



EVIDENCE-BASED CASE STUDY

Applying the Rupture Resolution Rating System (3RS) to Group Therapy: An Evidence-Based Case Study

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Objective: Despite the known association between therapeutic alliance ruptures and outcomes in individual therapy, there is almost no research on the topic in group therapy. Group therapy is inherently more complex such that interactions occur at multiple relational levels, including member-to-member, member-to-therapist, and member-to-group. Ruptures may occur at any of these levels, and therapists or group members may initiate repair strategies. We used an evidence-based case study to evaluate the utility and feasibility of using the Rupture Resolution Rating System (3RS) in group therapy. **Method:** Participants were 8 members with perfectionism and 2 therapists in a middle session of group therapy. We coded ruptures and repairs with the 3RS, the relational level of the group's interactions, and the actor and target of rupture or repair behaviors. Perfectionism outcomes were assessed pre- and posttreatment. **Results:** Members' perfectionism showed clinically meaningful improvement. The group therapy session had both withdrawal and confrontation ruptures at each relational level of the group, with half of all ruptures occurring between members. Therapists initiated most of the repair strategies, but members initiated about one third of repairs. **Conclusions:** The 3RS may be useful to code ruptures and repairs in a group therapy context. Modifications were necessary so that the relational level of group interactions and the target of the behavior (member, therapist, group) were concurrently coded. This concurrent coding strategy makes use of the richness of 3RS coding, accounts for the complexity of group therapy interactions, and may be useful to inform clinical practice and research.

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Highlights and Implications

- This is the first study to code group therapy alliance ruptures and repairs using the Rupture Resolution Rating System (3RS), which was developed for individual therapy.
- We supplemented the 3RS ratings to include relational levels of group interactions (e.g., member-to-member, member to therapist, and member-to-group) as well as indicating the actor and target of the rupture or resolution behaviors.
- In this case study, we found that two thirds of ruptures were withdrawal types and one third were confrontation types, and although therapists initiated most resolution strategies, group members initiated more than one third of resolutions.
- It is possible that the target of resolution strategies in groups (e.g., therapist-to-group) needs to match the target of the rupture behavior (e.g., member-to-group) for successful repair to occur.
- The 3RS appears to be a useful tool for group therapy research and practice if combined with modifications to include coding for the relational level of the group at which ruptures and resolutions occur and the actor and target of these behaviors.

Keywords: therapeutic alliance, alliance rupture and repairs, group therapy, 3RS, rupture resolution rating system

The therapeutic alliance is one of the most researched concepts related to change in individual psychotherapy (Norcross & Lambert, 2018; Flückiger Del Re, Wampold, & Horvath, 2018). Defined as the collaborative stance between the patient and the psychotherapist (Doran, 2016), the therapeutic alliance is composed of three elements: the emotional bond between patient and therapist, an agreement on the tasks of therapy, and an agreement on the goals of therapy (Bordin, 1994). A strong therapeutic alliance between patient and therapist is associated with positive outcomes, regardless of treatment type (Doran, 2016; Flückiger et al., 2018). Indeed, a recent meta-analysis examining the relationship between therapeutic alliance and psychotherapy outcomes in 295 independent studies showed a moderately large and robust association between therapeutic alliance and outcomes ($r = .278$; Flückiger et al., 2018).

Second generation research is examining the specific role of the alliance in determining psychotherapy processes and outcomes (Zilcha-Mano, 2017). One important development in this research is the view of the alliance as non-static, that is, that the alliance may fluctuate within and between sessions indicating patterns of disruptions and resolutions. Safran and Muran (2000) conceptualized disruptions in the therapeutic alliance as *ruptures*. Ruptures occur when there is a strain in the emotional bond

between patient and psychotherapist, a disagreement on the tasks of psychotherapy, or a disagreement on the goals of psychotherapy (Eubanks-Carter, Muran, & Safran, 2010; Safran & Muran, 2000). Safran and colleagues identified two types of therapeutic alliance ruptures: withdrawal ruptures and confrontation ruptures (Harper, 1989a, 1989b; Safran & Muran, 2000). Withdrawal ruptures occur when the patient moves away from the therapist and the work of therapy (e.g., avoidance, minimal responding), and confrontation ruptures occur when the patient moves against the psychotherapist and the work of therapy (e.g., criticizing the therapist, complaining about the therapy itself; Harper, 1989a, 1989b; Safran & Muran, 2000). Psychotherapists can attempt to repair a rupture by using strategies such as acknowledging their contribution to the rupture, exploring the rupture with the patient, and tying the rupture to a larger pattern in the patient's life (Eubanks, Muran, & Safran, 2018). When the psychotherapist successfully repairs a rupture, the work of psychotherapy resumes, and the emotional bond is reinstated and possibly reinforced (Eubanks et al., 2018). That is, having weathered a disagreement or misattribution, the therapist and patient gain a new understanding and experience of their relationship and their selves as more resilient and durable. Zilcha-Mano (2017) suggested that for some patients, rup-

tures are inevitable and that the repeated resolutions of ruptures provide a new experience of the self in relationships and may be the very aspect of psychotherapy that is transformative. In a meta-analysis, Eubanks and colleagues (2018) found that rupture repairs were moderately associated with positive patient outcomes ($r = .29$; Eubanks et al., 2018). The rupture-repair process likely plays an important role in affecting change in individual psychotherapy.

