocate the position that the therapeutic alliance should be attended to in order to strengthen it. An implication is that a weak alliance is not related to improved therapeutic outcome.

Pinsof and Catherall (1986) were the first theorists to develop a formal theory of the working alliance in multi-systemic family therapy by adapting Bordin's (1979) concept of the working alliance. They asserted that the systemic aspects of the working alliance in family and marital therapy have not been addressed, and that therapists form relationships and alliances with patient systems. As previously discussed, Pinsof and Catherall defined the therapeutic alliance within family therapy as “that aspect of the relationship between the therapist system and patient system that pertains to their capacity to mutually invest in, and collaborate on, the therapy” (p. 139). Two dimensions are included in this definition, the interpersonal system dimension which refers to the different levels and loci of the alliance, and the content dimension which refers to
specific qualities of the alliance and its content within the content of the different subsystem levels.

Figure 2. The theoretical structure of the integrative psychotherapy alliance (Pinsof, 1994)

<table>
<thead>
<tr>
<th>Interpersonal System</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tasks</td>
</tr>
<tr>
<td>Individual</td>
<td></td>
</tr>
<tr>
<td>Interpersonal Subsystem</td>
<td></td>
</tr>
<tr>
<td>Whole System</td>
<td></td>
</tr>
<tr>
<td>Within-System</td>
<td></td>
</tr>
</tbody>
</table>

The model put forward by Pinsof and Catherall (1986) can represent several systemic levels. In couple therapy, a therapist system forms an alliance with each individual client in the room, and the couple system. The presence of multiple clients influences the alliance between each client and therapist, and the couple subsystem and therapist system in a circular, iterative fashion.

There are several differences between the therapeutic relationship with a single client, and when there are two or more clients are in a session. A therapist has to create a trusting, collaborative relationship with two or more clients, each of whom often have different motivations, and usually some degree of interpersonal conflict (Friedlander, Escudero, & Heatherington, 2006). In addition, the allegiance between a couple based
on their shared history, and gender based relational power differences are specific to couple therapy (Symonds & Horvath, 2004). Another difference is the need to balance the therapeutic alliance between each couple member. Johnson and Greenberg (1989) emphasize “this is a system where paying attention to one client is potentially entering a coalition against another” (p. 103). The perceived relationship a therapist develops with one client can influence the development of other alliances within the session. A multi-client environment is more dynamic because other clients can reveal painful information at more unpredictable pace than dyadic therapy, where the therapist and client have a higher level of control over how and when painful, upsetting material is explored (Friedlander et al., 2006). For example, against her husband's wishes a wife brings up details of childhood abuse that her husband experienced because she thinks he needs to “bring it out into the open”.

Measures of the Working Alliance in Couples Therapy

To date there are three measures of the working alliance which encompass couple therapy. Both the Couple Therapy Alliance Scale – Revised (CTAS, Pinsof, 1999) and the Working Alliance Inventory – Couple (WAI-Co, Symonds, 1999, Symonds & Horvath, 2004) are self-report questionnaires based on Bordin's conceptualisation of the working alliance. The relationship between each client and the therapist, the respondents view of their spouse and the therapist, and the respondents view of the “couple” relationship with the therapist can be assessed. The System of Family Therapy Alliance (SOFTA, Friedlander, Escudero, Horvath, Heatherington, Cabero, & Martens, 2006) is a relatively new observer rating scale that measures four dimensions of within-family and between-systems (client and therapist) alliances. The dimensions consist of Engagement in Therapeutic Process, Emotional Connection with the Therapist, Safety
within the therapeutic context, and Shared Sense of Purpose within the family. The SOFTA is discussed in further detail in the next chapter. With the advent of these measures which operationalise the complex, dynamic alliances within couple therapy, further research can begin to develop the concept of the working alliance. However, the unit of measure for these instruments is a judgement which averages either a participant's or an observer's perception over a session. The weakness of this unit of measure is that subtle, within session processes may be hidden in the averaging of final scores. This may become an area of concern when further delineating fine-grained change processes.

**Strains and Ruptures in the Working Alliance**

The concept of stresses in the relationship between client and therapist has long been documented under a variety of guises. Embedded in the different theories of the therapeutic relationship has always been some reference to difficulties in the relationship. Some different descriptors and conceptualisations of this stress in terms of patient experiences and therapist reactions (McEwan, 2005) include impasses, breaches, strains (Bordin, 1994), ruptures (c.f. Safran, Crocker, McMain, & Murray, 1990), empathic failure (Kohut, 1984), misalliance movements (Garrison, 1993), disjunctions (Frankel, 2006), defensiveness (c.f. Zetzel, 1956), transference and countertransference, and misattunement (Kohut, 1984, Winnicott, 1956). The terminology used depends upon the theoretical orientation and the perceived role of difficulties in the therapeutic relationship. However, within these overlapping conceptualizations lie two common themes. First, the sense of potential for therapeutic failure if the strain is not appropriately dealt with. Secondly, these stresses in the therapeutic relationship are commonly perceived as an opportunity for significant
therapeutic change. For example, Kohut (1984) suggested repeated minor lapses in empathy or "misattunements" helps clients learn how to negotiate separateness from their therapists in tolerable doses. This enables them to cope better with the inevitable disappointments in the therapeutic relationship and other interpersonal relationships, seeing them not as potentially catastrophic events, but rather as minor disagreements.

Initial discussions about tension in the therapeutic relationship were theoretical or based on single case studies (e.g. early psychoanalytic formulations). This paucity of empirical studies was perhaps associated with the lack of a transtheoretical model of the therapeutic alliance which could be operationalised for research purposes. With the wider acceptance of the working alliance, the concept of ruptures have developed a broad appeal for psychotherapy researchers as they seek to determine how ruptures relate to working alliance development and therapeutic outcome.

Bordin (1994) posited that one of the keys to developing a strong working alliance, is the resolution of strains in the working alliance. Landsford (1986) argues that the alliance building and repair sequence itself is the treatment. When a person enters into therapy they carry with them the capacity to form "distorted and undistorted" relationships, which is influenced by transference. The types of problems that induced them to seek help can become manifest in the "process of entering into a meaningful partnership and/or in participating in the work of therapy as represented by the therapeutic task" (Bordin, 1994, p. 18). Bordin viewed the collaborative process as an opportunity for a client to re-enact "self-defeating propensities" (1994, p.18) and achieve a more self-fulfilling "mode of response" that can be generalised to other relationships. Bordin strongly advocated that strains stem from self-sabotaging tendencies originating in the client, and could be used to "highlight a schema's dysfunctional properties" (p. 20). Bordin preferred the term "strain" as opposed to "rupture" in his discussion, perhaps to emphasise his view of the continuous flexing between client and therapist – with strains
being part of the normal therapeutic process. There is also the possibility that he considered the term “rupture” as capturing only the most extreme negative events, or at best a stochastic process (Horvath, personal communication, 2007). The posited process of tear and repair (Bordin, 1974, Pinsof, 1986, 1995, Horvath, 1995; Safran, Muran & Samstag, 1994) within the working alliance, also known as the rupture repair process, has garnered the increasing attention of researchers (c.f. Safran, Crocker, McMain & Murray, 1990; Samstag, Muran & Safran 2004; Nagy, 2002; Stiles, et al., 2004; Bennett & Parry, 2004; Stevens, 2002; Nieuwenhuis, 2002) as they seek to elucidate how ruptures relate to outcome.

The term rupture has become the dominant way of describing tension in the working alliance. More specifically, a rupture is defined as:

“a deterioration in the quality of the relationship between patient and therapist: it is an interpersonal marker that indicates a critical opportunity for exploring and understanding the processes that maintain a maladaptive interpersonal cycle”

p. 447, Safran & Muran, 1996

When therapists engage in maladaptive interpersonal cycles, they confirm the clients’ dysfunctional interpersonal schemas (Safran & Muran, 1996). Both client and therapist contribute to the occurrence and progression of the rupture, which varies in terms of strength, duration, frequency and intensity (Safran & Muran, 1996). Samstag et al. (2000) suggest that ruptures differ from transference and countertransference because they are complementary, mutual behaviours that both client and therapist engage in. Safran and Muran (1996) argue that ruptures that remain below the conscious level or undetected may not impede treatment progress, however at worst ruptures can lead to dropout or treatment failure. Following Bordin’s formulation of the
working alliance, Samstag et. al. (2004) stated that ruptures in the working alliance could occur as disagreements in the task or goal of therapy, or strains in the bond.

Research into ruptures and the relationship with therapeutic outcome has occurred at the session (macro) and within session (micro) level of psychotherapeutic process analysis. At the macro level researchers have measured the working alliance at the end of a specific session, and noted patterns of alliance strength in their relationship to therapeutic outcome. At the micro level qualitative, studies and fine-grained quantitative analyses have delineated in-session processes and associated micro-outcomes.

**Ruptures and Alliance Development Patterns**

Stiles, Glick and Osatuke et. al. (2004) identified clients with sessions that had large deflections in alliance strength, followed by a swift return to previous or higher alliance levels which they attributed to a rupture-repair cycle. This subset of 17 clients with a rupture-repair cycle had significantly larger average therapeutic gains, suggesting the possibility that this cycle may influence therapeutic outcome. Fearing (2003) also found that the rupture-repair cycle was significantly associated with clients who completed therapy rather than dropped out. These studies indicated that the presence of a rupture-repair cycle may be related to positive therapeutic outcome and continuance in therapy. While the association between a rupture-repair cycle and outcome has not yet been widely researched, these investigations are in accord with the proposed theoretical importance of the rupture-repair cycle and therapeutic gain.

The consequences of unresolved ruptures or difficulty establishing a working alliance can be problematic. Using self-report measures Samstag, Batchelder, Muran, Safran and Winston (1998) found that dropouts and clients who experienced poor
outcome after 40-sessions of psychotherapy reported the therapeutic relationship as problematic compared to the good outcome group. Clients in the dropout group found the relationship even more problematic than the poor outcome group. This finding is consistent with results that overall weak alliances are associated with poor treatment outcome and withdrawal from therapy (Tyron & Kane, 1990, 1993, 1995, Fearing, 2003). Poor treatment outcomes have also been associated with hostile, negative interactions between client and therapist (Henry, Schacht, & Strupp, 1986, 1990). Ruptures in the working alliance need to be attended to and appropriately dealt with to reduce early termination and to offer an opportunity for significant therapeutic change.

**Detecting ruptures in the working alliance**

According to Hartley and Strupp (1983) before further progress in therapy can be made, the therapist must detect strains in the relationship, and intervene. However, ruptures can be difficult to detect for both researchers and therapists. A qualitative study by Regan and Hill (1992) reported that most thoughts and feelings not expressed by therapists and patients during therapy were negative, and therapists were aware a client was holding something back 17% of the time. Hill, Thompson, Cogar and Denman (1993) also reported similar findings, with only 27% of experienced clinicians aware their clients might be withholding concerns, and 65% of clients reporting that they usually did not express negative thoughts. This corresponds with a study that found that therapists were often surprised by a client’s decision to terminate therapy and client’s discontent with therapy (Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996). Even with training targeted at attending to negative processes and rupture events, therapists had trouble identifying them (Henry, Strupp, Butler, Schacht, & Binder, 1993). When therapists do notice strains arising in the working alliance, they can become more rigid
and directive in their application of therapeutic techniques, causing the working alliance to become more strained (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). These findings are particularly troublesome given that Henry, Schacht, and Strupp (1990) reported even low levels of observable negative therapist behaviour can be enough to prevent change if not therapeutically addressed. In a multi-level, complex alliance environment such as couple and family therapy, a therapist may find it even more difficult to recognise a rupture is occurring with a particular client or subsystem. Hill et al. (1996) concluded that “early recognition of interpersonal relationships is the key to resolution of such problems” (p. 215). The study of in-session rupture events needs to focus not just on how to cope with strains and ruptures in the working alliance as they arise but, as a first step, researchers and therapists need to be able to detect when a rupture or strain has occurred. Rupture identification for research purposes is discussed below.

**Rupture and Rupture Resolution Model**

Safran and Muran (1996) used a task analysis approach (Rice & Greenberg, 1984) to develop a stage process model of the rupture and rupture resolution process. This approach for studying significant process events seeks to discover recurrent “patterns of change” by studying therapist-patient interaction episodes, rather than process variables taken out of their immediate ecological context (Henry, Schacht, & Strupp, 1986). Instead of focusing on what is occurring during therapy, or on comparing the client’s state before and after treatment, the emphasis is on “identifying, describing, explaining, and predicting the effects of the processes that bring about therapeutic change over the entire course of therapy” (Greenberg, 1986).
Following the task analysis procedure (Greenberg & Newman, 1996, Appendix B), descriptive markers of an alliance rupture were developed by qualitatively identifying themes in sessions deemed to contain ruptures (Safran et. al., 1990). They included indirect communication of hostility, non-compliance, avoidance manoeuvres, self-esteem enhancing operations, overt expressions of negative sentiments, disagreement about the goals or tasks of therapy, and non-responsiveness to interventions. These markers were all based on client indicators, however Safran et. al. acknowledge that both client and therapist contribute to ruptures. Rupture markers were described by Safran and Muran (1996) who, influenced by rupture types developed by Harper (1989a, 1989b), proposed two types of ruptures – confrontation and withdrawal ruptures. Confrontation ruptures are defined as a patient clearly expressing anger, dissatisfaction or resentment with either the therapeutic process, or the therapist. Withdrawal ruptures occur when a patient disengages or withdraws from some aspect of the therapeutic process. Safran and Muran used the Structural Analysis of Social Behaviour (SASB, Benjamin, 1974) to operationalise behavioural markers exhibited by a patient to determine the start of a rupture. Ruptures identified using the SASB were the basis of the subsequent rupture-repair model (Figure 3) proposed by Safran and Muran (1996).
One of the key elements of the stage-process model is the therapist attending to the rupture marker, before the rupture-resolution process can begin. This is the only stage-process model of ruptures in dyadic therapy, and to date it has not been widely replicated or tested outside of the Beth Israel Medical Centre’s Brief Psychotherapy Research Program.

