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CLINICAL CASE REPORT

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Alliance ruptures in cognitive-behavioral therapy: A cognitive conceptualization

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Abstract

The therapeutic relationship is crucial to the ethical and effective practice of any psychotherapy. In Cognitive Behavior Therapy (CBT) as formulated by Aaron T. Beck, the generic elements of the relationship including expressed empathy, expressions of positive regard, agreement on goals, and agreement on tasks within a therapeutic bond were considered a necessary condition for change. Alliance ruptures can therefore have a detrimental effect on therapy if left unrepaired. This article contributes to the *In-Session* issue on rupture repairs by outlining the role of the alliance as a component of the therapeutic relationship in CBT and illustrates how ruptures can be identified and effectively resolved through detailed case examples. Given the central importance of using collaborative empiricism and Socratic dialogue for the therapeutic relationship in CBT, we demonstrate the distinctive role of these elements in repairing ruptures.

KEYWORDS

alliance/therapeutic alliance, cognitive-behavioral therapy, collaboration, ruptures, therapeutic relationship

The formulation of Cognitive Behavior Therapy (CBT) that was originally termed "Cognitive Therapy," was based on the theory of psychopathology developed by Aaron T. Beck and first appeared as a practice guide in "*Cognitive therapy of depression*" by A. T. Beck et al. (1979). As part of its appeal, it included several necessary conditions for the delivery of short-term psychotherapy in less than 20 sessions (Bruijniks et al., 2020): structured sessions, specific techniques to facilitate treatment processes (Kazantzis et al., 2018), and regular between-session (homework) assignments (Kazantzis et al., 2010). CBT gained support in randomized controlled trials of depressive relapse (Cuijpers et al., 2013). Chapter 3 in Beck et al. (1979) was devoted to an explanation of the therapeutic relationship in cognitive therapy and included a statement that the therapeutic relationship was a "*necessary, but*

not sufficient condition for change (p. 45)." The statement was bold and lead to therapeutic relationship being mischaracterized as not central in CBT (Kazantzis, 2018). It is perhaps understandable that the therapeutic relationship has been viewed as a secondary condition in CBT. Early clinical guides from the 1970s emphasized "rational disputation" and "challenging" cognitions and fostered the impression that therapists should be 100% logical beings that are stoic and devoid of the rich tapestry of human emotion (Weinrach et al., 2006). Given that many patients' *sense of self* is intertwined with their moment-to-moment thoughts, assumptions, and core beliefs, the terminology of "challenging thoughts" can be easily interpreted as meaning that part of the patient is being challenged. In the decades that followed, clinician guides on the practice of CBT would spend countless pages identifying "misconceptions of CBT" and go into some detail about the importance of the relationship.

Those fortunate enough to have watched Aaron T. Beck conduct therapy witnessed a warm, empathic, collaborative, and often times good-humored man engage with his patients. When delivered skillfully, CBT rests upon a deep empathic understanding of the patient. Indeed, a large proportion of the items in the Cognitive Therapy Rating Scale, an observational measure to be used in clinician training and supervision included in the appendix to Beck et al. (1979), center on "empathic understanding," "interpersonal effectiveness," "collaboration," and "feedback." In particular, expressed empathy, mutually agreed-upon goals, and work towards those goals are essential elements of the therapeutic relationship in CBT (Bordin, 1979). Following the same path, the subsequent clinical practice guides that espouse the Beckian approach positioned the therapeutic relationship as central (Beck, 2020) and specific clinical practice guides have been published on using the case formulation to anticipate, address, and incorporate strains in the working relationship (Kazantzis et al., 2017).

The therapeutic relationship in CBT both incorporates the general concept of the alliance and specific relationship-based elements that carry an essential role through each session. The below clinical guidelines will rely on the principles of the Beckian cognitive model and modern conception of its change processes (Kazantzis et al., 2018; Mennin et al., 2013) as an integrative therapy that can incorporate techniques from a broad spectrum of evidence-based therapies (Petrik et al., 2013). Central is the concept of collaboration, which in the context of CBT is more than an agreement on the goals and tasks intended to achieve those goals; it reflects active shared work (Tee & Kazantzis, 2011) and has some departures from the concept of collaboration in psychoanalytic modalities that center on unconscious processes within the patient and relationship (e.g., Berdondini et al., 2012; Wiseman et al., 2012).