There is considerably less research on the rupture-repair process in the context of group psychotherapy (Lo Coco, Tasca, Hewitt, Mikail, & Kivlighan, 2019). Part of the challenge of doing this type of research in groups is with conceptualizing interpersonal phenomena (like alliance ruptures and repairs) that occur within an inherently more complex structure than in individual therapy. That is, interactions within groups happen at least at three different levels: intrapersonal level (member-to-therapist), interpersonal level (member-to-member), and group-as-a-whole level (member-to-group; Burlingame, Mackenzie, & Strauss, 2004; Tasca, Francis, & Balfour, 2014). Tasca and colleagues (2014) argued that the most effective group psychotherapists target their attention and interventions flexibly at all three levels of the group in order to maximize group therapeutic factors. One therapeutic factor that is unique to group psychotherapy is interpersonal learning (Yalom & Leszcz, 2005). By creating a safe context, the group psychotherapist can encourage group members who have developed problematic interpersonal styles (e.g., passivity, intrusiveness, coldness, dominance) to enact those processes within the group, reflect upon the impact on themselves and others, and practice alternative ways of interacting with others (Tasca, Mikail, & Hewitt, 2020; Yalom & Leszcz, 2005). Creating a safe therapeutic context, however, is contingent on a positive alliance between member and member, member and therapist, and member and group.

A few empirical studies have examined the relationship between alliance at the intrapersonal, interpersonal, and group-as-a-whole levels with patient outcomes (Crowe & Grenyer, 2008; Marziali, Munroe-Blum, & McCleary, 1997; Norton & Kazantzis, 2016; Owen, Antle, & Barbee, 2013). However, the methods and measures vary from study to study. The concept of group cohesion (i.e., a group-as-a-whole

quality) has also been studied extensively (Burlingame, McClendon, & Yang, 2018), but researchers disagree on whether cohesion and alliance represent equivalent aspects of group therapeutic relationships (Bakali, Baldwin, & Lorentzen, 2009; Burlingame, Fuhrman, & Johnson, 2002; Johnson, Burlingame, Olsen, Davies, & Gleave, 2005). So far, the few studies that focused on alliance fluctuations in group therapy reported on overall alliance ratings at various group levels, rather than specific rupture and repair processes as they occur within sessions (Lo Coco et al., 2019). Therefore, the impact, quality, and quantity of alliance ruptures and repairs in group therapy remains largely unknown.

The goal of this study is to evaluate the utility and feasibility of using the Rupture Resolution Rating System (3RS) in a group therapy context. In terms of utility, we want to examine how the assessment of alliance ruptures and repairs using the 3RS can apply to group therapy in order to inform our understanding of group therapy interactions, help group therapists detect and repair alliance ruptures, and inform research on the utility of assessing alliance rupture and repairs as they occur in a session. In terms of feasibility, we want to see whether modifications need to be made to the 3RS to render it useful to a group therapy context. The group therapy session used for this study came from a randomized controlled trial of group dynamic-relational therapy for perfectionism (Hewitt, Flett, & Mikail, 2017) that is currently underway. Previous studies demonstrated the effectiveness of this approach to reduce trait, interpersonal, and self—relational aspects of perfectionism (Hewitt et al., 2015; Hewitt et al., 2020).

One instrument that researchers use to identify alliance ruptures and repairs during individual psychotherapy sessions is the 3RS; (Eubanks, Lubitz, Muran, & Safran, 2019). The 3RS is an observer-rated system to code alliance ruptures and repair attempts in psychotherapy transcripts or videos. The 3RS allows one to identify different kinds of patient ruptures and psychotherapist repair attempts (Eubanks et al., 2019). Despite that both client and therapist may contribute to ruptures and resolutions, the current version of the 3RS only takes into account patient behaviors as markers of ruptures (Eubanks, Muran, & Safran, 2015). Also, the

3RS does not necessarily code all disagreements between patients and therapists as ruptures if therapists and patients express and discuss the disagreement in a collaborative manner. For example, a therapist might remark that the patient appears afraid while talking about a particular memory, and the patient might respond by calmly saying: “What you just said doesn’t totally ring true. I think I’m feeling more sadness than fear right now . . .”. This response might not be coded as a rupture because of the collaborative nature of the client’s statement that was intended to modify the therapist’s understanding. That is, the 3RS only codes a rupture when the patient stops collaborating with the therapist by becoming overly critical or withdrawn (Eubanks et al., 2015).

The 3RS classifies ruptures into two categories: confrontation ruptures and withdrawal ruptures (Harper, 1989a, 1989b). In confrontation ruptures, the patient moves against the therapist by trying to control the therapist or by expressing their dissatisfaction in a noncollaborative manner (Eubanks et al., 2019). For example, a patient responding by yelling: “You’re wrong, I don’t feel afraid at all. I’m sad. Were you even listening?!” would likely constitute a confrontation rupture. This is in contrast to withdrawal ruptures, in which patients move away from the therapist by disengaging from the work of therapy. For example, a patient responding by saying: “Afraid? Hmm . . . I don’t know” and immediately changes the topic would likely constitute a withdrawal rupture. Coders rate the frequency of alliance rupture and repair markers within predetermined time intervals in videos or transcript sections. Once coders have rated the whole session video or transcript, they assign overall ratings to the clinical impact of the ruptures on the alliance, the extent to which ruptures were repaired within the session, and the contribution of the psychotherapist to the ruptures (Eubanks et al., 2019). To our knowledge, no researcher or clinician has used the 3RS to code alliance ruptures and repairs in group therapy sessions.

In the current study, we take an intensive case study approach to evaluate the utility of the 3RS in assessing alliance ruptures and repairs in a group therapy session. It is unknown whether alliance ruptures and repairs as conceptualized by the 3RS are relevant to groups, whether the measure is ecologically or clinically valid, and

whether it can capture the complexity inherent in the relational levels of group therapy interactions. And so, we chose an intensive case study as a preliminary test of the 3RS’s utility and feasibility in groups prior to implementing the measure in a larger empirical study of group therapy involving a number of groups and sessions. A key question is whether the 3RS assessment framework can be applied to the relational levels of group interactions (e.g., member-to-member, member-to-therapist, member-to-group), and whether it makes sense from a research or clinical perspective to do so. For example, in individual therapy the 3RS conceptualizes a rupture (patient withdrawal or confrontation) as occurring between a therapist and a patient, with resolutions initiated only by therapists. However, in groups it is quite possible that a rupture may occur between two group members (member-to-member), between a member and therapist, or between the group-as-a-whole and a patient or therapist. Similarly, a group member or a therapist may attempt a resolution of a rupture. In fact, a patient’s attempt at resolving a rupture that they initiated may be an indication of their progress in terms of self-reflection and interpersonal learning—both key group therapeutic factors (Yalom & Leszcz, 2005). Hence, in this case study we explore (1) whether the 3RS can be used to identify alliance ruptures and repairs during a group therapy session, (2) whether modifications need to be made to the 3RS in order to render it useful to a group therapy context, and (3) the unique issues that arise when applying a rupture-repair assessment framework such as the 3RS to group therapy.