**Measure of Ruptures in the Working Alliance**

The Working Alliance Inventory (Horvath, 1981, Horvath & Greenberg, 1984) and Agnew Relationship Measure (Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998) have been used to measure specific changes in working alliance strength between sessions. These changes have been used as indicators of rupture presence. While this has been helpful measuring working alliance development and the tear and repair process across therapy sessions, these measures can not localise or sequence...
process events that occur within therapy sessions. Therefore, a more fine grained analysis of rupture events cannot be performed using these measures.

Currently there is one specific measure of working alliance ruptures within a dyadic therapy session. Samstag, Safran and Muran (2000, 2006) created the observer rated Rupture Resolution Scale – revised (RRS) which assesses the rupture resolution process. It measures the presence, intensity and duration of a rupture within a 5 minute segment, a misunderstanding event, and subsequent interactions related to rupture resolution. The RRS operationalises the presence of a rupture as a client rupture marker that follows a misunderstanding event involving patient and therapist contributions. The RRS is discussed further in the Methodology chapter.

McEwan (2005) used the RRS to code a rupture segment from each of 37 patient-therapist dyads undergoing Brief Relational Therapy (Safran & Muran, 2000) to study therapeutic interventions and whether they resolve ruptures in the therapeutic relationship. Observers identified three distinct types of rupture - “Walling Off and Avoiding”, where the client moves away from the therapist, “Deferring and/or Appeasing”, where the client moves towards the therapist in a hostile compliant and anxiously helpless manner, and lastly where the client moves against the therapist. This third rupture type includes two subtypes; a) “Attacking and Blaming”, when the client is dismissive or critical of therapy or the therapist, and b) “Approaching to Manage”, when the client manipulates and undermines the therapist by focusing on surface, non-therapeutic issues.

Interrater reliability proved to be adequate (ICC=.60–.99). Within the 20 minute segments most dyads were observed to have more than one type of rupture, and all segments had Walling Off & Avoiding ruptures. McEwan attributed this to the complexity of the rupture process, where the therapist might not be attuned to a client’s more subtle Walling Off & Avoiding markers, which subsequently leads the client to display Attacking
& Blaming behaviour. The frequency of Walling Off & Avoiding was ascribed to the training of coders which attuned them to the subtlety of nonverbal behaviours, such as a client checking their watch or keeping their coat on in session. An alternative explanation is that the behavioural markers associated with this rupture are not sufficiently different from behaviour unrelated to a rupture. McEwan's study found that therapists seem to perceive Attacking & Blaming ruptures in particular as "exemplars" of a poor alliance, and that therapists might not perceive the other types of ruptures as problematic. The Deferring & Appeasing rupture was positively related to patient and therapist alliance ratings, but not significantly so. McEwan related this to the finding that submissive clients tend to self-report their alliance as "good" (Muran, Segal, Samstag, & Crawford, 1994). It is also in accord with Rennie's (1992) findings that clients tend to hide difficulties they have with the therapist or therapeutic process. While not significant, there was a moderate effect size between a patient's self-reported resolution scores and outcome, but not for the self-reported therapist resolution scores. This is consistent with views that the client perspective is highly related to outcome (Horvath & Symonds, 1991, Orlinsky & Howard, 1986, Martin, Garske, & Davis, 2000).

Ruptures in Couple Therapy

There is a paucity of either qualitative or quantitative studies in the area of ruptures in the working alliance in couple and family therapy. Rait (2000) advocates that couple and family therapists should deal with difficulties in the alliance and "indirectly or directly convert these difficulties into learning opportunities by offering a corrective experience, modelling new behaviours, or avoiding participating with family members in a redundant, uncreative fashion" (p. 222). Just as the working alliance in dyadic therapy has a pattern of strains and ruptures (Bordin, 1994), so too could couple and family
therapy. Given the unique aspects of couple therapy, it is possible that there are ruptures exclusive to couple and family therapy.

Behavioural markers that a therapist is engaged in a rupture with a family have been described by Hodas (1985). Markers include lack of therapeutic intensity and pacing, inability to challenge the system, being ahead of the family, neglecting a family member or subsystem or overidentifying with them, being too directive or taking too central a role, lacking leadership, and insufficient joining. At present there is no empirical support or operationalisation of these markers.

A rupture unique to a multi-systemic environment was proposed by Pinsof and Catherall (1986) who suggested that “unbalanced” or “split” alliances are ruptures. Pinsof and Catherall defined a split alliance as a significant difference in the clients’ attitudes towards the therapist or therapy, which can occur either between-system or within system. This definition was further refined by Friedlander, et. al. who defined it as “notable differences in individual family members’ emotional connections with the therapist”. Not only the strength of the split, but the power differential couple or family subsystem members determines how problematic the split can be – whether it impedes therapeutic progress, or perhaps leads to early termination. Studies have shown that self-reported “split” or “unbalanced” alliances are common (Bennun, 1989; Heatherington & Friedlander, 1990; Mamodhoussen, Wright, Tremblay, & Poitras-Wright, 2005; Reif, 1998, Robbins, Turner, Alexander, & Perez, 2003; Symonds & Horvath, 2004). In addition, these unbalanced alliances account for more variance in outcome than any particular client’s alliance with the therapist (e.g., Bourgeois, Sabourin, & Wright, 1990; Robbins et al., 2003; Bennun, 1989, Symonds & Horvath, 2004). Beck, Friedlander, & Escudero (2006) suggest that split alliances in family therapy may be more consistent with differing and/or conflicting motives of clients, rather than individual’s perceptions of the therapist. Being able to balance multiple alliances,
including shared agreement on task and goals, is a critical therapeutic skill to reduce opportunities for a split alliance.

Tomicik (2005) argues that if a couple does not feel safe enough to enact and explore conflict, this is a type of rupture in the working alliance. Another potential rupture specific to couple and family therapy is when a therapist unwittingly becomes enmeshed in a couple dynamic that maintains the problem, becoming triangulated. For example, a client actively seeks the therapist as an ally, or communicates problems with their spouse through the therapist rather than towards their spouse. This may seem similar to the RRS rupture state “Approaching to Manage”, however the additional interpersonal dynamics make motivation and expression of rupture behaviour less clear.

A recent qualitative study by Tomicik (2005) asked 151 therapists from professional listserves to describe alliance ruptures that could occur in couple therapy. Tomicik’s study explored what ruptures in couple therapy may look like from the perspective of clinical therapists. Other studies have addressed split alliances (for example: Bennun, 1989, Reif, 1998) in couple or family therapy in the context of the working alliance, however they did not explore the possibility of other types of ruptures. Therapists’ narrative responses regarding unique couple ruptures were placed in pre-established categories by narrative coders. Pre-established categories were based on review of the literature. Problems were noted with balancing the alliance (split alliance ruptures, 54%), resisting triangulation (17%), “other” unique ruptures to couple therapy (16%), ruptures that could also occur in dyadic therapy (8%) and poor physical safety (2%). “Other” unique ruptures included the couple aligning against the therapist, intentional sabotage of therapy by a client, hidden agendas such as the desire to leave a relationship, and keeping secrets that impeded the progress of therapy. Results showed therapists were most concerned about split alliances and resisting triangulation.
Ettinger’s (2000) qualitative and quantitative study is the only investigation that has addressed rupture markers in family therapy. A task analysis approach was used to advance a complex model of the rupture-resolution process for Multidimensional Family Therapy (MDFT, Liddle, 1995). Ettinger adapted the seven rupture markers described by Safran et. al. (1990) to develop a Therapeutic Alliance Rupture Event Rating Form. Raters were asked to simply note if the rupture marker was present or absent within 4 selected videotaped segments, in order to discriminate segments for further analysis. Ettinger chose to use the earlier qualitative descriptors of Safran et. al. because they are less specific than than the later SASS method of identifying ruptures (Safran & Muran, 1996), and more flexible both in terms of theoretical context and rupture and resolution behavioural markers. A percentage agreement between raters about rupture presence was 87.5% for the four cases studied.

The iterative coding system used by Ettinger (2000) identified three main rupture dimensions – Therapist Action, Ecosystemic Obstruction/Influence, and Maladaptive Characterological/Interpersonal/Client Distortions. In the 4 case studies Therapist Error dominated the number of ruptures that occurred, and twice as many Ettinger rupture types were reported in the unresolved cases as opposed to the resolved cases. While this study does begin to address the complex systemic issues in family therapy and offers a new stage-process model for rupture-resolution in family therapy, findings are limited. The number of cases studied was quite small (n=4), limited to the parent-therapist alliance (excluding the adolescent-therapist alliance), and results are specific to MDFT. Additionally, multi-systemic alliance difficulties such as a split alliance were not addressed in this study. There is a need for clear in session markers of rupture behaviour in couple and family therapy that encompass ruptures that may be unique to couple and family therapy.
Measures of Ruptures in Couple Therapy

To date there are no specific rupture measures in couple therapy. The SOFTA, WAI-Co and CTAS have been used in studies (noted above) to establish the presence of split alliances within a session. However they are unable to specifically localise rupture events within a session, therefore fine grained analysis can not be performed about subsequent processes relating to successful and unsuccessful rupture resolution.

Summary

This literature review presented an analysis of both empirical and theoretical support for the heuristic and clinical usefulness of understanding in-session fluctuations in the working alliance related to strains and ruptures. As has been shown, unattended ruptures can have a dilatory effect on therapeutic outcome, yet little research has been carried out on the rupture-resolution process in couple and family therapy. At present, there are no studies that have adequately identified the start of a rupture in couple therapy.
CHAPTER III
METHODOLOGY

Design

A pragmatic parallel mixed method design (Tashakkori & Teddlie, 1998) was adopted to relate the clinical acumen of experienced therapists to structured observational coding systems. The use of quantitative and qualitative data measurement could enable triangulation on the presence of a rupture between clients in couple therapy and the therapist.

In order to decide whether a rupture has actually occurred, it was decided that the perspective of the expert raters (ERs) would determine whether a rupture was present, as ERs are most likely to capture ruptures unique to the complex couple therapy environment.

This chapter includes information about participant demographics, and the measures (SOFTA and WAI-Co) used to select segments of videotaped sessions for further analysis. The three methods used to detect ruptures (SASB, RRS and ER Questionnaire) are then described, followed by information about the coders and the coding procedures used for each rupture detection method. Finally, the procedures involved in segment selection for investigation and rupture detection are included, and a summary of the statistical analyses performed.
Methods

Participants

Volunteers

Data was used from a previous study of 47 couples participating in time-limited (6 session) couples’ therapy. Each couple was assigned to one of six systemic family therapists. Mean age for male participants was 41.3 years, and for females was 39.2, with an age range of 23-69 years. Couples had lived together for a mean of 13.5 years, ranging from 1-49 years.

Therapists

The six therapists, 4 men and 2 women, ranged in age from 30-45 years. Therapeutic experience ranged from 5 to over 20 years. Specific theoretical orientations included: strategic/systemic, eclectic-systemic, eclectic, family of origin, and narrative. Therapists were informed that the study would examine factors affecting therapeutic outcome.

Measures

Event Selection Measures

Two measures, the Working Alliance Inventory – Couples (WAI-Co, Symonds, 1999) and the System of Observing Family Therapy Alliances (SOFTA, Friedlander, Escudero, Horvath, Heatherington, Cabero & Martens, 2006), were used to help select sessions which were likely to contain a rupture or strain in the working alliance. The
WAI-Co and SOFTA are summarised below. The coders, coding procedures, and how the measures were used for event selection is described later in this chapter.

Working Alliance Inventory – Couples (WAI-Co)

The Working Alliance Inventory – Couples (WAI-Co, Symonds, 1999) is a self-report measure developed to measure alliance in couples’ therapy. It is based on the Working Alliance Inventory (Horvath, 1981, Horvath & Greenberg, 1984) which was created to measure the working alliance in individual therapy. The development of the WAI-Co was influenced by Pinsof and Catherall’s (1986) argument that working alliance measures must account for the systemic aspects of couple and family therapy. The WAI-Co asks each client and the therapist to rate 63 items related to Bordin’s (1979) conceptualisation of Bond, Task, and Goal between client and therapist. For example, a goal item is “The counsellor and I have an understanding about what we are trying to accomplish in therapy”. The clients rate each item from their own viewpoint (Self), what they believe their partner thinks (Partner), and the viewpoint of the couple (Couple). The therapist version parallels the client questionnaire and asked therapists about their alliance with the female, male, and the couple.

