The Psychology of Repair: A Grounded Theory Review of Cognitive Behavioural Therapy Approaches for Navigating Therapeutic Relationships

Nicole O. Chidi-Njemanze

Faculty of Behavioural Management and Social Sciences, University of Twente

Master of Psychology

Y. Namer

T. Vaessen

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Abstract

Ruptures in the therapeutic relationship are disruptions in the client-therapist relationship that, if not adequately addressed, can undermine therapy outcomes. While previous research has explored rupture conceptualisation and repair strategies in Cognitive Behavioural Therapy (CBT), existing findings remain fragmented. This literature review synthesises existing literature through a Grounded Theory methodology to provide a comprehensive and structured understanding of ruptures and their repair strategies within the CBT framework.

The review identifies four core rupture dimensions: *Impact on the Therapeutic Relationship, Nature and Intensity of Ruptures, Rupture Characteristics: Confrontation vs. Withdrawal, and Opportunity for Change*. These findings suggest that ruptures in CBT are understood as disruptions within the therapeutic relationship, defined by relational and behavioural dynamics. Furthermore, this review offers an integrative definition of rupture within the CBT framework, positioning ruptures as *opportunities for change that arise from varying degrees of disruptions in one or more core components of the therapeutic relationship, characterised by either confrontation or withdrawal behaviours*. In addition, the review organises CBT repair strategies into a tiered model comprising three key levels: (1) *Assessment and Detection,* (2) *Repair Skills,* and (3) *Repair training*. These findings equip therapists with techniques for managing ruptures adaptively.

While this review integrates and extends existing literature, limitations include the reliance on secondary research and the lack of triangulation. Future studies can address these limitations by incorporating multiple coders and alternative research methods.

Overall, this review advances the understanding of rupture and repair in CBT, offering practical tools for therapists and contributing to both research and clinical practice.

Introduction

In the ever-evolving landscape of psychotherapy research, the question of how therapists navigate the intricacies of therapeutic relationships maintains salience. According to Flückiger et al. (2018), the therapeutic relationship or alliance is one of the most reliable indicators of treatment outcomes, regardless of the theoretical approach behind the intervention. Hughes et al. (2021) expounded that this alliance is built on collaboration, mutual investment, and shared understanding between the therapist and client. Various factors determine its effectiveness, including communication styles and the alignment of therapeutic goals (O'Keeffe et al., 2020).

While many factors contribute to the strength of the therapeutic alliance, one of the most vital yet challenging factors is how therapists navigate alliance disruptions. Unresolved disruptions can significantly reduce treatment outcomes and increase dropout rates (Babl et al., 2024). Dropout itself has been strongly associated with negative consequences, such as inadequate care and an increased risk of poor clinical outcomes (Cooper & Conklin, 2015; Reis & Brown, 1999; Sijercic et al., 2021, as cited in Murphy et al., 2022). Despite these risks, research on the predictors of dropout remains limited. Existing studies suggest that the therapeutic alliance plays a vital role in treatment retention, serving as a protective factor against termination (Cooper et al., 2016, as cited in Murphy et al., 2022). Given this, it is essential to understand disruptions in the alliance, known as ruptures, and strategies for their repair.

Safran & Muran (2000) describe ruptures as a regular occurrence in treatment, characterised by the degradation or strain of the client-therapist alliance, evident in discontinuity or rigidity during therapy (as cited in Dolev-Amit et al., 2022). A study involving 988 psychotherapy sessions found that ruptures can arise from various factors, including misalignment in therapy goals and tasks, countertransference dynamics, and external stressors unrelated to therapy (Dimmick et al., 2022). Given the potential impact of ruptures on treatment outcomes, researchers have sought to understand their nature and repair strategies better. One way to do this has been by classifying ruptures into two main types: withdrawal ruptures and confrontation ruptures (Eubanks et al., 2018a). Withdrawal ruptures are conceptualised as subtle markers of friction between the client and therapist that are usually more covert, like avoidance or non-verbal cues. In contrast, confrontation ruptures have more easily observable markers like expressing anger or dissatisfaction (Eubanks et al., 2018a). Recognising these distinctions is crucial because different types may require distinct intervention strategies to restore the alliance effectively.

Rupture and Repair in CBT

While ruptures occur across all therapeutic approaches, they may be particularly relevant in CBT due to its view of the therapeutic alliance as essential for therapy (Wolf et al., 2022). Elements like goal-setting, active client participation, and continuous feedback, essential to CBT (Kennerley et al., 2016), can also contribute to ruptures. Clients may experience frustration during goal-setting or disengage when tasks feel misaligned with their personal experience (Bannink, 2012). Moreover, the structured nature of CBT can sometimes create rigidity in therapist-client interactions, making it difficult to navigate interpersonal challenges when they arise (O'Keeffe et al., 2020).

