

RUPTURE RESOLUTION
RATING SYSTEM (3RS):
MANUAL VERSION
2022

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Table of Contents

What is new in the 3RS version 2022	2
Introduction	3
Coding Procedures	4
Working Together Subscale	5
Withdrawal Rupture Markers	12
Confrontation Rupture Markers	18
Repair Strategies	25
Repair Effectiveness Ratings	36
Frequently Asked Questions	38
References	41

What is New in the 3RS version 2022

The 3RS v 2022 (Eubanks & Muran, 2022) is a revision of the 2015 version of the 3RS (Eubanks, Muran, & Safran, 2015). While the 2015 version is a useful tool for identifying rupture and repair processes, we realized that it had a number of limitations that we have tried to address with this revision.

Dyadic focus: The 2015 version of the 3RS did not fully reflect our understanding of ruptures and repairs as dyadic, co-constructed processes (Muran & Eubanks, 2020; Safran & Muran, 2000) because it operationalized ruptures in terms of patient behaviors and repair attempts in terms of therapist behaviors. The 3RS v 2022 attempts to address this limitation by including both patient and therapist rupture markers and both patient and therapist repair strategies.

Effectiveness of repair: The 2015 version of the 3RS included a session-level overall rating of the extent to which ruptures were repaired in the session. Colleagues have expressed interest in having ratings of the effectiveness of repair at the segment level, to allow them to look more closely at the impact of specific interventions. Rating the effectiveness of repair at the segment level can be challenging, as it may not be immediately clear how a repair attempt is landing. We have concerns that it may prove difficult for coders to produce reliable and valid codes of effectiveness at the segment level, but we decided to treat this as an empirical question, and hence have included this code in the 3RS v 2022.

Working Together: There is a saying that if you have a hammer, everything looks like a nail, and we are always mindful of the risk that coders trained to look for ruptures and repairs may overcode them. The 2015 version of the 3RS advised coders to proceed in a stepwise manner in which they first observe the alliance (the quality of the collaboration and bond between patient and therapist); then *if* they identify a problem in the alliance, they identify what kind of rupture it is; then they identify if there are any efforts to repair the rupture. However, in practice, it seemed that coders sometimes skipped or shortchanged the first step of observing the alliance. In the 3RS v 2022, we decided to make that step an explicit part of the coding process by including the Working Together subscale. These items assess aspects of the collaboration and bond—i.e., how well is the dyad working together? In addition to helping orient the coder, they can also be used as a brief observer-based alliance measure.

Consolidation and Conciseness: The 2015 version of the 3RS asked coders to make separate ratings for different subtypes of withdrawal ruptures, confrontation ruptures, and resolution strategies. Since the 3RS v 2022 asks coders to attend to and rate more processes, we felt it important to streamline some ratings so that coders are not overburdened. We also felt that trying to reach reliability on different subtypes of ruptures often led to coder discussions that were focused on minor differences that were unlikely to be clinically or empirically meaningful (e.g., abstract communication vs. avoidant storytelling). We concluded that the most useful data for clinicians and researchers alike would be ratings of the level of withdrawal and confrontation in each segment of a session, as well as the session as a whole. If researchers wish to focus on specific subtypes of withdrawal and confrontation or repair, they are welcome to, but we suspect that it likely requires an excessive amount of time and effort to reach interrater reliability at this level, and we are not confident that these types are sufficiently distinct from each other to warrant being coded and analyzed separately.

Introduction

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

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

In English, the word "rupture" connotes a sudden or dramatic break; however we have found it useful to include not only severe alliance difficulties but also more subtle strains and misattunements under the umbrella of rupture. Attending to subtle rupture markers has both research and clinical value: researchers can trace how ruptures develop, and clinicians can notice early warning signs of rupture and identify opportunities to intervene before the therapeutic relationship reaches a crisis point.

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

Ruptures can be organized into two main subtypes: **withdrawal** and **confrontation** ruptures (Harper, 1989a, 1989b). In differentiating between these two subtypes, we draw on Horney's (1950) concept of responding to anxiety by moving *away*, *toward*, or *against* others. In withdrawal ruptures, there is movement *away* from the other or the work of therapy (e.g., avoiding answering the other's questions), or there is movement *toward* the other in a deferential and appeasing manner that denies an aspect of one's experience (e.g., underlying frustration or disappointment with the other or therapy) and is therefore a withdrawal from the work of therapy. In confrontation ruptures, there is movement *against* the other or the work of therapy, either by expressing anger or dissatisfaction in a non-collaborative manner (e.g., hostile complaints) or by trying to pressure or control the other. Ruptures can also include elements of both withdrawal and confrontation.

A **rupture resolution** or **repair** process enables the patient and therapist to renew or strengthen their emotional bond, and to begin or resume collaborating on the tasks and goals of therapy. The resolution process may also serve as a corrective emotional experience. **Repair strategies** are interventions that are used in an attempt to repair or resolve a rupture. These include strategies that involve focusing on therapy tasks and goals, exploring the rupture, acknowledging one's contribution to a rupture, and making links between a rupture and larger interpersonal patterns.

Coding Procedures

Unit of coding: The 3RS v 2022 is designed to be applied to videos of therapy sessions. Ideally, these videos will allow the coder to see and hear everyone involved in the therapy (e.g., both patient and therapist in individual therapy). Coders watch the entire session and make segment-level ratings in 5-minute intervals, and then make session-level ratings once they have viewed the entire session. Researchers are welcome to use different time bins if that better fits their project.

Rating scales: The 3RS v 2022 employs two different five-point Likert-type scales. The scale used for rating the effectiveness of repair includes anchors for each point on the scale (see page 36). The scale that is used for rating the Working Together items, the rupture markers, and the repair strategies is a 5-point scale that only includes anchors for ratings of 1, 3, and 5.

- **Why are there only 3 anchors for a 5-point scale?**

We think of this scale as essentially a three-point scale that accommodates the common tendency of coders to wish that they could add intermediate ratings when they feel something falls “between” two ratings. Hence, when coders feel something falls between 1 (not salient) and 3 (somewhat salient), they can give a rating of 2; when coders feel something falls between 3 (somewhat salient) and 5 (very salient), they can give a rating of 4.

- **What does salient mean on the 3RS v 2022?**

Salient means “prominent,” “leaps out,” “something of significance that merits the attention given it” ([merriam-webster.com/dictionary/salient](https://www.merriam-webster.com/dictionary/salient)). Something that occurs frequently will often also be more salient, but salience is not equivalent to frequency, as salience also encompasses clarity and intensity. For rupture markers and repair strategies to merit a rating of 3 (somewhat salient) or above at the segment level, there must be at least one clear example of the relevant rupture marker or repair strategy in the segment.

- **“Very salient” does not mean “the most I have ever seen or could ever imagine”**

Coders are sometimes reluctant to rate a 5 (very salient) if they can either recall or imagine an example in which the phenomenon being rated is even more salient than the segment they are rating. However, if coders treat the rating of 5 this way, it will become extremely rare and, in effect, they will be working with a 4-point scale. “Very salient” simply means “very salient.”

Working Together Subscale

A rupture is a weakness or deterioration in the working alliance, so before we try to identify ruptures, we should first gauge the working alliance. The Working Together (WT) subscale helps to orient the coder by focusing on the key question of *“How well are the patient and therapist working together?”* In contrast to the focus on events (rupture markers and repair strategies) of other parts of the 3RS v 2022, the WT subscale calls for a more holistic approach as coders draw on both verbal and nonverbal behaviors to inform their general sense of how well the patient and therapist are engaging in the work of therapy together.

The WT subscale is informed by Bordin’s (1979) conceptualization of the alliance as being comprised of agreement on goals and collaboration on tasks (WT 1), as well as the presence of a bond (WT 2). These items are followed by items that assess the therapist’s (WT 3 and WT 4) and the patient’s (WT 5) individual contributions to the dyad’s ability to work together effectively. Each WT item is rated for each 5-minute segment of the session using a 5-point scale ranging from “Not salient in this segment” to “Very salient in this segment.” Descriptions for the endpoint (1, 5) and midpoint (3) labels are provided below.

Coders may find it helpful to mentally start at a 3 for a “typical” therapy session in which the patient and therapist are collaborating to a moderate degree, and then move up if/when they observe that the dyad is working together particularly well and move down if/when they observe that the dyad is having difficulties working together. A moderate score of 3 can also be used when the patient and therapist work together poorly for part of the segment and very well for the other part of the segment, and the coders determine that a moderate score best captures the overall extent of how well the patient and therapist worked together across the segment.

For all codes, coders should attend to both verbal and nonverbal behaviors. Particularly when learning the measure, coders may find it helpful to watch a segment once and code the WT items, and then watch the segment a second time to code the rupture and repair items.

Coders should be careful not to conflate WT ratings and rupture ratings. Certainly, coders will encounter segments in which the dyad has difficulty working together and that difficulty is manifested by rupture markers, and this will result in both lower WT ratings and higher rupture ratings; this is not “double coding,” this is accurately capturing two related phenomena. If this is the case, coders may wonder how WT ratings add value? We propose that they add value in a few ways.

