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From Emotion to Rupture

Beauty, Poetry, she is All: once more all in the figure of the other, All except herself.

—SIMONE DE BEAUVOIR (1949/2010)

The etymology of the word *emotion*—from the French word *émouvoir* for “to stir up”—captures the struggle to define its meaning. Despite considerations from many philosophers of diverse cultures, dating back to ancient times (Frevert, 2016), and from psychologists such as William James (see his 1884 article “What Is an Emotion?”) in the 19th century, the definition continues to be a challenge fraught with controversy. Since the 1980s, we have witnessed rapid growth in the study of emotion: The most recent edition of the *Handbook of Emotion* (fourth ed.; Barrett, Lewis, & Haviland-Jones, 2016) consists of 50 review chapters that cover the interdisciplinary spectrum—from the philosophical, sociological, biological, developmental, cognitive perspective to perspectives related to personality and health. Since the 1990s, we have witnessed a similar development with regard to emotion regulation: The most recent edition of the *Handbook of Emotion Regulation* (second ed.; Gross, 2014b) consists of 36 review chapters that concern biological bases; cognitive, developmental, and social considerations; and perspectives on personality, psychopathology, and intervention.

Likewise, we have witnessed a significant shift in emphasis on emotion in psychotherapy—from something secondary or epiphenomenal to something central or essential in the change process. For example, in the

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Therapist Performance Under Pressure: Negotiating Emotion, Difference, and Rupture,

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cognitive-behavioral tradition, emotion was once construed as a postcognitive phenomenon (A. T. Beck, 1976; Ellis, 1962) before significant reformulations (L. S. Greenberg & Safran, 1987; Guidano & Liotti, 1983) brought emotion front and center and highlighted its integral relationship to core processes. We have seen this turn in psychoanalytic and humanistic psychotherapies as well (e.g., Muran, 2001c; Safran & Greenberg, 1991). With this change has come a proliferation of treatment models¹ in which emotional experiencing and regulation are primary targets of intervention; certain models have gained some degree of empirical support. (See also Peluso & Freund, 2018, for meta-analyses regarding emotional expression in treatment.)

In this chapter, we review the literature on emotion, including conceptualizations that define its functional properties and propositions that define it in basic and complex terms as elemental and multivariate. We highlight a constructionist conceptualization that suggests emotion as pluralistic and idiosyncratic—organized by previous experience and shaped by social influence. We elaborate on this complex conceptualization with a consideration of emotion regulation. We then turn to a consideration of clinical perspectives on multiple selves and intersubjectivity, not only to further this conceptualization but also to justify greater focus on emotion in the therapist. We consider identity politics and revisit the notion of ruptures in the therapeutic relationship. Whereas in Chapter 2 of this volume we concentrated on patient communications or behaviors as interpersonal markers of ruptures, in this discussion we focus on therapist experience of emotions as possible internal or intrapersonal markers of these critical events.

EMOTION: FROM BASIC TO COMPLEX

Emotion is a type of affect, and in contrast to other affects such as mood, temperament, and sensation, emotion can be understood as a state or a process (G. Johnson, 2009). As a state, it has been defined as a type of mental or feeling state, a conscious or subjective experience that interacts with other mental states and is related to certain behaviors and bodily responses. As a process, it has been defined as progressing from stimulus perception and evaluation (including interpretation, judgment, construal, or some other mental representation of the stimulus) to bodily response (including heart rate, skin conductance, facial expression, and behavioral action tendency).

Much has been written about the functional properties of emotion. In this regard, it has long been considered evolutionary and adaptive, beginning with Charles Darwin's (1892/2002) book *The Expression of the Emotions in Man*

¹Affect-phobia therapy (McCullough, 2003), dialectical behavior therapy (Linehan, 1993b), emotion-focused therapy (L. S. Greenberg, 2011), emotion regulation therapy (Mennin & Fresco, 2013), emotional schema therapy (Leahy, 2009; Young, Klosko, & Weishaar, 2003), integrative cognitive-affective therapy for bulimia nervosa (Wonderlich, Peterson, & Smith, 2015), and mentalization-based therapy (Bateman & Fonagy, 2006).

and Animals and including its more contemporary characterization as “an action-oriented form of skillful engagement with the world” (Griffiths & Scarantino, 2005, p. 437). Emotions serve several adaptive functions. First, emotions *inform*: They tell us about our world and where we are in context, help orient us to the environment, and provide meaning. For example, anger indicates violation, fear indicates danger, and sadness indicates loss (Schwarz, 2010). Second, emotions *motivate*: They mobilize the individual through physiological changes and action tendencies to prepare and negotiate with emotion-eliciting events. For example, anger mobilizes us to protect against violation, fear mobilizes us to avoid danger, and sadness mobilizes us to resolve or replace something lost (Salovey, Detweiler-Bedell, Detweiler-Bedell, & Mayer, 2008). Third, emotions *influence*: They influence memory and thought, and they affect decisions we make and actions we take. Research has demonstrated how decisions made based on transient incident emotions can have an enduring impact on future decisions (Andrade & Ariely, 2009; Grecucci & Sanfey, 2014). Fourth, emotions *communicate*: They inform others about our intentions and action tendencies. We read the emotional states of others, especially through vocal, facial, and behavioral expressions; we can empathize and sympathize (Zaki & Ochsner, 2016). Finally, emotions *affect*: They affect the emotions and behaviors of others. Much has been written about emotional contagion and how one’s emotion can trigger a similar state in another, such as how anxiety begets anxiety (Hatfield, Cacioppo, & Rapson, 1994).

Emotion has been defined as both basic and complex. By basic, there has been a long-standing view of a select set of discrete, elemental emotions (as seminal examples, see Ekman, 1972; Izard, 1971; Tompkins, 1962; see also R. W. Levenson, 2011). This view consists of six to eight primary emotions organized by positive (e.g., happiness, surprise) and negative (e.g., anger, fear, sadness) dimensions. Complex emotions or variations on these categories are considered the result of combinations or blends of the basic categories, much like the spectrum of colors is formed from the primary colors.

The definition of basic emotions has included the proposition that they are physiologically and behaviorally distinct, but empirical research has challenged this notion and led to reformulations (Barrett et al., 2016; Barrett & Russell, 2015). The research evidence supports neither a unique biological “fingerprint” of an emotion nor dedicated neural circuit or brain region, nor bodily response pattern, nor facial or vocal expression consistently associated with a so-called basic emotion. The functional magnetic resonance imaging research regarding neural activity and emotion does support a core affect founded on the dimensions of arousal and valence (positive and negative), from which emotional experience is constructed.