In CBT, specific techniques are both facilitated by collaboration and delivered via the therapeutic relationship. Consider the case of "Jessica," a 40-year-old single woman who had made significant initial progress with identifying and monitoring emotions, keeping a mood log, and scheduling activities to increase exercise, enjoyment, and accomplishment:

Jessica: It's strange, I'm feeling blocked when trying to change up the activities to improve my mood. I just don't understand why. I realize all these things are actually good for me, and they're things I've identified as important for myself, like spending more time knitting, going for short walks, enjoying a coffee in the sun outside… but when I come to do them I feel blocked.

Therapist: That sounds important. You've really clearly described the feeling; it's as though there's part of your mind, perhaps the thinking part, that knows there's value to these things, but there's a feeling blocking you.

Jessica: Exactly.

Therapist: Well, I wonder if that's important for our session today? Do you think we could prioritize that for discussion, to see if we can find out some more about the block that you feel, without judging, or necessarily trying to change things – because it's very likely that the feeling you describe is telling you something.

Jessica: It's really useful that you said that. I do feel conflicted and it seems that there's a bigger picture here.

Therapist: Yes, and sometimes with exploration we can bring into conscious awareness the concepts that make up a feeling, so that we can acknowledge it, define it, and then consider what are the useful and less useful parts of that.

In the above example, the therapist sought to work with Jessica to identify the pros and cons of her scheduling pleasurable and self-soothing activities. By engaging Jessica in a collaborative discussion and shared decision making regarding her feelings on the agenda, the therapist chose not to address the process as "resistance," which in CBT is conceptualized as the therapist forming a distinct assumption about the patient's behavior (see Leahy, 2001), and instead operated from a position of curiosity and openness to what would be discovered.

The evidence for the alliance in CBT is as clear as it is for any other psychotherapy, reflected in the correlation between the alliance and symptom reduction (Flückiger et al., 2018; Zilcha-Mano et al., 2018). The resolution process itself may present psychological benefits in the context of the therapeutic relationship and symptom levels (Eubanks-Carter et al., 2012; Safran & Muran, 2000). Our team has posited a hierarchical model describing the nested nature of treatment and relational processes (Kazantzis, 2018) as part of an outline of opportunities for enhancing the psychotherapy process research in this area (Huibers et al., in press).

Ruptures in the therapeutic alliance can be defined as minor or major breakdowns of the collaborative relationship between patient and therapist (Safran et al., 2011). Safran and Muran (2000) distinguish between confrontation and withdrawal ruptures, with the notion that they are not mutually exclusive. Confrontation ruptures involve the patient directly expressing dissatisfaction with the therapist or aspects of therapy whereas, in withdrawal ruptures, the patient completely or partially disengages from therapy. Withdrawal ruptures may lead to inferior recovery and lack of treatment benefit (Boritz et al., 2018), but unresolved confrontation ruptures are more likely to result in premature termination, preceded by increased confrontation and withdrawal scores immediately before dropout from CBT (Coutinho et al., 2014).

Conversely, the resolution process of ruptures can harness the therapeutic potential of interaction between patient and therapist. There is growing evidence that patient and therapist dyads with unrepaired alliance ruptures have poor treatment outcomes, and those with repaired ruptures have enhanced outcomes (Haugen et al., 2017, see also Zilcha-Mano et al., 2019).

During ruptures, the patient's beliefs about self and others are being activated and warrant exploration (Safran & Muran, 2000). The general principles of responding to ruptures in CBT are not intuitively different from what therapists from other theoretical backgrounds would do, including nondefensive and collaborative exploration of the rupture, and validating and empowering the patient in the process (Aspland et al., 2008). However, the specific elements of a CBT relationship have not been operationalized or measured or have been mischaracterized in process-outcome studies to date (Kazantzis, 2018; Huibers et al., in press). For example, the evidence for homework adherence-outcome relations has been presented as evidence for collaboration-outcome relations (see review in Kazantzis et al., 2015).

The following strategies delineate recommendations for addressing a rupture from the CBT perspective. They are not necessarily sequential and may partially overlap. For example, validation (Strategy 2) and self-reflection (Strategy 8) may be used throughout the different stages of the resolution process and seeking/integrating patient feedback (Strategy 7) can be construed as validation (Strategy 2).

