RUPTURE AND REPAIR in Psychotherapy

A CRITICAL PROCESS FOR CHANGE

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INTRODUCTION

Rupture in a Wicked and Wonderful World

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What is a cornerstone? The first stone set in a construction lays a foundation, joins intersecting elements, and serves as a reference for all other stones in a structure. In this introduction, we present a review of our own efforts to study and define rupture and repair from over the past 3 decades (see Muran & Eubanks, 2020, and Safran & Muran, 2000, for more detailed reviews)—with the ultimate aim of setting a cornerstone to this book project where we have invited other scholars with diverse therapeutic orientations to contribute their expertise to the architecture.

CONSIDERING CONTEXT

Human relations are inherently messy. Building off his "still-face" research on parent–infant interactions, Ed Tronick (2007) colorfully characterized human relations as comprising millions of moments of attunement and mis-attunement. By *attunement*, he meant the matching of verbal and nonverbal expressions (from vocal coordination to mutual gaze) that can occur in a

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1ST PAGES

16079-01_Intro,Ch01.indd 3 3/4/22 9:08 PM

dyadic interaction, "the specific recognition of the other's subjective reality" and "what is happening now between us" (p. 414)—what has been described as a *moment of meeting* (Sander, 2002). He demonstrated that misattunement is inevitable (occurring as much as 70% of the time) and that reattunement or repair is essential to growth and creativity. Out of multiple mismatches in human interactions, we can develop resilience in surviving and repairing them, increasing a sense of agency and hope that we can negotiate mismatches and the stress of a complex social environment. We can define difference in self and other. We can create new meanings of self and other, as Jerome Bruner (1990) would describe it, by engaging with the mess, by moving through mismatch and repair.

Despite all our efforts to systematize, to manualize method, and to train application, psychotherapy also remains messy. Therapist individual differences have been shown to be a prevailing predictive factor (Wampold & Imel, 2015). Since Donald Kiesler's (1966) seminal critique, pursuits to uniformize the therapist continue and remain as elusive. Irving Yalom (1980) famously described attending a cooking class in which he and his fellow students could never duplicate the taste of the instructor's dishes, no matter how carefully they followed the recipe. Then Yalom noticed that once the instructor finished a demonstration, she would give the dish to her assistant, who, in turn, threw in additional seasonings on the way to the oven. He referred to this as a dash of the real thing and suggested that is what therapists do. Patients also add their own realness to the psychotherapy process. Interpersonal theorists (e.g., Basescu, 1987; Ehrenberg, 1992; Hirsch, 2008; Levenson, 1972; Singer, 1965; D. B. Stern, 1997) have been describing for generations the idiosyncratic nature of the patient–therapist dyad and its various interactions and potentials.

Robin Hogarth (2001) made a useful distinction between "kind" and "wicked" learning environments when considering the challenges of decision making and performance. A *kind environment* is one in which patterns are predictable, like a chessboard with fixed rules and limited possible plays and outcomes. A *wicked environment* is unpredictable and ambiguous; in this environment, some information is hidden, feedback is inconsistent or nonexistent, and our experience is significantly shaped by heuristics and biases (see Kahneman, 2011, for some of these). It is best to think of such learning environments on a spectrum and psychotherapy toward the wicked end despite the various efforts to systematize or structure it. Psychotherapy remains embedded in a complex social environment. It still involves a good deal of messiness. Consistent with Tronick, a number of interpersonal and intersubjective theorists have described patient–therapist interactions as

1ST PAGES

16079-01_Intro,Ch01.indd 4 3/4/22 9:08 PM

invariably involving “a survival of collisions”—as a bumping up against a unique other (Havens, 2004, p. 58)—and “as power plays”—as continuous negations of the other (Benjamin, 1990, p. 43)—toward greater recognition of self and other and thus great intimacy.

RECOGNIZING RUPTURE

“Rupture” has become a marker for the messiness in the patient–therapist relationship or alliance. It has been described in numerous ways over the years: from breaches, breakdowns, challenges, derailments, deteriorations, dissociations, disturbances, disruptions, dysfluencies, failures, impasses, misalliances, misattunements, miscoordinations, misunderstandings, negations, pulls, resistances, splits, strains, and threats to weakenings. Rupture also has been associated to such concepts as enactments, negative process, projective identification, transference-countertransference, and vicious circles or cycles (see Muran, 2019, for a review). As a result, there is a good deal of latitude and too much confusion regarding what is meant by rupture.