- WT ratings foreground the alliance and help coders deliberately reflect on how well the dyad is working together before focusing on specific markers of ruptures. Our hope is that this will foster valid ratings of ruptures and repairs.
- WT ratings and rupture ratings will not always be perfectly correlated. For example, it is possible for a dyad to work together well for most of a segment and still exhibit some markers of rupture.
- WT ratings may capture an important moderating variable—the context of the alliance in which a rupture or repair occurs. For example, we anticipate that an intense rupture that occurs in the context of a session in which the dyad was working very well together will have a different clinical meaning and impact than an intense rupture that occurs in the context of a session in which the dyad was not working very well together.

- WT ratings can capture important repair processes. There are times when ruptures are repaired not through the use of specific repair strategies like focusing on the task or exploring the rupture, but rather through behaviors captured in the WT items such as the therapist maintaining a stance of acceptance and curiosity, or the patient being collaborative and engaged in the work.

For most research studies, we recommend calculating and using the mean of the five WT items as a subscale score. It can be employed as a predictor of subsequent rupture/repair, as a proximal outcome for previous rupture/repair, or as a moderating variable, as ruptures and repairs may have different impacts in the context of weaker vs. stronger alliances. Hence, coders would need to be reliable at the level of the WT subscale mean, not at the level of each WT item.

WT 1: Patient & Therapist are collaborating on the work of therapy

Note that this is a *dyadic* code. If one person is behaving in a collaborative manner but the other person is not, then *the dyad* is not collaborating on the work of therapy.

Also note that with this item, we seek to capture the degree to which P & T are collaborating *on the work of therapy*. We recommend that prior to coding, coders discuss how they are defining “the work of therapy” to make sure they have a shared understanding. We recommend a very general, broad definition of the work of therapy; it is not our intention that coders use this item to rate adherence to a particular type of therapy. Rather, we want to make sure coders can distinguish good collaboration from collusion to avoid the work. Hence, if a patient and therapist are engaging in a friendly, well-coordinated chat about the weather for much of the session, and appear to be avoiding doing therapy, then they would receive a low score for collaboration on the work of therapy.

Rating	Label Description
1	Not salient: P & T are not collaborating on the work of therapy. They are not on the same page. They are not cooperating and coordinating their efforts. They are not engaged in a shared task in service of a shared goal.
2	
3	Somewhat salient: P & T are collaborating on the work of therapy to some degree. P & T are somewhat on the same page. They are cooperating and coordinating their efforts to some extent. They are engaged in a shared task in service of a shared goal to some extent.
4	
5	Very salient: P & T are collaborating very well on the work of therapy. They are very much on the same page. They are cooperating and coordinating their efforts a great deal. They are engaged in a shared task in service of a shared goal to a great extent.

WT 2: Patient & Therapist have a bond of mutual trust and respect

Note that this is a *dyadic* code. If one person is trying to build a bond of trust and respect but the other person is not reciprocating, then *the dyad* does not have a bond of *mutual* trust and respect.

A coder may find that a dyad seems to have more trust than respect, or vice versa. Keeping in mind that WT ratings should be approached in a holistic way, the coder should consider both the degree of mutual trust and the degree of mutual respect and do their best to choose the rating that best captures their overall sense of the strength of the bond between patient and therapist.

Rating	Label Description
1	Not salient: P & T do not have a bond of mutual trust and respect. They do not seem close and connected. They do not appear to be comfortable with each other. They appear not to believe each other or seem to lack confidence in each other. They fail to be considerate of each other or appear not to value each other.
2	
3	Somewhat salient: P & T have some bond of mutual trust and respect. They seem somewhat close and connected. They appear somewhat comfortable with each other. They appear to believe each other and have confidence in each other to some extent. They are somewhat considerate of each other and appear to value each other to some extent
4	
5	Very salient: P & T have a strong bond of mutual trust and respect. They seem very close and connected. They appear very comfortable with each other. They appear to believe each other and have confidence in each other to a great extent. They are very considerate of each other and appear to value each other greatly.

WT 3: Therapist accepts/validates Patient

With this item, we seek to capture the degree to which a therapist maintains a stance of accepting the patient and regarding their experience as valid. A therapist can convey this through both nonverbal and verbal behaviors. Note that maintaining an accepting and validating stance does not necessarily equate to offering specific verbal validations (e.g., “it makes sense that you feel that way...”). It is possible for a therapist to maintain an accepting and validating stance without explicitly offering verbal validations, and it is possible for a therapist to offer verbal validations that seem insincere and do not convey an accepting and validating stance.

Rating	Label Description
1	Not salient: T does not accept and validate P. T does not appear to understand or legitimate P’s experience in a nonjudgmental, supportive way. T does not acknowledge that P feels, thinks, and behaves as P does for a reason.
2	
3	Somewhat salient: T accepts and validates P somewhat. T appears to understand and legitimate P’s experience in a nonjudgmental, supportive way to some extent. T does not have to agree with P, but T somewhat acknowledges that P feels, thinks, and behaves as P does for a reason.
4	
5	Very salient: T accepts and validates P very much. T appears to understand and legitimate P’s experience in a very nonjudgmental, supportive way. T does not have to agree with P, but T very much acknowledges that P feels, thinks, and behaves as P does for a reason.

WT 4: Therapist is curious/engaged

With this item, we seek to capture the degree to which a therapist maintains a stance of being curious about the patient's experience and engaged in and committed to the work of therapy. A therapist can convey this through both nonverbal and verbal behaviors. Note that maintaining a curious and engaged stance does not necessarily equate to being energetic in the session. A therapist could bring a great deal of energy to a session but fail to be curious about, interested in, and attentive to the patient and their experience. Similarly, a therapist could be reserved but still convey a strong sense of being curious, engaged, invested, and present.

Rating	Label Description
1	Not salient: T is not curious and engaged. T does not appear interested in P and P's experience and is not attentive and committed to what T and P are working on in therapy. T does not closely track what the patient is saying and how the patient is saying it. T's nonverbals convey a lack of interest and engagement. T does not demonstrate curiosity by asking relevant and thoughtful questions.
2	
3	Somewhat salient: T is somewhat curious and engaged. T appears somewhat interested in P and P's experience and somewhat attentive and committed to what T and P are working on in therapy. T tracks what the patient is saying and how the patient is saying it to some extent. T's nonverbals convey some interest and engagement. T may demonstrate some curiosity by asking questions that are somewhat relevant and thoughtful.
4	
5	Very salient: T is very curious and engaged. T appears very interested in P and P's experience and very attentive and committed to what T and P are working on in therapy. T closely tracks what the patient is saying and how the patient is saying it. T's nonverbal behaviors convey a great deal of interest and engagement. T may demonstrate curiosity by asking relevant and thoughtful questions.

WT 5: Patient is engaged in the work; authentic, open

With this item, we seek to capture the degree to which a patient is engaged in and committed to the work of therapy—the patient appears to be approaching the work as authentically and genuinely as they can, and they seem to be interested in and open to listening to what the therapist has to say. There is an overall sense that the patient is invested and trying their best. A patient can convey this through both nonverbal and verbal behaviors.

Rating	Label Description
1	Not salient: P is not engaged in the work, not authentic, not open. P is not attentive and committed to what T and P are working on in therapy; P is not making a sincere effort. P's nonverbal behaviors convey a lack of interest and engagement. P does not share their experience and is not receptive to new ideas or perspectives.
2	
3	Somewhat salient: P is somewhat engaged in the work, somewhat authentic and open. P is somewhat attentive and committed to what T and P are working on in therapy; P is making a sincere effort to some extent. P's nonverbal behaviors convey some interest and engagement. P shares their experience to some extent and is somewhat receptive to new ideas or perspectives.
4	
5	Very salient: P is very engaged in the work; very authentic and open. P is very attentive and committed to what T and P are working on in therapy; P is very much making a sincere effort. P's nonverbal behaviors convey a great deal of interest and engagement. P very much shares their experience and is very receptive to new ideas or perspectives.

Withdrawal Rupture Markers

In a withdrawal, there is movement away from the other and/or from the work of therapy. The patient may be moving away from the therapist and/or the work, or the therapist may be moving away from the patient and/or the work. Coders use the 5-point scale below to make one rating for *Patient moves away* and one rating for *Therapist moves away* for each 5 minute segment.

Coders should not focus on identifying *why* someone is moving away. That is not our task; we are simply describing the movement that we observe. Hence, questions about “is this interpersonal or intrapersonal withdrawal,” or “how much of this is related to the alliance and how much to personality or interpersonal style” are not relevant to the coding task. If we see movement away, we code it. Many coders have found it helpful to think about the coding task as identifying markers that *may* signal the presence of ruptures. This takes some pressure off the coder who may not have enough information within a 5-minute segment to be sure that the movement they are seeing is best described as an alliance rupture but could say with confidence that they are observing movement away (or for confrontation, movement against).