One reformulation that has gained a great deal of traction involves a constructionist interpretation, prominently promoted by Lisa Feldman Barrett (2017; Russell, 2015; Scarantino, 2015). According to Barrett, emotions are constructed by multiple brain networks, organized by previous experiences and shaped by social influence—both familial and cultural. “In every waking moment, your brain uses past experience, organized as concepts, to guide your

actions and give your sensations meaning. When the concepts involved are emotion concepts, your brain constructs instances of emotion” (Barrett, 2017, p. 31). As the research suggests, there are multiple emotion systems (e.g., multiple anger systems) and flexible response tendencies as a rule (e.g., multiple expressive behaviors). This formulation provides for a more nuanced understanding of emotion. Leslie Greenberg and Juan Pascual-Leone (1995, 2001) proposed a dialectical-constructivist perspective that attempts to integrate the notion of basic emotion with a constructivist conceptualization.

The complexity of emotions can also be understood by noting that they consist of multiple dimensions, described as “a syndrome of components” (Barrett & Russell, 2015). These dimensions include (a) phenomenological or subjective experience (what is felt in an emotional state), (b) cognitive processes (from construal to appraisal), (c) expressive and instrumental behaviors (from facial and vocal expressions to action tendencies), and (d) neurological and physiological changes (e.g., Scherer, 2005). Emotions are highly variable on these components, as research evidence indicates (Barrett et al., 2016), which translates into *complexity within emotion* and emotional experience that can be quite idiosyncratic (e.g., Barrett, 2017; Lindquist & Barrett, 2008).

EMOTION: FROM GENERATION TO REGULATION

Another primary source of complexity or variability is due to the interaction between various emotions and emotion regulation (Scarantino, 2015). This translates into *complexity between emotions*. *Emotion regulation* refers to mental and behavioral processes by which we shape and change the trajectory of our emotions (Gross, 1998): Although it has been distinguished from emotion generation, the relationship between the two is complicated, as emotions are often regulated by the generation of others (Johnston & Olson, 2015).

Leslie Greenberg and colleagues (L. S. Greenberg, 2016; L. S. Greenberg & Paivio, 1997; L. S. Greenberg & Safran, 1987) captured complexity between emotions in terms of various dualities, specifically the distinctions between primary versus secondary and adaptive versus maladaptive emotions. Primary emotions are “fundamental states for which the adaptive value is clear—for example, sadness at loss, anger at violation, and fear at threat” (L. S. Greenberg & Paivio, 1997, p. 38): They organize and motivate the individual for adaptive action. Secondary emotions are developed subsequently, built in relation to primary emotion experiences and comprising a complex integration of cognitive-affective processes that are shaped by social learning: anxious, embarrassed, or hopeless reactions to sadness, anger, or fear. Maladaptive emotions are learned responses that no longer fit a situation that an individual is facing; for example, the individual may have learned that the expression of anger is dangerous and could lead to rejection by a parent, so develops an anxious, avoidant reaction to anger to maintain close attachment. Subsequently, in an abusive adult relationship, the individual experiences anxiety in the face of

violation rather than the more appropriate experience of anger that might move them to an adaptive action.

As discussed in Chapter 1 of this volume, Gross (2014a) defined a number of effective regulation strategies, including attentional distraction, expressive suppression, and cognitive reappraisal, and highlighted research demonstrating that reappraisal is more effective than distraction and suppression. More recent research has found affect labeling (which is essentially putting words to feelings—also described in terms of *granularity*), distancing, and acceptance (which is likened to *mindfulness*) to be more effective than reappraisal (see Barrett, 2017, for a review).

Jamil Zaki and Craig Williams (2013) elaborated on Gross's (2014a) definition in their distinction between intrapersonal and interpersonal emotion regulation strategies. They defined the two strategies as existing on a continuum, with the former emphasizing internal processes, such as cognitive reappraisal and expressive suppression, and the latter the presence of another to influence the trajectory of an emotion. They differentiated response-dependent from independent mechanisms (where the response of the other is required vs. when only the presence of the other is needed) and intrinsic from extrinsic strategies (where a person seeks contact with another to regulate their own emotions vs. where a person seeks to regulate another's emotions). In their own effort to organize the research literature, Butler and Randall (2013) proposed an operational definition of *coregulation* (or "social affect regulation"), which consists of "a bidirectional linkage of oscillating emotional channels (subjective experience, expressive behavior, and autonomic physiology) between partners, which contributes to emotional and physiological stability for both partners in a close relationship" (p. 203). Rimé (2009) also provided a critical review of the research on social interdependency in emotion regulation, specifically using the terminology *social sharing of emotion*, or affective states.

These efforts highlighted research on mother–infant face-to-face communication to advance research on emotion regulation in the context of adult relationships. An extensive body of research demonstrates bidirectional dependence in mother–infant interactions, using such terms as *mutual influence*, *reciprocity*, *matching*, *coordination*, *attunement*, and *synchrony* (see Lewis & Rosenblum, 1974, for early examples). Edward Tronick's (2007; see also Beebe & Lachmann, 2002, 2015) "mutual regulation" model, which has received considerable attention, found that mothers and infants demonstrate self- and other-directed actions toward each other to maintain optimal levels of arousal and engagement. The model describes nonverbal contingencies of signaling and synchrony in the mother–infant interaction. Of interest, it indicates that such interactions are typically "messy"—what is normative is mismatch or misattunement, and the critical process that distinguishes healthier interactions or dyads is the extent that there is *reparation*. This model has been furthered by other "dynamic dyadic systems" research programs that were based on Daniel Stern's (2000) original propositions and have tested how self-processes (each person's behavior in relation to their prior behavior) and

interactive processes (in relation to the other person's behavior) coordinate in face-to-face communication. These programs have studied communication modalities such as attention (gaze on and off on the other person's face), facial affect (positive to negative), and vocal affect (positive to negative), and they have uncovered significant self- and interactive contingencies, as well as complicated contingencies between contingencies, such as the finding that one's self-regulation is influenced by the way one coordinates with one's partner (see Beebe et al., 2016). There is also a growing body of research on the neurobiological mechanisms of mother–infant interactions (e.g., Fleming, O'Day, & Kraemer, 1999).