A WAI-Co reliability study (Symonds, 1999) based on the same data as this study reported at the third session a split half reliability (R) of R=.97 for females and R=.95 for males. Cronbach’s alpha (α for both administrations of therapist and client versions) ranged from α=.95 to α=.98.

System of Observing Family Therapy Alliances (SOFTA)

The System of Observing Family Therapy Alliances (SOFTA, Friedlander, Escudero, Horvath, Heatherington, Cabero & Martens, 2006) assesses alliances both
between-systems alliances and within-family alliances. Coders tally observations of descriptors within four dimensions - “engagement in the therapeutic process”, “safety”, “emotional connection to the therapist” and “shared sense of purpose within the family”. Then they use a Likert scale to score each dimension. Descriptive statements within each category included both positive and negative behaviours and interactions e.g. “client has good eye contact with the therapist” and “client makes hostile or sarcastic comments to family members”. The strength of these four dimensions both between individual family members and the therapist, and within the family, are summarised at the end of the session using a Likert-scale.

A summary of five validity studies (Friedlander et. al., 2006) found that reliability interclass correlations ranged from .72 to .95. Factorial analysis suggested that the SOFTA dimensions represent elements of a single construct, however intercorrelations between dimensions were sufficiently variable (.18 for Safety and shared purpose, to .75 Engagement and Emotional Connection) that these dimensions seem to assess different aspects of the underlying alliance construct (Friedlander, Escudero, & Heatherington, 2006).

**Event Process Measures**

Three different measures of therapeutic process events were used to detect the presence of ruptures – two quantitative instruments (Structural Analysis of Social Behaviour, Benjamin, 1974, Grawe-Gerber & Benjamin, 1989, and the Rupture Resolution Scale, Samstag, Safran, & Muran, 2006) and one questionnaire (ER questionnaire) designed to collect both qualitative and quantitative information. These measures and their purpose in this study described below. Later in this chapter the coders and coding processes for each measure are described together with an analysis of coder reliability.
**Structural Analysis of Social Behaviour (SASB)**

The SASB (Benjamin, 1974, Grawe-Gerber & Benjamin, 1989) is a context-sensitive, micro-analytic observer rated measure of social behaviour. The three circumplex surfaces represent interpersonal behaviour directed towards others (Surface 1), the self (Surface 2, what a person's reaction is to the other person), as well as introjects (Surface 3, what intrapsychic action a person takes towards themself, e.g., "I hate myself") (Appendix C). Underlying each surface are two axes along which the coder "locates" the utterance: interdependence (independence-dependence), and affiliation (friendliness-unfriendliness).

There are three levels of coding complexity that can be used – the full SASB model (Appendix C), the quadrant, or the cluster version. The SASB cluster version was used by Safran and Muran (1996) and has 8 codes arrayed in a circular form across each surface. This study, like Safran and Muran's, used codes from two surfaces of the SASB cluster version (Figure 4) to categorise interactions between referents (defined below).

The two axes within each surface represent behaviours ranging from disaffiliative (left) to affiliative (right), and behaviours ranging from independent (top) to dependent (bottom). A two-digit code represents a series of judgements the coder makes about affiliation and independence. The first digit represents the interpersonal surface, and the second represents a point along the circumplex diamond. For example, a code of 2-5 (Deferring and Submitting) is focused on the self, indicates a very high level of dependence, and a neutral affiliation.
Figure 4. Surface 1 (focus on other) and Surface 2 (focus on self) of the SASB model cluster version (Benjamin, 1999).

FOCUS ON OTHER

1-1, FREEING & FORGETTING
1-8, IGNORING & NEGLECTING
1-7, ATTACKING & REJECTING
1-6, BELITTLE & BLAMING

FOCUS ON SELF

2-1, ASSERTING & SEPARATING
2-8, WALLING-OFF & DISTANCING
2-7, PROTESTING & RECOILING
2-6, SULKING & SCURRYING

Adapted from combined quadrant and cluster SASB models. Copyright Lorna Smith Benjamin, 1999, University of Utah

Transcripts are divided into Units (usually speech turns) and Elements. Elements represent a complete thought, and there may be more than one element within a Unit. Coders assign each verbally expressed element one or more codes – a process ("here and now") code should always be assigned, and a content code (what is being discussed) where possible, based on the SASB circumplex model. This effectively separates what the client and therapist discuss from the impact of client and therapists.
verbalisations on each other. An advantage of the SASB is that it identifies the initiator and a communication target i.e. who is referring to whom. Referents can be a group, not present in the session, or even historical. For example, the therapist talks to the "couple", the client discusses his previous wife (not present in session), or a client refers to his "younger self" (historical). Because this study looked solely at the "here and now" interactions between participants, only process codes were recorded.

When the original rupture-repair stage-process model was developed (Safran & Muran, 1996) the SASB was used to detect the start of a rupture event. Specifically, the beginning of a rupture event was defined as two consecutive SASB categories consisting of either "Walling Off and Avoiding" (2-8), "Sulking and Appeasing" (2-6) or "Deferring and Submitting" (2-5). This SASB method will be one measure used to identify the start of a rupture for this investigation. This particular operational definition of the start of a rupture will subsequently be referred to as a "SASB identified rupture" (SIR). The SASB was used to code all videotaped segments selected for the study.

**Rupture Resolution Scale - Revised (RRS)**

The Rupture Resolution Scale – Revised (RRS, Samstag, Safran, & Muran, 2006) is an observer rating system developed to measure ruptures in the alliance between a single client and therapist (Appendix D). The measure consists of two parts: a) identification of a rupture episode, and b) the resolution process. For the purposes of this study, only the rupture identification section was used. Rupture presence is operationalized by the RRS as a misunderstanding event followed by a behavioural marker of client distress. For example, the therapist may appear bored to the client (misunderstanding event), and the client may subsequently becoming increasingly quiet and reticent (client withdrawal marker). There are three different types of ruptures identified by Samstag, Muran and Safran, (2004), these are: the patient moving away,
towards, and against the therapist. The rupture “moving away” from the therapist is described as hostile autonomy and isolation. The SASB cluster code associated is with this rupture is “Walling Off and Avoiding” (2-8). The rupture “moving towards” the therapist is described as anxious helplessness and hostile compliance, and is associated with the two SASB cluster codes “Deferring and Appeasing” (2-5, 2-6). The third type of rupture “moving against” the therapist is described as hostile control and power. There are two sub-types of this rupture - “Attacking and Blaming” (1-6, 1-7) and “Approaching to Manage” (1-5 and 2-2).

More than one type of rupture can be identified by the RRS within a 5 minute time period. For each type of rupture observed two questions are asked - the length of time behaviours representative of a particular rupture are present, and the level of emotional intensity expressed by the client. For example, withdrawn behaviour may be observed at the beginning of a time period and the latter part of the time period. These two times would be added together to ascertain the total time these rupture behaviours were present.

For the rupture type “moving against” the therapist, how direct or indirect the rupture related behaviour is also assessed. Lastly, the degree to which a misunderstanding event it complete within the time segment is judged using a Likert scale. The reader is referred to the manual (Samstag et. al., 2006) for a fuller description of this scale. The Author changed the language of the RSS to reflect client gender in order to prevent coding confusion.

McEwan (2005) reported RRS interrater correlation coefficients ranging from \( r = .60-.99 \) based on a protocol that recoded segments when correlation coefficients fell below .60. The presence of four separate rupture states was supported by a lack of significant positive correlation coefficients between the rupture states, and a significant negative correlation was found between “Walling Off and Avoiding”, and “Approaching to
Manage" (McEwan, 2005). Because the RRS is a new instrument there are no other published reliability studies. However, it is the only specific measure of ruptures in the working alliance. The RRS was used in this study to identify the presence of a rupture within each selected videotaped segment. Ruptures identified by the RRS will be referred to as an RRS identified rupture (RIR).

**Expert Raters (ERs) questionnaire**

A two part questionnaire (Appendix E) was iteratively developed by the Author to elicit expert therapists' observations of the vignettes. Initial drafts based on extensive literature readings were modified after discussions with my Senior Supervisor, Dr Adam Horvath, and piloting the questionnaire on two practice vignettes. Part A consists of broad, open-ended questions designed to provoke a narrative reflection without informing the therapist of the study's purpose e.g. “Were there any interactions or events that you thought were significant for the therapy process?”. Respondents were asked to identify where in the transcript significant events began, and rate the event's level of emotional intensity. Part B asked ERs whether they observed a negative interaction, and if they thought the negative interaction caused “a negative shift in the quality of the client's relationship with the therapist”. This broad definition of a rupture is based in part on Safran and Muran’s (1996) definition “a deterioration in the relationship between therapist and client” (p. 447) and “negative shift in the quality of the existing alliance, or as difficulty establishing one” (Samstag, Muran, & Safran, 2004, p.188). Because ERs might have their own personal definition of the alliance, it was decided not to use terminology such as “alliance” when asking them to distinguish possible ruptures. The two definitions were merged to create a broad definition that would capture the essence of a strain or rupture in the working alliance. The last few questions explored the reaction of the other client, and there was a section for ERs to offer any further thoughts.
stimulated by questions in Part B. Ruptures identified by ERs will be described as ER Identified Ruptures (ERIRs).

Selection of Events and the Coding Process

Coders who rated the selection process measure (SOFTA) and rupture identification measures (SASB, RRS and ER Questionnaire) are described below, followed by the coding process and inter-rater reliability findings.

System of Observing Family Therapy Alliances (SOFTA)

Coders for the SOFTA:

Two graduate counselling students, one male and one female, coded sessions 1 and 3 of the data pool for part of a previous study by Friedlander et. al. (2006). The male coder was a 26 year old PhD Clinical Psychology candidate with 2 years clinical experience, and a self-described humanistic therapy orientation. The female coder (the Author) was a 32 year old MA Counselling Psychology candidate with 3 years clinical experience, and a self-described systemic psychotherapy orientation. Coders learned to use the SOFTA through the use of training video vignettes and through direct instruction by Dr. Friedlander.

Coding process for SOFTA

Coders achieved interclass correlations ranging from .67 (Emotional connection to the therapist) to .88 (Shared sense of purpose within the family), and an overall interclass correlation of .72 (Friedlander et. al, 2006). While reliability was adequate, the information used for this study was whether either coder noted SOFTA descriptors that could reflect rupture markers. Because this study is looking at subtle, fine-grained incidents within sessions, a coder notation of negative descriptors or interactions were
considered most relevant for identifying sessions with potential, observable, rupture markers. Therefore, a high level of reliability was not considered a prerequisite in order to use this archival data.

**Structured Analysis of Social Behaviour (SASB)**

**Coders for SASB**
All videotaped segments were coded by two graduate students. One was the author, a counselling psychology MA program with three years clinical experience and a systemic psychotherapy orientation. The other coder was a doctoral student with 15 years of clinical experience, who described her therapeutic orientation as psychodynamic.

The SASB training manual (Benjamin & Cushing, 2000) suggests a 30-50 hour sequence of training and offered training materials. In preparation for this study, both coders spent 100+ hours meeting and training together over a period of 1 year. During this time readings about the SASB and its theoretical orientation were discussed and a Coding Guide created.

**Coding for SASB**
The issue of uncodable material became important in this study. The coders often disagreed about which utterances were codable and which were not. Normally the level of agreement about codability of utterances has not been problematic in the literature. However, initially the levels of agreement about what was codable on practice data were quite poor\(^1\). This was attributed to ambiguous sounds such as "uhmmm" being coded differently by each coder, despite extensive discussion. For example, one

\(^1\) Assessed over three 3-5 minute videotaped practice segments using a Chi-square level of agreement analysis.
coder might decide "uhmmm" was an encouraging verbalisation towards the male, and assign a cluster code of 1-2 (Affirming and Understanding), whereas the other coder would decide they could not judge who the utterance was directed to, or perhaps not make a decision about interdependence or affiliation – making it uncodable. To resolve this issue was decided that when one of the two coders could not assign a code to an utterance, it would be treated as ambiguous for both and thus uncodable.

A weighted kappa analysis (Cohen, 1969) was used to establish inter-rater reliability. Although no specific level of acceptable inter-rater reliability for process code is given in the SASB manual, Florsheim and Benjamin (2001) indicated several studies with acceptable inter-rater reliability. For example, Humphrey (1989) ranged from .63-.83 and Ratti, Humphrey and Lyons (1996) study ranged from .60-.93. This study obtained a weighted kappa of 0.87, and a Chi square level of agreement ($p \leq 0.001$) between coders. These results were taken as indicators that sufficient reliability had been obtained to start coding data.

Both coders rated each of 12 videotaped segments. During the coding process the coders regularly checked in with each other to discuss coding issues and problems to maintain a high level of judgement consistency. For actual data, the Chi square level of agreement between coders ranged from $p \leq 0.01$ to $p \leq 0.05$ (Table 1).
Table 1: Level of agreement between two SASB coders about whether utterances could be coded.