1 | RUPTURE REPAIR PRINCIPLES IN CBT

1.1 | Identifying and acknowledging the rupture

While seemingly a straightforward step, identifying and acknowledging a rupture may pose a challenge to clinicians. As noted, ruptures do not always manifest as a major breakdown but include minor tensions and withdrawals from collaboration. Given that in the CBT context, the alliance refers to the overt agreement on goals and tasks in the context of a therapeutic bond, the problems can start with the therapist and patient failing to secure an agreement on the goals of therapy. The patient and therapist may drift apart from the very beginning without consciously attending to this departure. Additionally, the clinician may not always be aware of

how the patient perceives the therapist's words or actions. For these and many other reasons, the therapist may not always recognize that a rupture has occurred. This in itself may constitute a problem, as the congruence between the patient's and therapist's rupture reports appears to be related to alliance quality and symptom improvement. For example, one study found that while mutually perceived ruptures in outpatient CBT were correlated with higher symptom distress levels the next session, they were less likely to negatively impact alliance quality than ruptures that were only identified by either patient or therapist (N = 1210 patients in Rubel et al., 2018). In another study, therapists who received training sensitizing them to the alliance issues were more alert to recognizing ruptures (N = 162 therapist-patient dyads in Zilcha-Mano et al., 2020). If these data can be meaningfully generalized beyond the research context, it could be suggested that seeking the patient's feedback on alliance can function both as a step for identifying ruptures as well as a tool for preventing ruptures in the first place.

In the case of major ruptures, the experience itself is likely to activate belief systems for both patient and therapist. For example, the therapist may have their own core beliefs activated, and as a result, may avoid the repair process as preliminarily demonstrated in the study that focused on CBT ruptures with depressed patients (N = 4 therapists; N = 117 patients in Aspland et al., 2008). However, addressing ruptures is a skill and as such, can be developed. There is evidence that training therapists in resolving resolution leads to better patient outcomes (see meta-analysis in Eubanks et al., 2018). If the therapist suspects a rupture or observes patient responses that could have various underlying reasons including withdrawal ruptures (e.g., repeatedly rescheduling the session), the best course of action would be to address it in the session. The therapist can start the process by providing his or her reflection of the patient's withdrawal or confrontation and inquiring what is happening from the patient's perspective, thus paving the way forward for shared decision-making and re-establishing the alliance via mutual agreement on how to proceed.

1.2 | Validating the patient's experience

Emotion-focused and perspective-taking empathy as a validation strategy is expected in any CBT session. Although validation is a general strategy rather than specific to CBT, it is an important one to focus on throughout the rupture repair to support collaboration. While used within different variants of CBT (Kazantzis et al., 2009), validation is especially emphasized in DBT as both a therapeutic strategy and the foundation for addressing ruptures (Linehan, 1997).

The rupture may activate the patient's dysfunctional beliefs about other people and the world, subsequently precipitating frustration, irritation, and annoyance. If a therapist asks the patient about their experience and starts the next sentence with “Yes, but…,” it may signal their dismissal of the patient's perspective. A minimal level of validation consists simply of staying attentive to the patient, not changing the topic, and using active listening to communicate accurate understanding (Linehan, 1997). Patients, for their part, may also initially respond with less helpful behaviors such as avoidance or blaming, and therapists may feel tempted to discard the topic. However, these behaviors can be conceptualized as an attempt to cope with the activated belief system and associated emotions, and should not be treated as a basis for abandoning the rupture repair.

1.3 | Exploring the circumstances that led to the rupture in collaboration with the patient

In CBT, collaboration refers to teamwork supporting active patient participation (Beck, 1995). Collaboration is a component of the therapeutic relationship, operationalized through distinct therapist behaviors occurring throughout the session: solicitation of patient input, responsiveness to that input, shared decision making, and

solicitation of patient feedback (Kazantzis et al., 2017). In the context of building a foundation for rupture resolution, this means that the therapist seeks to actively understand the patient's perspective of what happened before engaging the patient in decision-making on how to proceed (see the following steps). Sometimes therapists may find themselves reacting based on their own relational history that shaped their belief system, rather than responding to the rupture (Haarhoff & Kazantzis, 2007). A common way to inhibit emotions and distance oneself is through a defensive explanation of their strategy. For example, a therapist's unrelenting standards may lead them to overexplain or justify their own interpretation of events, and inadvertently miss the patient's issues. While it is important to develop an understanding of how the thoughts, feelings, and behaviors during the rupture relate to the patient's history and inform case conceptualization as well treatment goals, this should entail a collaborative inquiry that includes the therapist soliciting feedback about their own behaviors and openly acknowledging their part in the rupture.