In addition, these reviews highlight other research on related interpersonal processes indicating the effect of emotion from one individual to another, including (a) motivation to help others improve emotional states through *altruism* or *compassion* (Batson, 2011; Goetz, Keltner, & Simon-Thomas, 2010); (b) *emotional transmission* and *contagion*, which involve one person's emotional state affecting another's (Hatfield et al., 1994; Larson & Almeida, 1999); and (c) *social support*, *stress buffering*, and *emotional modulation*, which refer to the mere presence of another to attenuate negative emotion in the face of stress (e.g., Coan, 2011; Coan, Schaefer, & Davidson, 2006; Diamond & Aspinwall, 2003; Niven, Totterdell, & Holman, 2009; Randall & Bodenmann, 2009; Uchino, 2004; Uchino, Cacioppo, & Kiecolt-Glaser, 1996). These research threads provide further evidence for the complex but intrinsic role of emotion in interpersonal process.

EMOTION: FROM MULTIPLICITY TO INTERSUBJECTIVITY²

Understanding emotion complexity and regulation should include a consideration of the idea that each of us comprises multiple selves, a concept founded on the recognition that we live in a world of plurality and changeability, of infinite constructions and reconstructions. Accordingly, the human condition is marked by ever-shifting and ever-expanding realities and identities (see Gergen, 1991, 1994, 2009; Metzinger, 2009; see Muran, 2001a, for a review). Of interest, the notion of multiple selves is not necessarily a new one. In tracing the history of ideas, dating the origin of a line of thought can be a somewhat arbitrary punctuation, but this notion was at least present in various disciplines in the latter part of the 19th century, when James (1890/1981)

²Portions of this section were adapted from "Contemporary Constructions & Contexts," (pp. 3–44), by J. C. Muran, in *Self-Relations in the Psychotherapy Process*, edited by J. C. Muran, 2001, Washington, DC: American Psychological Association; "A Relational Turn on Thick Description," (pp. 257–274), by J. C. Muran, in *Dialogues on Difference: Studies of Diversity in the Therapeutic Relationship*, edited by J. C. Muran, 2007, Washington, DC: American Psychological Association; and "Reply: The Power of/in Language," (pp. 285–288), by J. C. Muran, in *Dialogues on Difference: Studies of Diversity in the Therapeutic Relationship*, edited by J. C. Muran, 2007, Washington, DC: American Psychological Association.

described the self as “a stream of selves” (see also Nietzsche, 1888/1968; Whitman, 1855/1950). More recently, it is reflected in considerations of the self as the *intersectionality* of various cultural identities (Crenshaw, 2019). In the clinical literature, the idea of multiple selves was sown early on in humanistic psychotherapies, especially those inspired by Carl Rogers (Meador & Rogers, 1979: “[The self] is a fluid and changing process, but at any given moment it is a specific entity,” p. 147) and interpersonally oriented psychoanalyses, beginning with Harry Stack Sullivan (1964; “For all I know every human being has as many personalities as he has interpersonal relations,” p. 221).³

Self Schemas

Many contemporary conceptualizations are founded on a representational formulation of the self (see Muran, 2001a, for a review). As previously presented (Muran, 2001a, 2007b; Muran & Safran, 2002; Safran & Muran, 2000), the self comprises memory stores or knowledge domains that are derived from interpersonal experience and that include internalized self-assessments and expectations regarding other people, which inform the individual how to relate to others. These can be considered self (or relational) schemas that are abstracted on the basis of interactions with attachment figures and others of interpersonal significance in order to increase the likelihood of maintaining a relationship with those figures. Self schemas contain implicit beliefs about self and other—the idea that relationship patterns, the whole and not the isolated elements, are internalized or represented (see Bowlby, 1969; Fairbairn, 1952; Laing, 1972; D. N. Stern, 1985; Sullivan, 1953).

These schemas also contain specific procedural information regarding expectancies and strategies for negotiating needs for self-definition (agency) and relatedness (communion). These oft-cited fundamental motivations drive how individuals relate to their social worlds (see Bakan, 1966; Guisinger & Blatt, 1994): *Self-definition* refers to the need to master, to assert the self, to achieve, and to experience competence and power; *relatedness* refers to the need to cooperate, connect, and closely relate to others. They are considered to have a dialectic relationship to each other, an inherent tension that individuals invariably negotiate in pursuit of fulfilling these needs. Wanting to achieve something can work at odds with wanting to be loved by others. These needs have been shown to vary in emphasis depending on various cultural (including gender) differences (see Diehl, Owen, & Youngblade, 2004).

These schemas represent the multiple discrete experiences of the self. In theory, there may be as many “selves” as there are different interactions in one’s life, as Sullivan (1964) originally suggested. This forms the basis for the notion that each individual comprises a unique configuration of selves. The schemas include one’s various identities (e.g., those related to gender or race),

³Both Rogers and Sullivan were greatly influenced by William James, largely through George Herbert Mead (1934).

which are shaped by certain biological constraints (e.g., temperament, physical features) and the familial and cultural experiences of an individual's history. Here the recognition of intersectionality is useful—that “we are all, to some degree, formed by cultural crisscrossing of gender, class, race, sexuality, and religion” (Sullivan, 1964, p. 14) among other characteristics; we move “in and out of borders constructed around coordinates of difference” in a series of identity axes (Awkward, 1995, p. 9; see also Kristeva, 1991, and N. K. Miller, 1991, regarding the identity politics of positionality). Thus, the schemas can be understood as the *foundation for individual differences* (Muran, 2007b).

These schemas should be known as emotional structures (or templates for emotional experience) that are innately given and then elaborated over time through learning into subtle and idiosyncratic variations (Muran, 2001a; Safran & Muran, 2000; see also Leventhal, 1984; Piaget, 1970). From birth, the infant develops memory stores that consist of specific expressive-motor responses, physiological arousal, associated images, and relevant eliciting stimuli. These stores serve a communicative function in that they continually orient the individual to the environment and the environment to the individual. They should also be considered as emergent properties (not representational objects) that involve an interaction of large numbers of simpler elements, a network of units with connections weighted so that activating part of the network will produce an activation pattern that functions like a schema (see Cilliers, 1998; Rumelhart, Smolensky, McClelland, & Hinton, 1986). This consideration captures the complexity of how memories, identities, emotions, and motivations intersect and organize experience.