Addressing them becomes crucial for maintaining the alliance and therapy when ruptures occur. Repairing these ruptures involves restoring the emotional bond and resuming collaborative therapeutic work between the therapist and the client (Eubanks et al., 2018a). Within CBT, repair might include modifying the approach to technique application and fostering collaborative engagement, allowing clients to experience corrective interpersonal interactions that reshape their maladaptive interpersonal schemas (Aspland et al., 2008). Repair strategies are commonly classified into two key dimensions: (1) direct versus indirect repair strategies and (2) immediate versus expressive strategies (Eubanks et al., 2018a). Direct strategies address ruptures through open acknowledgement and engaging the client in open conversation about the rupture, collaboratively working towards repair. In contrast, indirect strategies resolve the rupture through subtle shifts in therapeutic technique without overtly acknowledging the rupture (Eubanks et al., 2018a).

Furthermore, repair strategies can be immediate or expressive (Eubanks et al., 2018a). The immediate strategies are intended to resolve the rupture promptly, which allows the therapeutic process to proceed without significant interruption. These strategies often involve clarifying misunderstandings or adjusting the therapeutic technique. Conversely, expressive strategies aim to explore the rupture in-depth and address the client's underlying needs, encouraging them to reflect on their emotions and behaviours (Eubanks et al., 2018a).

These dimensions are not mutually exclusive. For instance, Safran and Muran's (1996) rupture resolution model combines direct and expressive strategies by acknowledging rupture markers early, facilitating a process where clients can explore and express their experience of the rupture, investigate possible avoidance behaviours, and clarify the interpersonal schema that triggered the rupture. In recent years, researchers have built upon Safran and Muran's model, adapting it to fit a variety of treatment approaches and client populations (Cirasola et al., 2022), further demonstrating its relevance for enhancing therapeutic outcomes.

The Research Gap

Despite the clinical significance of rupture and repair strategies, there is a notable gap in the literature regarding how ruptures are defined within CBT. While many studies acknowledge the importance of resolving ruptures in therapy (e.g., Eubanks et al., 2018a; Safran & Muran, 1996), the term "rupture" is defined in various ways, and there is no universal definition within the CBT literature. This lack of consensus on what constitutes a rupture in CBT makes it challenging for therapists to identify and repair ruptures.

Eubanks et al. (2017) note that therapists from different theoretical approaches use different strategies to address ruptures. For instance, psychodynamic therapists focus on transference interpretations and therapist-client patterns, while CBT therapists focus on coping strategies. However, these strategies are not always effective and may even escalate the rupture (Eubanks et al., 2017). As CBT is one of the most widely implemented therapeutic approaches, with extensive empirical support for its effectiveness across various psychological issues (Beck, 2023), ensuring a good alliance is pivotal. Without a solid conceptual foundation of what constitutes a rupture in CBT, therapists may unintentionally undermine therapeutic progress (Babl et al., 2024; Eubanks et al., 2018a).

Beyond research, this gap extends to clinical training and psychology education. Despite the well-documented impact of ruptures on treatment outcomes, little attention is given to rupture identification and repair training in education. As a result, many therapists struggle to recognise, understand, and address ruptures in practice (Urmanche et al., 2021b). Therefore, there is a clear need for research synthesising existing literature to identify commonalities and provide guidance on how ruptures can be understood and repaired in CBT.

The Present Study

This review will explore how CBT conceptualises ruptures in therapeutic relationships and examine their proposed repair strategies. Through a Grounded Theory review, existing research will be explored to identify common themes and patterns within CBT. Therefore, the research questions in the review are: (1) How are ruptures understood within CBT frameworks? (2) What repair strategies for therapeutic ruptures emerge from CBT literature? By thematically synthesising insights from diverse perspectives, this review seeks to provide a comprehensive understanding of therapists' strategies to repair ruptures within the therapeutic alliance. This study holds the potential to inform clinical practice, enhancing therapists' ability to navigate and resolve challenges within therapeutic alliances, ultimately promoting more effective psychotherapy outcomes.