Method

We selected the session examined herein from one psychotherapy group that was part of a randomized controlled trial for perfectionism (Hewitt et al., 2017). In the trial there were a total of five 12-session therapy groups. We chose this particular session from this one group because the principal investigator and supervisor of the trial and groups (Paul L. Hewitt), who has extensive psychotherapy research and clinical experience and knowledge of alliance ruptures and repairs, identified the session as containing several instances of alliance ruptures and repairs. Because people with perfectionism

tend to use various defense mechanisms (e.g., intellectualization, isolation, denial) during therapy sessions (Hewitt et al., 2017), we believed that choosing a group therapy session for this particular population would provide a variety of ruptures to code. Recall that the main goal of this case study was to evaluate the potential utility of the 3RS in a group therapy context, and not necessarily to generalize specific findings (e.g., frequencies of ruptures and repairs) to all group therapy sessions.

Group Therapy Participants

Participants in the group session included eight individuals (five women, three men) ranging in age from 29 to 73 ($M_{\text{age}} = 45$ years, $SD = 17.92$) who volunteered to participate in the perfectionism group treatment study. As such they each reported highly elevated levels of perfectionism in a clinical interview and in self-report measures (see Table 1). Participants had an average of 17.4 years ($SD = 2.48$) of education (minimum = 13 years, maximum = 18 years). Three participants were students, three were retired, and one was employed. Their names were changed, and identifying information was removed from the transcripts.

Group Therapists

The two cotherapists (one woman and one man) were senior clinical psychology graduate students. The therapists were working under the supervision of two registered clinical psychologists who developed the treatment and who provided weekly supervision (PLH, SFM).

The therapists received extensive training on the treatment approach (described in the following text) by the principal investigator of the clinical trial (PLH) prior to commencing group therapy.

Procedure

Participants were recruited through advertisements for a treatment program for perfectionism that were posted in community and clinical centers in a medium-sized city in western Canada. Participants had to be 18 years of age or older, fluent in English, and have high levels of perfectionism (as assessed through a clinical interview and self-report measures). Participants were excluded if they were suicidal, experiencing psychotic symptoms, or if they had not previously had any form of close relationship. Individuals were randomly assigned to receive 12 weekly, 90-min sessions of dynamic-relational group therapy for perfectionism (Hewitt et al., 2017). Participants received a psychological assessment including the development of a clinical formulation (see Hewitt et al., 2017), and a pregroup preparation session prior to commencing group treatment in order to educate them about perfectionism and orient them toward the therapy group (see Hewitt et al., 2017; Tasca et al., 2020). Participants completed measures of various perfectionism components and symptoms pretreatment and posttreatment.

The perfectionism treatment approach (Hewitt et al., 2017) is an evidence-based transdi-

Table 1
Means and Standard Deviations for Pre- and Posttreatment Outcomes

Perfectionism scale	Pretreatment		Posttreatment		<i>d</i>	<i>p</i>	Clinically improved
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>			
Self-oriented	89.38	9.47	58.13	10.01	3.21	<.001	100%
Other-oriented	70.50	12.81	53.13	14.87	1.24	.015	62.5%
Socially prescribed	74.63	10.08	50.38	14.01	1.59	.003	87.5%
Self-promotion	58.88	4.45	35.88	11.87	2.45	.001	87.5%
Nondisplay	62.00	4.47	40.38	12.27	2.30	.002	62.5%
Nondisclosure	32.50	6.72	19.50	5.40	2.11	<.001	100%
Cognitions	67.88	22.83	51.62	25.64	0.66	.053	50%

Note. $N =$ eight participants. Cohen's d was calculated for repeated measures. The p values are from dependent samples t tests. Percentage clinically improved was calculated by the frequency of participants with pretreatment scores that were one standard deviation above the community normative sample mean as the denominator, and the frequency of participants who scored less than half of a standard deviation above the normative sample mean at posttreatment as the numerator.

agnostic approach to group therapy that has been shown to be effective in a clinical trial for perfectionism (Hewitt et al., 2015, 2020). The approach is based on interpersonal (Benjamin, 1996; Kiesler, 1983) and psychodynamic (Kohut, 1971; Strupp & Binder, 1984) models that target relational patterns, attachment and other relational needs, aversive affects, and defense mechanisms that underlie perfectionism and attendant problems. The method also emphasizes tailoring interventions to developmental stages of the group (see Tasca et al., 2020). In early stages, the therapists focus on developing and maintaining the therapeutic alliance and group cohesion. Therapists make use of group therapeutic factors like interpersonal learning and feedback, they work to establish group therapeutic norms (e.g., self-disclosure, self-reflection), and they use the metacommunication about the here-and-now as they work with all levels of group interactions (member-to-member, member-to-therapist, member-to-group) in order to clarify interpersonal intentions. The middle stage of treatment emphasizes identifying and encouraging change in inter- and intrapersonal maladaptive patterns that maintain problems. Interventions target these patterns as they occur during interactions between group members and with the therapists. Group therapists aim to keep patients present-focused in order to facilitate emotional expression and feedback among members for the purpose of exploring interpersonal patterns. Alliance ruptures may be more likely to occur during middle stages because of the tensions inherent in trying to change maladaptive patterns through interpersonal feedback received from therapists and other group members. Supervisors guided therapists in this case study group to identify when an alliance rupture occurred and to work toward repair.