Self States (Within-Subject Relations)

With the activation of a particular self schema, there is the emergence of a corresponding emotional experience—a particular state of mind or self state (colored by a particular emotion). Self states are the experiential products of the various processes and structures of the self, crystallizations in subjective experience of an underlying schema—put another way, portals to schemas. They may be understood as automatic thoughts or images (in cognitive-behavioral terms) and immediate feeling states such as sadness, fear, or anger. They may be out of awareness but can come into awareness through attention. Different self states can activate different relational schemas, resulting in cycling through different states of mind. The transition points or boundaries among the various self states that each person experiences vary in terms of seamlessness but are often marked by changes such as vocal quality, facial expression, focus and content of verbal reports, or emotional involvement. Indicative of our self-organizing and integral capacities, they are naturally smoothed over, creating the illusory sense of continuity and singular identity, through the process of dissociation. The more conspicuous and abrupt the transitions between self states, however, the more problematic the dissociative process (more on this notion next).

The concept of multiple selves holds that there is no central executive control, in the form of the ego (Mitchell, 1992; see Muran, 2001c). Consciousness is a function of a coalition of different self states. It is thus an emergent product of a self-organizing system. The bifurcation of the psychic system into conscious and unconscious is overly simplified and overly static. That which is conscious is that which is attended to. Attention to different self states in different moments is a function of different stimulus cues, both internal and external. Dissociation is basic to the understanding of multiple selves. It is useful in this regard to make the distinction between dissociation as a “healthy” process of selectively focusing attention and dissociation as an “unhealthy” process resulting from traumatic overload and resulting in severing connections between self schemas (see Bromberg, 1998, 2006). Dissociation is a healthy, adaptive function of the human mind, a basic process that allows individual self states to function optimally and that permits a person to maintain personal continuity, coherence, and integrity of the sense of self. The particular configuration of one’s self-experience is always selective. At any time, certain aspects of self-experience are predominant and others not: It is inevitable that certain aspects of self-experience will be out of focal awareness when others are dominant. There is also a systemic direction of attention away from aspects of self-experience associated with anxiety (Sullivan, 1953). In the case of extreme anxiety—dreaded states considered to be potentially dangerous and associated with a traumatic experience—an aspect of the self can be split off and stranded from awareness in an “unhealthy” sense (Davies & Frawley, 1994).

Experiencing and accepting the multiplicity of self is part of the change process. Psychotherapy essentially brings different parts of the self into dialogue with each other through awareness (Muran, 2001a, 2007b). This process is central to contemporary relational perspectives (e.g., Bromberg, 1998, 2006; D. B. Stern, 1997, 2015, Wachtel, 2008, 2014; see also Safran & Muran, 2000). It is consistent with the emotion-focused, process-experiential perspective (see L. S. Greenberg, 2011; L. S. Greenberg, Rice, & Elliott, 1995), which identifies different patient behaviors as markers to guide therapists to invite their patient through two-chair work to dialogue with the different aspects of the self toward creative resolution. There are two marker types called *self-splits*: the conflict split and the interruptive split. The former is when two parts of the self are in conflict—typically between a coercive “should” and adaptive “need.” In contrast, the interruptive split involves an interruptive activity against the self—when one part of the self interrupts a second part. In this case, the individual feels cut off or loses contact with a part of the self (integral to the pursuit of one’s needs), which can result in a paralyzed state of confusion, helplessness, and hopelessness. This conceptualization of the change process is also consistent with what has been discussed in the third-wave cognitive-behavioral literature, in which (likewise) the emphasis is on how one *relates* to various internal experiences (e.g., S. C. Hayes, Wilson, Gifford, Follette, & Strosahl, 1996; see also Chawla & Ostafin, 2007). Here, the critical marker is defined as *experiential avoidance*, which refers to any

attempt to avoid an internal experience, such as thoughts, feelings, or memories. Such attempts are considered to be maintained by negative reinforcement: That is, the avoidance results in short-term relief of discomfort or pain, which in turn increases the probability that the avoidance will continue. Thus, dysfunction is defined by *how* one avoids and *not* by what one avoids.

This perspective has various implications for the psychotherapeutic situation. One is the importance of facilitating patient immediate awareness of their self states. This perspective suggests working in the here and now, drawing attention to self states (with simple questions such as “What’s going on for you now?” or observations such as “I notice a trembling in your hands”) and to transitions between various states (often marked by vocal, verbal, or gestural shifts, such as the softening of one’s voice, the abrupt change of a topic, the emergence of a misplaced smile, or the diverting of one’s eyes). It promotes an orientation to what is manifest and to the details of emotional experience (as windows to underlying self schemas)—a respect, even a reverence, for particularity or *granularity* (Barrett, 2017)—basic to a phenomenological sensibility (Husserl, 1931). From a multiple selves perspective, it suggests a process of discovering who within the patient is speaking.

Hannah presented feeling “paralyzed by life.” She sat before me [JCM] arms crossed, describing what sounded like a very upsetting experience with her ex-husband. Her description was matter-of-fact, no upset in manner, only in words (what we defined as a content-affect split in Chapter 2, this volume): “So Bill didn’t show again to pick up our daughter after school, another excuse, another time I had to ask to leave work earlier than I was supposed to.” When I commented, “Sounds pretty upsetting,” she just continued, “I hope he comes next time . . .” At some point, I asked, “Can you give me a sense of what’s going on for you? It sounds pretty upsetting, but I’m not sure what you’re feeling right now.” Hannah struggled with this. She revealed some “annoyance” but continued to try to move away; there was a good deal of back-and-forth movement in this regard. My comments appeared to be briefly considered, then dismissed: “I’m just hoping he comes next time.” When her movement away from anger was brought to her attention—“I’m not sure how you’re taking my wondering about feeling angry”—she began to put words to some fears, including her fear that her anger at her ex would leave her completely alone, and more profoundly her fear that she would fail her daughter. This crystallized her experience of paralysis.

Having patients put words to their immediate experience will have a regulating effect (as suggested by the research previously presented; see Barrett, 2017). In Hannah’s case, she was able to recognize and explore the relationship between her frustrations and fears. With such an expansion of awareness also comes an increased sense of responsibility—a greater awareness of how one constructs one’s experience. It is at the more molecular level that one can begin to develop a sense of the choices one is making; thus, for one to develop a greater sense of responsibility and agency, one must attend to the details of experience at successive moments of perception and begin to discover the choices one is making on a moment-by-moment basis. For

Hannah, she could begin to see how she would construct her paralysis by stifling her anger (how she was pursuing communion at the expense of agency), which she needed to experience in order to respond with more adaptive action to her ex's violations. Promoting this type of awareness de-automates habitual patterns and helps one experience oneself as an agent in the process of constructing reality rather than as a passive victim of circumstances, which has been argued from an existential point of view to be at the heart of neurotic experience (Basescu, 2009). (In reality, our personal responsibility lies somewhere between active and passive: We both shape and are shaped by our environment ongoingly.)