Method

Research Design

This paper is a literature review that employs a Grounded Theory approach to explore how ruptures of therapeutic relationships are conceptualised within the CBT framework and the strategies they propose for repairing therapeutic ruptures. Grounded Theory is an inductive approach which analyses significant concepts from existing data (Wolfswinkel et al., 2013). It is a suitable approach for generating new theories methodically. The Grounded Theory approach involves organising data into meaningful categories, identifying recurring patterns and exploring relationships between emerging themes (Hughes & Şirin, 2022). This highlights the capability of the Grounded Theory approach to facilitate a detailed and interrelated understanding of complex mechanisms.

In line with the Straussian approach to Grounded Theory, this literature review engages with relevant literature throughout the research process (Thornberg & Dunne, 2019). Unlike the Glaserian approach, which discourages reviewing literature early on to prevent theoretical contamination, the Straussian approach integrates literature in a controlled manner. Rather than postponing literature engagement until the end of the study, it is integrated at multiple stages of the research process to enhance theoretical sensitivity (Thornberg & Dunne, 2019). In practice, an initial, limited literature review is conducted in the introduction to establish the research context and frame the study. However, this engagement remains broad and exploratory, ensuring that discovery is possible in later stages. As the research progresses and themes begin to emerge from the data, the literature is reviewed more comprehensively during the analysis phase. This allows for comparisons between emerging findings and existing research. Thornberg and Dunne (2019) highlight that this approach balances prior knowledge with ongoing exploration and discovery.

To ensure that the review process remained structured and transparent, existing literature was systematically examined with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Page et al., 2021). Adhering to these guidelines helps maintain a high level of methodological accuracy and consistency.

Eligibility Criteria

This review selected existing literature that meets the following inclusion criteria: (1) focus on therapeutic ruptures and/or repair strategies, (2) explicitly discuss cognitive-behavioural therapy (CBT), (3) peer-reviewed articles published in academic journals, (4) available in English. Existing literature is excluded if they meet the following exclusion criteria: (1) articles that do not directly address therapeutic ruptures or repair strategies (for

instance, studies that are purely on other aspects of psychotherapy without addressing ruptures or repairs); (2) articles that focus on psychotherapies other than CBT. (3) non-peer-reviewed articles (e.g., conference proceedings, dissertations, books, or opinion pieces); (4) articles that are not available in English. There is no publication time limitation to ensure that the review captures the full historical context and developments that have shaped and continue to influence CBT.

Search Strategy

The scientific databases used for this review include PubMed, Web of Science, Scopus, and PsycINFO. To access a broader range of relevant articles, three multidisciplinary academic databases (PubMed, Web of Science, and Scopus) and one domain-specific database (PsycINFO) were utilised. PubMed provides a wide range of biomedical literature, including peer-reviewed journal articles relevant to psychotherapy, accessible through an interface of the same name. Web of Science offers multidisciplinary literature articles, including those in psychology and psychotherapy, through its interface. Scopus is a comprehensive database that provides access to a broad range of disciplines, including psychotherapy and is accessible via the Scopus interface. Lastly, PsychINFO is a leading database of psychology and related fields, offering extensive peer-reviewed literature through the EBSCO interface.

A selection of search strings was formulated to navigate the extensive existing literature. The central concepts that serve as a basis for the literature search include therapeutic ruptures, repair strategies, and CBT as the specific psychotherapeutic approach. Synonyms of these terms were incorporated to ensure the inclusion of various dimensions of rupture and repair. The selected keywords for the final search query can be seen below in Table 1.

Table 1

Final search query keywords

Variable	Keywords
Rupture	(“rupture*” OR “therapeutic rupture” OR “therapy rupture*” OR “therapeutic alliance disruption*” OR “alliance ruptures” OR “ruptures in the therapeutic relationship” OR “relationship challenges in psychotherapy” OR “therapeutic rift” OR “psychotherapeutic impasses” OR “therapeutic impasses” OR “psychotherapeutic conflict” OR “therapeutic conflict” OR “disruption” OR “therapeutic abandonment” OR “psychotherapeutic disengagement” OR “therapeutic disengagement”)
Repair	(“repair” OR “therapeutic repair techniques” OR “resolution*techniques” OR “conflict resolution” OR “reconciliation” OR “mending” OR

	"conversation repair" OR "conversational repair")
Cognitive Behavioural Therapy	("cognitive behavio*ral therapy" OR "CBT" OR "cognitive therapy" OR "behavio*ral therapy" OR "cognitive behavio*ral intervention")

Table 2 displays the final search queries used in the different scientific databases and the hits per database.