All group therapy sessions were video recorded. The video for this case study is from session nine, thus representing the middle stage of the group treatment for these participants. As indicated, we selected this session for the case study because it included a number of examples of alliance ruptures as well as repair strategies. Participants provided informed consent to have therapy sessions videotaped and used for research purposes. The Research Ethics Board at the University of British Columbia approved the study.

Measures

Outcomes. The Multidimensional Perfectionism Scale (Hewitt & Flett, 1991) is a 45-item scale that assesses the trait dimensions of perfectionism. The MPS comprises three subscales including: Self-Oriented, Other-Oriented, and Socially Prescribed Perfectionism. This measure demonstrated good reliability and validity (Hewitt & Flett, 1991, 2004; Hewitt et al., 1991).

The Perfectionistic Self-Presentation Scale (Hewitt et al., 2003) is a 27-item measure that assesses three facets of perfectionistic self-presentation: perfectionistic self-promotion, nondisplay of imperfection, and nondisclosure of imperfection. The subscales have good internal consistency and are correlated but distinct from measures of trait perfectionism (Hewitt et al., 2003).

The Perfectionism Cognitions Inventory (PCI; Flett, Hewitt, Blankstein, & Gray, 1998) is a 25-item measure that assesses automatic thoughts that reflect perfectionistic themes. Research attests to the reliability and validity of the PCI, including its incremental validity relative to other perfectionism measures (see Flett & Hewitt, 2015).

Alliance ruptures and repairs. The 3RS (Eubanks et al., 2015; Eubanks et al., 2019) is an observer rated scale used to code therapeutic alliance ruptures and therapist resolution strategies from psychotherapy videos or transcripts. The 3RS coding results in frequency counts of alliance ruptures that are characterized as either withdrawal ruptures or confrontation ruptures. Markers of withdrawal ruptures include behavior of the patient toward the therapist characterized by the following specific types: denial, minimal response, abstract communication, avoidant storytelling/shifting topic, deferential and appeasing behavior, content/affect split, and self-criticism/hopelessness. Markers of confrontation ruptures include behaviors of the patient toward the therapist characterized by the following specific types: complaints and concerns about the therapist, rejecting therapist interventions, complaints and concerns about the activities of therapy, complaints and concerns about the parameters of therapy, complaints or concerns about progress in therapy, defending self against therapy, and efforts to control or pressure the therapist. In addition to counting

withdrawal and confrontation rupture markers, the 3RS also allows one to count the number of resolution strategies used by therapists in response to a rupture. Resolution strategies may include clarifying misunderstanding, changing tasks or goals, illustrating tasks or provide rationale for treatment, inviting thoughts or feelings about the therapist or some aspect of therapy, acknowledging contribution to a rupture, disclosing internal experience of the interaction, linking the rupture to a larger interpersonal pattern, validating defensiveness, and redirecting. The 3RS also allows one to assign a global rating per session for the overall extent to which ruptures were resolved, the degree to which the therapist caused or exacerbated ruptures, and which ruptures or resolutions had a significant clinical impact. For the present study, we used the 3RS only to count withdrawal ruptures, confrontation ruptures, and resolution strategies.

Recently, Eubanks and colleagues (2019) reported on interrater reliability for overall frequency of withdrawal markers where the intraclass correlation coefficient (ICC [1, 2]) = .85, the overall frequency of confrontation markers where the ICC (1, 2) = .98, and the overall frequency of resolution strategies where the ICC(1, 2) = .95. They also assessed criterion validity, predictive validity of the measure by relating rupture markers to drop-out rates, as well as incremental validity with the Structural Analysis of Social Behavior (Benjamin, 1996).

Coders modified the 3RS in two ways. First, in order to capture the varied and complex interactions that can occur in a group therapy session, coders noted the relational level of the group in which the rupture or repair behavior occurred (member-to-member; member-to-therapist; member-to-group). Second, coders also indicated who initiated the rupture or repair (member or therapist), and who was the target of the rupture or repair behavior (member, therapist, or group). Hence, in addition to rating type of rupture or repair with the 3RS (as would be done in individual therapy), coders also indicated if the rupture or repair behavior occurred: member-to-member, member-to-therapist, therapist-to-member, member-to-group, or therapist-to-group.

Session 9 of a group therapy for perfectionism was coded by three graduate students in clinical psychology (Camille Garceau, Livia Chyurlia, Danielle Baldwin), who each attended

a webinar and studied the 3RS manual (Eubanks et al., 2015). One of the students (LC) and a senior clinical psychologist supervisor (Giorgio A. Tasca) also attended a workshop by Catherine Eubanks, author of the 3RS, and practice-coded a transcript with another coauthor (Tali Boritz) who was previously trained as a reliable rater with the 3RS by Catherine Eubanks. The group therapy video for this case study was transcribed. The three student coders watched the video in 5-min increments and coded therapeutic alliance ruptures and resolution strategies using the categories of withdrawal ruptures, confrontation ruptures, and resolution strategies including subtypes from the 3RS, marking instances on the transcript. Only ratings agreed upon by all three coders were recorded. Consensus was reached through discussions among coders and by clarifying types of events using the 3RS manual. The rationale for consensus coding was based on the exploratory nature of our study. Our goal was to examine whether the 3RS could potentially be used to code ruptures and resolutions in group therapy sessions, and/or whether modifications were needed to the 3RS coding in order to account for the complex interactions that occur in groups. Previous researchers relied on consensus coding with the 3RS in exploratory studies of individual therapy interactions (Boritz, Barnhart, Eubanks, & McMains, 2018). Once the entire transcript was coded with the 3RS, it was sent to a reliable 3RS coder (TB), and final codes were based on decisions made by the reliable coder. Following these verifications, the number and proportion of ruptures and resolutions and group therapy level at which they occurred were summarized.