We (J.C.M., C.F.E., and L.W.S.) originally based our definition of rupture on Ed Bordin’s (1979) transtheoretical reformulation of the alliance construct as comprising the interdependent dimensions of *purposeful collaboration*—agreement on the tasks and goals of treatment—and *affective bond*—mutual trust and respect—which laid the foundation for its consideration as an integrative variable or common factor (Wampold & Imel, 2015; Wolfe & Goldfried, 1988). Accordingly, *rupture* has been defined in general terms as

- any disagreement on how the patient and therapist work together (e.g., on tasks, such as exploring thoughts and feelings, creating in-session exercises and between-session experiments) and to what end (goals, such as greater self-awareness, skill development, or decrease in symptom distress); and
- a deterioration in the bond—that is, the extent to which there is distrust and disrespect between patient and therapist (see Safran & Muran, 2000, 2006).

We considered this an explicit account of alliance rupture.

We found that Bordin’s (1979) emphasis on the mutual and dynamic permitted an implicit account of the alliance as intersubjective—as involving an interaction of patient and therapist’s respective subjectivities (Muran & Eubanks, 2020; Safran & Muran, 2000). Thus, we also defined ruptures as breakdowns in how patients and therapists negotiate their respective needs or

1ST PAGES

16079-01_Intro,Ch01.indd 5 3/4/22 9:08 PM

desires. This is at the heart of the messiness. In this regard, we have invoked how individuals struggle to fulfill needs for agency or self-definition (to feel effective and worthwhile) and communion or relatedness (to feel connected to or recognized by another). There is an inherent dialectical tension that occurs in the pursuit of these two motivations. Relatedly, we have highlighted how human relations begin with *objectification*—putting others in categories according to implicit biases or heuristics based on past experiences and social constructions to negotiate ambiguity—before *subjectification*, which is seeing the other as having their own unique experience. Subjectification is integral to recognizing one's own subjectivity or experience—an understanding based on existential (e.g., Buber, 1958; Hegel, 1807/1979), developmental (e.g., Mahler, 1975; D. N. Stern, 1985), feminist, and analytic (e.g., Aron, 1996; Benjamin, 1990, Mitchell, 1993) observations. Ruptures invariably involve some form of objectification (experienced as negation by another).

More specifically, we have defined ruptures in terms of specific interpersonal behaviors. We have adopted the distinction between withdrawal and confrontation markers (Muran & Eubanks, 2020; Safran & Muran, 2000; Samstag et al., 2004). *Withdrawal markers* include *movements away* from another: movements toward isolation, like going silent or pivoting away with another topic or abstract talk. Withdrawals can also include move-ments away from some aspect of oneself in an effort to appease the other, like begrudgingly going along with another to avoid conflict. We understand withdrawals as efforts to preserve relatedness, to not risk severing ties with another, at the expense of self-definition (or sense of agency). As for *confron-tation markers*, we define these as *movements against* the other: movements involving aggression or control, like criticisms or manipulations. We have also described confrontations as efforts to promote self-definition (agency), ignor-ing one's impact on another, at the expense of relatedness (or communion). One can see these markers in either patient or therapist behavior.

Defining ruptures by such markers (whether expressed by patients or therapists) is useful for recognition purposes, but it remains important to appreciate that they emerge in a context, in the field of the therapeutic relationship. Ruptures are coconstructed. In addition to interpersonal markers, ruptures can also be defined in terms of *intrapersonal markers*, more specifi-cally, emotional states that indicate empathic failures, interpersonal pulls, enactments, and power plays. These experiences are especially important sources of information for therapists to attend to. We have suggested that therapists use their emotional (or internal) experience as a compass to indicate

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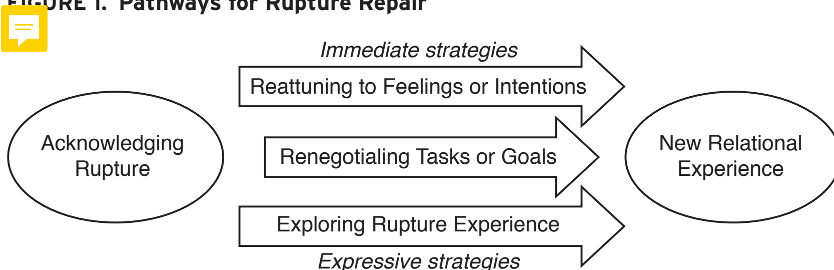
1ST PAGES

where they are in relation to their patient and that they have particularly considered such basic to self-conscious emotional experiences as anxiety, anger, despair, guilt, shame, competitiveness, boredom, and seduction to be meaningful markers (see Muran & Eubanks, 2020).