<table>
<thead>
<tr>
<th>Segment</th>
<th>N Codes</th>
<th>Chi Square</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>221</td>
<td>58.73</td>
<td>.01</td>
</tr>
<tr>
<td>2</td>
<td>258</td>
<td>40.67</td>
<td>.01</td>
</tr>
<tr>
<td>3</td>
<td>211</td>
<td>80.49</td>
<td>.01</td>
</tr>
<tr>
<td>4</td>
<td>156</td>
<td>4.03</td>
<td>.05</td>
</tr>
<tr>
<td>5</td>
<td>282</td>
<td>127.87</td>
<td>.01</td>
</tr>
<tr>
<td>6</td>
<td>126</td>
<td>9.09</td>
<td>.01</td>
</tr>
<tr>
<td>7</td>
<td>197</td>
<td>54.24</td>
<td>.01</td>
</tr>
<tr>
<td>8</td>
<td>231</td>
<td>46.19</td>
<td>.01</td>
</tr>
<tr>
<td>9</td>
<td>170</td>
<td>163.93</td>
<td>.01</td>
</tr>
<tr>
<td>10</td>
<td>120</td>
<td>44.21</td>
<td>.01</td>
</tr>
<tr>
<td>11</td>
<td>164</td>
<td>133.91</td>
<td>.01</td>
</tr>
<tr>
<td>12</td>
<td>115</td>
<td>71.02</td>
<td>.01</td>
</tr>
</tbody>
</table>

The average Kappa weighted inter-rater reliability was 0.88 (Table 2, range 0.78-0.94). The second coder was unaware of the SASB definition of the start of a rupture, or that there were non-rupture segments included. To resolve differences between coders about the start of a rupture, it was decided that rather than use consensus coding just the second coder’s cluster codes would be used for analysis purposes. This was because of the high level of SASB inter-rater reliability found in all segments coded.
Table 2: Kappa weighted inter-rater reliability of two SASB coders

<table>
<thead>
<tr>
<th>Segment</th>
<th>$K_w$</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.88</td>
</tr>
<tr>
<td>2</td>
<td>.90</td>
</tr>
<tr>
<td>3</td>
<td>.86</td>
</tr>
<tr>
<td>4</td>
<td>.88</td>
</tr>
<tr>
<td>5</td>
<td>.89</td>
</tr>
<tr>
<td>6</td>
<td>.78</td>
</tr>
<tr>
<td>7</td>
<td>.93</td>
</tr>
<tr>
<td>8</td>
<td>.90</td>
</tr>
<tr>
<td>9</td>
<td>.83</td>
</tr>
<tr>
<td>10</td>
<td>.88</td>
</tr>
<tr>
<td>11</td>
<td>.94</td>
</tr>
<tr>
<td>12</td>
<td>.88</td>
</tr>
</tbody>
</table>

Mean = .88 (range .78 - .94); SD = .04

Rupture Resolution Scale

Coders for RRS

Coders were the Author, a graduate student in a counselling psychology MA program with over three years clinical experience, and one undergraduate student with 2 years of group therapy coding experience.

Coding the RRS

The coders practiced coding the RRS on videotaped couples' therapy sessions over a period of 4 months. The unpublished revised RRS manual (Samstag, Safran & Muran, 2006) and readings about SASB coding categories were discussed, and one of the RRS authors, Dr. Samstag, was consulted extensively. The misunderstanding event completeness scale was not clearly delineated in the manual and aspects required inferential judgements by coders. For example, "wish" was not described in the manual, nor was a completeness scale rating. It was found during practice segments that this
scale was most difficult to rate reliably. Coders attributed this to the presence of another client and the inferential nature of the scale. In addition, the conversation flowing between three people rarely addressed issues such as a patient’s relational expectations directly within the five minute time period being coded. Frequently relational needs and expectations could only be inferred. After some consultation with Dr. Samstag, and extensive practice, the coders agreed on some descriptors of the misunderstanding event completeness scale for this study (Appendix F). This scale has not been approved by the RRS authors. Data coding began when an average Pearson’s Correlation \( r = 0.81 \), range \( 0.55 - 1.00 \) was achieved for the practice RRS over 72 time periods.

**Table 3: Pearson correlation of RRS inter-rater reliability for two raters**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Pearson's Correlation (r)</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Walling Off &amp; Avoiding</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Presence</td>
<td>48</td>
<td>0.77</td>
<td>0.01</td>
</tr>
<tr>
<td>- Emotional Intensity</td>
<td>48</td>
<td>0.88</td>
<td>0.01</td>
</tr>
<tr>
<td><strong>Deferring &amp; Appeasing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Presence</td>
<td>48</td>
<td>0.62</td>
<td>0.01</td>
</tr>
<tr>
<td>- Emotional Intensity</td>
<td>48</td>
<td>0.48</td>
<td>0.01</td>
</tr>
<tr>
<td><strong>Attacking &amp; Blaming</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Presence</td>
<td>48</td>
<td>0.83</td>
<td>0.01</td>
</tr>
<tr>
<td>- Directness</td>
<td>48</td>
<td>0.93</td>
<td>0.01</td>
</tr>
<tr>
<td>- Emotional Intensity</td>
<td>48</td>
<td>0.90</td>
<td>0.01</td>
</tr>
<tr>
<td><strong>Approaching to Manage</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Presence</td>
<td>48</td>
<td>0.40</td>
<td>0.01</td>
</tr>
<tr>
<td>- Directness</td>
<td>48</td>
<td>0.40</td>
<td>0.01</td>
</tr>
<tr>
<td>- Emotional Intensity</td>
<td>48</td>
<td>0.43</td>
<td>0.01</td>
</tr>
<tr>
<td><strong>Misunderstanding Event Completeness</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>48</td>
<td>0.68</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Mean \( r = 0.67 \) (range \( 0.40 - 0.93 \))
RRS Pearson’s correlation inter-rater reliability results were variable (average 0.67, range 0.40-0.93, Table 3). Three of the four correlations falling below a minimum r=.60 threshold were related to the rupture “Approach to Manage”, and the fourth was “Deferring and Appeasing” emotional intensity. Because reliability for the RRS rupture “Approaching to Manage” was particularly poor (0.40-0.43), rather than choose one coder’s judgements for further analysis, Likert scores were averaged between the two coders for each segment. This increased the likelihood of the number and type of RRS rupture markers identified, however in a pilot study the increased risk of Type I errors, rather than Type II errors, was preferred.

**Expert Raters Questionnaire**

**Expert Raters**

Three volunteer therapists who were experienced in couples and family counselling were asked to observe and respond to the videotaped segments using the ER questionnaire. Each therapist held an MA or MSW, was a member of the American Association of Marriage and Family Therapy, and had an average of 24 years of clinical group or couples’ experience (range 10-33 years). The therapists self described themselves as a systemic therapist, eclectic therapist, and a combination family systems theory and eclectic therapist.

**Expert Raters Coding**

Three ERs were each given the 12 segments identified as vignettes of therapeutic sessions. The ERs were told they would be asked to comment on the therapeutic processes the observed. Therapists signed confidentiality agreements (Appendix G) and agreed to view videotaped data in private. They were informed that
the purpose of the study was to investigate therapeutic processes, and were otherwise
blind about specific research aims. They were given Part A and B of the questionnaire
in different envelopes. Each therapist was strongly enjoined to complete all twelve Part
A’s of the questionnaire before completing Part B, and encouraged to view the segments
as often as required.

Expert Rater’s results indicated some disparity between raters regarding rupture
detection (Appendix H). An interclass correlation revealed a very low level of agreement
about rupture occurrence within T1 and T2 ($r=.28$, df=23). Therefore, to define the
presence of an ER identified rupture (ERIR) for further analysis, it was decided that two
of the three ERs must agree on the presence of a rupture in T1 or T2.

**Procedure**

Within this section the segmentation selection process and rupture detection
process are described in detail. Because data was mined, the segmentation selection
process involved several steps. This included selecting sessions that met specific
process measure criteria, and judgements about when a rupture may have occurred.
The rupture detection measures were then applied to the data.

**Segment Selection Process**

**Rupture Events**

Because data was archival, a three step procedure was developed to narrow
down the data pool to nine segments of 10 minute each. It was the author’s aim to
identify nine sessions that were likely to contain rupture behaviour, and 3 segments of
10 minutes each that did not contain behaviour considered to be ruptures². Sessions 1 and 3 were included in the pool because these were the only sessions where two measures used in the segment selection process (described below) were administered – the WAI-Co (Symonds, 1999), and the SOFTA (Friedlander et al. 2006).

Previous studies of ruptures in the working alliance have used some type of post session questionnaire (c.f. Safran & Muran, 2006, Eames & Roth, 2000) to gain each individual’s perspective of events within a session to help identify sessions that were likely to contain a rupture event. Because the data pool was archival, a series of logical steps were taken to try to distinguish sessions that may contain a rupture event. In summary:

1) Archival self-reported alliance strength data (WAI-Co, Symonds, 1999) and relevant negative descriptors noted by coders (SOFTA, Friedlander et al, 2006) were used to locate sessions which might contain rupture-like behaviour.

2) Three independent judges were presented with sessions which had poor WAI-Co scores and SOFTA descriptors considered relevant to a rupture. They were then asked to identify whether a session contained a rupture, and when the rupture started.

---

² Ten minute time segments were chosen for three reasons: 1) the labour intensive coding requirements of the SASB dictate a shorter time period rather than an entire session; 2) the RRS scores summarise 5 minute time periods, and at least two sets of RRS scores were desired per segment to be able to perform inter-rater reliability analysis; and 3) the likelihood of more richly detailed, focused narratives from ERs probably increases because observers focus on a shorter segment.
Figure 5 represents more precisely the decisions made at each stage.

Figure 5. Event selection decision tree

*An exception was made for a negative shift in the working alliance that all three judges thought was expressed nonverbally by a client, and scored an observational clarity value of 1.*

Male and female clients' and the therapist were ranked according to their Individual total WAI-Co scores and the Therapist's Total WAI-Co score. When any of
the three session participants (client or therapist) were ≤ 33rd percentile, this was taken as an indication that two people may have perceived the working alliance as weak, and that strains and stresses may have occurred within the session. Twenty-seven sessions met this criterion.

Archival data (Friedlander et. al., 2006) included tallies of SOFTA ratings. SOFTA descriptors noted by coders, that were considered relevant to rupture behaviour directed towards the therapist (Appendix I) were compared to the subset of low WAI-Co score sessions. This comparison yielded sixteen sessions that had two participants with a low WAI-Co score and which had one or more negative SOFTA descriptors noted.

Lastly, the selected sessions were viewed separately by two judges. One judge was the Author and the other a psychodynamic therapist PhD candidate with an MA and MSW, and 12 years of clinical experience. The two judges met and agreed which sessions had a “negative shift in the quality of the alliance between client and therapist”. This definition was used to make it comparable to what ERs were asked in the questionnaire, and to be as inclusive as possible. Because the rupture construct in couples’ therapy has not been rigorously studied, the risk of a false positive or Type I error was more acceptable than the risk associated with not identifying all ruptures present.

The first nine sessions selected by the pair of judges as containing a rupture were sent to a third, independent judge with 20+ years of clinical experience. She self-described as a structural therapist and had experience in working alliance research. This third judge was asked to view the sessions selected by the first two judges and record whether there was a “negative shift in the quality of the alliance between client and therapist”. If a rupture was present the beginning was located in the session, and the judge rated how clearly observable the rupture was on a scale from 0 (not observable at all) to 3 (very clear presence of rupture related behaviour).
When the start of a negative shift was identified at a similar time within a session by all three judges the event could be included in the study. Ruptures noted by all judges at the beginning of a session were excluded because it was unclear whether behaviour was related to the previously established relationship with the therapist, or some external event prior to the session. It was decided to choose more clearly observable events (≥2), with one exception - a segment where the rupture event appeared entirely nonverbal to all three judges (rupture clarity = 1) was included to investigate what observer coding measures and ERs perceived. Nine rupture events were subsequently included in the Rupture group.

**Non-Event Vignettes Selection Process**

In order to match the rupture session pool, the Author randomly selected from session’s one and three, three different couples. None of the sessions selected were in the Rupture group. A 10 minute segment from each tape was picked which did not seem to contain any stresses between a client and the therapist. However, within each session an effort was made to locate a segment that involved dialogue about the clients’ relationship. This was done to heighten the possible level of emotionality in the segment, to make rupture and non-rupture segments less distinguishable to coders and ERs. All three judges concurred that there was no apparent “negative shift in the quality of the working alliance”. These three segments comprised the Non-rupture group.