Withdrawal markers can be subtle and difficult to detect. Some coding tips:

- If you feel bored while watching a segment, this *might* be a sign that withdrawal is occurring, as moving away from the other and the work often means moving away from what is engaging, compelling, and interesting. Relatedly, if you observe that either the patient or therapist appears bored, this might be a sign that withdrawal is occurring.
- If the patient and therapist are acting friendly, but you sense tension or discomfort under the surface, then the friendliness may be a “pseudoalliance” that is marked by withdrawal behaviors like being deferential or avoiding difficult subjects.

Withdrawal: Patient/therapist moves away

Rating	Label Description
1	Movements away are not salient. There are no withdrawal markers in this segment, or there is only one possible marker that does not stand out because it is of very low intensity and clarity (e.g., one very brief smile that the coder thinks might constitute masking via content/affect split).
2	
3	Movements away are somewhat salient. Withdrawal markers stand out somewhat and are generally of moderate intensity and clarity. There should be at least one clear withdrawal marker .
4	
5	Movements away are very salient. Withdrawal markers stand out very much and are generally very intense and clear. Usually, a rating of 5 will mean there were multiple withdrawal markers in the segment, but it is possible to have a segment in which one marker is so intense and clear that it warrants a 5 (e.g., spending the entire 5 minutes telling a very avoidant story).

Below we describe three different types of movements away: **shutting down**, **avoiding**, and **masking aspects of one's experience**. Some coders find it helpful to track when these three types occur within a segment to inform their ratings of *Patient moves away* and *Therapist moves away* for the segment. For most research projects, we do *not* recommend using the 5-point scale to generate codes for each of these three withdrawal subtypes because 1) it likely requires an excessive amount of time and effort to reach interrater reliability at this level, and 2) we are not confident that these types are sufficiently distinct from each other in a clinically impactful way that warrants being coded and analyzed separately.

Shuts down

The patient or therapist moves away from the other and the work of therapy by shutting down the work. This may take the form of:

- **Avoidant denial**, in which the patient or therapist denies a feeling state that is manifestly evident or denies the importance of interpersonal relationships or events that seem important and relevant to the work of therapy.¹ The patient/therapist may or may not be aware that they are using denial to avoid the other or the work. We are not coding their internal experience, but rather observing avoidant denial behaviors that function to shut down the current discussion or activity, thereby hindering the work of therapy.
 - **Patient shuts down via avoidant denial**
P tears up.
T: You look upset.
P: I'm fine, it's nothing.
 - **Therapist shuts down via avoidant denial**
P & T are meeting online. P is at their office, and there is a great deal of background noise of people talking. T visibly startles when someone laughs loudly in the background.
P: I'm so sorry about the noise, I hope it isn't too distracting or annoying. We have tons of team meetings today so everyone is in the office. Maybe I should have rescheduled for later when it's less hectic.
T: I barely noticed it.
- **Minimal response**, in which the patient or therapist goes silent or gives minimal responses to questions or statements that were intended to initiate or continue discussion. The minimal response functions to shut down the other's efforts to engage in the work of therapy.
Do not assume that every pause or brief reply is a minimal response. For example, a dyad that is working well together could have a moment of shared silence while both process what they have been discussing, and this would not constitute movement away.

¹ A denial that is expressed with hostility and functions to move against the other or the therapy is better described as **hostile denial**, a type of **pushing back** (see Confrontation Rupture Markers).

If you are uncertain whether a pause is a minimal response, listening carefully to what is said *after* the pause may be helpful; a pause followed by a thoughtful, on-topic answer suggests that the pauser is engaged in the work of therapy.

- **Patient shuts down via minimal response**

T: That sounds like it was very difficult. How did it make you feel?

P: *(Shrugs.)*

T: So is it upsetting to even talk about it right now?

P: Sort of.

- **Therapist shuts down via minimal response**

Patient talks. Patient pauses, therapist says nothing, just looks blankly at patient. Patient continues talking. Therapist stays silent and looks bored and distracted.

- **Giving up**, in which the patient or therapist gives up on the other and/or the therapy. They may convey that they are hopeless about the possibility that a therapy task can be useful or that their therapy partner can contribute effectively to the work of therapy.

- **Patient shuts down by giving up**

T: That sounds important. Can you tell me more about that?

P: *(Shakes their head.)* It's such a mess. I don't think anything can help.

- **Therapist shuts down by giving up**

Therapist suggests a reason why patient is having difficulty in her relationships.

P: I'm not sure that's it.

T: *(Shrugs and sighs, looks defeated).* Well, it's something to consider, maybe, I don't know. *(Therapist throws up their hands.)*

- **Nonverbals** can be used to identify when someone is moving away by shutting down (e.g., sitting in a collapsed posture and avoiding eye contact).

Avoids

The patient or therapist moves away by avoiding the other and/or the work of therapy. This may take the form of:

- **Abstract communication**, in which the patient or therapist avoids by using vague or abstract language. The abstract language functions to keep the other at a distance from the speaker's true feelings, concerns, or issues. The speaker may intellectualize by focusing on rational concepts and complex terminology, or they may make global statements that allude to an issue rather than directly stating their true thoughts or feelings. They may rely on abstract or vague language to such an extent that the other member of the dyad—or the coder—may become confused and have difficulty following what the speaker is saying.

- **Patient avoids via abstract communication**

P: Things aren't so great right now in my marriage. I know that I have a pattern with romantic relationships, once things start going well, I tend to sabotage things. It goes back to my childhood, my attachment style, my fear of failure, and my belief that I don't deserve to be happy. And birth order, I've read about birth order and I think that explains a lot about my marriage.

- **Therapist avoids via abstract communication**

P: I'm so upset about my mother's diagnosis. I'm afraid she's dying.

T: You are under a lot of stress right now. You know, there are several different kinds of stress that people can encounter in their lives, and they call for different kinds of coping strategies...

- **Avoidant storytelling**, in which the patient or therapist tells a story that functions to move away from the other and/or the work. These stories are often long and tangential or circumstantial, but they can also be brief or even entertaining and may foster the sense of a "pseudoalliance." An avoidant story may shut the other person out, as if the speaker is not even aware that the listener is there.

Talking about someone else's reactions in an effort to avoid talking about oneself can also be an example of avoidant storytelling. (Talking about people in general to avoid talking about oneself is a form of abstract communication.)

It is important to note that not all stories are avoidant stories that move away from the other or the work of therapy. Patients and therapists can use stories to foster communication and engagement in the work.

Sometimes stories are a mix of engagement and avoidance. It is appropriate to reflect that in your coding (e.g., using moderate scores).

- **Patient avoids via avoidant storytelling**

P: Yeah, we visited my sister in the hospital this weekend and it was hard seeing her like that. She had a roommate who just had a hip replacement....*(P proceeds to talk at length about sister's roommate.)*

- **Therapist avoids via avoidant storytelling**

T: You know, what you are saying reminds me of another client I worked with who had this colleague at work who was very critical of everything he did...*(T proceeds with story about former client that does not seem relevant to what this patient was talking about.)*

- **Topic shift**, in which the patient or therapist shifts the topic in a manner that functions to move away from the work of therapy. A good indication that a speaker is moving away by shifting the topic is if they change the topic from a "heavy" subject to a "light" one. It is important to note that not all topic shifts are moves away: a patient or therapist can shift the topic to facilitate the work of therapy (e.g., "I know we were talking about X, but I just remembered something important about Y that I think we

should discuss,” or “I see we only have a few minutes left in the session, should we touch base quickly about that other matter you mentioned?”).

Topic shifts can occur in conjunction with other markers—for example, a speaker could shift the topic by launching into an avoidant story.

- **Patient avoids via topic shift**

T: Are you experiencing me as angry right now? [*T invites P to explore rupture marker*]

P: That’s something my boyfriend asked me the other night. He said...

- **Therapist avoids via topic shift**

P: Yeah, I finally confronted him last night and he admitted that he was cheating on me. It was pretty devastating.

T: Um, I see. Um, let’s look at that worksheet I asked you to complete about sleep hygiene.

Masks aspects of their experience

The patient or therapist moves away by masking aspects of their experience. This may take the form of:

- **Deferential and appeasing behavior**, in which the patient or therapist is overly compliant and submits to the other in an overly deferential manner that is not a genuine expression of their underlying feelings of dissatisfaction or disappointment. This behavior hinders the work of therapy because it makes it harder for the listener to understand the speaker’s experience and what is taking place between them. One person “yes-ing” another—agreeing with everything they say in a manner that seems insincere or superficial—is an example of masking by being deferential and appeasing.

- **Patient masks by being deferential and appeasing**

T: How was the homework?

P: Oh, it was *so* helpful. You give *such* wonderful advice!

- **Therapist masks by being deferential and appeasing**

P: (*angry tone*) I’m really frustrated with how therapy is going. [*Patient moves against*]

T: (*speaking cautiously, nervously, “walking on eggshells”*) Um, OK, I hear what you are saying. You have worked so hard in therapy. I’m so impressed by your effort and your insights.

- **Content/affect split**, in which the patient or therapist exhibits affect that does not match the content of their narrative. For example, they are describing an upsetting event, but their affect is incongruent because it is too positive (smiling, laughing) or too neutral. Content/affect splits are particularly noteworthy when the speaker uses positive affect to soften or minimize a complaint or concern. Note that not every smile or laugh or “straight face” is a movement away. The key question is whether the incongruent affect is masking the speaker’s experience in a way that hinders the dyad’s ability to communicate and collaborate with each other.