RESOLVING RUPTURE

Much has been written over the past 30 years about *rupture repair* or resolution as a critical change process (otherwise described as a change principle, mechanism, or event; Castonguay et al., 2019; Norcross & Lambert, 2019). We formulated a typology of rupture-repair strategies that we recently revised (Muran & Eubanks, 2020; Safran & Muran, 2000). This formulation was derived from our study of the clinical literature, both practical and empirical. In our revision, we defined three possible pathways (see Figure 1), each beginning with some acknowledgment (by the therapist or patient, or both, and either implicitly or explicitly) and ending with some provision of a new relational experience (or corrective experience; see Castonguay & Hill, 2012). It is important to recognize that these models are representational, and, in reality, the repair process is quite messy. We categorize the first two pathways as *immediate* strategies because they focus on immediately responding to the rupture and taking some sort of corrective action to get treatment back on track. The third and final pathway is what we have categorized as an *expressive* strategy because it involves the exploration of the rupture, including patient and therapist respective contributions (their emotional states and behavioral actions) toward a clearer expression and recognition of implicit needs. It is not uncommon for these pathways to intersect. Often efforts to reattune (Pathway 1) are present in efforts to renegotiate a task or goal (Pathway 2) and to explore a rupture experience

FIGURE 1. Pathways for Rupture Repair



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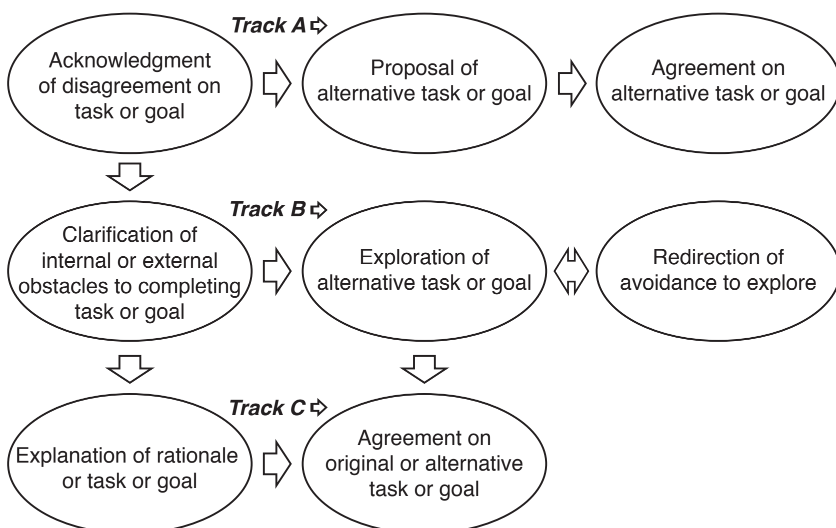
1ST PAGES

(Pathway 3). Sometimes efforts to renegotiate (Pathway 2) include some exploration (Pathway 3), and efforts to explore (Pathway 3) can result in renegotiation (Pathway 3).

The first pathway (Pathway 1) involves simple clarifications or validations of feelings or intentions—often two-turn exchanges that explain a position ("What I really meant by what I said . . ."), correct a misunderstanding ("Now I understand what you meant by . . ."), or support the truth value of an experience ("It makes sense for you to feel that way with me right now . . ."). These can be understood as responses that recognize a feeling, redress a misattunement, and thus result in reattunement. We have also described these efforts as *alliance-building strategies*, efforts that should go on in the building of any good alliance and that are especially consistent with what Tronick (2007) described in his dyadic systems model, including their relevance for developing a resilience for misunderstanding and optimism for (re)connection to another. They can challenge and correct beliefs and expectations that one person cannot be understood by another.