To capture the complexities of group interactions, coders (CG, LC, DB) also identified the relational level of the group at which the rupture or repair strategy occurred, who initiated the rupture or repair, and the target of the rupture or repair behavior by indicating one of the following codes: member-to-member, member-to-group, member-to-therapist, therapist-to-member, therapist-to-group. One of the authors with extensive experience in group psychotherapy research and practice (GAT) reviewed the entire transcript to verify accurate coding of the relational level of interactions in the group. Any disagreement in coding of group therapy level was resolved by consensus.

Results

Outcomes

The group began with eight participants, and there were no drop-outs. Seven of the participants attended the session that we transcribed for this study. Hence, the drop-out rate for this group is lower than the mean drop-out rate (19.7%) that one might expect in a randomized controlled trial of psychotherapy (Swift & Greenberg, 2012). To place the case descriptions of alliance ruptures and repairs in context, we first report the pre- to posttreatment outcome data for the eight participants in the group. Because the small sample size for the dependent samples *t* tests that we conducted would result in low power to detect a statistically significant result, we focused on the clinical outcomes as indicated by the repeated measures Cohen's *d* statistic in which $d \geq .20$ indicates a small effect, $d \geq .50$ is a medium effect, and $d \geq .80$ is a large effect. As indicated in Table 1, there was a decline in all perfectionism mean scores from pre- to posttreatment with medium to large effects.

As another index of clinical significance of the change, we identified the participants who scored more than one standard deviation above a community normative sample mean on the Perfectionism scales (Hewitt & Flett, 2004; Hewitt et al., 2003; Flett et al., 1998) at pretreatment. Then, we assessed the percentage of participants who scored less than one half of a standard deviation above the community normative sample mean at posttreatment as an index of "clinically improved." That is, we calculated the proportion of those with elevated Perfectionism scales whose scores changed by

more than half a standard deviation from pre- to posttreatment and whose scores were now within the nonclinical normative range. Using this approach, we considered between 50% and 100% of participants as clinically improved in terms of trait, self-presentational, or self-relational components of perfectionism (see Table 1).

Alliance Ruptures and Repairs at Group Levels

In Table 2 we summarize the frequencies and percentages of therapeutic alliance ruptures and attempts at repairs during the 90-min therapy group. There was a total of 34 alliance ruptures coded with the 3RS—fewer than two thirds of which (61.76%) were withdrawal ruptures, and more than one third (38.23%) were confrontation ruptures. Four of the seven patients who attended the session (57.14% of patients) were responsible for initiating all the ruptures.

Regarding relational level of the group within which ruptures occurred, more than half (55.88%) occurred at the member-to-member level, about one quarter were member-to-therapist ruptures (26.47%) and less than one fifth were member-to-group (17.64%). Therapists were responsible for initiating more than half of resolution attempts (therapist-to-member: 55.55%), including a few that therapists aimed at the group (therapist-to-group: 5.55%). And, as one might expect in an interactional process-oriented group in the middle stage of treatment, participants attempted more than a third of resolution strategies aimed at other members (member-to-member: 38.88%).

Table 2
Frequencies and Percentages of Therapeutic Alliance Ruptures and Repairs

Group level/actor-to-target	Confrontation ruptures		Withdrawal ruptures		Total ruptures		Repair strategies	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Member-to-therapist	2	15.38	7	33.33	9	26.47	0	0
Therapist-to-member	0	0	0	0	0	0	20	55.55
Member-to-member	8	61.53	11	52.38	19	55.88	14	38.88
Member-to-group	3	23.07	3	14.28	6	17.64	0	0
Therapist-to-group	0	0	0	0	0	0	2	5.55
Total	13	38.23	21	61.76	34	100	36	100

Note. The group therapy session included two therapists and eight participants.

Regarding temporal sequence of ruptures and repairs, we divided the session into early (first 30 min), middle (second 30 min), and late (last 30 min) segments. We found no compelling evidence that ruptures and repairs occurred more frequently in one part of the session compared to another, although 46% of all confrontation ruptures occurred in the early stage (see Table 3).

Clinical Examples and Transcript Coding

To illustrate types of ruptures and repair strategies, we provide several vignettes from the coded transcripts. We indicate the category of rupture (withdrawal or confrontation) and the specific type within the category. We also indicate the resolution strategy and specific type. The coding also specifies at which relational level of the group in which the rupture or resolution strategy occurred, who initiated the rupture or repair, and the target.

Confrontation rupture and repair: Group level. The following is an example of a confrontation rupture in which an individual member (Sophie) confronts the group as a whole with a complaint. One of the therapists (Therapist 2), and then another group member (Ashley) attempted resolution strategies aimed at the individual member (Sophie). Despite these attempts at a resolution, Sophie's confrontation sparked similar complaints from other members (Erika and Ashley). The other therapist (Therapist 1) then initiated another resolution strategy, which was this time aimed at the group-as-a-whole. This illustration shows that after one resolution strategy aimed at a single group member was unsuccessful, the therapists changed the target of the resolution strategy to

the group level (therapist-to-group) to match the target of the confrontation ruptures (member-to-group). Thus, illustrating the principle of flexibly moving from one relational level of the group to another (Tasca et al., 2014).

Sophie: I think the reason I couldn't come the last two sessions was because I was actually feeling not accepted . . . , I-I received feedback that I ask questions rather than sharing part of my own experience, or myself or my own feelings. I do not feel like I'm doing that because I'm hiding part of myself, rather that's just my natural way of being because . . . I feel like I want to remove myself from the equation so I can solely focus and understand another being, and I think that the reason I do not want to necessarily bring a lot of very . . . sensitive emotions is because I feel [cries] . . . I do not like the part of myself that I'm very sensitive, and I do not even like to put that weight on anybody else to be responsible for my feelings. . . . (Confrontation rupture: complaint about group; member-to-group).