1.4 | Sharing decision-making on how to proceed with the resolution process

After the therapist has solicited input regarding the patient's perspective and they have reached a shared understanding, or at least mutual recognition of rupture-related moments, the next step is to proceed with collaborative decision-making on how to move forward. The role of the therapist is facilitating collaborative resolution process. The therapist should not assume that they know what is best for the patient. While the therapist may have some ideas, collaborative decision-making supports the patient's agency, and implicitly communicates both the therapist's responsiveness and the empowerment of the patient. Additionally, even the most seasoned therapists may not always correctly evaluate the patient's tolerance level and psychological needs, given the complexity of two intersecting personal histories of conflict resolution within the therapist-patient dyad. Moreover, being asked to contribute and share in decision making is, particularly for patients with pervasive relational difficulties, likely to activate negative core beliefs about others, the world, the future, and also activate the patients' assumptions about how to cope (e.g., adopt a suspicious, oppositional, or accommodating response to the therapist's contributions). The therapist may simply ask the patient how they should proceed, and offer a few options if the patient has difficulties articulating desired courses of action.

1.5 | Incorporating the patient's direct experience in the rupture resolution process and evaluating its effectiveness

CBT relies on drawing information from the patient's concrete experience rather than logic or general principles. Instead of considering what other people would feel in the same situation, we want to know what thoughts and feelings the patient experienced, and how beneficial the interventions were in alleviating emotional distress. In focusing on the patient's direct experience, the therapist uses empirical data, as opposed to giving the patient opinions, interpretations, or recommendations. This allows a demonstration of the assumption of the cognitive model—that perception creates reality—while also presenting the patient opportunities to advance progress towards therapy goals.

During the process of rupture repair, the therapist can ask the patient about thoughts about him/herself or the therapist that come up and assist the patient in testing them or looking for evidence in support of or against the thoughts. In this way, the repair of a rupture could be used as an in-session experiment in CBT, where the patient's belief rating before and after the exercise can be the gauge for determining the success of the rupture repair process. For example, evaluating the evidence for and against an interpretation that the therapist "missed some of what I said and therefore does not care about me" could introduce flexibility in the patient's beliefs about others and the world.

While therapists may feel wary about putting themselves into the spotlight and/or somehow triggering the patient, it may be helpful to remember that the rupture itself has already occurred and bringing it out in the open gives the patient permission to process these experiences. In one study, there was evidence to suggest that therapist attempts to openly address the issue and resolve the rupture were more strongly associated with symptom reduction, as compared to instances where therapists avoid confrontation and do not attempt resolution (multiple samples *ns* = 12 to 77 patients; *N* = 24 therapists in Moeseneder et al., 2019). Particularly with patients who frequently experience ruptures, the thoughts and feelings activated by the process can become so salient in therapy that it impedes therapeutic work. Therapists can inquire about the chain of events that led up to certain behaviors as well as their consequences, especially given that some consequences such as attention or expressions of concern can help maintain the behaviors over time.

1.6 | Using socratic questions to explore the situation, shift perspectives, or synthesize different viewpoints

Socratic questions are sequential, discovery-oriented questions that either assist the patient to explore the situation and his/her feelings, consider alternative viewpoints, or synthesize different perspectives. Socratic questions, and the broader array of communication strategies known as Socratic dialogue (Kazantzis et al., 2017), represent the therapist's facilitation of cognitive reappraisal (i.e., a discovery) via the therapeutic relationship (Kazantzis & Stuckey, 2018).