**Rupture Detection Process**

Expert Raters completed questionnaires about the 12 videotaped segments. Both SASB and RRS coders were given transcripts and videotaped data, and coded data according to coding procedures described above.
Analyses of the Data

The analysis was conducted in the following manner:

1. Descriptive statistics of SASS and RRS measures are reported.
2. Inter-rater reliability of ERs was analysed.
3. Research Question 1 – Percentage agreement of RIR with ERIR was analysed. Primary analysis compared the two measures of rupture detection without matching rupture participants. A secondary level of analysis matched ruptures according to rupture participants.
4. Research Question 2 – Percentage agreement of SIR with ERIR was analysed. As with Research Question 1, a primary and secondary level of analysis was performed.
5. Research Question 3 – The SIR and RIR agreement with ER findings were compared. As with Research Question 1, a primary and secondary level of analysis was performed.
6. Research Question 4 – The level of agreement about rupture presence between SASS measure and the RRS was analysed. As with Research Question 1, a primary and secondary level of analysis was performed.
7. Research Question 5 – The number of ruptures identified as “couple” ruptures by the SASS and ERs are noted. These specific ruptures will separately be matched for similarity of location.
8. Research Question 6 – Ruptures noted by ERs but not identified by either the SASS or RRS detection methods were noted. The Author then searched for observable patterns and themes between the narratives related to unmatched ERIRs.
CHAPTER IV
RESULTS

Introduction

The primary aim of this study was to discern whether ruptures in the working alliances in couples’ therapy can be identified by either Safran and Muran’s (1996) operational definition of the start of a rupture, or the RRS (Samstag, Safran, & Muran, 2006). The presence of a rupture for this study is operationally defined as when two of the three ERs judged a rupture had occurred. Two levels of comparative analysis will be carried out for each hypothesis. The primary level of analysis will be between ERIRs, RIRs and SIRs within an RRS time period. The secondary level will match rupture presence both for time period and rupture participants.

The three methods of rupture event identification generated complex quantitative and qualitative data. This chapter consists of three sections. The first section includes descriptive statistics for each rupture detection method. The second section answers specific hypotheses at the primary and secondary level of analysis, and the exploratory question. The third section includes post hoc analyses.

Descriptive Statistics

SASB Descriptive Data

The 120 minutes of videotaped clinical segments yielded 2057 SASB cluster codes, of which 1015 were initiated by either the male or female client, and involved the client and therapist. For example, Male or Female withdraws from therapist, or
expresses anger towards the therapist. Appendix J shows the percentage of frequencies of SASB codes initiated by either male or female client, involving the therapist, separated by Rupture and Non-rupture group. The therapist was assigned 64 SASB cluster codes directed towards the couple referent in the Rupture group (mean = 7.1), and 14 in the Non-rupture group (mean = 4.7). This indicated that the coder was using the couple entity as a coding referent. However, no SASB cluster codes were initiated by the couple entity towards the therapist. There are two possibilities why there were no SASB codes initiated by the couple entity towards the therapist. First, it may have been easier for the coder to perceive behaviours from the therapist towards the couple subsystem, then from the couple subsystem towards the therapist. Alternatively, there may have been no behaviours judged to be from the couple subsystem (the couple acting together) towards the therapist.

The sum of the percentages of SASB cluster code frequencies included in the SASB rupture definition (2-5, 2-6, and 2-8) were noticeably different between the Rupture (10.98%) and Non-rupture (0.35%) groups. While these SASB codes did not meet the definition of a SIR, it did indicate the presence of tension or stress in the therapeutic relationship may have been higher in the Rupture group. Overall, a total of 15 SIRs occurred in the Rupture group (mean=1.7), and as expected no ruptures were observed in the Non-rupture group. This suggests that the three judges who assigned segments to the Rupture or Non-rupture group matched the SASB method of detecting ruptures.

**RRS Descriptive Data**

A rupture could be assigned to either the first 0-5 minute segment (T1) or the second 5 minute segment (5-10 minutes, T2) of each 10 minutes of videotaped
Similar to the SASB method of rupture detection, no ruptures were recorded in the Non-rupture group. Within the Rupture group there were 18 time segments during which an RRS rupture could be observed. Of these eighteen time periods, seven T1 and seven T2 had one or more types of rupture presence reported. For example, within a single time period the male client might alternate between two rupture states - withdrawal behaviours and attempting to manage the therapeutic process/therapist. Within the 14 time periods containing a RIR, 34 separate RRS rupture states were identified in the Rupture group (Appendix K). The maximum number of rupture states assigned to a specific client in one time period was 3 (mean=1.9). For later comparison purposes, any number of rupture states that occurred within a time period was simply considered a single rupture event.

**ER Questionnaire Descriptive Data**

The three ERs cumulatively noted 133 events or interactions they considered significant to the therapy process in Part A of the ER Questionnaire (Table 4). When prompted to identify a negative shift in the quality of the relationship between client and therapist in Part B of the questionnaire, ER A identified 8 ruptures, ER B identified 5, and ER C identified 32 (71% of total ERIRs). Twenty-six of the significant interactions noted in Part A were identified as ruptures by an ER and an additional 19 ruptures, not previously noted, were observed by an ER.
Table 4: Frequency and mean of significant interactions, negative interactions, and negative shifts in the relationship between client and therapist observed by ERs in Rupture and Non-rupture groups.

<table>
<thead>
<tr>
<th>Group</th>
<th>Significant interaction (mean)</th>
<th>Negative interaction (mean)</th>
<th>Negative shift in relationship between client and therapist rupture (mean)</th>
<th>Rupture identified in Part A (mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rupture (n=9)</td>
<td>110 (12.2)</td>
<td>55 (6.1)</td>
<td>40 (4.4)</td>
<td>21 (2.3)</td>
</tr>
<tr>
<td>Non-rupture (n=3)</td>
<td>23 (2.3)</td>
<td>9 (3)</td>
<td>5 (1.7)</td>
<td>5 (1.7)</td>
</tr>
<tr>
<td>Total</td>
<td>133</td>
<td>64</td>
<td>45</td>
<td>26</td>
</tr>
</tbody>
</table>

Two ruptures recorded by ER C were excluded from further analysis because the ER did not specify a start place for the rupture, but instead referred to the “whole session” being a rupture. This was considered to vague for the purpose of analysis. Because of poor inter-rater reliability it was decided that an ER rupture was present when two ERs identified a rupture within the same time period.

**Comparative Analysis**

In order to compare ERIRs, SIRs and RIRs to each other, decisions about raw data interpretation were required. At the first level of analysis, if two separate rupture detection methods noted the start of any rupture during an RRS time period this was considered a match. If more than one rupture was noted during an RRS time period, for example if an ER noted three ruptures within T1, this was defined as a single rupture.
event when another ER recorded noted a rupture. Table 5 compares ERIRs, RIRs and SIRs for the Rupture group (segments 1-9) and Non-rupture group (segments 10-12).

Table 5: Overall comparison of ERIRs, RIRs, SIRs for Rupture group and Non-rupture group in each time period.

<table>
<thead>
<tr>
<th>Time Period and Segment</th>
<th>Rupture Presence</th>
<th>Rupture Match</th>
<th>ERIRs</th>
<th>RIRs</th>
<th>SIRs</th>
<th>ERIRs and SIRs</th>
<th>ERIRs and RIRs</th>
<th>SIRs and RIRs</th>
</tr>
</thead>
<tbody>
<tr>
<td>T1 (0-5 mins)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>6</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>9</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>T2 (5-10 mins)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>3</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>5</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>7</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>8</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>10</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
<td>7</td>
<td>6</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

● = A rupture was detected.
The secondary layer of analysis for each hypothesis had a more demanding criteria match. Not only was rupture presence matched, but also rupture participants. For example, if an ERIR occurred between the female and therapist, only an RIR or SIR between the female and therapist within the same TP was considered a match. ERs had the option of identifying a rupture between the couple and therapist. When this occurred, for comparison purposes couple ruptures were transformed into two separate ruptures between the male and therapist, and female and therapist. Appendix L shows two tables representing the secondary level of analysis.

**Research Question 1**

Can the RRS identify the same ruptures observed by ERs? Do ERs or the RRS identify more ruptures? It was expected that some ruptures observed by the ERs would also be identified by the RRS. However, because the RRS was developed to identify ruptures in dyadic therapy, and the differences between couple and dyadic previously discussed, it was hypothesised that ERs will identify more ruptures than the RRS.

**Primary Analysis**

To investigate this question ERIRs and RIRs were matched and percentage agreement obtained. The operational definition of rupture presence in couple therapy for this pilot study was when any two of the three ERs observed a rupture. Of the 6 ERIRs observed (Table 5), 100% were matched by an RIR within the same time period. The ERs did not detect any unmatched ruptures. This did not support the hypothesis that ERs would detect more ruptures than the RRS. Surprisingly, eight RIRs were unmatched by ERIRs, suggesting the possibility of false positive RIRs, or that RIRs and
ERIRs had overlapping but different definitions. This is discussed in detail in the conclusion.

**Secondary Analysis**

A secondary level of analysis required a different matching criteria – both rupture presence in a time period, and rupture participants. For example, if a Male and therapist were recorded by the ER as engaging in a rupture, then a matching RIR or SIR also had to be between a Male and therapist. Appendix L illustrates there was a 100% male client and therapist RIR and ERIR match, and a 100% female client and therapist RIR and ERIR match. Similarly to the primary analysis, unmatched RIRs were noted for male client and therapist ruptures (n=8), and female client and therapist (n=6).

**Research Question 2**

Can the SASS method (Safran & Muran, 1996) detect ruptures observed by ERs? Do ERs or the SASS method identify more ruptures? The SASS method of operationalising the presence of a rupture was expected to identify some ruptures observed by ERs. It was hypothesised that more ruptures would be noted by ERs than the SASS method because of the previously discussed differences between couple and dyadic therapy.

**Primary Analysis**

To answer this hypothesis, the number of ERIRs matched by SIRs was compared. Table 5 illustrates that 33% of ERIRs were also detected using the SASS method. Therefore the hypothesis that SIRs would correspond with some, but not all,
ERIRs was supported. Further analysis found that SIRs were unmatched by an ERIR 75% of the time.

**Secondary Analysis**

When ERIRs and SIRs were matched according to rupture participants and time period, for male client and therapist ruptures the single ERIR did not have a corresponding SIR, and 25% of female client and therapist ruptures ERIRs were matched by a SIR (Appendix L). Again the hypothesis that the ERs would detect more ruptures than the SASS detection method was supported. However, for the male client and therapist ruptures 100% of SIRs were not matched to an ERIR, and for female client and therapist ruptures 83% of all SIRs were not matched to an ERIR.

**Research Question 3**

Is the SASS method or the RRS more accurate at detecting ruptures in couple therapy? It was anticipated that the RRS would have more matches to ER identified ruptures than the SASS rupture detection method, because the RRS identifies more types of ruptures.

**Primary Analysis**

A simple comparison of the data in Table 5 showed the number of matches between ERIRs and SIRs (33%) and ERIRs and RIRs (100%). This revealed that the RRS detected three times as many ERIRs as the SASS identification measure.
Secondary Analysis

When a rupture was identified between the male client and therapist (Appendix L), RIRs matched 100% of ERIRs, and SIRs matched just 25% of ERIRs. When a rupture was detected between the female client and therapist, an RIR matched the ERIR, and no SIR matched the single ERIR. Therefore, RIRs matched at least four times as many ERIRs compared to SIRs.

Research Question 4

Do the SASS rupture detection method and the RRS localise similar events as ruptures? It was hypothesised that the SASS rupture detection method and the RRS should localise similar events as ruptures. However the RRS was considered more likely to identify ruptures then the SASS method because the RRS identifies more types of ruptures.

Primary Analysis

It was found that SIRs and RIRs occurred in the same time periods (n=6, Table 5), suggesting SIRs and RIRs can observe similar rupture events (Figure 6). Eight RIRs were unmatched by SIRs, consistent with the hypothesis that the RRS would detect more ruptures than the SASS rupture detection method. What was unexpected was the two extra SIRs unmatched by RIRs. Both RIRs and SIRs converged on 33% of ERIRs. Therefore, the two parts of the hypothesis - that the RRS would identify more ruptures than the SASS detection method and that the RRS and SASS method would identify some similar rupture events were supported.
Secondary Analysis

When matched for participants, findings were similar to the overall comparison. For the male client and therapist rupture matches there was an overlap of 3 RIRS and SIRS (Appendix L). The female client and therapist rupture matches revealed an overlap of 5 RIRS and SIRS. Ten RIRS and five SIRS were observed when the male client and therapist engaged in a rupture, and ten RIRS and six SIRS were observed when the female client and therapist participated. This secondary level of analysis supports the hypothesis that the RRS detected more ruptures than the SASS method, and that they identified some ruptures in the same time periods.

Research Question 5

Can the SASS rupture detection method or ERs identify couple subsystem ruptures? It was anticipated that the SASS rupture detection method and ERs would identify couple subsystem ruptures. The RRS was not included in this hypothesis because it only assesses ruptures between a single client and the therapist.

To answer this question the frequency of ERIRs and SIRs between the couple subsystem and the therapist were noted. No SIRs were recorded between the couple subsystem and therapist, therefore SIRs and ERIRs for the couple subsystem and therapist did not match. ERs identified six ruptures involving the couple subsystem and
therapist across six time periods, however they did not meet the study's criteria for rupture presence. Therefore, the hypothesis that ERs and SIRs would detect ruptures between the couple subsystem and therapist was not supported.