Therapist 2: Sophie, before you kinda go into this piece . . . you know, it seems very apparent that this is painful for you, and I'm wondering, even as you talk to the group about sharing these hidden aspects of yourself, what's going on for you as you do that? (Resolution strategy: redirection, inviting thoughts and feelings; therapist-to-member).

Ashley [to Sophie]: There was like a coincidence in you missing those

Table 3
Frequencies of Ruptures and of Repair Strategies Coded With the Rupture Resolution Rating System (3RS) in Early (First 30 Minutes), Middle (Second 30 Minutes), and Late (Last 30 Minutes) Stages of Group Therapy Session

Rupture/strategy	Stage of the session		
	Early	Middle	Late
Withdrawal rupture	7	7	7
Confrontation rupture	6	3	4
Resolution strategy	13	11	12

two sessions and I missed two sessions earlier for like the same reason, where I felt like . . . my contribution was in these first two sessions was too conceptual and too, like theory-based, and was not personal experience-based, and I felt like that was not so welcome in the group. So, I felt like I was disrupting things, and it'd be better if I stepped out and let things like kind of roll on their own and then step back in and then adjusted to what people were doing. But as far as you not feeling welcome, I feel like I've had the most affinity with you. So, I really appreciate your way of being and I understand—that emotional distance thing . . . (Resolution strategy—validate defensiveness; member-to-member).

. . . Erika and Ashley also disclosed that sometimes they felt that their contributions were not appreciated in the group. . . . (Confrontation ruptures: complaints about group; member-to-group).

Therapist 1: Uh if I can jump in for a moment . . . I wonder if something which I'm hearing across Sophie, Erika, and Ashley, I wonder if there's this theme of sometimes, what we're trying to get across in terms of how we feel and the very real and deep emotions that we struggle with, sometimes that doesn't translate when it comes to us trying to put it into words. (Resolutions

strategy: redirection; therapist-to-group).

Withdrawal rupture and repair: Member level. The following is an example of a rupture resulting from an interaction between two participants. A group member (Jack) directly comments on Sophie's defensiveness regarding her feelings, however Jack's comment was followed immediately by Sophie engaging in intellectualization as a means of withdrawal. Intellectualization is common among those with perfectionism as a defense mechanism against revealing the self, one's vulnerability, and painful affects like anxiety and shame (see [Hewitt et al., 2017](#)). The therapist attempted to resolve this withdrawal rupture by emphasizing the utility of the defense for Sophie.

Jack
[to Sophie]: . . . maybe the reason you find it difficult to express your feelings in group is because you're trying to protect yourself from getting hurt.

Sophie: I try to actually really deeply contemplate about my emotions, it's just that . . . it's not that I do not care about my feelings, my feelings are there, it's just that I created a space to look at them logically and see if I have to react in that moment based on the feeling that are aroused in my body. Or, is it possible that maybe I'm not really seeing it through, maybe I should pause that feeling and first get more information in, and then react accordingly? And also, sometimes it could be that, for example, somebody reacts to me in a very insulting way. I could perhaps react to them because I feel angry, I could react to them really badly, because that's just my emotional reaction naturally. But then I could look in

my emotion as it arises rationally and be like “okay this person usually is not an insulting or disrespectful person, usually they’re fine, maybe today they’re having a bad day.” Then I can kinda like pause my emotion and, and not react based on my emotion. (Withdrawal rupture: abstract communication; member-to-member).

Therapist 1: Yeah, so like right now . . . if I’m hearing correctly, it sounds like you’re saying that you do have quite strong emotional experiences, which you very much value, and hear. But often times it’s useful to have a more analytical approach in the situation, right? (Resolution strategy: redirection, validate defensiveness; therapist-to-member).

Confrontation rupture and repair: Member level. This third exchange illustrates how group therapy principles can guide therapists’ choice of resolution strategy and group level at which they target the strategy (see [Tasca et al., 2020](#)). For example, the group therapist in the following example used the principle of interpersonal learning ([Yalom & Leszcz, 2005](#)) when he focused on Ashley’s feedback to Sophie about her interruptions. The principle of interpersonal learning guided the therapist’s resolution strategy (i.e., invite thoughts and feelings), such that he asked Sophie about her feelings regarding Ashley’s feedback. Later in the session Sophie initiated her own resolution strategy (i.e., link with other relationships) when she returned to the previous interaction with Ashley. Sophie did this partly as a means of understanding herself better and partly as a continuing repair of the rupture with Ashley. The ongoing work of the therapists to encourage self-reflection and interpersonal feedback in the

group may have paved the way for Sophie to attempt her own resolution.

Ashley and Erika were discussing that Erika often brings up her childhood as an explanation for her perfectionism. Ashley questions the utility of this narrative and wonders if it is impeding Erika’s progress. Sophie, who is listening to the conversation, interjects.

Sophie: Um, I feel like I need to stop you [Ashley] before it offends her [Erika]. Uh, I have the urge, um, because I feel like you’re assuming that as soon as somebody has a solution to their problem and they know the problem, they know the solution. . . . (Confrontation rupture: control another member; member-to-member).

Sophie and Ashley engage in a brief exchange.

Therapist 1: If I can stop you guys for a minute, yeah? So, Ashley let’s go to you, what’s going on for you right now? In this, in this conversation? (Resolution strategy: invite thoughts and feelings; therapist-to-member).

Ashley: . . . I felt lectured and interrupted.

Therapist 1: Sophie, what is it like for you to hear Ashley was feeling a bit interrupted and not heard? (Continuation of the resolution strategy: inviting thoughts and feelings; therapist-to-member).