The therapist could start by inquiring about what happened during the rupture from the patient's perspective, what thoughts and emotions came up for the patient, and what may be some of the reasons why the patient believes the rupture occurred. To explore alternative viewpoints, the therapist could ask if there are any other explanations to what happened or ask how a patient's best friend or role model would look at the situation. To help the patient synthesize different perspectives, the therapist could invite the patient to find common ground between different viewpoints or inquire about what the patient sees in the big picture.

1.7 | Inviting feedback from the patient and exercising responsiveness to it

Throughout the various stages of the rupture resolution process, the therapist is encouraged to solicit feedback from the patient regarding how the process is going and how the patient perceives the impact and helpfulness of the interventions used by the therapist. The therapist should make an explicit effort to apply the feedback to guide and improve the resolution process.

1.8 | Engaging in self-reflection, self-practice, and mindfulness

Given that therapist characteristics are likely to impact treatment efficacy and patient retention, therapists are encouraged to engage in self-reflection—by identifying their beliefs and biases, reappraising their belief systems, and experimenting with behaviors that facilitate change in beliefs (Bennett-Levy et al., 2004; Presley et al., 2017). Therapists need to consider the role that their personal and cultural characteristics play in the therapeutic relationship with their patients to be able to respond appropriately when ruptures occur (Kazantzis et al., 2017). If the therapist wishes to practice awareness and nonjudgmental acceptance of the present moment, therapists can utilize various mindfulness practices as “reflection-in-action” skills to navigate relational challenges, including but not limited to the body scan, insight dialogue, sitting meditation, mindful movement, breathing space, and others (McDonald & Muran, 2020).

The following case illustration presents an example of a withdrawal rupture in therapy and illustrates strategies that the therapist employed to resolve the rupture.

2 | CASE ILLUSTRATION

2.1 | Presenting problem and patient description

Bibi is a 53-year-old female who sought treatment for depression, generalized anxiety, and alcohol addiction. She identifies as Black American of mixed ethnic background (Scandinavian and African heritage). Bibi's parents moved from Europe to the East Coast just before Bibi started elementary school, and went through what Bibi describes "as an ugly divorce." Her father "checked out as a parent" and Bibi stayed with her mother, who became depressed and started hoarding things. Bibi was often left in charge of her three younger siblings. Bibi never felt like she belonged at her predominantly white school. She got along with her classmates but did not have any close friends. Bibi started drinking at age 16, as it gave her a sense of relaxation and social ease. She engaged in romantic relationships but ended them "before things got serious." She did well in her career but described herself as a functional alcoholic. At the age of 50, Bibi was laid off from the company she had worked at for 15 years. She developed depressive and anxiety symptoms and had difficulties securing new employment. She often perfected to-do lists and focused on her immediate surroundings as a way of avoiding the job search. At 52, she sought therapy due to increased hopelessness and her alcohol use, which she felt was spiraling out of control. She became homeless and spent months sleeping on trains and in shelters. Bibi went through several hospitalizations and police incidents related to erratic behavior while intoxicated but attributed them to racism, prejudice, and bad luck. With help from shelters and the treatment team, Bibi was able to secure low-income housing. Bibi states that all the other tenants at her apartment building—who are mostly Black—view her as "stuck up" due to her lighter skin tone so she mainly keeps to herself. Bibi has continued to make progress with reducing anxiety, depressive symptoms, avoidant behaviors, and alcohol use.

2.2 | Case formulation

From her family relationships, Bibi learned that she could not count on anyone else other than herself and that she may not be able to control what happens in relationships. She isolated herself to minimize the risk of being hurt by other people. Belonging to a racial/ethnic minority status and her socialization at a white school contributed to her sense of not belonging and always expecting the worst to happen. Taking care of her siblings taught her that relationships are about giving and not receiving. She used alcohol as her companion and reward.

Throughout her life, her career responsibilities provided her with a sense of competence and purpose. Losing her job and failing at various job interviews precipitated strong anxiety and then depressive symptoms. These symptoms were exacerbated by perimenopausal changes and increased alcohol use. Bibi felt easily fatigued, developed a sense of worry and apprehension about the future, and often did not get out of bed until late afternoon; even regular chores such as going to a grocery store or opening mail filled her with anxiety. She motivated herself to do things by starting drinking in the morning. While intoxicated, she got into yelling matches with strangers and a few times, passed out on the street. Her encounters with the police and being hospitalized underlined the feeling of powerlessness and prompted anger at prejudicial treatment (e.g., "They would not have taken me to the hospital if I was a white woman"). Homelessness and sleeping on trains increased her hypervigilance about the potential danger and her expectations that something bad will happen.