Self Relations (Between Subjects)

Different self states emerge in different relational contexts (see Muran, 2001a, 2001b). This perspective provides a way of viewing the intersection between interpersonal and intrapersonal realms in therapy in terms of the mutual influence of shifting self states in the patient and therapist. Accordingly, each individual experiences a perpetual cycling between different self states, which in turn evoke complementary self states in the other. As individuals cycle through various self states in an interpersonal encounter, they both influence and are influenced by the various self states of the other; there is continuous emotional communication and regulation, as demonstrated in the mother–infant mutual regulation literature (e.g., Beebe et al., 2016; Tronick, 2007). There are subtle movements and fluctuations in intimacy and varying degrees of relatedness. In the case of Hannah, the therapist often felt confused by her conflict-affect splits and frustrated when he tried to focus on her upset or anger. Much like mood naturally cycles, individuals cycle in degree of contact, approaching and avoiding an other. To some extent, this is dictated by individual pursuits of privacy and intimacy—or put another way, the previously cited needs for self-definition and relatedness.

Another way to understand internal states (and behavioral expressions) in relation to the external world is to consider how the reciprocal relationship in a dyadic interaction is based on the conception that a self schema shapes one's perception of the interpersonal world and leads to cognitive-affective and behavioral processes (e.g., cognitive distortions, security operations, defense mechanisms), which in turn shape the environment in a manner that confirms the schema; thus, a self-perpetuating cycle emerges. Interpersonal theorists have described versions of this perspective, including Edgar Levenson (2005), who suggested that an individual can exert a tremendous pull on another, thus “entrapping” and “transforming” the other. Paul Wachtel (1982) invoked “vicious circles” (Horney, 1950/1991), and Jeremy Safran (1998) referred to a “cognitive-interpersonal cycle” in this regard; Stephen Mitchell (1988) and Jay Greenberg (1995) described this self-perpetuating cycle in terms of a “relational or interactive matrix.” Donald Kiesler (1996) similarly suggested that the more restricted one's cognitive and interpersonal repertoire, the more redundant one's patterns of interaction with others, and the

more one operates as a closed system. This perspective (and various versions) provides some insight on personality disorder and its persistence.

The interaction of self states between individuals suggests the value of attending to the reciprocal changes of self states in the patient–therapist system during the course of therapy. As previously mentioned, the transitions between self states vary in seamlessness, often objectively marked by observable behavior but also subjectively marked, as Philip Bromberg (1998) noted—that is, these shifts can become apparent in the therapist’s experience by a corresponding shift in self state for the therapist. Thus, as certain authors have articulated (Bromberg, 1998; Mitchell, 1992), psychotherapy can be understood as figuring out who is speaking to whom in a given moment—which patient self is communicating to which therapist self (and vice versa). Stuart Pizer (1998) described this process as involving “intersubjective negotiation,” whereby patient and therapist ongoingly negotiate what to make of each other. Through dialogue between a patient’s dissociated self and a therapist’s self, a bridge can be built between that dissociated self and other selves within the patient’s self-system. With Hannah, the therapist was able to use his own experience (confusion or frustration) to build a bridge to her angry and fearful selves and to bring her struggle with agency and communion into relief.

Jessica Benjamin’s (1988, 1990, 1995) notion of intersubjectivity integrated several perspectives (Buber, 1923/1958; Dinnerstein, 1976; Habermas, 1971; Hegel, 1807/1969; Winnicott, 1965) and provided a comprehensive view of mutual recognition and regulation in the psychotherapeutic situation. One of the central themes in her work follows feminist criticism and challenges the traditional analytic view of the mother as an object to the infant’s drives and needs. Benjamin (1990) argued that the child must recognize the mother as a separate subject with her own experiential world, with her own intentions and desires, and that the capacity for such recognition is a developmental achievement. Accordingly, Benjamin (1990) suggested that the aim of the analytic inquiry is such that “where objects were, subjects must be” (p. 34). For her, the developmental achievement of subjective recognition is one that is inconsistently maintained, and the analytic situation must invariably involve a dialectic tension between relating to the other as an object and relating to the other as a subject; the process continually involves the recognition and negation of the other as a separate center of subjectivity (see Muran, 2001a, for a review of various considerations of intersubjectivity in the therapeutic encounter).

Prejudice and Power

The clarification of the patient’s self-definition invariably involves more clarification of the therapist’s self-definition as well. The idea behind this is essentially twofold: One, we are always embedded in an interpersonal field that exerts a great influence on the emergence of a self state we experience in a given moment (D. B. Stern, 1997; see also Heidegger, 1927/1962). Two, greater self-definition can be achieved only by defining the edges of one self

in relation to another self—in this case, the patient in relation to the therapist (Ehrenberg, 1992). In a Hegelian sense, I cannot know myself in isolation; I need another self in order to become aware of my own selfhood (Hegel, 1807/1969). The therapeutic relationship provides a laboratory of sorts in which the subjective and objective aspects of the patient's self can be more sharply or clearly defined in relation to the subjective and objective aspects of the therapist's self. Thus, the therapeutic aim to cultivate mindfulness in patients with respect to the details of their own experience involves therapists becoming mindful of corresponding details of their own experience. This suggests that with every therapeutic encounter, therapists must courageously confront themselves and expand their awareness of themselves in relation to yet another individual (E. Singer, 1965). The therapeutic process should, therefore, *involve change for both participants*.

In this regard, Hans-Georg Gadamer's (1960/1975) dialogic model of understanding seems useful. Gadamer argued that our perception of things is always constrained by our preconceptions or prejudices. We cannot understand anything without reference to them. These preconceptions can be understood as our self schemas, shaped by all our various personal, familial, and cultural experiences. They should not be understood as just limiting factors but rather the ground for all experience, without which new experience is meaningless. Here, one can include the "implicit bias" literature (see Banaji & Greenwald, 2013), according to which the mind is construed as a "difference-seeking machine" that helps one navigate and adapt to the complexities of human relations. Gadamer also suggested that awareness of our prejudices can emerge only (i.e., partially emerge) in dialogue with another, where there is a possibility for "a fusion of horizons"—a moment when a prejudice can be differentiated from its alternative. Thus, understanding becomes an event, not a thing, moving from a static phenomenon to an interactive or interpersonal one.