○ **Patient masks via content/affect split**

T: It's hard for you to talk about those sad feelings.

P: *(A bright, forced smile)* Yes, it is. It's not easy to talk about.

T: How long have you felt depressed?

P: *(laughing)* Over 20 years!

P *(calm, neutral affect)*: Well, my father passed away last week, and then when we got back from the funeral I found out that my husband had gambled away the money we were saving for a house. I am so angry at him.

○ **Therapist masks via content/affect split**

T: *(smiling nervously)* So we should talk about payment. I sent you a bill a few weeks ago *(nervous laugh)*.

Confrontation Ruptures Markers

In a confrontation, there is movement against the other and/or the work of therapy. Movement against can include expressing hostility toward the other, competing with the other for control of the session, trying to control the other, or opposing or thwarting the other in their pursuit of their needs, desires, and/or therapy goals. The patient may be moving against the therapist and/or the work of therapy, or the therapist may be moving against the patient and/or the work of therapy. Coders use the 5-point scale below to make one rating for *Patient moves against* and one rating for *Therapist moves against* for each 5 minute segment.

In our experience, confrontation markers are often more overt and easier to recognize than withdrawal markers. What can be challenging with respect to confrontation markers is distinguishing between confrontation and self-assertion: when is a speaker moving against the other vs. standing up for themselves? The Structural Analysis of Social Behavior (SASB; Benjamin, 1974), can be a helpful tool for thinking about this question. On the SASB, affiliation is conceptualized as a horizontal dimension with poles of hostility/hate at one end and friendliness/love at the opposite end. The SASB also includes a vertical dimension of Interdependence, with poles of emancipation/separation on one end and control/submission on the other end. If the speaker is expressing hostility and/or trying to control the other, then it is a confrontation rupture. Generally speaking, a healthy self-assertion will be located at the midpoint of the affiliation axis (a neutral position between hostility and friendliness) and at the emancipation/separation end of the Interdependence axis (where the speaker freely asserts themselves and endorses the freedom of the listener to freely take or leave what the speaker says).

Sometimes when patients who have been withdrawing begin to assert themselves, their initial efforts may include confrontation markers that a clinical observer might regard as evidence of progress for that patient (e.g., the frustrated patient who has been silently stewing finally voices their frustration). Similarly, a therapist may challenge and put pressure on a patient in a way that a clinical observer regards as therapeutic and even necessary. The 3RS coder who is rating confrontation markers, however, is not judging the patient's progress or the therapist's competence; we are only observing moves against. As we noted in the section on withdrawal markers, many coders have found it helpful to think about the coding task as identifying markers that *may* signal the presence of ruptures. This takes some pressure off the coder who may not have enough information within a 5-minute segment to be sure that the movement they are seeing is best described as an alliance rupture but could say with confidence that they are observing movement against.

Coding tips: Consider coding for moves against when

- One is attacking the other or defending themselves against the other
- Patient and therapist are engaged in a power struggle
- One is trying to control or pressure the other in a manner that does not respect the other's autonomy and freedom

Confrontation: Patient/therapist moves against

Rating	Label Description
1	Movements against are not salient. There are no confrontation markers in this segment, or there is only one possible marker that does not stand out because it is of very low intensity and clarity (e.g., one very slight, brief interruption of the other that might constitute some control/pressure).
2	
3	Movements against are somewhat salient. Confrontation markers stand out somewhat and are generally of moderate intensity and clarity. There should be at least one clear confrontation marker .
4	
5	Movements against are very salient. Confrontation markers stand out very much and are generally very intense and clear. Usually, a rating of 5 will mean there were multiple confrontation markers in the segment, but it is possible to have a segment in which one marker is so intense and clear that it warrants a 5 (e.g., a very direct and harsh criticism of the other).

Below we describe three different types of movements against: **complaining about/criticizing**, **pushing back**, and **controlling/pressuring**. Some coders find it helpful to track when these three types occur within a segment to inform their ratings of *Patient moves against* and *Therapist moves against* for the segment. For most research projects, we do *not* recommend using the 5-point scale to generate codes for each of these three confrontation subtypes because 1) it likely requires an excessive amount of time and effort to reach interrater reliability at this level, and 2) we are not confident that these types are sufficiently distinct from each other to warrant being coded and analyzed separately.

Complains about/criticizes

The patient or therapist moves against by complaining about or criticizing one of the following:

- **The other**, as in the patient complains about or criticizes the therapist or the therapist complains about or criticizes the patient. They may express negative feelings about the other or convey that they feel angry, impatient, distrustful, manipulated, hurt, judged, controlled, or rejected by the other. Microaggressions, or communications of prejudice and discrimination (Shelton & Delgado-Romero, 2011; Sue, 2010) may also fit in this category if they involve attacking, criticizing, denigrating, insulting, or invalidating the other.
 - **Patient complains about/criticizes therapist.** The patient may express that they feel the therapist has failed to support, encourage, help, or respect them. They may criticize the therapist's style or decisions or express doubts about the therapist's competence or effectiveness.

P: *(angry tone)* I can see I'm not going to get anything useful out of you.

- **Therapist complains about/criticizes patient.** The therapist may criticize the patient's behavior. They may sound judgmental and blaming.

T: *(critical tone)* It seems to me that you are giving up quickly.

Many patients and therapists may feel uncomfortable directly criticizing the other, so coders should be alert to subtle expressions of negative feelings. Subtle complaints/criticisms may appear in conjunction with a withdrawal marker (e.g., criticism expressed with a smile, so there is both complaint and content/affect split); these **mixed ruptures** can be captured by coding both movement away and movement against in the same segment.

- **Activities or interventions**, as in the patient² complains about or criticizes the activities or interventions of therapy. The patient may disagree with, dismiss, or reject a task that the therapist proposes.

P: I don't see the point of these stupid questions.

Note that not every difficulty a patient has with a therapy activity or intervention is a move against. A patient sharing their difficulties with a therapy task in a collaborative way is evidence of a strong alliance:

P: I'm not sure I understand this part of the thought record. Can we talk through it again?

- **Parameters**, as in the patient complains about or criticizes the parameters of treatment such as the therapy schedule (e.g., appointment times, session length, number and frequency of sessions) or other clinic or research requirements (e.g., completing questionnaires, being videotaped).

P: Once a week is not enough time to address all my problems!

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

- **Progress**, as in the patient expresses complaints, concerns, or doubts about the progress that has been made or that can be made in therapy.

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

² We focus on instances in which patients complain about/criticize therapy activities, interventions, parameters, and progress because we anticipate that it would be rare for therapists to move against the patient or the work of therapy by complaining about or criticizing these aspects of treatment.

- **Nonverbals** can be used to identify when someone is moving against by complaining about or criticizing the other (e.g., making an expression of disgust while commenting on the other's behavior).

Pushes back

The patient or therapist moves against by pushing back against the other or the work of therapy. This may take the form of:

- **Rejecting the other's ideas**, in which the patient or therapist rejects or dismisses the others' opinions, suggestions, or interpretations in a noncollaborative manner. Whether the idea is correct or not is not the issue—the idea might be wrong—but is the idea (and the person presenting the idea) being taken seriously in a respectful way, or is there a refusal to really hear and consider what the other is saying?
 - **Patient moves against by rejecting the therapist's ideas**

T: When did your insomnia begin?
P: (*hostile tone*) What difference does that make? That's not relevant.
 - **Therapist moves against by rejecting the patient's ideas**

P: I'm worried that I'm not being a good parent. I'm not supporting my child enough.
T: (*exasperated tone*) Oh, that's nonsense! You're a supportive parent. That's not your real issue.
- **Defends self**, in which the patient or therapist defends their thoughts, feelings, or behavior against what they *perceive* to be the other's criticism or judgment of them. The speaker makes a case to support, validate, and defend themselves. Note that the other member of the dyad does not have to actually express criticism for the speaker to anticipate or perceive criticism and become defensive.
 - **Patient moves against by defending self.**

T: That makes a lot of sense.
P: Of course it does! I'm not an idiot!
 - **Therapist moves against by defending self.**

P: You said you would give me some mindfulness exercises.
T: (*frustrated tone*) Yes, that's what I'm getting to!

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

- P: It was like he didn't understand how much I had on my plate, and he just kept demanding that I do more...How do you do that? How do you do that? I'm not superhuman....

If the coder believes that this patient is not only defending herself against her boyfriend, but is also trying to make her case to the therapist because she thinks the therapist shares the boyfriend's views, then this is an example of the patient pushing back by defending herself. If it seems likely that the patient is only defending herself against her boyfriend or her own inner critic, but there is a small possibility that she is in some ways trying to defend herself against the therapist, then consider this as a possible or unclear example of *Patient moves against* that warrants a low score.