Table 2

Final search queries used in the databases and hits per database

Date	Database	Search query	Hits
09-07-24	Scopus	("rupture*" OR "therapeutic rupture" OR "therapy rupture*" OR "therapeutic alliance disruption*" OR "alliance ruptures" OR "ruptures in the therapeutic relationship" OR "relationship challenges in psychotherapy" OR "therapeutic rift" OR "psychotherapeutic impasses" OR "therapeutic impasses" OR "psychotherapeutic conflict" OR "therapeutic conflict" OR "disruption" OR "therapeutic abandonment" OR "psychotherapeutic disengagement" OR "therapeutic disengagement") AND ("repair" OR "therapeutic repair techniques" OR "resolution* techniques" OR "conflict resolution" OR "reconciliation" OR "mending" OR "conversation repair" OR "conversational repair") AND ("cognitive behavio*ral therapy" OR "CBT" OR "cognitive therapy" OR "behavioural therapy" OR "cognitive behavio*ral intervention")	34
09-07-24	PsycINFO	("rupture*" OR "therapeutic rupture" OR "therapy rupture*" OR "therapeutic alliance disruption*" OR "alliance ruptures" OR "ruptures in the therapeutic relationship" OR "relationship challenges in psychotherapy" OR "therapeutic rift" OR "psychotherapeutic impasses" OR "therapeutic impasses" OR "psychotherapeutic conflict" OR "therapeutic conflict" OR "disruption" OR "therapeutic abandonment" OR "psychotherapeutic disengagement" OR "therapeutic disengagement") AND ("repair" OR "therapeutic repair techniques" OR "resolution* techniques" OR "conflict resolution" OR "reconciliation" OR "mending" OR "conversation repair" OR "conversational repair") AND ("cognitive behavio*ral therapy" OR "CBT" OR "cognitive therapy" OR "behavioural therapy" OR "cognitive behavio*ral intervention")	11
11-07-24	PubMed	("rupture*" OR "therapeutic rupture" OR "therapy rupture*" OR "therapeutic alliance disruption*" OR "alliance ruptures" OR "ruptures in the therapeutic relationship" OR "relationship challenges in psychotherapy" OR "therapeutic rift" OR "psychotherapeutic impasses" OR "therapeutic impasses" OR "psychotherapeutic conflict" OR "therapeutic conflict" OR "disruption" OR "therapeutic abandonment" OR "psychotherapeutic disengagement" OR "therapeutic disengagement") AND ("repair" OR "therapeutic repair techniques" OR "resolution* techniques" OR "conflict resolution" OR "reconciliation" OR "mending" OR "conversation repair" OR "conversational repair") AND ("cognitive behavio*ral therapy" OR "CBT" OR "cognitive therapy" OR "behavioural therapy" OR "cognitive behavio*ral intervention")	10
11-07-24	Web of Science	("rupture*" OR "therapeutic rupture" OR "therapy rupture*" OR "therapeutic alliance disruption*" OR "alliance ruptures" OR "ruptures in the therapeutic relationship" OR "relationship challenges in	12