Research Question 6

If there were ER ruptures unmatched by either SIRs or RIRs, is there something different about the ERIRs? To explore this question ER narratives of ruptures detected only by the ER were to be compared to each other. However, no ER ruptures were unmatched with either SIRs or RIRs.

Further Analysis

Nonverbal rupture

Because of the exploratory nature of this investigation it was decided to include a specifically non-verbal rupture because it might provide interesting data for future studies. The only clearly non-verbal segment that met all criteria for inclusion, except how clearly observable the rupture was (clarity=1 according to Judge 3), was included in the Rupture group for further analysis. All three selection judges thought that the male client's body language indicated a non-verbal rupture was occurring between the male and therapist in Segment 7. The clinician directed all therapeutic conversation to the female client, and the male client did not say anything during the segment.

The SASB detection method did not identify a rupture in Segment 7. This was expected because the SASB coding system only assigns cluster codes to thought elements. The RRS did detect a Walling Off and Avoiding rupture, however it had a minimum score for presence (0.5/4) and emotionality (0.5/4). No ER identified a negative shift in the relationship between a client and the therapist. On closer
examination, there were narrative comments by two ERs that indicated that there may have been some difficulty perceived in the working alliance.

ER A commented:

"Male bored throughout"

"Cannot understand why Male was completely ignored - did not even remove his sunglasses!"

"Find this surprising because male partner not included at all in this vignette - but he did seem to be listening so possibly Therapist had connected well with him prior to the segment"

ER C commented:

"The whole vignette was a dialogue between the therapist and the female client. There was NO soliciting the male client's input WHATSOEVER"

"Therapist's relationship with the male member of this couple is NON-EXISTENT - difficult to say how it [the therapeutic relationship] changed, as there was NOTHING taking place."

"No joining with male client WHATSOEVER in this segment - male client seemed invisible - not in the room - totally disengaged body language, male therapist ignored male client."

ER B did not note any significant interactions, negative interactions, or ruptures.
CHAPTER V

CONCLUSIONS

The primary focus of this study was to identify a method that could detect ruptures in couples’ therapy. Rupture presence was defined as two clinical expert raters judging that a rupture was present (ERIRs). The results of this study showed that the RRS detected all ERIRs, compared to the SASS method which identified only 1/3 of ERIRs. When rupture participants were matched between RIRs and ERIRs, the RRS identification rate was excellent, whereas SIRs matched fewer ERIRs. At face value this suggests that perhaps the RRS could be used to identify some ruptures. However, what these ruptures represent in couples therapy, and whether the RRS captures all rupture types that occur in couples therapy, is questionable. Also, ERs or the RRS may have provided false positive and false negative results.

Expert Raters’ judgments were chosen to define rupture presence in this study because their clinically informed judgments were considered more likely to encompass subtle and obvious ruptures unique to couple therapy. In addition, it was anticipated that their decisions would indicate clinically significant events. However, three difficulties arose using ERIRs to define rupture presence that require further discussion – a) poor ER inter-rater reliability; b) a number of RIRs unmatched by ERIRs, and; c) some SIRs unmatched by ERIRs.

It was anticipated that ER judgments would be informed by their own theoretical framework and practical experiences about what constituted a “negative shift” in the therapeutic relationship. Despite these individual differences, it was theorized that the pantheoretical nature of a rupture in the working alliance would be similarly noticed by
ERs. However, differing standards between ERs about what behavioural markers caused a negative shift in the therapeutic relationship was evident in the poor interrater reliability achieved. ER C clearly had a lower signal detection threshold than the other two ERs, and was quite accurate as an individual in matching RIRs. However, unlike any selection judge (N=3) or the RRS or SASB, ER C reported ruptures in the Non-rupture Group, suggesting a hyper sensitivity that needed to be moderated by another coders judgment. This post hoc requirement for a more stringent ERIR criteria may have led to false negatives. Poor inter-rater reliability might have been due to expert raters simply having difficulty discerning a rupture had occurred. This is similar to findings that therapists in session, even with training, had difficulty perceiving ruptures (Henry, Strupp, Butler, Schacht, & Binder, 1993) and may represent the need for explicit training in the clinical community about how to consistently recognize rupture markers.

A possible explanation for the discrepancy between number of RIRs and ERIRs is that the RRS may have had a different operational definition from ERs about what constitutes a rupture. Underlying the RRS is Samstag et. als. (2004) definition of a rupture as a "negative shift in the quality of the existing alliance, or as difficulty establishing one" (p.188). This was operationally defined in the RRS as a behavioral rupture marker associated with a misunderstanding event, and the manual provides a thorough, descriptive raters’ scale for the identification of rupture types. Similar to Samstag et. al’s rupture definition, ERs were asked to identify "a negative shift in the quality of the relationship between client and therapist". In order to avoid constricting ERs written narratives because of the exploratory nature of this pilot study, no operational definition or examples were offered to ERs.Hints of differences between RIRs and ERIRs were evident in narratives provided by ERs. ERs indicated there were problems in the therapeutic relationship, such as a client appearing bored. However this behaviour was not considered a negative interaction, or a negative interaction leading to
a rupture. In contrast, the clear criteria provided by the RRS manual about even quite subtle rupture markers, such as a client leaving a coat on, would have lead a coder to note a rupture marker and, together with a misunderstanding event, a RIR would have been detected. This suggests that the RRS and ERs may have been using different definitions about what type of behaviour constituted a rupture. Also, RRS inter-rater reliability was considerably better than ER inter-rater reliability. The inconsistent ER criteria about when a negative shift in the therapeutic relationship occurred, indicated by some narratives and poor inter-rater reliability, may be another indicator that ERs have a different rupture operational definitions compared to the RRS.

Alternatively, ERs may have had a higher threshold about what behavioural markers reflect rupture presence than the RRS. It was observed by the author that some ER narratives about significant interactions appeared to reflect a negative interaction, but were not recorded as a negative interaction or a rupture. For example, in segment 3 an ER commented that the therapist “finally connects” with a client and then “loses her”. The ER went on to attribute this to “transference and countertransference”, and stated that the therapist was unable to use the event in a positive way. The ER concluded that the process was “contaminated by negativity and lack of clarity”, and that the therapist sounds angry. From the narrative, this event seems to have been a negative interaction and a rupture. However, it was only recorded as a significant event. These observations lead to questions such as how do clinicians separate an actual rupture from simple disagreement about goals? Does a low level of tension in the therapeutic relationship always reflect a rupture? Perhaps ERs are aware of subtle tensions or difficulties and consider them part of the ebb and flow of therapeutic interaction in couple therapy, rather than indicative of a rupture between client and therapist. There is also a possibility that the RRS misunderstanding event scale was ineffective as a differentiator between behavioural markers indicating a rupture and a
negative interaction. When combined with a misunderstanding event, the RRS can assess quite subtle tensions as a rupture. However, there was a misunderstanding event present for every behavioural marker. This will be discussed in more detail below.

In contrast to ERIRs, the threshold for an RIR presence may have been quite low, offering a possible explanation of why there were a number of RIRs unmatched by ERIRs. Raising therapists' awareness about the occurrence of working alliance ruptures is a major focus of this study. However, future research may be necessary to determine the clinical usefulness in couples' therapy of differentiating between a rupture and a negative interaction with the therapist. Perhaps a low level of tension in the therapeutic relationship always represents an underlying rupture that needs to be addressed, and the ERs threshold for rupture presence is too high. Alternatively some interpersonal tension may be a constant in the ongoing process of negotiating the working alliance – particularly in couples’ therapy where a more complex level of negotiation is generally needed – and yet not reflect a negative shift in the working alliance. Therefore ERs may have considered some tension or degree of negotiation “normal” between clients and therapist, without thinking this behaviour represented a rupture. Process research aims at explicating clinically significant events. If ERs do consider some tension normal in a relationship, is this a clinically significant change process? Researchers may need to consider this question when developing instruments to assess rupture presence.

One last explanation of the RIRs unmatched by ERIRs is procedural decisions made to moderate inter-rater reliability problems. With one significant exception (Watching & Managing) the level of RRS inter-rater reliability achieved was generally acceptable. The decision to average RRS coders’ results to account for poor coder agreement about the Watching & Managing rupture may have caused a higher number of ruptures to be detected than other methods of dealing with this difficulty – such as
recoding or having an independent judge arbitrate. In contrast, poor ER reliability led to a more difficult criteria of 2/3 judges agreeing a rupture had occurred. Fewer ERIRs may have been reported, and might under-represent the number of ruptures actually present. While these were the best possible statistical decisions given resource constraints, they raise the possibility of false positive RIRs, and false negative ERIRs, and could explain the different detection rates between the RRS and ERs. The few SIRs unmatched by ERIRs might be due to chance, or possible underreporting of ERIRs. These difficulties encountered in this exploratory study could be solved by using a different methodology in future investigations.

As hypothesized it was found that the SASS method did not detect as many ruptures as the RRS when rupture participants were matched or unmatched to ERIR rupture participants. More RIRs were unmatched by SIRs than converged on the same rupture event as SIRs. This finding is unsurprising considering the RRS was developed to identify more types of rupture than the original SASS method. In addition, the SASS method requires two consecutive SASS codes, based on verbalizations, to meet criteria for a SIR. This seems to be a stricter criteria than the RRS requirement of a single verbal or non-verbal rupture marker and a misunderstanding event. Despite this, the SASS method did identify most rupture group segments as containing a SIR, and has the advantage of precisely identifying the temporal location of a rupture marker. The SASS also has the potential to identify couple ruptures, although none were found in this study. With more specific coder training, an independent judge to arbitrate important coding judgment differences, and if the SASS method is adjusted to include all the SASS codes the RRS, the SASS may have a role in identifying specific times when a rupture occurs.

Given that, at the surface level, the RRS appears accurate at identifying whether a rupture has occurred, what exactly does an RIR represent in couples therapy? The
RRS identifies behaviours which are believed to be related to ruptures in the working alliance. However in this study rupture related interactions between the couple, and the couple and the therapist, were unable to be measured by the RRS except in terms of the individual client and therapist relationship. Conceptually, the RRS rupture types can apply to both individual and couple therapy, but at present it is does not capture ruptures that may be specific to couple therapy.

Tomicik's (2005) study reported two main rupture types specific to couple therapy that concerned therapists – triangulation and splitting. Friedman et al (2007) and Pinsof and Catherall (1986) would also argue that ruptures can also occur at the systemic level between the couple subsystem and the therapist subsystem. With further research to assess how behavioural markers between a couple might represent a “splitting” rupture or triangulation, and how to adapt the misunderstanding event to couple therapy, the RRS or a similar instrument could be developed to measure both RRS rupture types, and ruptures specific to couple therapy.

This study intended to examine narratives relating to ERIRs that were unmatched by SIRs and RIRs to discern any patterns or interesting observations made by ERs that could be used as a stepping stone to develop a taxonomy of ruptures unique to couples' therapy. Disappointingly this part of the study could not be carried out because no ERIRs were unmatched. This may have been due to a small sample size, poor inter-rater reliability, or possible false positive RIRs.

It was also hypothesised that the SASS method and ERs would detect couple ruptures. However, neither rupture detection method identified any couple ruptures. The SASS coder did record quite a few codes from the therapist to the couple subsystem, but none at all from the couple towards the therapist, let alone codes that might meet SIR criteria. This difference in SASS coding could be attributed to a need for further training about how to identify comments made from a couple member that
seemed to clearly represent both members of the couple subsystem e.g. “we don’t want to come here any more”. It may also be that, as couples often attend therapy because of relationship difficulties, there were no verbalisations made on behalf of the couple towards the therapist. ERs did record some couple ruptures, but none met criteria for an ERIR. Again, this could be due to poor inter-rater reliability. Couple ruptures may also be difficult to identify as a couple acting together, and therefore may often have been considered individual ruptures. If experienced therapists rating these segments from an observer perspective did have difficulty perceiving when a couple subsystem experiences a rupture with the therapist, this may reflect a wider problem in the clinical community dealing with multi-client environments, and could be worth further investigation.

Another aim of this study was to explore non-verbal ruptures in couples’ therapy, particularly as McEwan (2005) suggested that therapists may be inclined to miss non-verbal behaviours relating to ruptures because they are subtle. An entirely non-verbal rupture was chosen for inclusion in this study. During the segment, the male client did not speak, but showed signs of disengagement from the therapeutic process. All three selection judges, who were familiar with working alliance rupture literature, agreed there was a negative shift in his relationship with the therapist. No ERIR was recorded for this segment although two ERs expressed concerns about the quality of the relationship between client and therapist. This may represent a higher ER rupture behaviour threshold previously discussed. Unsurprisingly there was no SIR because the SASB only codes verbalizations. An RIR was recorded, although it achieved the lowest possible score for both presence and emotional intensity. Based on one clinical segment, the RRS seemed best at identifying a non-verbal rupture, however ERs were aware of difficulties in the therapeutic relationship.
Limitations of this study and future directions

Some limitations of this investigation have been discussed above. Further limitations include the small sample size and short segments. Sample size and segment length decisions were influenced by the laborious nature of SASB coding, limited resources, and the reasonable expectation that volunteer ERs would find it difficult to commit extensive time to the project. Increasing the sample size would enable more powerful statistical analysis. Lengthier segments would help assess the accuracy of the RRS more thoroughly, and perhaps capture unique couple ruptures.