- **Hostile denial**, in which the patient or therapist denies a feeling state that is manifestly evident or denies the importance of interpersonal relationships or events that seem important and relevant to the work of therapy in a hostile way.³ The patient/therapist may or may not be aware that they are using denial to move against the other or the work. We are not coding their internal experience, but rather observing hostile denial behaviors that function to push back against the other or the current discussion or activity, thereby moving against the work of therapy.
 - **Patient pushes back via hostile denial.**
P tears up.
T: You look upset.
P: (*angry tone*) I'm not upset!
 - **Therapist pushes back via hostile denial.**
P: We keep going in circles. I'm worried that I'm trying your patience.
T: (*annoyed tone*) I'm not losing my patience!
- **Nonverbals** can be used to identify when someone is moving against by pushing back (e.g., sitting with arms crossed and an angry facial expression).

Controls/pressures

The patient or therapist moves against by attempting to control or pressure the other. Efforts to provoke or manipulate the other—including in a sexual manner—are coded here.

While watching a segment, if you can imagine feeling very pressured if you were the patient or the therapist, then consider this code. Also consider this code whenever patients and therapists interrupt each other or talk over each other in a way that feels like they are competing or struggling for their turn or their right to speak (as opposed to crosstalk that is not a move against, such as both speaking excitedly as they share and celebrate good news).

Control/pressure may take the form of:

- **Patient controls/pressures therapist**, in which the patient attempts to control the therapist and/or the session (e.g., patient tells the therapist what to do or what not to do in a noncollaborative way), or the patient puts pressure on the therapist to fix the patient's problems quickly.

³ A nonhostile denial that functions to move away from the other or the work of therapy is better described as **avoidant denial**, a type of **shutting down** (see Withdrawal Rupture Markers).

- P: Just tell me what my problem is and what I need to do.
- **Therapist controls/pressures patient**, in which the therapist attempts to control the patient or puts pressure on the patient in a manner that is noncollaborative because it is hostile and/or it fails to respect the patient’s ability to share in the work of therapy.

This code can be challenging because to a certain extent, the therapist’s role is to guide or direct the therapy session. To help coders distinguish between control/pressure and “therapists doing therapy,” we describe some forms that therapist control/pressure may take:

Therapist is overly directive: The therapist tells the patient what to do or controls the session in a way that obstructs the patient’s ability to collaborate on the work of therapy. The therapist’s directiveness hinders the patient’s ability to contribute, offer feedback, or express their preferences about therapy tasks and goals.

P describes stressful experience at work.

T: That must have made you feel angry, so let’s do an exercise around coping with anger...

In the example above, the therapist moves against the patient in a controlling, overly directive way by 1) making an assumption about what the patient is feeling, 2) not checking in with the patient about this assumption, and 3) deciding unilaterally to move directly to a therapy task that is based solely on the therapist’s assumption.

Therapist pushes ideas on patient: The therapist pressures the patient to agree with the therapist’s opinion, perspective, agenda, or interpretation. The therapist may tell the patient what to do in a controlling or overbearing manner that does not respect the patient’s autonomy or perspective.

P: I’m just not attracted to the guys who find me attractive.

T: You aren’t even giving them a chance! You could be surprised, you could meet someone who’s completely not what you expect. You should challenge yourself to try, just to see what happens.

P: So go out with someone I’m not even interested in?

T: What’s so wrong with that?

P: Maybe this isn’t even the right time for me to be in a relationship.

T: You have to give people a chance. What about trying that dating app again?

Therapist does not give patient space: The therapist may talk so much that the patient has no space to respond, share, or process what is being said.⁴ The therapist may interrupt the patient frequently or aggressively. The therapist may rush the patient, trying to move the patient along to get to what the therapist wants to talk about.

⁴ If a therapist’s excessive talking consists of avoidant storytelling or abstract communication (withdrawal markers), then you can reflect this by coding both *Therapist moves away* and *Therapist moves against* in the segment.

Therapists often use expressions like “OK” or “mm-hmm” to indicate that they are listening to the patient and affirming the patient’s right to speak. However, in the example below, the therapist interjects *mm-hmm* at a quick pace that increases the tempo of the exchange and conveys a sense of the therapist rushing the patient because the therapist wants to move on to a different task.

P: Yeah, it’s hard to relax, even with my friends.

T: Mm-hmm

P: So when I left here last time and thought, why do I feel this way? And then I try to –

T: Mm-hmm

P: To change my mind I say –

T: So even, mm-hmm –

P: If I’m late, I’m late, don’t feel bad after --

T: Mm-hmm, mm-hmm

P: Don’t feel bad after the fact

T: Mm-hmm (*places worksheet in front of patient*) Okay so let’s look at this again...

- **Nonverbals** can be used to identify when someone is moving against by trying to control or pressure the other, for example: a patient or therapist adopts an imposing or intimidating body posture or tone of voice, a patient or therapist behaves seductively or flirtatiously, or a patient who has been seeing a therapist for a while sits in the therapist’s chair.

Repair Strategies

Repair strategies are interventions that are used in an attempt to address and repair or resolve a rupture. Hence, in order for an intervention to be coded as a repair strategy, ***it must occur in the context of a rupture.***

Ruptures and repair attempts may not correspond one-to-one, and there may be a time lag between ruptures and repair attempts. Multiple ruptures throughout a session may be addressed by one repair attempt at the end of the session. In some instances, coders may be able to recognize that a member of the dyad is attempting to repair a rupture from a previous therapy session—for example, one member of the dyad may explicitly refer to a conflict in the last session, or if the coder is coding multiple sessions from the same dyad, the coder may be able to detect a more subtle reference to an earlier rupture (e.g., “I was thinking about our last session....”) The coder does not have to observe the rupture to code a repair strategy, but the coder needs to be confident that the repair strategy is being used in reference to a rupture.

The rule that repair strategies must occur in the context of ruptures is important because some therapist repair strategies overlap with general therapy strategies. For example, therapists change therapy tasks throughout the course of therapy for multiple reasons, but only changes to a therapy task that are undertaken ***in response to a rupture*** should be coded with the 3RS. Differentiating therapist repair efforts from therapists “just doing therapy” can at times be very challenging, and coders may feel that they are trying to read the therapist’s mind to identify the therapist’s motivation for their clinical choices. A rule of thumb: if a coder is not ***confident*** that a therapist is employing an intervention ***in response to a rupture***, then that intervention is not a ***clear*** example of a repair strategy, and a segment must have at least one clear example to warrant a score of 3 or above. A segment that includes one example of a repair strategy that ***might*** be in response to a rupture should generally be coded as a 1, and a segment that includes multiple unclear examples could warrant a 2. If an intervention begins in the context of a rupture but then continues across more than one segment (e.g., therapist starts to illustrate task in response to rupture, and then patient and therapist become very engaged in clarifying the task together; or therapist or patient links a rupture to an interpersonal pattern, and then the dyad becomes very engaged in discussing the interpersonal pattern across multiple relationships), the coder can ask themselves: is this ***still*** a repair strategy that is ***still*** being employed in the context of a rupture? If the coder concludes that the repair strategy successfully repaired the rupture and the dyad has “moved on,” then the coder would cease coding the intervention as a repair strategy and would shift to viewing it as the dyad “just doing therapy.”

With respect to patient repair strategies, coders may find it challenging to distinguish between patient rupture markers and patient repair strategies, as patient repair strategies can overlap with rupture markers. For example, is a patient who is talking about their disappointment in their therapist engaging in a confrontation (***complaining about the therapist***) or a repair (***exploring the rupture***)? Relatedly, coders may observe a therapist employing a repair strategy in an aggressive, controlling, critical manner—is this repair or therapist movement against? Differentiating between rupture and repair is related to the challenge of distinguishing between confrontation and self-assertion (see Confrontation Rupture Markers): the presence of hostility and/or controlling behavior would suggest confrontation, while more neutral self-assertion would suggest repair. Given the “messiness” of most ruptures and

repairs, coders should not be surprised to find that elements of rupture and repair may be mixed together or appear in rapid succession within the same segment—and if they are, both rupture and repair can be coded.

Coders may observe what appear to be efforts to “preempt” ruptures by using a repair strategy before a rupture occurs. The 2015 version of the 3RS allowed for such preemptive or “prophylactic” repair efforts to be coded. 3RS v 2022 includes more coding options that may capture such moments more accurately. For example, a therapist’s efforts to preempt ruptures by focusing on enhancing collaboration and the bond could be captured via the *Working Together* items. The actions of a therapist who is nervously scrambling to avoid upsetting a patient might be better captured via *Therapist Moves Away* (masking—deferential and appeasing). We now recommend that coders *not* code interventions used in anticipation of a rupture as “prophylactic” repair strategies, as it will probably be hard to reach reliability when so much inference is required.

Coders use 5-point scales to code the **salience** of repair strategy use for each type of repair strategy. The extent to which ruptures were repaired, i.e., the **effectiveness** of repair, is captured by a separate rating (see pp. 36-37).

Repair Strategies

In this section, we describe four different categories of repair strategies: *focusing on the task/goal*, *exploring the rupture*, *acknowledging contribution*, and *linking to patterns*. For repair strategies, we ask coders to use the 5-point scale to rate each category of strategy.