The second pathway (Pathway 2) involves the renegotiation of tasks or goals, any change in the work or in its direction. Following the task analytic paradigm (Greenberg, 2007), we recently developed a rational model for this pathway (with input from 12 cognitive behavior therapy [CBT] experts) that depicts three possible tracks (see Figure 2; Muran et al., 2021):

FIGURE 2. A Rational Model for Renegotiating a Task or Goal



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Each begins with some acknowledgment of disagreement on a task or goal. Track A involves the therapist's detecting a disagreement and establishing an agreement on an alternative. For example, the therapist picks up on the patient's reluctance to do an exposure exercise and, without discussion, makes an alteration to it that the patient more readily agrees to.

Track B involves the therapist's clarifying any internal (thoughts or feelings) or external (behavioral or circumstantial) obstacles for the patient in completing a task or goal and then exploring and establishing agreement on an alternative. For example, the therapist asks the patient what got in the way of completing a thought record; the patient, in turn, discloses that they don't see the point of it; the therapist then invites a collaboration to devise a self-monitoring task that makes more sense to the patient. In some instances, a patient might become anxious and avoid such an exploration (perhaps for fear of the therapist's frustration), and the therapist will have to recognize this avoidance and redirect the patient back to exploring an alternative.

Track C involves the therapist's moving from clarifying negative feelings to explaining the rationale for the work before establishing agreement on the original task or goal. For example, the therapist might have to provide a better explanation for the therapeutic value of keeping a thought record. As previously suggested, all these tracks can provide the patient with a new relational experience—of being acknowledged and accommodated by another, of being able to negotiate differences.

The third pathway (Pathway 3) in Figure 1, what we have categorized as "expressive," involves the exploration of the rupture, including patient and therapist respective contributions and their states (thoughts and feelings) as well as behavioral actions (disclosures and avoidances), toward a greater understanding of their implicit needs (for agency "to self-assert" or for communion "to be nurtured"). Here, the rupture marks an entry point: It serves as a window into the relational world of the patient (as well as the therapist). Our original research efforts (Safran & Muran, 1996; Safran et al., 1994) concentrated on the expressive pathway—on defining the various processes (patient–therapist interactions) and evaluating the validity of a rational-empirical stage-process model presented in Figure 3 that operationally defines the sequence of these processes.

Our stage-process model on expressive repair describes a process whereby the therapist invites the patient to collaborate on an exploration around a rupture marker that ultimately leads to the recognition of an underlying need. It requires both patient and therapist to step back from or out of an enactment (e.g., vicious circle) and treat it as an object of curiosity and

1ST PAGES

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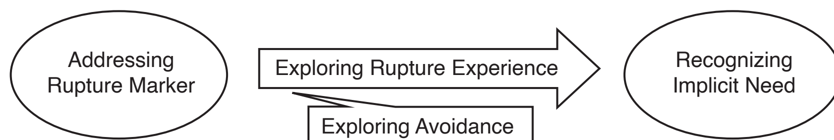
FIGURE 3. A Rational-Empirical Model for Expressive Repair



dialogue ("What's happening between us right now?"). The trajectory we see when exploring a withdrawal marker involves the mixed expression of negative sentiments (ambivalent feelings about the therapist or the therapy) toward a relatively clearer self-assertion by the patient ("I don't find this task helpful"). The trajectory when exploring a confrontation involves the expression of hurt or disappointment (with regard to the therapist) toward an expression of vulnerability by the patient ("It is painful to me when I see you as not listening"). Both these trajectories also often include an exploration of some avoidance by the patient (i.e., when a patient becomes anxious about some assertive or vulnerable expression or is afraid of the therapist rejecting in response to an assertion or vulnerable expression). Such avoidance can also be construed as further rupture and is quite common, contributing significantly to the messiness of repair. In addition, it is important to acknowledge that confrontation and withdrawal are often mixed, in which case the first steps to repair are to facilitate a clearer expression of the confrontation, a move to assertion similar to the trajectory in withdrawal repair. Thus, in reality, there can be great complexity in this stage-process model of expressive repair.