Even after obtaining housing, Bibi felt reluctant to leave home as she overestimated the level of threat and expected things to go wrong. She felt that her resources were not enough to cope with situations she might

encounter and preferred to avoid any negative emotions. For example, she avoided her neighbors "not to get involved in drama." She considered visiting one of her sisters but found several reasons to postpone the trip. The perception of the world as dangerous was maintained through Bibi's avoidance strategies, as she believed that the efforts to keep herself safe were paying off. She had frequent automatic thoughts:

- "Something bad will happen."
- "I can't trust anyone."
- "It's too much for me right now—I can't handle it."

Her emotional response varied between anxiety, anger, and sadness, and her behavioral response was avoidance and distraction—for example, organizing or rewriting her to-do list.

2.3 | Course of treatment

Bibi's treatment plan included weekly field-based therapy and case management meetings, as well as 24/7 crisis phone support available in that program. Bibi made considerable progress in treatment and formed a bond with the treatment team. Her therapist was a Caucasian female who was 5 years younger than Bibi, that sparked discussions on how cultural issues and racism impacted Bibi's mental health issues and the therapeutic relationship. Bibi was conscientious about her appointments but had to reschedule a few times due to drinking. In therapy, she responded well to emotional exposures to various negative emotions, cognitive restructuring, behavioral activation, and learning mindfulness skills to stay in the present moment instead of worrying about the future. Bibi enrolled in a college to get a degree in finance and cut her alcohol use to a few days per week. She frequently expressed gratitude to treatment team members and stated that she trusted them. However, she generally tended to avoid confrontation and not share when something upset her. This *status quo* was challenged by a rupture between Bibi and the therapist.

2.4 | Key moments of rupture and repair

A day before her scheduled session, Bibi calls her therapist, crying inconsolably.

Therapist: Bibi, what's wrong?

Bibi: I don't know that I can even explain. Everything's wrong.

Therapist: Are you safe? Where are you?

Bibi: Yes (sobbing). No… I don't know. I'm at home.

Therapist: You seem upset. What happened?

Bibi: It's about the building manager.

Therapist: Did he do or say anything to you?

Bibi: We haven't talked. It's been going on the whole week. Just the way he looks at me; I know he doesn't like me. He's an angry person. I just feel very unsafe.

Therapist: What do you worry might happen?

Bibi: I don't know (cries).

The conversation goes on for a while. Bibi appears agitated and tearful but has trouble identifying exactly what she is afraid of. The therapist suspects that Bibi has been drinking and feels annoyed by having to talk to Bibi while she is intoxicated.

Therapist: Okay, Bibi. I want to support you but I am a little confused here.

Bibi: I know, it's confusing for me, too. It's very hard to explain.

Therapist (trying to set aside feeling annoyed): Have you been drinking today?

Bibi: (stops crying, voice changes to low tone) You KNOW I have.

Therapist: I didn't mean to offend you. I'm just asking to understand what state you are in. Have you eaten or drunk any water today?

Bibi: No.

Therapist: Did you get enough sleep?

Bibi: I couldn't sleep last night.

The therapist asks a few more questions but Bibi's answers are terse.

Therapist: Okay Bibi. I understand you feel rather upset and exhausted. How about you eat something and try to rest? We could still talk later or tomorrow at the scheduled time.

Bibi: Sure.

However, the next day, Bibi texts her therapist: "I think it's best we reschedule." She does not answer the therapist's phone call. In response to a text message, she states that she is "okay" and will contact the therapist in a day or two. She does not. Two days later the therapist calls Bibi again. Bibi is hesitant to meet but she agrees to talk over the phone.

Therapist: How have you been doing these past days?

Bibi: I'm fine.

Therapist: Are you upset with me?

Bibi does not respond.

Therapist: My sense is that you are, and it could be helpful to talk about it. What would *you* like to do?

Bibi: Yes, I think we should talk.

Therapist: Was it invalidating when I asked about your alcohol use?