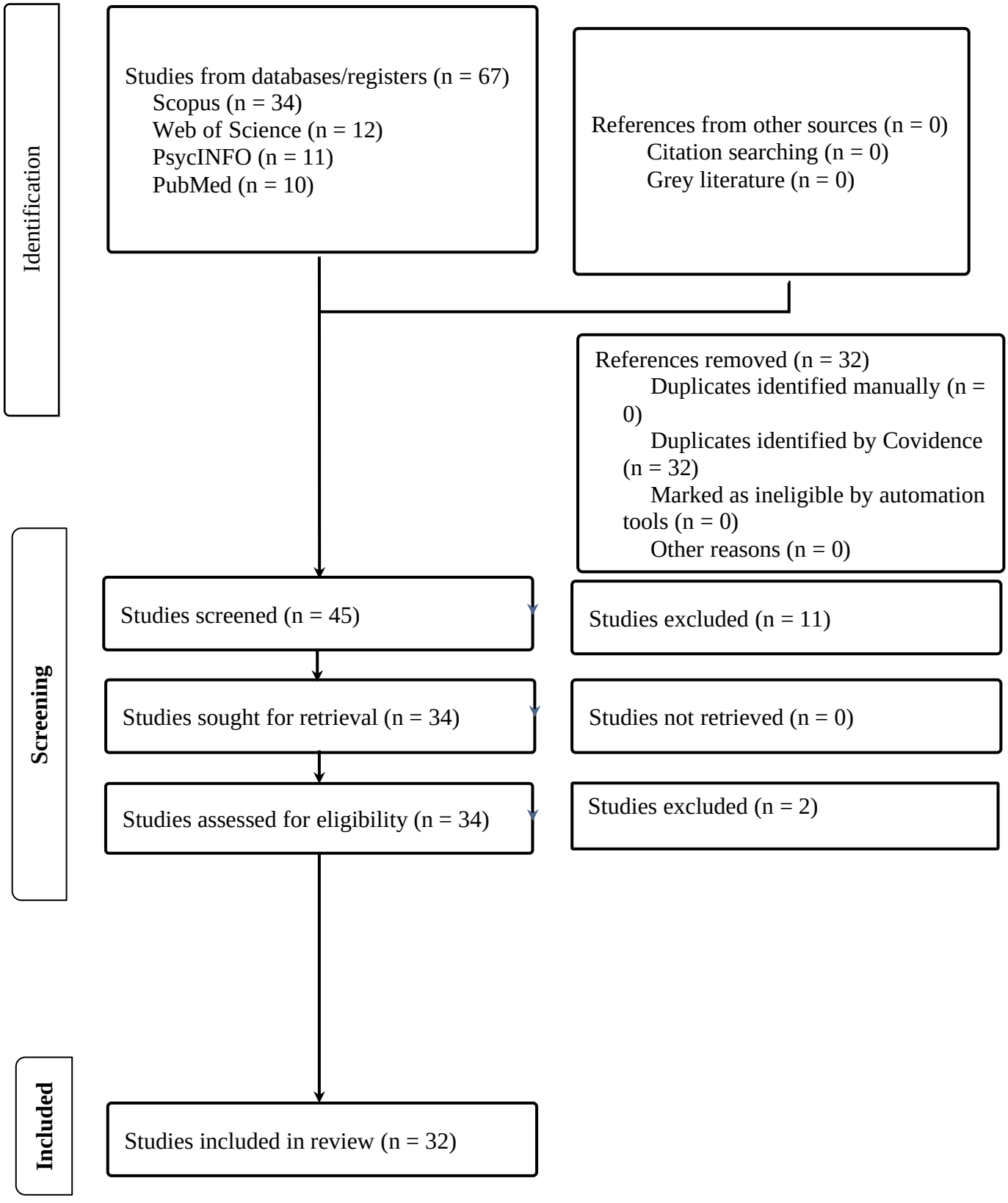
psychotherapy" OR "therapeutic rift" OR "psychotherapeutic impasses" OR "therapeutic impasses" OR "psychotherapeutic conflict" OR "therapeutic conflict" OR "disruption" OR "therapeutic abandonment" OR "psychotherapeutic disengagement" OR "therapeutic disengagement") AND ("repair" OR "therapeutic repair techniques" OR "resolution* techniques" OR "conflict resolution" OR "reconciliation" OR "mending" OR "conversation repair" OR "conversational repair") AND ("cognitive behavio*ral therapy" OR "CBT" OR "cognitive therapy" OR "behavioural therapy" OR "cognitive behavio*ral intervention")

Screening

The screening process was carried out using Covidence, which streamlined the review procedure. Covidence is an online tool that facilitates screening and data extraction based on the predetermined criteria of the review. Using the search strings, the peer-reviewed articles were exported from their database and imported into Covidence. The titles and abstracts of all the imported articles were then screened based on the inclusion and exclusion criteria to assess their relevance. Articles that did not meet the predetermined criteria were excluded at this stage of the process. The articles selected during the initial stage were subsequently reviewed in full text. The PRISMA flow diagram in Figure 1 summarises the screening and data extraction process.

Figure 1

PRISMA flow diagram



Data Extraction

For each included article, the following data was systematically extracted: (1) Information like the authors and publication year, (2) study design, (3) conceptualisations of ruptures, and (4) strategies for repair. An Excel sheet was used to keep track of the extracted data (see Table 5).

Data Synthesis

The data analysis for the literature review was conducted using the Grounded theory approach. This iterative process involved several steps aimed at identifying and developing theoretical insights into how CBT literature understands and addresses ruptures in the therapeutic relationship. The five-stage process of the Grounded Theory methodology outlined by Wolfswinkel et al. (2013) was followed.