The technical principle that we have emphasized to guide the therapist in this repair is *metacommunication* (Kiesler, 1996; Safran & Muran, 2000), which simply is communicating about the communication process as it unfolds. It can begin with observations or questions about the patient's experience ("What's going on for you right now?"), the interpersonal field ("We seem to be in some game of cat-and-mouse"), or the therapist's experience ("I'm aware of feeling a little wary with you right now"). We have described metacommunication as a form of *mindfulness-in-interaction*—that is, bringing bare attention to patient and therapist states and actions in the here and now. And we have suggested its potential to regulate both patients and therapists' emotions (by putting words to experience) and to promote awareness of their own and the other's subjective experience. Metacommunication is a means to the end of realizing *mutual recognition* of patient and therapist respective subjectivities (thus overcoming the pitfalls of objectification) and

1ST PAGES

16079-01_Intro,Ch01.indd 10 3/4/22 9:08 PM

resolving the dialectical tension experienced by both patient and therapist as they each negotiate their respective needs for agency and communion (see Muran, 2019; Muran & Eubanks, 2020).

WANDERING WONDERING WE

Like ruptures, repairs are coconstructed. It takes two. It is important to recognize that neither patient nor therapist should take full responsibility for the rupture and its repair. For the therapist, this means understanding that there needs to be some cooperation, some sense of shared responsibility ("we-ness"), in the repair process on the part of both patient and therapist. We have identified fundamental attitudes to guide therapists in these expressive efforts to repair ruptures: Perhaps most fundamental are curiosity and humility (Muran & Eubanks, 2020).

By *curiosity*, we mean the phenomenological orientation of going "to the details" of experience (Gendlin, 1962) and of "courting surprise"—of asking "good questions" in which the answer comes as a surprise to both therapist and patient (D. B. Stern, 1997). Here, we are influenced by Jerome Bruner's (1990) notion of "effective surprise" as well as Ernst Schachtel's (1959) "allocentricity" and Shunryu Suzuki's (1973) "beginner's mind." And we suggest this approach to both self and other. In line with the interpersonal orientation (Ehrenberg, 1992; Havens, 2004; Levenson, 1991; D. B. Stern, 1997), we understand change as defining individual differences or idiosyncrasies between patient and therapist (see also Muran, 2007): Rupture marks such an opportunity.

By *humility*, we recognize the limitations of knowing, especially in the context of the "messy" and "wicked learning environment" of human relations. We recognize the pernicious use and effect of overconfidence and conviction noted by Daniel Kahneman (2011) and Adam Grant (2021) that we are prone to as we try to negotiate ambiguity. Here, we advocate for the need for the other toward greater understanding (also interpersonal in orientation; see authors cited earlier in this section). Our understanding of any interpersonal encounter is only partial at best, and it is through conversation with another that we can expand understanding, to know better who we are and what is going on between us: Repair affords such a possibility. Thus, we suggest an orientation to wonder about rupture as we wander about the very human exchanges in the therapeutic relationship, the messiness, the bumps and bruises from the incalculable collisions that we encounter over the course of a session and a treatment—and the messiness we invariably encounter in repair as we try to reattune, to renegotiate, and to explore.

1ST PAGES

RESEARCHING RUPTURE

Research on the alliance has resulted in several meta-analyses over the past 30 years, each of which has demonstrated its robust predictive relationship to treatment outcome (Flückiger et al., 2018, 2020; Horvath et al., 2011; Horvath & Symonds, 1991; Martin et al., 2000). Research on rupture has been described as a second generation of alliance study (Safran & Muran, 1996, 2000, 2006) and has proliferated over the past 20 years. It represents a movement to build on the research demonstrating the predictive value of the alliance and to provide more insight on how the alliance works, especially with regard to negative process. This research has resulted in multiple meta-analyses and reviews demonstrating the prevalence and prediction of rupture and repair (Eubanks et al., 2018; Safran et al., 2011; see also Muran, 2019). Much of this research has defined rupture and rupture repair by changes in patient postsession ratings of the alliance (what we have categorized as *indirect* assessments). These efforts have found ruptures in 25% to 68% of cases and repair (what are called *v-episodes*–based patient postsession alliance ratings) in 16% to 81% of cases, with a medium predictive relation to treatment outcome in both respects. Some have assessed rupture and repair with *direct* patient queries about "any tension or problem, misunderstanding or disagreement" and "problem resolution" (see Muran et al., 2009, p. 237) and found rupture in 37% to 42% of cases and a medium association of rupture and repair to outcome.