Use of the RRS proved to be somewhat difficult in couple therapy with regards to the misunderstanding event scale. Because of the extra person present in the room, it was observed by coders that therapeutic conversations did not often specifically refer to individual styles of relating to people, generally they could only be loosely inferred within the 5 minute period. Coders had poor inter-rater reliability during training – perhaps because the manual was unclear about how to assign a misunderstanding event Likert scale score. The author acknowledges the misunderstanding event coding guide (Appendix F) subsequently developed by RRS coders was not approved by the RRS authors. Concretely observable components such as session task were inadvertently emphasised because it was difficult to even infer patients’ expectations or wishes in couple therapy. Therefore, because a misunderstanding event was always possible to some degree, a misunderstanding event was coded as present for all time segments containing behavioural markers that might be related to a rupture. The misunderstanding event scale should act as a screen to differentiate behaviours which are or are not related to a rupture. However, the effectiveness of this function is questionable. Future researchers could adapt the RRS misunderstanding event to the different interpersonal conversations that seem to occur in couple therapy.
A potential weakness in using the RRS and SASB method for rupture detection was the contribution of patient and therapist to the rupture. Despite repeatedly commenting that ruptures are contributed to by both client and therapist, Safran and colleagues (e.g. Safran, Crocker, McMain & Murray, 1990, Safran & Muran, 1996) underscore that a rupture can be a window into the underlying maladaptive interpersonal schemas of the client, rather than addressing in depth the therapists contribution to, or initiation of, a rupture. RRS rupture markers are only observed in a client’s behaviour - not the therapist’s behaviour. However, alliance strength has been found to be the “product of the mutual influence of patient and therapist on one another” (Binder & Strupp, 1997, p.125), and is particularly affected by negative reactions of the therapist to provocative patient behaviours, and even low levels of negative therapist behaviour may impede therapeutic change (Henry, Schacht, & Strupp, 1990). This suggests that a therapist’s behavioural markers are as important as a client’s behavioural markers. Also, there is a possibility that some ruptures may only be observable in the behaviour of the therapist, because the client internalises their response. Rennie’s (1992) qualitative study found that clients could be pleasant and cooperative on the surface, while harbouring resentment and uncertainty about the therapeutic process or therapists. Because the RRS and SASB method of detecting ruptures focused on client markers, they might not have captured rupture events initiated by the therapist, that are not easily perceivable in client reactions. The relationship of ruptures expressed by therapists and therapeutic outcome is worthy of further investigation.

In addition, researchers might examine gender based differences in couples therapy ruptures. For example, whether gender influences the frequency of rupture types and whether ruptures types expressed by male and female clients interact with therapist gender. Previous research in couples’ therapy has suggested gender differences in the alliance between men and women. (Symonds & Horvath, 2004,
Delaney, 2006). It was observed in this study that males had more Walling Off & Avoiding RRS ruptures and females had more Attacking & Blaming RRS ruptures. While the statistical significance of this cannot be determined, this finding hints that it may be an avenue worth investigating.

Therapist and client perceptions of tension or ruptures in couple therapy would also be interesting to study and compare to observer measures such as the RRS, particularly clients who drop out. The different viewpoints could offer validity to an RRS measure adapted to couple therapy.

The RRS focuses on rupture markers expressed by clients. It might be interesting to consider therapist rupture markers. Some sequences observed in this study had irritated or frustrated therapists, and clients who then seemed to placate them or ignore the negative emotions expressed by the therapist. In these cases, the start of the rupture event was the therapist's behaviour, although the RRS would only note the client's behavioural marker. The therapists' behaviour might, instead, be considered part of a misunderstanding event.

Lastly, with the finding that RRS rupture types can be identified in couple therapy, researchers could use the RRS to detect these ruptures for qualitative and quantitative investigation. The SASB and Conversational Analysis could be used to temporally sequence changes and describe procedures through which conversationalists generate their own behavior and understand and respond to others' behavior. These measures could begin to determine rupture progression in couple therapy outcome.

With limitations, the RRS can apparently detect some ruptures in couple therapy. Further investigation is needed to ascertain how the RRS rupture types relate to couples therapy and whether the RRS captures the full range of ruptures in couple therapy. This finding opens the door to studies that could increase our knowledge about how to
therapeutically work with ruptures in the working alliance when they occur in couple therapy.
APPENDICES
APPENDIX A

Ethical approval
Ms. Jacqueline Gruter-Andrew  
Graduate Student  
Faculty of Education  
Simon Fraser University  

Dear Ms. Gruter-Andrew:  

Re: Identifying ruptures in couples therapy – Ref. #36274  

I am pleased to inform you that the above referenced Request for Ethical Approval of Research has been approved on behalf of the Research Ethics Board. This approval is in effect until the end date of September 13, 2007. 

Any changes in the procedures affecting interaction with human subjects should be reported to the Research Ethics Board. Significant changes will require the submission of a revised Request for Ethical Approval of Research. This approval is in effect only while you are a registered SFU student. 

Your application has been categorized as 'minimal risk' and approved by the Director, Office of Research Ethics, on behalf of the Research Ethics Board in accordance with University policy R20.0, http://www.sfu.ca/policies/research/r20-01.htm. The Board reviews and may amend decisions or subsequent amendments made independently by the Director, Chair or Deputy Chair at its regular monthly meetings. 

"Minimal risk" occurs when potential subjects can reasonably be expected to regard the probability and magnitude of possible harms incurred by participating in the research to be no greater than those encountered by the subject in those aspects of his or her everyday life that relate to the research.
Please note that it is the responsibility of the researcher, or the responsibility of the Student Supervisor if the researcher is a graduate student or undergraduate student, to maintain written or other forms of documented consent for a period of 1 year after the research has been completed.

Best wishes for success in this research.

Sincerely,

Dr. Hal Weinberg, Director
Office of Research Ethics

c: Dr. Adam Horvath, Supervisor

/jmy
Appendix B

Steps of task analysis
Steps of Task Analysis

Orientation  Steps

Discovery  Explicate implicit map of expert clinician

Select and describe the task and task environment

Verify the significance of the task

Rational analysis of performance: Constructing performance diagrams

Empirical analysis of performance: Measurement of actual performance

Comparison of actual and possible performances: Construct a specific model

Verification  Validation of model

Relating complex process to outcome

From Greenberg and Newman, 1996
Appendix C

SASB circumplex model – full version
Appendix D

Rupture Resolution Scale – Revised (RRS) coding sheets (male and female)
Rupture Resolution Scale

A. Rupture Episode

I. Rupture Types

1. Patient is moving away from therapist (hostile autonomy & isolation):
   Walling off and avoiding (2-6)

2. Patient is "moving towards" the therapist (anxious helplessness & hostile compliance):
   Deferring and/or appeasing (2-5, 2-6)

3. Patient is "moving against" the therapist (hostile control & and power):
   a) Attacking and blaming (1-6, 1-7)
   b) Approaching to manage (1-5 and 2-2)

4. What position does the partner take? Check what best applies:

II. Misunderstanding event: Rate degree to which misunderstanding event is complete

1. Session Task
   a) Patient Session Task
   b) Therapist Session Task

2. Patient Expectations of other (identify person: )
   a) Response of self
   b) Response of other

3. Precipitant
   a) Actual response of therapist
   b) Wish
A. Rupture Episode
I. Rupture Types
1. Patient is "moving away" from therapist (hostile autonomy & isolation):
   Walling off and avoiding (2-6)

2. Patient is "moving towards" the therapist (anxious helplessness & hostile compliance):
   Deferring and/or appeasing (2-5, 2-6)

3. Patient is "moving against" the therapist (hostile control & and power):
   a) Attacking and blaming (1-6, 1-7)
   b) Approaching to manage (1-5 and 2-2)

4. What position does the partner take? Check what best applies:
   Partner is moving away from Patient
   Partner is moving away from Therapist
   Neutral
   Partner is moving towards Patient
   Partner is moving towards Therapist

II. Misunderstanding event: Rate degree to which misunderstanding event is complete
1. Session Task
   a) Patient Session Task
   b) Therapist Session Task

2. Patient Expectations of other (identify person: )
   a) Response of self
   b) Response of other

3. Precipitant
   a) Actual response of therapist
   b) Wish
Appendix E

Experienced Clinical Observer (ECO) Questionnaire
Couples Therapy Questionnaire

Directions:

Your clinical observations, thoughts and feelings about what you view in these segments are important to us, and we value any comments you might have. Please answer every question as fully as you can. If you need to, please repeat information that you have previously written. Please do not write "see above" or other similar answers. Do clearly mark any questions you think irrelevant to this vignette i.e. by crossing through the answer section, so we know that this question was not missed by mistake.

We would appreciate it if you would answer Part A for each video segment first. Once you have finished all of the Part A sections, then please go back and answer each Part B in the same order that you answered the Part A sections. We ask that you do this to help avoid any influence later questions may have on your first impressions.

Attached are pages to write your answers on. If you require further space or feel that there are more interactions/events to comment on, please use additional pages as needed.

If you have any questions, please contact Jacky Gruter-Andrew at 604 732 3922.

Part A

1. Were there any interactions or events that you thought were significant for the therapy process? Please describe in detail, including what made them appear significant to you.

2. At what point in the transcript did these events or interactions occur? (Please use transcript line numbers to identify the beginning, and highlight in yellow the first few words).

3. Please rate the level of emotional intensity of each event/interaction you have identified.

4. Please describe if the relationship between the clients and therapist changed during the segment you observed. If so, how did it change and why do you think it changed?
Part A – Response Section

1. Were there any interactions or events that you thought were significant for the therapy process? Please describe in detail, including what made them appear significant to you.

(i) Event/Interaction: __________________________
Significance? __________________________

(ii) Event/Interaction: __________________________
Significance? __________________________

(iii) Event/Interaction: __________________________
Significance? __________________________
2. At what point in the transcript did these events or interactions occur? (Please use transcript line numbers to identify the beginning, and highlight in yellow the first few words).

(i) Event/Interaction: 
Transcript Line Number: ________________ (highlight in yellow the first few words)

(ii) Event/Interaction: 
Transcript Line Number: ________________ (highlight in yellow the first few words)

(iii) Event/Interaction: 
Transcript Line Number: ________________ (highlight in yellow the first few words)
3. Emotional intensity of interaction/event:

Please rate the level of emotional intensity of each event/interaction you have identified.

This can be assessed at both the verbal (content and tone) and non-verbal level.

1 – mild, almost unnoticeable emotional reaction by participant, such as glazed eyes, compression of lips, minor change in tone of voice

3 – moderate, noticeable reaction, such as sniffling, laughter, wriggling, frowning, sniping comment,

5 – strong, very obvious emotional reaction, such as crying profusely, strong expressions of anger or joy

(i) Impact of event/interaction on affect of participants (please identify by line number where it starts):

<table>
<thead>
<tr>
<th>Male</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mild</td>
<td>moderate</td>
<td>strong</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>mild</td>
<td>moderate</td>
<td>strong</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>mild</td>
<td>moderate</td>
<td>strong</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(ii) Impact of event/interaction on affect of participants (please identify by line number where it starts):

<table>
<thead>
<tr>
<th>Male</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mild</td>
<td>moderate</td>
<td>strong</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>mild</td>
<td>moderate</td>
<td>strong</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>mild</td>
<td>moderate</td>
<td>strong</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(iii) Impact of event/interaction on effect of participants (please identify by line number where it starts):

<table>
<thead>
<tr>
<th>Male</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>mild</td>
<td>moderate</td>
<td>strong</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. **Relationships descriptions** (please use line numbers to clearly identify each event):

Please describe if the relationship between the clients and therapist changed during the segment you observed. If so, how did it change and why do you think it changed?

<table>
<thead>
<tr>
<th></th>
<th>Mild</th>
<th>Moderate</th>
<th>Strong</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Male</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Female</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td><strong>Therapist</strong></td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

* (iv) Impact of event/interaction on affect of participants (please identify by line number where it starts):
Couples Therapy Questionnaire

Please contact Jacky Gruter-Andrew if you have any questions at 604 732-3922

Part B

7. Did you observe any negative interaction(s) between individuals within the session?

8. If you answered "yes" to Q. #7, at what point did you first observe the negative interaction(s), and between whom? Please use the transcript line number to identify where it started, and mark with a green highlighter the first few words where it occurs on the transcript.

9. Why do you think that the interaction(s) was/were negative?

10. Was the negative interaction only verbal, only nonverbal, or a combination of both?

11. Do you think the negative interaction caused a negative shift in the quality of the client’s relationship with the therapist? If yes, please describe the change in the relationship. How did the client and therapist behave?

12. Do you feel the negative shift in the quality of the relationship between the client and therapist interaction(s) occurred suddenly or gradually? Please describe.

13. a. If there was a negative shift in the quality of the relationship between one client and the therapist, how did the client’s partner react?
   b. If both clients had a negative shift in the quality of their relationship with the therapist, how did they interact with each other, and towards the therapist?