Bibi: Yes! Extremely. You made it all about alcohol. I could hear it in your voice. You don't know what it's like for me to live in that building. I am different; they treat me differently because of my light skin tone. I'm constantly worried that the manager or one of my neighbors will want to talk to me in the hallway and get me involved in their drama. Having to live with that fear, it just makes me so angry. It's my home; it should be my castle. I'm not worried about myself, I'm worried that when they come at me, I can't control myself. If someone calls the police, I'm scared I can't protect myself or explain myself, and I'll end up helpless in a hospital again. It's not about me drinking.

Therapist: Right. First of all, thank you for sharing that. I could sense that asking about drinking really did not sit well with you.

Bibi: Yes. Because what happened has nothing to do with drinking. It has everything to do with the powerlessness that I experience every single day. I'm SO tired of it.

Therapist: I can see it. You are tired of not feeling in control. You don't feel safe at your home, which should be your safe harbor. You're concerned that if things escalate, you will have no say about what happens to you. And while you were trying to tell me all that, I asked you about the drinking and it felt like I was dismissing all the real problems.

Bibi: Yes. That's exactly how I felt.

Therapist: Why do you think I asked about the alcohol?

Bibi: You probably thought I was that upset'cause I'd been drinking.

Therapist: You're partly right. I could not make sense of everything you were saying, and I thought that perhaps the alcohol contributed to how you were feeling. But I did not think that you were upset only because you were drinking. I trusted you had other reasons; it's just that I struggled to understand the big picture. I find it hard to have meaningful conversations with you when you are drinking. That's why I've asked you to reschedule the therapy sessions if you drink.

Bibi: But I didn't call for a therapy session. I just needed to talk to someone, and I didn't know who else to call.

Therapist: So you just wanted some support and hoped I would hear you out.

Bibi: Yes.

While Bibi slowly warms up during the session, the therapist finds doing a lot of rationalizing and explaining instead of soliciting Bibi's feedback and asking open questions about the patient's experience. They end the conversation and agree to continue the next day. After some self-reflection and consulting with a colleague, the therapist realizes that she was judging Bibi's alcohol use and has been trying to suppress and minimize her resentment due to her belief that a skilled therapist should not get angry at their patients. After reappraising her beliefs, she decides that her response was human and she can use it for modeling emotional disclosure, given the patient's history of difficulties expressing anger. She wonders how their interactions during the rupture fit into Bibi's case conceptualization, given her developmental history of not being comforted by adults.

Therapist: So Bibi, I am realizing that when I asked you that question about drinking, it came with some resentment from my side. Can you tell me how it impacted you?

Bibi: I feel like I reached out to you for help and you judged me. I felt rejected.

Therapist: I am wondering how my response ties into your childhood experiences of not having enough support?

Bibi: I guess it's similar. My mom was so consumed with the divorce so when I went to her for help, she couldn't really focus on my needs. And my dad wasn't even there.

Therapist: So my response kind of reconfirmed what you learned as a child – that you should not be reaching out for help and there's no one to support you.

Bibi: Yeah, sort of, in the heat of the moment. But it's also different with you.

Therapist: How is it different?

Bibi: Well, you want to know how I am feeling. I know you care.

Therapist: I am wondering how we could move forward from here and what would be helpful for you, given what has transpired.

Bibi: I am not sure… (pauses). I feel it's already helpful that we are talking about it.

Therapist: Perhaps we could continue doing it then and explore together what these invalidation experiences meant for you, both in the past and with me?

Bibi: Okay. But I don't want to delve into my past again right now.

Therapist: Does it feel like I am asking you to go somewhere where you don't want to go? Or even talk about something that's not helpful?

Bibi: No, I can see how it can be helpful but I'd just prefer not to talk about my Mom again right now. I feel too vulnerable… I would much rather focus on the present.

Therapist: I see. It looks like talking about her is impacting you quite a bit and you are observing your limits of what you can carry in the moment. So like you suggested, perhaps we can focus today's session on us and on our present relationship and return to Mom some other day.

Bibi: Yes, thank you. That sounds good.

Therapist: Can you tell me a little bit more about the moments that you perceived as helpful in our conversation?

Bibi: Well, when you first asked if I had been drinking, and it hurt me, you did not just leave it at that. You came back to ask how I was feeling so it showed me you care.