Defining differences between self and other—bringing respective prejudices into awareness—should be a fundamental task of psychotherapy, regardless of the gender or cultural match between patient and therapist. This should be a given because of the unique nature of the personalities involved in every therapeutic encounter. In cases of obvious mismatch—say, between a male and a female or between an Asian American and a European American—there is the advantage of immediately recognizing a difference (D. B. Stern, 1997). There is also the challenge of "mutual anxiety" because of the explicit difference (Perez Foster, Moskowitz, & Javier, 1996). However, it is important to bear in mind what we see, or think we see, can be at once revealing and concealing of difference. This concept was poignantly portrayed in Ralph Ellison's (1952) *Invisible Man*, which captured the experience of being both recognized to some extent and unrecognized to an even greater extent—an experience that can be applied to people of any race or color in a variety of ways. This is attributable not only to prejudice but also to the nature of attention, which is always a selective process of bringing some things to awareness and keeping other things out of view.

An important part of the negotiation process is the role of the power imbalance in the relationship between patient and therapist. Lewis Aron (1996) described this in terms of the asymmetrical versus mutual dimensions of the therapeutic relationship (see also Burke, 1992). Irwin Hoffman (1998) emphasized that the therapist's gestures toward mutuality, those that are spontaneous and personally responsive, must always be understood in the context of the therapist's assigned role of authority. Jessica Benjamin (1995) suggested that the process toward mutual recognition in psychotherapy is tempered by the patient's investment to not divest the therapist of their authority. The role of authority and power also has a variety of oft-cited implications for different cultural identities (including gender; see Pinderhughes, 1989). As noted by Michel Foucault (1972), it is important to recognize socially assigned conditions of power: When we define someone by some cultural category (and here, *culture* is used in the broadest sense to capture the various gender, sexual, religious, racial, and ethnic identities), we introduce a power inequality: male over female, straight over gay, White over Black, Gentile over Jew. According to Foucault, knowledge (as produced by language) is power to define others, thus power over others.

Gadamer (1960/1975) has been criticized for not fully addressing how inequalities in power can condition dialogue. Another critical theorist, Jürgen Habermas (1979), who wrote extensively on intersubjectivity and recognized the potential to reconcile differences and approximate truth through dialogic consensus, challenged Gadamer on this point. For Habermas, although dialogue does not require an egalitarian relationship, it does require some sort of symmetry and reciprocity. Otherwise, our responses in a given dialogue will be seriously distorted by the concern that what we say may be used against us by a more powerful other. So what does this mean for a therapeutic relationship in which, beyond a mutual dimension of two humans encountering each other, there are potentially *multiple* dimensions of asymmetry, including the power inequalities between therapist and patient, male and female, straight and gay, Gentile and Jew, and so on? Can Gadamer's dialogic model be realistically applied to a complex therapeutic encounter in which there are many power inequalities? Can a fusion of horizons or a meeting of minds ever be achieved in such encounters?

To answer these questions, we think it is important to distinguish between authority assigned by social conditions (as Foucault described) and power integral to the natural course of human relations. With regard to the latter, Jessica Benjamin (1995) invoked Hegel's master-slave dialectic to better understand the intersubjective process. Hegel described the self as requiring the other in order to become aware of its consciousness or existence. He also described an unavoidable conflict between the self's wish for absolute independence and the self's need for recognition by the other. Accordingly, a precarious tension exists, one that we at least initially try to resolve by mastering the other or by submitting to the other. Either position of extremes—master or slave—involves some form of negation, some form of objectification: The former involves objectifying the other and risks isolation; the latter involves

being objectified by the other and risks absolute dependency. There is an ongoing struggle to determine who defines the other and who accommodates whom. Ultimately, to recognize its subjectivity, a self must recognize another as a separate subject, and likewise the other must recognize the self as a separate subject. There must be mutual recognition. This is the realization of the intersubjective position.

Jessica Benjamin suggested that Donald Winnicott's (1965) thinking on object use can be considered a version of the Hegelian master–slave dialectic, whereby it is only through seeing the other survive one's destructive attempts (or attempts at negation) that one can see the other as a separate subject. Pizer (1998) developed this perspective further with his notion of intersubjective negotiation. For him, therapists in their interventions and patients in their responses are recurrently saying to each other, "No, you can't make this of me. But you can make that of me" (p. 218). Thus, there are ongoing power plays between patient and therapist: accommodations and refusals to accommodate, which convey to the patient that the world is negotiable and composed of others with separate subjectivities. Returning to Foucault's (1972) treatise, these power plays must also be understood as occurring in the context of therapists' already assigned authority. As Irwin Hoffman (1998) highlighted, the therapists' personal responsivity stands in dialectic relation to their assigned authority—that is, one can be understood only in the context of the other. For a therapist to admit a mistake, for example, is much different than for a patient to do so. These power plays are also modified by other assignments by social conditions—for example, shaped by the gender and sexuality, race and ethnicity, and other power imbued identities of my patient.

We have painted a complex picture of intersubjectivity and the prospect of achieving a meeting of the minds in the therapeutic relationship—of coming to a position where one recognizes another as a separate subject, and likewise feels recognized as such. All the possible power differentials represent potential pitfalls. For Hannah, her struggle to experience agency with communion was complicated by her status as a single working mom and had to be negotiated in the context of working with a male therapist in a more privileged position. How could she feel agentic in such a relationship? This complexity might evoke dread, but as Habermas (1979) has maintained, once there is conversation, there is hope. However complex our positioning, however distorted our communication, each expression holds some possibility of dialogue and further understanding. Moreover, the psychotherapeutic situation can encourage its participants, to the extent there is a shared recognition that the therapeutic relationship can be used as a laboratory of sorts to unpack these complexities and can provide the opportunity for greater awareness for both patient and therapist.

Discovery and Construction

Thus far we have suggested a process of change that emphasizes the discovery of self-experience and expansion of self-awareness in the context of the

therapeutic relationship. It is important to recognize, however, that the psychotherapeutic process in a paradoxical sense is not only discovery oriented but also constructive. As Stephen Mitchell (1993) described, self-experience does not simply flow forth without impediment but is channeled by the efforts of the individual to communicate and the other to understand—a basic premise of all intersubjective theories, including various formulations of interpersonal and mutual regulation (or coregulation). Thus, the course it takes is a moment-by-moment coconstruction. For example, the therapist's own experience—and articulation of that, which includes her theoretical orientation (Aron, 1999; Schafer, 1983; Spence, 1982)—has an enormous impact on the patient's experience and articulation. And of course, this is a bidirectional and iterative process.