The promise of such research is to permit a finer grained analysis, to identify sessions with rupture and repair events with demonstrated relations to overall change, and to yield clinically useful data—that is, what to do when a rupture occurs. The modeling efforts described earlier and based on task analytic method (Greenberg, 2007) illustrate this promise. There are other task analyses (and other mixed-methods approaches) that have provided support for the models we presented earlier, specifically, the value of exploring a rupture (Agnew et al., 1994; Bennett et al., 2006; Cash et al., 2014; Daly et al., 2010; Swank & Wittenborn, 2013; see also Hill, 2010) and for changing an in-session task (Aspland et al., 2008). The development of various observer-based assessment tools, such as the Rupture Resolution Rating System (Eubanks et al., 2019) and the Collaborative Interactions Scale-Revised (Colli et al., 2019) has also facilitated more direct assessment of in-session processes regarding rupture and repair. Studies based on these tools have demonstrated even greater prevalence, indicating withdrawal markers in 100% of sessions and confrontation markers ranging from 43% to 91% of sessions, as well as predictive validity with a medium association found with regard to the relationship of confrontation to outcome.

1ST PAGES

The study of rupture repair has also led to the development of training protocols designed to facilitate therapists' abilities to negotiate negative process and improve treatment outcomes, with some empirical support (for a review, see Eubanks et al., 2018, and Muran, 2019). Our own protocol, called alliance-focused training (AFT; Eubanks-Carter et al., 2015; Muran & Eubanks, 2020; Muran et al., 2010), has been shown to improve interpersonal process, including variables associated with treatment outcome (Muran et al., 2018). AFT includes a didactic component that sensitizes therapists to rupture definitions, repair pathways and trajectories, fundamental attitudes, and metacommunication (video review and analysis are important to this component). AFT also includes an experiential component: the use of mindfulness meditation and awareness exercises, such as role play and two-chair work, to expand therapists' awareness of their own emotions in interaction and to facilitate their abilities to regulate their emotions, especially their anxieties (which can be particularly pernicious in making therapists avoid other critical states, such as anger and despair, that they may be feeling). AFT was very much influenced by the performance science literature that demonstrates the value of reflecting in action, having support from experts, practicing under pressure, and developing mental representations (Ericsson et al., 1993; Schon, 1984; Vygotsky, 1980; see Muran & Eubanks, 2020).

COURTING CONVERSATION

The conception of this book was born out of the second generation of alliance research—the proliferation of research on rupture repair and consideration of its importance as a change process across various theoretical orientations. We have been impressed by the plurality of perspectives, which suggests the integrative and transtheoretical appeal of rupture repair. In this book, we invited the following authors from diverse orientations to contribute to illustrate pluralism and integration. We asked them to present their perspectives and address the following questions: What is a rupture from the perspective of this approach? How do therapists and patients contribute to ruptures in this approach? What kinds of ruptures are most common and most challenging in this approach? How can therapists identify ruptures as they are occurring in session? What techniques or principles should therapists draw on to repair ruptures? How does a therapist judge whether a rupture is resolved? Are there specific considerations related to different patient and/or therapist characteristics and their impact on ruptures and/or rupture repairs? What research evidence is there to support this perspective

1ST PAGES

16079-01_Intro,Ch01.indd 13 3/4/22 9:08 PM

on ruptures and repair? Maybe most importantly, we asked them to concentrate on providing clinical illustrations or case examples (all appropriately anonymized) to bring respective considerations to life.

Here are brief abstracts of their contributions. Given that negotiating differences is central in navigating ruptures (see Muran, 2007), we thought it was important to begin with an explicit focus on the diverse identities of patients and therapists.

- Chang, Omidi, and Dunn address rupture with regard to therapist and patient differences regarding power, privilege, identity, and culture: Their **critical–cultural–relational** approach to rupture repair emphasizes therapist skills of what the authors call critical self-awareness, wise affect, and *antioppressive interpersonal engagement*, which refers to the capacity to empathize and explore the dynamics of oppression in the therapeutic relationship.

Here we clustered contributions regarding multiperson therapies—couple, family, and group:

- Tasca and Marmarosh consider rupture repair in **group psychotherapy**. They discuss the relationship of "alliance" to "group cohesion" (the connection members have to fellow members) and "group climate" (the overall experience of the group environment). They address the subject with regard to the complexity within the various group relationships, highlighting member-to-therapist, member-to-group, member-to-member, bystander, and coleader ruptures.

- Friedlander and Escudero address rupture and repair in **conjoint couple and family therapy**. They begin by distinguishing between individual versus couple/family alliance before describing various manifestations of ruptures in these alliances (including split alliances) and various interventions that can be applied to repair them (including efforts to enhance the experience of the therapist bond and of safety and attachment among the system's members).