14. Are there any other comments you would like to make about the quality of the relationship between the couple and the therapist, and how it changed during this vignette?
7. Did you observe a negative interaction(s) between the individuals in the session? Yes / No

8. If yes, who had the negative interaction(s), and at what point(s) in the session?

   ☐ Male and Therapist
   Transcript Line Number(s): _____________ (please highlight in green where it starts on the transcript)

   ☐ Female and Therapist
   Transcript Line Number(s): _____________ (please highlight in green where it starts on the transcript)

   ☐ Couple and Therapist
   Transcript Line Number(s): _____________ (please highlight in green where it starts on the transcript)

   ☐ Male and Female
   Transcript Line Number(s): _____________ (please highlight in green where it starts on the transcript)

9. Why did you think the interaction was negative?

   ☐ Between Male and Therapist 
   Transcript Line Number: _____________

   ☐ Between Female and Therapist 
   Transcript Line Number: _____________

   ☐ Between Couple and Therapist 
   Transcript Line Number: _____________
10. Was the negative interaction only verbal, only nonverbal, or a combination of both?
   (i) Transcript Line Number: ______________________
       Only Verbal / Nonverbal / Combination
   (ii) Transcript Line Number: ______________________
       Only Verbal / Nonverbal / Combination
   (iii) Transcript Line Number: ______________________
       Only Verbal / Nonverbal / Combination

11. Do you think the negative interaction caused a negative shift in the quality of the client’s relationship with the therapist? If yes, please describe the change. How did the client and therapist behave?
   (i) Yes / No  
       Transcript line number: ______________________
       Description: __________________________________
       _______________________________________________
       _______________________________________________
       _______________________________________________
       _______________________________________________
       _______________________________________________
       _______________________________________________
   (ii) Yes / No  
       Transcript line number: ______________________
       Description: __________________________________
       _______________________________________________
       _______________________________________________
12. Do you feel the negative shift in the quality of the relationship between the client and therapist occurred suddenly or gradually? Please describe.

(i) Transcript line number: ________________ Onset: *Sudden / Gradual*
Description: ____________________________________________________________________

(ii) Transcript line number: ________________ Onset: *Sudden / Gradual*
Description: ____________________________________________________________________

(iii) Transcript line number: ________________ Onset: *Sudden / Gradual*
Description: ____________________________________________________________________

13. a. If there was a negative shift in the quality of the relationship between one client and the therapist, how did the client’s partner react?

(i) Which client had the negative shift in the quality of the relationship with the therapist?
*Male / Female* Transcript line number: ________________
The other client was: Male / Female

Did the other client (tick all that apply):
- [ ] Support the therapist
- [ ] Support their partner
- [ ] Attempt to mediate
- [ ] Attempt to be neutral
- [ ] Show no observable awareness of the negative shift in their partner's relationship with the therapist
- [ ] Other (describe): __________________________

(ii) Which client had the negative shift in the quality of the relationship with the therapist?

Male / Female

The other client was: Male / Female

Did the other client (tick all that apply):
- [ ] Support the therapist
- [ ] Support their partner
- [ ] Attempt to mediate
- [ ] Attempt to be neutral
- [ ] Show no observable awareness of the negative shift in their partner's relationship with the therapist
- [ ] Other (describe): __________________________

b. If both clients had a negative shift in the quality of the relationship with the therapist:

Did they (tick all that apply):
- [ ] Present a united front towards the therapist
- [ ] Appear to independently, of each other, interact with the therapist
- [ ] Did one client (M / F) appear to resolve their own negative shift with the therapist, and the other client (M / F) did not?
- [ ] Did one client (M / F) appear to resolve their own negative shift with the therapist, and the other client (M / F) actively did also?
- [ ] Did one client (M / F) appear to resolve their own negative shift with the therapist, while the other client (M / F) seemed to
follow the lead of their partner, rather than clearly resolve their own negative shift with the therapist.

☐ Did one client (M / F) appear to develop a negative shift in their relationship with the therapist because their partner (M / F) did?

☐ Did one client (M / F) appear to develop a negative shift in their relationship with the therapist, and then enact this towards their partner instead of the therapist?

☐ Other (describe): ________________________________

14. Other comments - we would appreciate any other impressions that you have of this vignette that you consider important, particularly regarding the quality of the relationship between the couple and the therapist, and how it changed during this vignette.

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________
Appendix F

Rating Scale for Misunderstanding Event Completeness.
Rating Scale for Misunderstanding Event Completeness.

The misunderstanding event may be one discrete moment occurring within a session or be a larger sequence of interactions taking place over a number of sessions.

The scale below is just a guideline. Because the misunderstanding event completeness scale is fairly inferential, final judgement for this score may differ from these guidelines.

0 – No rupture observed, no hint of discord between patient and therapist. No hint of misunderstanding which causes a problem. If a patient simply misunderstands a question this is not necessarily a misunderstanding event – unless there are subtle undercurrents below the surface of the interaction.

1 – Some indication of patient feeling misunderstood or therapist not meeting patient’s needs. For example, sudden shift in client’s body language as if they had some unsettling thought. Hints of a previous misunderstanding that occurred.

2 – Patient and therapist task are described, and there seems to be some difference between what the therapist and patient are doing. There is some subtle, implicit disagreement regarding the tasks and immediate goals indicated. A sense they are working to a different agenda. There may be indications about patient’s relational needs not being met.

3 – Other elements of the misunderstanding event scale are able to be completed e.g. patients expected response of self and other, with some degree of confidence. There may be more of an indication of the precipitant than “2”, but not as clear as “4”.

4 – A clear precipitant is present. This is the therapist’s actual or observed response which seems to lead to a patient’s rupture state. It is obvious what the misunderstanding event is, and can be described in each part of the misunderstanding event section.

Wish – Because this was not clearly explained in the manual, it is not included in the judgement of the Likert scale for Misunderstanding Event completeness for this study.
Appendix G

ER confidentiality agreement
Data protocol: Couples Research Project.

Couples Research Project.
Dr. A Horvath, Principle Investigator., Dept. of Education, SFU
Jacky Grüter-Andrew, Designate

Conditions of loan:

All data collected under the auspices of the couples research project, or derived from it, are the property of the project.

The participants of the research project were promised anonymity and security of the data collected. Persons who are granted access to the research data promise to fully adhere to the spirit and the letter of the undertaking provided to the research participants.

No research data may be accessed without the express permission of the Principal Investigator (PI) or his designate.

If a researcher or collaborator, with the PIs or designates permission, is given data he or she is responsible for keeping the data securely under lock and key at all times and to take every precaution as necessary to ensure the safety and confidentiality of the documents and videotapes. You will be asked to sign a receipt upon receiving the data, and will be given one when you return the data to Jacky Grüter-Andrew. A lock box will be provided by Jacky Grüter-Andrew for this purpose if no locked storage area is available. When the researcher is working with data she or he will ensure the privacy of the data and prevent unauthorized individuals from accessing the data, on purpose or accidentally. No data may be stored on a computer, copied or duplicated, or made public without the express permission, in writing, of the PI.

If you have any questions about these requirements, please contact Jacky Grüter-Andrew at 604 732 3922.

I have read and understood the above statement and agree to abide by these conditions:

Name:

Signed:

Date:
Appendix H

Comparison of ER identification of rupture presence in T1 and T2.
Comparison of ER identification of rupture presence in T1 and T2.

<table>
<thead>
<tr>
<th>Segment and Time Period</th>
<th>Rupture Presence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ECO A</td>
</tr>
<tr>
<td>T1 (0-5 mins)</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>✓</td>
</tr>
<tr>
<td>2</td>
<td>✓</td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>✓</td>
</tr>
<tr>
<td>10</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
</tr>
</tbody>
</table>

| T2 (5-10 mins)          |       |       |       |
| 1                       | ✓     | ✓     | ✓     |
| 2                       | ✓     |       | ✓     |
| 3                       |       | ✓     |       |
| 4                       |       |       | ✓     |
| 5                       |       |       | ✓     |
| 6                       | ✓     |       | ✓     |
| 7                       |       |       | ✓     |
| 8                       |       |       | ✓     |
| 9                       | ✓     |       | ✓     |
| 10                      |       | ✓     |       |
| 11                      |       |       | ✓     |
| 12                      |       |       | ✓     |
| Total                   | 2     | 3     | 8     |
Appendix I

System of Observing Family Therapy Alliances (SOFTA) descriptors
System of Observing Family Therapy Alliances descriptors

Friedlander, Escudero, Horvath, Heatherington, Cabero, & Martens, 2006

Negative interaction descriptors used from the System of Observing Family Therapy Alliances

*Emotional Connection to the Therapist*

- Client refuses or is reluctant to respond to the therapist
- Client has hostile or sarcastic interactions with the therapist
- Client comments on the therapist’s incompetence or inadequacy

*Engagement in the Therapeutic Process:*

- Client expresses feeling stuck, questions the value of “therapy”, or states that therapy is not/has not been helpful.
- Client shows indifference about the tasks or process of therapy (e.g. paying lip service, “I don’t know”, tuning out).

*Safety:*

- Client expresses anxiety nonverbally (e.g., taps or shakes)
- Client crosses arms over chest.
- Makes an uneasy/anxious reference to the camera, observation, supervisor, or research procedures
Appendix J

Figures of percentage frequency of SASB cluster codes from both clients involving the therapist in Rupture and Non-rupture groups for Surface 1 and 2.
Percentage frequency of SASS cluster codes from both clients involving the therapist in Rupture group – Surface 1

Percentage frequency of SASS cluster codes from both clients involving the therapist in Non-rupture group – Surface 1
Percentage frequency of SASS cluster codes from both clients involving the therapist in Rupture group – Surface 2

Percentage frequency of SASS cluster codes from both clients involving the therapist in Non-rupture group – Surface 2
Appendix K

Frequency of male and female RRS rupture types in Rupture and Non-rupture groups.
Frequency of RRS rupture types identified in Rupture and Non-rupture group for male clients.

<table>
<thead>
<tr>
<th>Presence of Rupture</th>
<th>Part 1</th>
<th>Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rupture Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walling Off and Avoiding</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Deferring and/or Appeasing</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Attacking and Blaming</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Approaching to Manage</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Non-rupture Group</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Walling Off and Avoiding</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Deferring and/or Appeasing</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Attacking and Blaming</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Approaching to Manage</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*Part 1 Refers to first 5 minute period of each videotaped segment.*
*Part 2 Refers to second 5 minute period of each videotaped segment.*

Frequency of RRS rupture types identified in Rupture and Non-rupture group for female clients.

<table>
<thead>
<tr>
<th>Presence of Rupture</th>
<th>Part 1</th>
<th>Part 2</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rupture Group</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walling Off and Avoiding</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Deferring and/or Appeasing</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Attacking and Blaming</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Approaching to Manage</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td><strong>Non-rupture Group</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Walling Off and Avoiding</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Deferring and/or Appeasing</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Attacking and Blaming</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Approaching to Manage</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

*Part 1 Refers to first 5 minute period of each videotaped segment.*
*Part 2 Refers to second 5 minute period of each videotaped segment.*
Appendix L

Comparison of ERIRs, RIRS, SIRS for Rupture group and Non-rupture group in each time period, matched by rupture participants.
Table comparing ERIRs, RIRS, SIRS for Rupture group and Non-rupture group in each time period, with ruptures matched between female client and therapist.

<table>
<thead>
<tr>
<th>Time Period and Segment</th>
<th>Rupture Presence</th>
<th>Rupture Match</th>
<th>Rupture Presence</th>
<th>Rupture Match</th>
<th>Rupture Presence</th>
<th>Rupture Match</th>
<th>Rupture Presence</th>
<th>Rupture Match</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ERIRs</td>
<td>RIRs</td>
<td>SIRs</td>
<td>ERIRs and SIRs</td>
<td>ERIRs and RIRs</td>
<td>ERIRs and RIRs and SIRs</td>
<td>SIRs and RIRs</td>
<td></td>
</tr>
<tr>
<td>T1 (0-5 mins)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>•</td>
<td></td>
<td>•</td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>•</td>
<td></td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>T2 (5-10 mins)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>•</td>
<td>•</td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>•</td>
<td>•</td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>•</td>
<td>•</td>
<td>•</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>•</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

* = A rupture was detected.
Table comparing ERIRs, RIRS, SIRS for Rupture group and Non-rupture group in each time period, with ruptures matched between male client and therapist.

<table>
<thead>
<tr>
<th>Time Period and Segment</th>
<th>Rupture Presence</th>
<th>Rupture Match</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ERIRs</td>
<td>RIRs</td>
</tr>
<tr>
<td>T1 (0-5 mins)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>3</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>•</td>
</tr>
<tr>
<td>6</td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>T2 (5-10 mins)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>4</td>
<td>•</td>
<td>•</td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

• = A rupture was detected.
BIBLIOGRAPHY


Luborsky, L., Singer, B., & Luborsky, L. (1975). Comparative studies of psychotherapies: Is it true that “everyone has won and all must have prizes”? *Archives of General Psychiatry, 32*(8), 995-1008.


of therapeutic alliance and interpersonal behavior. *Journal of Psychotherapy Practice and Research, 7*, 126-143.