In a sense, the psychotherapeutic process can be likened to the post-modernist method of deconstruction (Derrida, 1978). The term is a hybrid between destruction and construction and in effect represents an effort to construct by destructing. It suggests the paradoxical idea of tearing something apart while creating something new (Lovlie, 1992). The deconstruction of the self results in a rejection of a substantialized or essentialized conception of self at the center of the world—the death of the modern self—for a relational conception of self, the birth of a postmodern self that exists in intricate relation to others in the world.

For Hannah, it was important for her to see—to discover—her agency in creating her paralysis; the choice points in submitting to another. This had obvious relevance for her relationship with her ex, as well as others in her life. In addition, it had relevance in her relationship with me as her therapist. In response to my comments and questions, my constructive influence on our process, it was also important for her to experience her agency by not submitting to me with simple requests (“Can we reschedule?”) or corrections of my observations (“No, that’s not quite right”). Inviting her to explore these expressions continued the process of discovery and construction but also promoted difference.

The construction of something different provides the opportunity for new learning, the provision of a new interpersonal experience. This perspective converges in many ways with Franz Alexander's notion of a “corrective emotional experience” (see Alexander & French, 1946), as well as the Mount Zion Group's (Silberschatz, 2013; Weiss, Sampson, & the Mount Zion Psychotherapy Research Group, 1986) view that patients unconsciously submit their therapists to “transference tests” to see whether they will confirm a pathogenic belief. For example, a patient who believes that independence will be punished speaks about quitting therapy, with the hope that the therapist will not react in a controlling fashion. If the therapist passes the test by not confirming the belief, therapeutic progress takes place.

Interpersonal theorists (e.g., Kiesler, 1996; Safran, 1998; Wachtel, 1982) have described this process by indicating that the challenge for therapists is to resist being transformed or pulled by the patient's interpersonal repertoire, to “being caught in a vicious circle or cycle.” This concept is consistent with the

tradition that originated with Ferenczi (1932/1988), who was the first to suggest that psychotherapy involves the creation of a new or different experience. It should be understood, however, that this is an epiphenomenal change process—one that emerges spontaneously through the process of codiscovery and not one that is deliberately determined (as Alexander originally envisioned). Thus, change is conceptualized as *a process consisting of codiscovery and coconstruction*.

EMOTION: FROM RUPTURE TO REPAIR

Alliance ruptures indicate a breach in the communication process between patient and therapist (Safran & Muran, 1996, 2000, 2006). As introduced in Chapter 2 of this volume, at an explicit level, we defined them as failures to collaborate on the tasks (what are the activities in psychotherapy, including self-reflection, exposure exercises, and skills training) and disagreements about the goals (what are the objectives, including greater insight, symptom reduction, and new behavior), as well as deteriorations in the emotional bond (trust and affection) between patient and therapist. Here we invoke the interdependent dimensions of Bordin's (1979) transtheoretical reformulation. At an implicit level, we defined them as tensions or conflicts between the respective needs or desires of the patient and therapist—as breakdowns in *intersubjective negotiation* (Pizer, 1998). These tensions can be attributed to the dialectics of the need for agency and communion and of the power dynamics inherent in human relations and identity politics of positionality. Ruptures can be understood by the following relational formulations:

- Dissociative disconnections or self-splits: Here we refer to aspects of the self that are split off from awareness because of fear or dread of a painful self state, a form of *experiential avoidance* (S. C. Hayes et al., 1996) that results in *empathic failure* (Kohut, 1984) or feeling disconnected from the other (see Bromberg, 1998; Greenberg et al., 1995; Muran, 2001a, 2001b; Pizer, 1998).
- Affective misattunements, mismatches, or miscoordinations: These refer to literature on mother–infant communication. In empirical analyses, approximately 70% of the time mother and infant are not affectively attuned—not in matched or coordinated states—and approximately 70% of the non-matched states return to a match within 2 seconds—a repair. This research has also shown that repair predicts optimal development, including sense of self-efficacy and capacity to cope (see Beebe & Lachmann, 2002, 2015; Tronick, 2007).
- Interpersonal pulls, transformations, or role-responsiveness: Any individual's interpersonal behavior or pattern of behaviors exerts a pull on the response from another (E. A. Levenson, 1991, 2005; Sandler, 1976; Sullivan, 1953, 1964). The more extreme the behavior, the more extreme the response; the more restrictive the range of behaviors, the more redundant the pattern of interactions. A good deal of circumplex-based research

supports this formulation (see L. S. Benjamin, 1993; Constantino, 2000; Horowitz & Strack, 2010; Kiesler, 1996).

- **Matrical enactments or vicious circles:** Similar to the previous formulation, enactments refer to recurrent patient and therapist interactions, their unwitting participation in an interactive matrix comprising their respective emotional states, interpersonal behaviors, and underlying beliefs (Greenberg, 1995; Mitchell, 1988); they can also be described as *vicious circles* (Horney, 1950/1991) involving two individuals' states and behaviors that continuously reinforce themselves through feedback loops (see Wachtel, 2008).
- **Power plays, negations, or objectifications:** To become more aware of one's subjectivity or existence, one invariably engages with another in an ongoing struggle fraught with power plays (accommodations and refusals to accommodate)—objectifications of the other and recognitions of the other's subjectivity. Thus negation is normative in human relations, as well as in the therapeutic relationship (see J. Benjamin, 1995; Pizer, 1998). Identity politics of positionality, including the socially assigned authority of the therapist, are factors in these power plays (Muran, 2007b, 2007c). And *microaggressions* (assaults, insults, and invalidations) can be understood as expressions of these power dynamics or differentials (see Sue, 2010).

Ruptures are founded on self schemas (belief systems including procedural operations) that include motivations for self-definition and relatedness. They can be understood as a result of a *dialectical tension* between the pursuits of these motivations. According to our distinction between *withdrawal* and *confrontation* ruptures, withdrawal ruptures are movements away from self (dissociating an aspect of the self to appease the other) or other (avoiding or isolating the self from the other) that promote relatedness at the expense of self-definition. Confrontation ruptures are movements against other (self attacks or controls other) that promote self-definition at the expense of relatedness: They include implicit microaggressions (insults and invalidations) to more explicit attacks or assaults on the other's identity or ability; they also include attempts to coerce or manipulate the other as an object, forcing the other to conform to a role, such as a pseudofriend or even sexual object. Self schemas are shaped in relation to the world (familial, cultural, and social histories) and by the intersection of various identities (gender, sexual, race, ethnicity, and class, to name the most obvious). The interaction of patient and therapist along the axes of these identities, including their various implications for power positions and *dialectical tension* from objectification/subjectification (J. Benjamin, 1995), is integral to how agency and communion are negotiated in the therapeutic relationship—and thus alliance ruptures.