- Cassell and Diamond consider therapist–adolescent ruptures in **attachment-based family therapy** (ABFT), specifically with regard to the adolescent's attachment style and state of mind. In ABFT, therapists aim to identify attachment ruptures and to improve the adolescent's ability to understand them and experience the primary emotions associated with them. With the inclusion of the parent(s), they facilitate "attachment conversations" to promote what is described as "narrative coherence" and "earned security."

1ST PAGES

Here, we clustered contributions regarding individual therapies from the following traditions: cognitive behavior (CBT, dialectical behavior therapy [DBT], acceptance and commitment therapy [ACT]), humanistic/experiential (emotion-focused therapy [EFT]), and psychoanalytic/psychodynamic (intensive short-term dynamic psychotherapy [ISTDP], mentalization-based therapy [MBT], and integrative relational):

- Impala, Okamoto, and Kazantzis examine the therapeutic relationship within **CBT**. They discuss key aspects of CBT, such as collaborative-empiricism and Socratic dialogue, based on which they define specific principles essential to establishing the working alliance and understanding ruptures and their repair in CBT. They also illustrate how case conceptualization can be used to detect and repair alliance ruptures.
- Boritz, Varma, Sonley, and McMain observe that interpersonal difficulties and emotion dysregulation often manifest as ruptures in **DBT** with borderline personality disorder. They bring a behavioral focus to ruptures by examining the function and context of specific ruptures and the various emotional processes that underlie them. They provide various DBT-informed repair strategies and also illustrate how a focus on rupture can enhance DBT case formulation.
- Walser and O'Connell examine ruptures from the perspective of **ACT**. They focus on how both therapist and patient psychological inflexibility and insensitivity to context contribute to ruptures and on how therapists' attention to their own experience and to the function of their own and the patient's behavior are essential for transforming a rupture into an opportunity to learn greater flexibility.
- Macdonald, Elliott, and Couto present an **EFT** approach to rupture, or what they describe as "alliance difficulties," outlining critical repair principles regarding therapist "readiness" (personal growth and emotional maturity, particularly the capacity for self-acceptance), and "relational dialogue" (an in-session task to resolve problematic emotions that they use to illustrate a stage-process model of rupture).
- Abbass and Town consider rupture repair within **ISTDP**, developed to address resistances in treatment that prevent the experience of feelings related to early attachment interruptions. The rupture process is understood as involving patient patterns of unconscious defenses and anxiety tolerance as well as requiring flexible application of techniques, including direct confrontation by the therapist.

1ST PAGES

16079-01_Intro,Ch01.indd 15 3/4/22 9:08 PM

- Fonagy, Campbell, and Luyten consider rupture repair in **MBT** with borderline personality disorder. They present a sociocommunicative approach that addresses the subject with regard to "mentalizing or reflective functioning" (the capacity to understand ourselves and others in terms of intentional mental states) to "epistemic trust" (the capacity to regard information conveyed to us as valid, relevant, and generalizable to other situations).
- Rudenstine, Wachtel, Schulder, and Bernstein present an **integrative relational** consideration of ruptures, repairs, and unfinished work that includes formulations from attachment, developmental, cultural, and behavioral theories and that invokes principles from control-mastery theory and contemporary relational psychoanalysis to address the significance of "learning in relationships"—from the therapeutic relationship to outside everyday relationships.

In our Conclusion, we synthesize what was presented in each chapter from a more intermediate level of abstraction, at the level of clinical principles (see Castonguay et al., 2019; Goldfried, 1980), to identify common principles (within the frames of rupture recognition and repair responsiveness) that are shared across the contributing chapters and that might provide practical guidance for therapists as they navigate alliance ruptures.[1]

We hope this book promotes greater conversation and further advances our understanding of rupture repair as a critical change process. As the philosopher Hans-Georg Gadamer (1975) colorfully conveyed, through open conversation among different perspectives, we hope to facilitate an enrichment of sorts—a more elaborated and nuanced understanding—here, of rupture and repair. We invite the reader to engage the text as such a conversation—and to build on what was constructed with this book.

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[1]A project with the same aim involving some of these authors was previously published in Eubanks et al. (2021). New material was required by these authors for their contributions to this expanded effort.

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