Patient/therapist focuses on the task/goal

Rating	Label Description
1	The strategy of responding to a rupture by focusing on the task/goal is not salient. There are no examples of this type of repair strategy, or there is only one possible example that does not stand out because it is of very low intensity and clarity (e.g., a therapist changes a task and it is unclear if this change is in response to a rupture or is “the therapist doing therapy.”).
2	
3	The strategy of responding to a rupture by focusing on the task/goal is somewhat salient. Examples of this type of repair strategy stand out somewhat and are generally of moderate intensity and clarity. There should be at least one clear example of responding to a rupture by focusing on the task/goal.
4	
5	The strategy of responding to a rupture by focusing on the task/goal is very salient. Examples of this type of repair strategy stand out very much and are generally very intense and clear. Usually, a rating of 5 will mean there were multiple examples of this repair strategy in the segment, but it is possible to have a segment with one example of a repair strategy that is so intense and clear that it warrants a 5 (e.g., in response to a patient’s complaint about a task, a therapist provides a very clear, explicit, and thorough description of the task and the rationale for it).

Strategies in this category are attempts to repair a rupture by focusing on therapy tasks and/or goals. Typically, task/goal-focused strategies will be employed in response to a rupture related to tasks or goals; that is, a movement against a task/goal (e.g., complaining about a task) and/or a movement away from a task/goal (e.g., avoiding or giving up on a task.)

Every therapy includes tasks—they are the pieces of work that the patient and therapist engage in during the session (e.g., reviewing a thought record, making connections between the patient’s current relationships and their past relationships, engaging in a role-play). Because coders with different training or theoretical orientations might bring different assumptions or expectations about how to define and differentiate various therapy tasks, we recommend that coders meet and reach some shared understanding about what tasks they are likely to encounter in a specific dataset before they start coding sessions independently. Having some shared sense of what the tasks of therapy are should help coders in their efforts to achieve reliability on repair strategies that focus on the task.

Patients and therapists may seek to repair a rupture by focusing on therapy tasks/goals

in several ways:

- **Discussing changing the task/goal.** The patient and/or therapist may respond to difficulties in collaborating on a task or goal by discussing the possibility of changing or modifying the task or goal. This discussion may focus on completely changing a task/goal (e.g., switching from one exercise or topic to another) or modifying a task/goal to make it more useful or palatable (e.g., discussing the possibility of changing the frequency or focus of a homework exercise). Even if the dyad ultimately decides to stick with the original task/goal, if they discussed the possibility of changing, then they employed a task/goal-focused repair strategy.

As can be seen in the examples below, a patient or therapist can discuss changing a task/goal by proposing a change, or by actively engaging in the discussion when the other member of the dyad proposes a change.

- P: You keep bringing it back to my parents. I told you, I don't think that is helpful for me right now! (*P moves against*)
T: Ok.
(*Long pause—both P and T are silent and look uncomfortable—both moving away*)
P: OK, here is something that I do think would be helpful for me right now. I'm thinking about applying for a new job. If it's ok with you, I'd like to talk about that, and some strategies for dealing with my anxiety around it. (*P discusses changing task/goal*)
- P: We're getting off track again. I don't think this is getting us anywhere. (*P moves against*)
T: I'm willing to follow your lead right now. What direction would you like to go in? (*T discusses changing task/goal*)
P: What about we pick up on what we were talking about last time? (*P discusses changing task/goal*)
- **Changing the task/goal.** A member of the dyad responds to a rupture by changing a therapy task or goal. Making this change might be the culmination of a discussion, as described previously, or a change might be made without discussion, as in the example below.
 - P: You keep bringing it back to my parents. I told you, I don't think that is helpful for me right now! (*P moves against*)
T: OK, I hear you. Well, I'm curious to hear more about your new job.
P: (*smiles, looks relieved*). It's great! I'm very excited about this new project...

As noted previously, repair strategies can include elements of rupture. If a coder is uncertain whether a change of task/goal is a repair or a rupture (movement away from the work of therapy), then it is appropriate to code both repair and rupture for that segment.

- **Illustrating task/rationale.** A member of the dyad—probably most commonly the

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

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

- P: I just don’t understand what you are asking me to do. I’m supposed to talk to this chair?
T: Yes, but I’m asking you to imagine that your mother is in the chair. Try to visualize her sitting there, looking at you...
- P: It’s annoying to have to remember to do these thought records all the time.
T: It may be frustrating, but it is really helpful to give us a better sense of what you are thinking and feeling in these challenging moments when you’re so overwhelmed.
- **Redirecting back to task/work of therapy.** A member of the dyad responds to a rupture by redirecting back to the therapy task or goal. Most commonly this is used in response to a withdrawal from a task.
 - *Session begins with a focus on the patient’s anxiety, which was one of his presenting problems. Patient talks at length about going to clubs to hear music. Patient is not engaging with the therapist at all and seems to be avoiding the tasks of therapy—this is a withdrawal, avoidant storytelling.*
P: It’s really hard to find a club that has consistently good music without having to pay through the nose.
T: Yeah.
P: And not having to buy a drink, which sometimes I do and sometimes I don’t. It’s like, if I’m going to listen to this music, I’m going to have to get a pint of beer and I’m not in the mood for a pint of beer.
T: Right.
P: I’d rather leave my system alone.
T: Yeah, OK, I hate—not to change pace too much, but I know that the last time we met, you had a lot of doctor’s appointments, a lot of health concerns. Is that contributing to your anxiety right now? *[The therapist attempts to stop the patient’s avoidant storytelling by redirecting the*

patient back to the task of therapy, discussion of his anxiety.]

If the dyad is exploring a rupture and there is movement away from the exploration, and then one member of the dyad redirects the other back to the exploration of the rupture, that should *not* be coded as redirecting to task, but rather should be considered part of *Exploring the rupture*.

Patient/therapist explores the rupture

Rating	Label Description
1	The strategy of responding to a rupture by exploring the rupture is not salient. There are no examples of this type of repair strategy, or there is only one possible example that does not stand out because it is of very low intensity and clarity (e.g., a therapist asks a patient to share their experience in the moment and it is unclear if this invitation is in response to a rupture or is the therapist “just doing therapy.”).
2	
3	The strategy of responding to a rupture by exploring the rupture is somewhat salient. Examples of this type of repair strategy stand out somewhat and are generally of moderate intensity and clarity. There should be at least one clear example of responding to a rupture by exploring the rupture.
4	
5	The strategy of responding to a rupture by exploring the rupture is very salient. Examples of this type of repair strategy stand out very much and are generally very intense and clear. Usually, a rating of 5 will mean there were multiple examples of this repair strategy in the segment, but it is possible to have a segment with one example of a repair strategy that is so intense and clear that it warrants a 5 (e.g., in response to a rupture, a therapist provides a very clear, explicit, and thorough disclosure of their internal experience of the rupture).

Strategies in this category are attempts to repair a rupture by exploring the rupture and how the members of the dyad are experiencing it. Exploration of a rupture may include any of the following:

- **Validating the other’s experience of the rupture.** This strategy is distinct from a more general validation of the other person (as in the Working Together item, Therapist accepts/validates patient); with this strategy, one validates how the other’s movements against or away are understandable and even adaptive. This is more than just reflecting back someone’s own explanations for their behavior—this involves communicating that their position with respect to the rupture is legitimate and valid.
 - P: This is so hard to talk about. (*P blinks back tears*). It’s hard to believe this happened to me. What a crazy world we live in. I don’t even want to check the news, it’s just too much. What a world.

T: You were feeling some very strong feelings just a minute ago, and now you are moving away from them. You are protecting yourself, and that makes sense. Maybe it's adaptive for you to have some distance from your pain right now.

- **Inviting an exploration of the rupture.** One member of the dyad invites the other to clarify or expand upon and explore their negative or vulnerable feelings about them and/or the work of therapy. They might invite the other to share the details of their experience of the rupture. For example, a therapist may encourage a confrontational patient to expand upon their complaint about a therapy task, or a therapist may observe that a patient is providing minimal responses and may ask them to voice their concerns directly.
 - T: It almost sounds like maybe you felt like you were in trouble, maybe you weren't doing things right.
 - P: Yeah.
 - T: Like I was disappointed.
 - P: Yeah. I was in trouble. That was the feeling.

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

 - T: You sound disappointed in how therapy is going. Can you tell me more about that disappointment?

Just checking in to make sure the other is still in agreement (e.g., "does that make sense?") is not inviting them to explore a rupture. In addition, inviting feedback outside of the context of a rupture is not an invitation to explore. For example, do not code if the therapist is simply following CBT protocol and asking for feedback at the end of the session. Do code if the therapist is asking for feedback in the context of a rupture: for example, "We had a challenging session today. We didn't really agree about the thought record. How are you feeling about it now?"

- **Engaging in an exploration of the rupture.** After one member invites the other to explore the rupture, the other accepts the invitation and actively engages in the exploration. A potential challenge for coders is distinguishing when someone is exploring a rupture vs. continuing the rupture, and the line between the two may not always be clear, especially if the person is gradually moving from rupture to repair, as in the example below:

- P: *(angry tone)* I really didn't like that question. *(Patient moves against)*
- T: Can you tell me more about that? *[Therapist invites patient to explore]*

rupture]

P: *(still angry tone)* I feel like you aren't listening to me. You should already know the answer to that. *[Patient moves against]*

T: It feels like I'm not paying attention to what you are saying?