Sophie: I was hoping that she [Ashley] would understand I’m just trying to give her another piece of the perspective. Yeah. I felt a little disappointed that you’re [Ashley] not exactly thinking the same way.

Therapist 1: Can you say that to her?

Sophie [to Ashley]: Well first I apologize . . . [Sophie and Ashley laugh nervously] but, I feel like I

was not expecting you to be offended because I was feeling like we would be very close. Uh and thinking in a very same manner, so when I say something, I was expecting for you to really get me.

Ashley: I guess my . . . my feelings of what triggered me feeling upset was the “before you offend her” part. That phrasing. And then also . . . also your quick summary of what I was saying doesn’t reflect what I think I was saying.

Sophie: Yeah, I can, I can see that and I can see how my first comment could’ve been . . . inconsiderate, yeah. (Resolution strategy: acknowledge contribution; member-to-member).

Later in the session

Sophie: . . . I just realized the reason I had the very big urge to jump in because I identified with your [Erika] coldness many times. I think I have always been told “be careful with your words how, like be considerate of other people’s emotions” or at least I have always told myself, because I’ve seen how I have been considered with my coldness to hurt others with having the best intentions, but still I come across inconsiderate. . . . Also I felt that connection with you [Erika] as if I so suddenly wanted to stop you to make the mistake that I constantly remind myself. (Resolution strategy: link with other relationships; member-to-member).

Discussion

The goal of this evidence-based case study was to evaluate the utility and feasibility of assessing therapeutic alliance ruptures and repairs in group therapy with the 3RS. To do so, we did an intensive coding of group therapy interactions in a middle session of a dynamic-relational group for perfectionism (Hewitt et al., 2017). Overall, we found that the 3RS was useful in coding alliance ruptures and repairs in group. However, important modifications were necessary to account for the complexities of group therapy, namely by (1) coding the relational level at which the rupture or resolution strategy occurred, (2) coding who initiated the rupture or resolution, and (3) coding who was the target of the rupture or resolution behavior. The treatment resulted in clinical improvements from pre- to posttherapy in the target problems of perfectionism among the eight members of this group, which is consistent to what was reported in an effectiveness trial with a different sample (Hewitt et al., 2017). Both withdrawal and confrontation ruptures occurred at each relational level of the group (e.g., member-to-member, member-to-therapist, and member-to-group). More than two thirds of ruptures were coded as withdrawals, which is similar to reports of previous research in individual therapy (Eubanks et al., 2019). Unique to group therapy is that more than half of the ruptures occurred between members and not with the therapist. Therapists initiated most repair strategies, but patients attempted more than a third of resolutions. This latter observation is also unique to the group therapy context.

Implications for the Theory of Alliance Ruptures in Groups

This case study also demonstrated that the theory underlying alliance ruptures and repairs appears relevant to group therapy. One can conceptualize alliance ruptures as an enactment of a cyclical maladaptive interpersonal pattern (Strupp & Binder, 1984) that underlies transference configurations of the individual. That is, a rupture may represent an “act of self” that pulls for complementary responses from others that sets off a chain of maladaptive interpersonal interactions. For example, a patient who tends toward with-

drawing from others when experiencing aversive affect like anxiety may do so by becoming silent, intellectualizing, isolating affect, or avoiding. Similarly, a patient who may be confronting of others when feeling anxious, may do so by complaining, blaming, or being defensive in response to others. According to the interpersonal theory of complementarity (Kiesler, 1983), withdrawal behaviors may pull for others to distance themselves from the patient or to pursue them even further, whereas confrontation behaviors tend to pull for others to counter with hostility. Such responses from other group members or the therapist could lead to an antitherapeutic climate of distrust and insecurity. Therapists who conceptualize such patient behaviors as withdrawal or confrontation ruptures may be able to sidestep complementary countertransference responses and consider ways to resolve the rupture.

In addition, some writers like [Zilcha-Mano \(2017\)](#) have described the repair of alliance ruptures as therapeutic in and of itself. That is, the experience of a repair to an alliance rupture may represent a corrective emotional experience ([Castonguay & Hill, 2012](#)) because the reparation may disconfirm well-learned or ingrained expectations of interpersonal interactions. [Yalom & Leszcz \(2005\)](#) referred to this group therapeutic factor as the recapitulation of early childhood experiences. The richness of interpersonal interactions that occur in group therapy are particularly conducive to such corrective experiences. As we noted in the transcript, not only do ruptures occur with the authority figures in the group (the therapists) that represent parental transference dynamics, but also with peers (other members) that may represent sibling transference dynamics. And so, therapists or other group members can and do initiate the repairs or resolutions. Alliance ruptures and repairs in group therapy may be aided by the interpersonal learning and feedback inherent in many group therapy orientations ([Yalom & Leszcz, 2005](#)) and in dynamically oriented group therapy in particular ([Tasca et al., 2020](#)). That is, repairing alliance ruptures in groups may provide opportunities for the disconfirmation of internalized expectations of relationships that drive maladaptive patterns.

Implications for Research of Alliance Ruptures in Groups

This case study also provides preliminary evidence for the utility of the 3RS as a tool to research group therapy interactions and functioning. When combined with coding for level of group interaction and for the actor/target of the rupture or repair behaviors, the 3RS provides a fine-grained analysis of the interpersonal transactions that are therapeutic or antitherapeutic in the group. We envision using the 3RS to facilitate intensive group process research into: the specific resolution strategies in a group following a specific rupture type, the relational levels of group at which resolution strategies are most effective, and the relative impact or success of member-initiated versus therapist-initiated resolution strategies. The 3RS may also be useful to evaluate the association between alliance ruptures and patient outcomes in groups, and the impact of successful resolution strategies on group therapy outcomes.