In Chapter 2, we identified withdrawal and confrontation markers by specific patient communications or behaviors—by various patient avoidant operations and aggressive maneuvers—including splits from or denials of emotional experience and complaints about the treatment process or progress. We defined ruptures in terms of what can be observed by the therapist—

markers in an *interpersonal sense*. This approach has resulted in a considerable amount of research demonstrating their prevalence and prediction of treatment failure (see Eubanks, Muran, & Safran, 2019; Muran, 2019, for reviews).

Such markers can also be identified by specific therapist communications or behaviors (also what can be observed; see Exhibit 3.1): For example, therapists can withdraw in silence from confusion or mind-wandering, shift a focus of discussion or pivot to another topic; they can engage in too much or abstract talk (including psychobabble); and they can be overly protective or accommodating. They can also confront patients by insulting, with put-downs or denials of a cultural identity, or by pathologizing them with a critical interpretation (about transference, a dysfunctional attitude or irrational belief) to explain their personality or lack of progress; and therapists can be coercive, forcing a patient to conform to a desire, expectation, or theory, including mismanaging the dimensions of mutuality and asymmetry—that is, emphasizing one at the expense of the other, being too friendly or too clinical. These therapist behaviors can also be used to mark ruptures and alliances at risk.

Ruptures can be marked by emotional experiences that indicate complications in communication. Although relatively less well operationally defined, this is an equally important marker of rupture as suggested by the emotion regulation and intersubjectivity literature reviewed so far. The specific aim of this book is to advance consideration of the therapist emotional responses as rupture markers in an *intrapersonal sense* (what can be felt): Here we have referred to the notion of *felt sense*—an internal awareness of “something” is experienced in the body that has not been consciously thought or

EXHIBIT 3.1

Rupture Markers as Therapist Interpersonal Markers

Withdrawal ruptures

- Movements *away* from other or self
- Efforts toward *isolation* or *appeasement*
- Pursuits of *communion* at the expense of *agency*

Examples

- Silences (confusion and mind-wandering)
- Shifts in topics or focus (avoidance)
- Too much or abstract talk (psychobabble)
- Overly protective or accommodating

Confrontation ruptures

- Movements *against* other
- Efforts towards *aggression* or *control*
- Pursuits of *agency* at the expense of *communion*

Examples

- Pathologizing patient (blaming and belittling)
 - Coercions to conform to a theory or due to empathic failure
 - Microaggressions against cultural identity
 - Coercions regarding mutuality versus asymmetry
-

verbalized (Gendlin, 1996). We have discussed how the therapeutic relationship should be considered a “laboratory” to explore and the therapist experience as a “compass” to navigate. We have developed a training model with empirical support (Eubanks, Muran, & Safran, 2015; Muran, Safran, & Eubanks-Carter, 2010; Muran, Safran, Eubanks, & Gorman, 2018; see also Chapters 5 and 6, this volume) that emphasizes developing therapist abilities to be more aware and effectively use their internal experience. Nevertheless, more definition regarding therapist emotional experience and regulation seems necessary to advance our understanding of ruptures.

Ruptures represent risk factors for treatment failure, whether measured as patient-report of low alliance and significant shifts or as observer-rated withdrawals or confrontations (Eubanks, Muran, & Safran, 2019; Muran, 2019). They also represent change opportunities: Rupture repair or resolution has been shown to be a change process predictive of overall treatment success (Eubanks, Muran, & Safran, 2019; Muran, 2019). How we understand rupture repair as a change process depends on the various definitions provided thus far. First, building upon Bordin’s (1979) formulation, repair can be understood as renegotiating agreement on the tasks and goals between patient and therapist: This process can provide a new relational experience in which the world is seen as more negotiable and others as potentially helpful and trustworthy though different in their own expectations and desires.

Rupture repair can also be understood as a way (a) to build bridges to dissociated selves (Bromberg, 1998; Pizer, 1998), (b) to reattune to the affective state of the other (Beebe & Lachmann, 2002, 2015; Tronick, 2007), (c) to resist interpersonal pulls or transformations (Kiesler, 1996; E. A. Levenson, 2005), (d) to disembed from interactional matrices or unhook from vicious circles (Greenberg, 1995; Wachtel, 2008), and (e) to bring the complex intersection of patient and therapist respective subjectivities and identities into relief (J. Benjamin, 1995; Muran, 2007b, 2007c)—to make the implicit more explicit. In this regard, rupture repair can provide a new relational experience by promoting the possibility of mutual recognition and by resolving various dialectical tensions concerning agency/communion and objectification/subjectification (Muran, 2019). Our research on rupture repair has provided some support for the realization of mutual recognition by demonstrating a movement to a more expressive position on the part of both patient and therapist (Muran, 2019; Muran et al., 2018; Safran & Muran, 1996). The research also suggests that emotion regulation is an important change process for the therapist as well as the patient.

CODA

How We Understand Emotion

Emotional experience can be understood as basic and complex, as personal and interpersonal. It can be understood as an emergent property of identity and motivation. For complexity, we presented its multicomponential nature

and its relationship to previous and cultural experiences and to other emotional states within the individual and between individuals: The latter relationship refers to how emotion is regulated and permits consideration of like-minded notions of multiple selves and intersubjectivity. We described emotions as self states that are reflections of self schemas comprising constructed gender and cultural identities or beliefs about self and other, including procedural information about the needs for agency and communion.

How We Understand Rupture

There is a dialectical tension inherent in the pursuit of the needs for agency and communion, which we argue is at the heart of ruptures (breaches in communication) between two individuals (especially with regard to patient and therapist interactions). We define ruptures as breakdowns in intersubjective negotiation, which can be understood in terms of identity and power differentials and described as dissociative disconnections or self splits, misattunements (mismatches or miscoordinations), interpersonal pulls or transformations, enactments or vicious circles, and power plays or negations. Rupture repair can be defined by these formulations and can involve bringing intersubjective negotiation into relief, promoting emotion regulation and mutual recognition.

How We Translate Knowledge to Practice

Practice is oriented toward defining the “details” and “particulars” of emotional experience (toward *granularity*). This requires focusing on both patient and therapist experience—self states—understanding that they emerge and exist in relation to other states in a person and to another person. This focus is understood as a process of discovery and construction and in the context of power differentials as patient and therapist both negotiate needs for agency and communion. Practice implications are furthered in the next chapter.