P: *(less angry tone)* Yeah.

T: Can you tell me more about that? What is that like for you, as you are working so hard, sharing all these things with me, and it feels like I'm not paying attention?

P: *(softening, gentle tone)* I feel unseen, unimportant. I feel—I feel really alone. *[Patient has shifted from anger to sadness as they access vulnerable emotions; patient is no longer moving away, patient is now collaborating with therapist and exploring rupture.]*

- **Exploring avoidance of rupture and redirecting back to the rupture.** In the context of exploring a rupture, if the patient and/or therapist gets uncomfortable talking about the rupture, they may start to move away from the exploration (an example of withdrawal). If one member of the dyad recognizes that avoidance and redirects the dyad back to exploration of the rupture, then code that as part of *Exploring the rupture*. This is different from *redirecting back to a task/goal*, which is a form of *Focusing on the task*.

- T: It feels like we've both been trying to protect each other.

- P: Yeah. I am a protector. Especially with my kids. I know it's important to give them space, but it's hard to just sit back and watch them make mistakes. *[Patient moving away]*

- T: I think you may be trying to protect us again. Can we go back for a minute, and focus on what's happening here?

- **Disclosing one's internal experience of the rupture.** In the context of a rupture, the patient or therapist discloses their internal experience of the rupture—that is, their thoughts or feelings about how the members of the dyad are moving away from or against each other.

Do not code every time a member of the dyad shares what they think or feel. Rather, to qualify for this code, the patient or therapist needs to be sharing their thoughts or feelings about the patient-therapist interaction when one or both members of the dyad are confronting or withdrawing.

- T: I feel like I'm walking on thin ice here...

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

- P: I feel like we are caught in a power struggle.

- T: I have to be honest with you. I'm a little angry with you. As a therapist that's not something that's comfortable to feel.
- P: Yeah. I felt like I was in trouble. A lot of times with people I feel like I did something wrong.
- T: I'm really glad that you were able to bring that up, that's great assertiveness. The other thing is, I'm *not* disappointed. I don't think you're doing a bad job or being lazy. I feel like you're really taking this seriously.

Patient/therapist acknowledges their contribution to the rupture

Rating	Label Description
1	The strategy of responding to a rupture by acknowledging one's contribution to the rupture is not salient. There are no examples of this type of repair strategy, or there is only one possible example that does not stand out because it is of very low intensity and clarity (e.g., the therapist comments that a homework worksheet is formatted poorly, and it is unclear if the therapist's comment is in response to difficulty the patient is having with a therapy task, or it is unclear if the therapist is taking responsibility for not giving the patient what they needed to successfully complete the task vs deflecting blame by criticizing whoever created the worksheet.).
2	
3	The strategy of responding to a rupture by acknowledging one's contribution to the rupture is somewhat salient. Examples of this type of repair strategy stand out somewhat and are generally of moderate intensity and clarity. There should be at least one clear example of responding to a rupture by acknowledging one's contribution to it.
4	
5	The strategy of responding to a rupture by acknowledging one's contribution to the rupture is very salient. Examples of this type of repair strategy stand out very much and are generally very intense and clear. Usually, a rating of 5 will mean there were multiple examples of this repair strategy in the segment, but it is possible to have a segment with one example of a repair strategy that is so intense and clear that it warrants a 5 (e.g., in response to a rupture, a therapist provides a very clear, explicit, and thorough acknowledgment of their contribution to the rupture).

Strategies in this category involve members of the dyad acknowledging how they are contributing to the rupture that is taking place between them. They may acknowledge ways in which they are frustrating, confusing, or upsetting the other. They may acknowledge their own movements against or away from the other.

- T: I can see how this could be frustrating for you. You're asking me for a direct answer and I keep putting the ball back in your court
- T: OK, I want to stay with this for a moment because it's possible maybe I was unclear, or without realizing it, gave you certain signals or messages.
- T: I have to admit, in this moment, I feel a little accusatory...
- T: You know, I've been thinking about it a lot, what happened last time. I need to take some responsibility for not making your environment here safe. Things got more painful than they needed to be, and there were some mistakes that I made.
- P: I'm sorry, I lost it with you last time. I was taking all my frustration out on you, and that wasn't fair to you.

Coders should be alert to distinguishing between acknowledging one's contribution as part of a repair vs. appeasing or deferring to the other in an effort to avoid conflict, which is a form of moving away. Coders may encounter situations that include elements of both, and they can reflect that by coding for both.

Patient/therapist links the rupture to a larger interpersonal pattern

Rating	Label Description
1	The strategy of responding to a rupture by linking the rupture to a larger interpersonal pattern is not salient. There are no examples of this type of repair strategy, or there is only one possible example that does not stand out because it is of very low intensity and clarity (e.g., a patient or therapist notes a similarity between the therapeutic relationship and another relationship, but it is unclear if this link is in response to a rupture or if the dyad is "just doing therapy.").
2	
3	The strategy of responding to a rupture by linking the rupture to a larger interpersonal pattern is somewhat salient. Examples of this type of repair strategy stand out somewhat and are generally of moderate intensity and clarity. There should be <i>at least one clear example</i> of responding to a rupture by linking the rupture to a larger interpersonal pattern.
4	
5	The strategy of responding to a rupture by linking the rupture to a larger interpersonal pattern is very salient. Examples of this type of repair strategy stand out very much and are generally very intense and clear. Usually, a rating of 5 will mean there were multiple examples of this repair strategy in the segment, but it is possible to have a segment with one example of a repair strategy that is so intense

and clear that it warrants a 5 (e.g., in response to a rupture, a patient or therapist describes in a very clear, explicit, and thorough way how a rupture the dyad is experiencing is similar to a larger interpersonal pattern).
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Strategies in this category involve members of the dyad making links between a rupture and a larger interpersonal pattern. This may be a larger pattern in the patient-therapist relationship, and the patient or therapist is connecting a current rupture with previous ruptures; for example, “I think we’re doing our dance again.” Alternatively, the patient or therapist may link a rupture to a larger interpersonal pattern in the patient’s other relationships. This code will encompass many—but not all—transference interpretations in a psychodynamic therapy. This code may also be appropriate for some discussions of core beliefs in CBT.

The person making the link may start with the rupture and then connect it to a larger pattern, or they may start with the larger pattern and then link it to the rupture.

- T: It’s hard for you to trust me right now. Does that feel familiar? Has that happened in other relationships?
- P: I’m just so tired of people telling me what to do and what to think.
T: Does it feel like that’s what I was doing just now? Was I pushing you to agree with me? *[In addition to making a link, the therapist is inviting the patient to explore the rupture and acknowledging the therapist’s contribution.]*
- T: There is still this distance between us.
P: Yeah. I think I’m pushing you away, just like I pushed my boyfriend away, like I push everyone in my life away. *[The patient is making a link and acknowledging their contribution.]*

Coders should be mindful that making a link from a rupture to larger patterns can be a form of moving away, by shifting the focus from tension or conflict in the dyad to a “safer” territory of talking about a different relationship. If it is unclear whether a link is part of a repair or part of moving away, the coder can consider it an unclear example of both and code accordingly.

Repair Effectiveness Ratings

Coders rate the effectiveness of repair for each segment and also for the session as a whole. With these ratings, we seek to capture ***the extent to which ruptures were effectively repaired***; note, this is *not* the same as rating how effective the repair strategies were. We chose to define effectiveness of repair this way for two reasons:

- First, we acknowledge that the 3RS v 2022 may not cover every possible repair strategy, and we wanted to be able to capture repairs that were achieved via strategies that we failed to include in the measure.
- Second, it is possible to repair a rupture via processes captured in the Working Together items, such as the therapist maintaining a stance of acceptance and curiosity, or the patient being collaborative and engaged in the work. We have previously described repair in terms of three pathways: 1) reattunement to feelings or intentions; 2) renegotiation of tasks or goals; and 3) exploration of the rupture (Muran & Eubanks, 2020). The first pathway can be captured in the Working Together items. The second pathway is reflected in the repair strategies of focusing on the task/goal. The third pathway is reflected in the strategies of exploring the rupture. The strategies related to acknowledging one’s contribution to the rupture and linking the rupture to larger interpersonal patterns can be employed as part of renegotiating a task/goal or exploring a rupture.