Therapist: So how do you put these two things together? That I did something that hurt your feelings, and that I care? What do you make of it?

Bibi: That people may not always be perfect but they may still care about me. That I may have to make more efforts from my side.

The therapist and Bibi continue exploring how the therapist's responses both during and after the rupture fit into Bibi's belief system about the world as a dangerous and lonely place and confirm or reject her hypothesis that she can only rely on herself. The therapist uses Socratic questions to help Bibi hold and integrate both perspectives, that even if she sometimes feels hurt or abandoned in relationships, people still care about her and want to support her. The therapist and Bibi also renegotiate the boundaries for communication when Bibi is drinking. They

agree that Bibi will let the therapist know if she has been drinking, they will not do any psychological work, and Bibi will generally reschedule the session. However, if Bibi experiences a crisis while drinking, she may call the therapist to share what happened, and the therapist will take five minutes to check in with her, evaluate her safety and set up a follow-up time to talk.

2.5 | Outcome and prognosis

Bibi continues making progress at the college. Being focused on learning and making friends at school has helped her to reduce both the amount and frequency of alcohol use. Due to COVID-19, the college courses are temporarily taught online. She finds the online courses comforting as a middle ground between fully immersing herself in relationships and feeling isolated. While Bibi still experiences anxiety during new situations, she can now handle daily tasks and social situations. Bibi observes that resolving the fallout with the therapist has impacted the way she relates to people; she is more likely to share what she feels or needs and to trust that people will care. Bibi says that she realizes that people may not always understand her right away, and she may have to make efforts to explain her needs. Recently, she arranged a meeting with her building manager and asked the treatment team case manager to attend so she could feel more supported. The prognosis for Bibi is guardedly optimistic, given that she is learning to seek emotional support and continuing to work towards reducing alcohol use.

2.6 | Clinical practices and summary

Bibi's case demonstrates a withdrawal rupture after the therapist asked a question about her alcohol use in a manner that communicated judgment. The impact of the rupture was intensified due to the situational context—Bibi feeling particularly vulnerable that day—and developmental context, including Bibi's experiences of discrimination, powerlessness, and cultural stereotyping, as well as the history of adults in her life failing to support her. The case shows that the therapist's brief clarification of her intent was not enough to alter the course of the rupture, and it was necessary to put time and effort into working through the issue. While it took multiple sessions, the resolution process contributed to corrective learning. The rupture initially underlined Bibi's belief that she can only count on herself and that the outer world is not sensitive to her feelings and needs. The resolution process challenged that belief by using the following strategies:

(1) Identifying and acknowledging the rupture. The therapist reflected her observation that the patient appeared upset and offered an invitation to address it.
(2) Validating the patient's experience. The therapist stayed present, used active listening, and acknowledged her part in the rupture.
(3) Exploring the circumstances that led to the rupture in collaboration with the patient. The therapist sought to actively understand the patient's perspective of what happened and asked questions about her own behaviors and their impact on the patient.
(4) Sharing decision-making with the patient on how to proceed with the resolution process. During several moments of the repair, the therapist offered courses of action and facilitated collaborative decision-making on how they should continue together.
(5) Incorporating the patient's direct experience in the rupture resolution and intervention evaluation process. The therapist asked questions about how this particular patient experienced the rupture, how the rupture related to her circumstances growing up, and how the rupture resolution process impacted the patient's beliefs about the world.

(6) Asking Socratic questions to help the patient shift perspectives. The therapist asked exploratory, perspective-shifting, and synthesizing questions to help the patient explore how the therapist's responses both during and after the rupture fit into her belief system. The therapist used Socratic questions to help the patient consider and integrate conflicting attitudes regarding asking for support.

(7) Inviting feedback from the patient and exercising responsiveness to it. The therapist sought patient feedback about the process, recognized its helpfulness, and made adaptations to the resolution process according to the feedback.

(8) Engaging in self-reflection, self-practice, and mindfulness. The therapist observed the patient's responses and her own responses, realized that she may need more time to process it, and took time to consult with a colleague to increase the awareness of her own reactions and contributions to the rupture and reappraise her beliefs.

DATA AVAILABILITY STATEMENT

Data sharing not applicable—no new data generated.

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