As we suggested previously, it is quite possible that the number and nature of ruptures may differ depending on the stage of group therapy. The theory of group psychodynamic interpersonal psychotherapy (GPIP; [Tasca et al., 2020](#)) for example suggests that ruptures are more likely to occur during the early or middle phases of therapy, which is often characterized by some patients maintaining a stance of politeness and well-rehearsed defensive self-presentations that may indicate withdrawal ruptures. On the other hand, the middle phase may be characterized by some patients enacting maladaptive interpersonal patterns in the group, followed by therapists encouraging these patients to try new ways of interacting with group members (see [Tasca et al., 2020](#)). The anxiety inherent in the therapeutic demands of the middle phase may result in a temporary increase in withdrawal or confrontation ruptures consistent with a patient's maladaptive patterns. Hence, research into the evolution or change in frequency and type of ruptures across group therapy sessions may provide a window into these theorized change processes (see also [Tasca, Balfour, Ritchie, & Bissada, 2006](#)). One might also predict that patient-initiated resolution strategies may increase over time as the group develops norms of interpersonal feedback and safety and

as group members become more active and responsible for the group's interactions.

Implications for Practice and Training

Although exploratory at this point, the results of this case study do suggest some intriguing clinical implications. For example, the first transcript that we presented above (i.e., Sophie's confrontation rupture with the group-as-a-whole) indicated that the most effective resolution strategy matched the interaction level at which the rupture occurred. That is, the confrontation rupture was at the group level (member-to-group), the first unsuccessful attempts at resolution were at the individual level (member-to-member and therapist-to-member), and the second more successful attempt at resolution was the group level (therapist-to-group). This may suggest that not only must group therapists identify a rupture and the appropriate resolution strategy, but they must also target the resolution strategy to the level of the group at which the rupture occurred. Such a finding, if replicated within a larger sampling of groups, would represent an actionable intervention strategy from this line of research.

A second possible clinical implication of this case study may be that therapists must frame resolution strategies to take into account group therapeutic factors (Yalom & Leszcz, 2005). A number of writers have described metacommunication as a method of making interpersonal intentions explicit and to clarify miscommunications (Leszcz, Pain, Hunter, Maunder, & Ravitz, 2015; Safran & Muran, 2000). And so, metacommunication may be used to facilitate resolution strategies. Recently, Tasca and colleagues (2020) described the use of metacommunication to identify alliance ruptures in GPIP, to further interpersonal learning, and to make explicit the interpersonal processes apparent in the group. For example, in the second transcript presented above, the therapist's resolution strategy was to validate defensiveness as a way of making evident the patient's interpersonal intent in the interaction.

Another clinical implication might include therapists encouraging patients to engage in self-reflection and develop mentalizing as a means of resolving a rupture with another member or the group. Bateman and Fonagy (2012) described mentalizing as the ability to recognize

that behaviors of self and others are determined by mental states, and the concurrent ability to understand one's own and others' mental states. Mentalizing is a key function by which patients may achieve more meaningful relationships and better affect regulation. In the third transcript example that we presented, Sophie was able to return to a previous rupture that she initiated in the session, but this time with a clearer understanding of what might have led her to interrupt others' conversations. She did so by linking the rupture to other relationships in her life. Presumably, Sophie felt sufficiently safe in the group to allow her to connect her specific inside-of-group behavior to that of her outside-of-group relational patterns. This further allowed her to link her interruptions to an internal state, and then communicate this insight to others in the group as a means of repairing the rupture. Sophie's example illustrates improved mentalizing ability that may have been an outcome of the group therapeutic interventions in which the therapists encouraged members toward increased capacity for self-reflection.

The proportion of member-initiated repairs was particularly noteworthy and deserves more attention in future research. If replicated, these findings have implications for understanding group development, for the theory of alliance ruptures and repairs in groups, and for clinical practice and training. For example, therapists in this trial were trained to recognize and repair alliance ruptures, but group members got no such training and yet the members accounted for a substantial proportion of repair efforts in this ninth session. It is possible that members experienced preceding efforts by therapists to repair alliance ruptures as a model for conflict resolutions. Therapists in training may need instruction and supervision to focus explicitly on helping group members to repair member-to-member alliance ruptures as a means of furthering group therapy goals and improving patient outcomes.

Limitations and Conclusions

Although the evidence-based case study approach provided rich information about this particular therapy session as rated by the 3RS, there are certainly limitations inherent in this design. Primarily, we were limited to commenting on one group of patients and therapists at

one session of the therapy. It is possible that this particular session or group was idiosyncratic when it came to alliance ruptures and repairs. In fact, we deliberately selected this session because it provided several instances of alliance ruptures and repairs. Also, the group resulted in clinically meaningful reductions of problems with perfectionism. So, this case study may be limited only to those groups that are effective at improving key factors that underlie certain types of problems like those related to perfectionism. As we noted previously, those with perfectionism may be prone to use intellectualizing defenses that are coded as withdrawal ruptures—and this may be quite different for patients with other clinical presentations who may be more prone to confrontation ruptures. In addition, the treatment used in this group was specific to a dynamic-relational group therapy (Hewitt et al., 2017; Tasca et al., 2020), which is a model that emphasizes developing and maintaining an alliance, use of metacommunication of group and individual processes, and focuses on changing interpersonal patterns and defense mechanisms. Whether the findings are relevant to group cognitive-behavioral therapy (CBT), for example is unknown. However, there is research on alliance rupture and repair in individual CBT that suggests that alliance training is transferrable to this modality (Muran, Safran, Eubanks, & Gorman, 2018).

This evidence-based case study demonstrated that the 3RS may be useful to code ruptures and repair strategies in a group therapy context. Modifications were necessary so that the relational level of the group and the target of the behavior (i.e., member, therapist, group) were concurrently coded. This concurrent coding strategy enhanced the richness of 3RS coding, accounted for the complexity of group therapy interactions, and may be useful to inform clinical practice and research. This case study bodes well for the future use of the 3RS with larger samples to assess the utility and importance of alliance ruptures and resolution strategies in group therapy.

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