The effectiveness of repair ratings employ a 5-point Likert-type scale with the following anchors:

Rating	Label Description
1	Ruptures were not successfully repaired and the alliance worsened (or was so poor that it could not get worse). This is the lowest rating on the effectiveness scale and reflects the fact that there is something less effective than failing to improve a situation—there is making the situation worse. If there is a lack of repair and the alliance gets weaker or is already at a very low point where there is a lack of agreement, collaboration, and bond, then use this rating.
2	Ruptures were not successfully repaired but the alliance did not worsen. There is one important caveat for this rating: When rating at the segment level, if the previous segment received a rating of 1 for effectiveness of repair, then coders should only move up to a 2 for the subsequent segment if there is an increase in the effectiveness of repair. In other words, “the alliance did not worsen” should not be interpreted to mean that when one segment receives a 1 for effectiveness, and the alliance is equally poor in subsequent segments, that they would qualify for ratings of 2 because the alliance remained at the same (very low) level. Increases (and decreases) in the effectiveness rating across segments should reflect actual changes in the extent to which ruptures were repaired.
3	Ruptures may have been repaired a little (little or unclear repair). This rating aims to capture when coders think there might have been a little repair. The extent of the repair may be minor or unclear at this point, if, for example, there has been an attempt to repair a rupture that has started to have some impact but not enough time has elapsed for the coder to fully gauge any shifts in the dyad’s collaboration

	and bond. Or the coder may observe that there is less conflict or strain present but is not certain if a rupture was repaired, or if both members of the dyad are colluding to avoid the rupture and “move on.” A rating of 3 captures when coders feel that saying that ruptures were not repaired (rating of 2) is too low, but they also do not feel confident that there was some degree of repair that they can clearly identify (rating of 4).
4	Ruptures were somewhat repaired. Coders observe that ruptures were addressed in some way (explicitly and/or implicitly by patient and/or therapist) and that there is some resulting increase in collaboration and/or the bond that the coder can clearly identify.
5	Ruptures were repaired a good amount. Coders observe that ruptures were addressed in some way (explicitly and/or implicitly by patient and/or therapist) and there is a resulting increase in collaboration and/or the bond that the coder can clearly identify and that the coder feels is greater than “somewhat”—it is considerable and notable. Ruptures do not need to be completely repaired and resolved in order to warrant a rating of 5.
N/A	Repair cannot be coded due to lack of ruptures. If there were no ruptures and no repairs, then you would not be able to rate the effectiveness of repair, so you would rate N/A (not applicable). Keep in mind, however, that due to the way the 3RS v 2022 operationalizes rupture and repair to include very subtle signs of rupture and repair, most segments of most sessions will include at least some minor markers, so N/A should be used sparingly.

Frequently Asked Questions

Why does the 3RS v2022 use 5-minute segments?

We find that 5 minutes usually gives coders enough material to identify ruptures and repairs, but not so much material that they cannot reach agreement on what they are seeing. However, 5 minutes is somewhat arbitrary. Researchers should feel free to use longer or shorter time bins if they feel that would work well for their particular project.

We have applied the 3RS v 2022 to transcript excerpts at the level of speech turns to illustrate rupture and repair processes in publications. Reaching interrater reliability at this microlevel may be challenging, so researchers who want to code at this level for a research study could also consider using consensus coding.

The 3RS v 2022 is designed for use with session videos. Can it be used with audiotapes or transcripts?

It can, but the question is, how much information is lost? We predict that the more information coders have (including paraverbals and nonverbals for both patient and therapist, which requires good quality video in which you can easily see and hear both members of the dyad), the more valid their codes will be. However, this is an empirical question.

The 3RS v 2022 appears to be designed for rating individual therapy. Can it be used with other forms of treatment, like couples, family, group therapy, etc.?

Yes, we welcome and encourage innovative applications of the 3RS v 2022 and have collaborated on some of these ourselves (e.g., coding ruptures and repairs in group supervision). We anticipate that applying the 3RS in other contexts may require adaptations, and we welcome this as well. We encourage researchers to clearly describe any changes they make so that we can all understand and learn from their efforts.

Can the 3RS v 2022 be used in different cultural contexts? Might ruptures and repairs look different across cultures?

Yes, we would expect that as interpersonal communication norms differ across cultures, then there are likely cultural differences with respect to which behaviors are and are not viewed and experienced as collaboration, as movements away or against another, or as effective repairs. The 3RS v 2022 inevitably reflects our own cultural assumptions and biases related to our identities and the cultural contexts in which we were raised, live, and do research (e.g., both authors are from the United States and currently do research in New York). Applying the 3RS v 2022 across different cultures and contexts may require adaptations to either the measure or the guidance given to coders, and we welcome this. We encourage researchers to think carefully about the role of culture—not only the culture of the patient, but also the culture of the therapist and the cultural beliefs and expectations of the coders—and to clearly describe any changes or adaptations they make so that we can all understand and learn from their efforts.

If there is a technical issue (e.g., internet connection problems during a therapy session conducted online), could that count as a rupture?

It depends. A technical issue could contribute to a rupture. For example, an internet malfunction could lead one member of the dyad to become frustrated with the other and exhibit confrontation markers (e.g., complaining about the other or about the therapy). However, it is also possible for a dyad to work together well to navigate a technical problem, and in that situation, the technical problem is not contributing to a rupture in the alliance.

How do you distinguish between a rupture and someone’s personality or interpersonal style?

We do not make this distinction. We code behaviors that impact the dyad’s ability to work together. If someone is moving away from or against the other or the work of therapy, then we code that behavior. We are not making a judgment about what caused the behavior, or about whether the ultimate, long-term impact of that behavior will be positive or negative, we are simply observing that it is happening.

In our experience, this question is raised most often in reference to withdrawal markers. For example, coders observe that a patient uses a great deal of abstract communication that impedes the therapist’s ability to understand what the patient is talking about, and the coders conclude that this is the patient’s “personality” or “interpersonal style” and are reluctant to keep coding it as a withdrawal marker segment after segment. Arguably, hostility could also be part of someone’s personality or interpersonal style, but coders are usually more comfortable coding hostile behaviors as confrontation markers. This may reflect a mistaken belief that when we rate rupture markers, we are “accusing” someone of “bad” behavior. This is where it is helpful to remember that ruptures are an inevitable part of therapy, and we are simply observing them, not passing judgments against the patient or therapist. In fact, if a coder believes that a particular behavior is “not so bad” and probably doesn’t predict poor outcome, and the coder is therefore inclined not to rate it as a rupture marker, we would remind them that by not rating it, you are missing the opportunity to collect data that could be used to support your belief.

What if it is early in therapy and the patient and therapist have not built an alliance yet—can I still code an alliance rupture?

Yes, for two reasons.

- First, our definition of an alliance rupture includes not only a deterioration in the alliance—which presumes a decline from a previously stronger alliance—but also a weakness in the alliance that could be present from the very beginning of therapy. If a patient and therapist never agree, never collaborate, and never experience a bond, then they are in a state of rupture from the first minute of the first session.
- Second, we would argue that there is some kind of an alliance in place even before treatment begins, because both patient and therapist are coming to the first session with expectations about how much they will agree, collaborate, and feel a bond with each other. In fact, a study that asked patients to rate their alliance with their therapist *prior* to meeting the therapist found that these pre-treatment alliance expectations predicted patients’ ratings of the alliance later in therapy (Barber et al., 2014). Hence, a movement against or away in the first minute of the first therapy session could be conceptualized as a rupture of the alliance that the patient and therapist brought to their first session in the form of their expectations.

What if a patient and therapist had a rupture in session 1 and then repaired that rupture in session 2? What if the coder is only watching session 2, so they never see the rupture itself—can they rate the repair?

This brings up an important point: Coders will have different amounts of information about a session depending on what else they are coding. Coders who are seeing multiple sessions from the same dyad will have more information that may help them code more accurately (e.g., because they can more easily recognize when something in session 2 is a repair of something in session 1), but at the same time the increased information could lead to less accurate coding (e.g., if coders develop biased expectations about session 2 based on what they saw in session 1). Whether the pros of having more information outweigh the cons of potential bias is an interesting empirical question. Until there is research to guide us, we suggest the following:

- First, researchers should consider the coders' perspectives and the impact of more information (and potentially more biases) when designing a study so that they can make decisions (e.g., about the number of coders, whether coders will see multiple sessions from the same dyad or same therapist, whether they will see sessions in chronological or random order, etc.) that best fit their research aims. They should also clearly report these decisions when writing up their study.
- Second, when coding ruptures and repairs, coders should just do the best they can. They cannot know what they have no way of knowing, and they cannot unlearn what they have already learned. Coders who see something in session 2 that they feel confident is a repair from something in session 1 should rate it as such. If they are somewhat but not fully confident that they are seeing a repair of a rupture from a previous session, they could consider this to be an unclear example of a repair strategy, and rate accordingly (e.g., rate it a 2). If they are only seeing repair and no rupture (because the rupture was entirely in the previous session), then they would rate only repair and no rupture. However, in our experience, when ruptures in one session are repaired in the following session, the second session usually still includes some carryover of the rupture (e.g., at least some minor withdrawal or confrontation markers).

What do I do if I really can't decide if something is withdrawal or confrontation? Or I really can't decide if something is a rupture or a repair?

If you are clear on the differences between withdrawal, confrontation, and repair, and you find yourself struggling with these either/or questions—or in a coding group, you find that some coders are arguing for one type of code and other coders are arguing for the other type of code—then consider the possibility of **both/and**. You may be seeing an example of a mixed rupture that includes elements of both withdrawal and confrontation (e.g., someone is being somewhat deferential but also somewhat critical in a passive-aggressive way), or you may be seeing a repair strategy that also includes elements of rupture (e.g., a therapist tries to explore a rupture in an aggressive way that puts pressure on the patient). You can reflect these mixtures by coding both elements.

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