Firstly, the research criteria were defined, and relevant sources were identified, ensuring a comprehensive literature selection. Subsequently, a thorough search for studies was conducted. Then, the iterative coding was carried out to identify key themes and alliances among the findings. The initial stage was open coding, which involved extracting data from the selected articles and analysing them to find important concepts and themes related to therapeutic ruptures and repair strategies. During this stage, each article was read multiple times to achieve a comprehensive understanding, and descriptive codes were applied to relevant text segments. For example, Lipner et al. (2021) state, “A rupture, in the context of Bordin's (1979) definition of the alliance, can be defined as a strain in the alliance as manifested by a lack of collaboration on goals and tasks and/or a deterioration in the emotional bond.” (p. 339). From this excerpt, the following open codes were derived: Strain in the alliance, Lack of collaboration on goals and tasks, and Deterioration in the emotional bond.

The next step was axial coding, which examined the connections between the codes found. This process entailed forming a coherent structure of related concepts. The goal was to find patterns that show how CBT conceptualises and addresses ruptures. For instance, the open codes Strain in the alliance, Lack of collaboration on goals and tasks, and Deterioration in the emotional bond were categorised as the axial code “Impact on the Therapeutic Alliance”, reflecting the overarching theme of how ruptures impact the quality of the client-therapist relationship.

The final step was selective coding. The core categories that combine the previous sub-categories were determined during this step. The selective coding process ensured a comprehensive understanding of ruptures and repair of the therapeutic relationship. An

example of this process is the integration of the two axial codes, "Impact on the Therapeutic Alliance" and "Nature and Intensity of Rupture", to form the selective code "Relational Dynamics of Rupture", capturing the relational impact of ruptures. This methodological process resulted in a coherent narrative that successfully incorporates ideas from the literature while adhering to the principles of thematic synthesis.

To enhance the efficiency of the coding process, the specialised tool ATLAS.ti was utilised to code and organise data. ATLAS.ti is a data analysis software that enables analysts to streamline the coding and analysis of qualitative data by effectively organising and labelling data, leading to fewer repetitive tasks (Lewis, 2004). Furthermore, ATLAS.ti improves the reliability of qualitative research through its systematic process (Adelowotan, 2021). Paulus and Lester (2015) argue that ATLAS.ti allows analysts to achieve a more comprehensive and nuanced level of analysis than was previously possible by facilitating focused analysis, cross-case comparisons, and collaboration.

Results

The systematic search yielded 67 hits across Scopus, Web of Science, PubMed, and PsycINFO. After identifying and removing 32 duplicate entries, 45 unique studies were screened for eligibility during the abstract review, resulting in the exclusion of 11 studies that did not meet the eligibility criteria. Subsequently, 34 full-text reviews were assessed, with two additional studies excluded. Ultimately, 32 studies were included in the final analysis (see Table 5).

Rupture Definitions in CBT

During the analysis process, multiple open codes were identified and subsequently organised into four key concepts: Impact on the Therapeutic Relationship, Nature and Intensity of rupture, Opportunity for Change, and Rupture Characteristics: Confrontation vs. Withdrawal. These concepts were then categorised into two overarching selective codes: Behavioural Components of Rupture and Relational Dynamics of Rupture. Table 3 provides an overview of the selective, axial, and open codes identified in the analysis. A detailed explanation of each selective and axial code is provided in the text below.

Table 3

Overview of Selective, Axial, and Open Codes for Rupture Conceptualisation in CBT

Selective code	Axial code	Open code
Relational Dynamics of Rupture	Impact on the Therapeutic Relationship	Drop in Working Alliance Inventory (WAI) score, Tensions in the therapeutic alliance, Deterioration of alliance, Risk-focused tension, Breakdowns in negotiation, Deterioration in the emotional bond, Disagreements in collaboration, Strain in the therapeutic alliance, Lack of collaboration on goals and tasks, Deterioration in the emotional bond, Strains in alliance, Weakening of alliance, Breakdowns in the relationship, Tensions, Deterioration of alliance, Lack of agreement, Strain in emotional bond, Breakdowns in negotiation, Deterioration in the emotional bond, Difficulty collaborating on tasks and goals, Difficulty versus disagreement, Strains in alliance, Breakdowns in collaborative relationship, Tensions, Confirming dysfunctional beliefs, Deterioration of alliance, Disagreements on treatment goals, Lack of collaboration on tasks, Lack of emotional bond, Weakening of alliance**,** Dissatisfaction, Reduction of quality of alliance, Strain in emotional bond, Halt of the therapeutic process, Difficulty in maintaining alliance, Breakdowns in collaborative relationship, Weakening.
	Nature and Intensity of Rupture	Major rift, Minor momentary tension, Major break in therapeutic alliance, Subtle tensions, Subtle, Acute incident, Subtle fluctuations in alliance, Dramatic breakdown in therapeutic relations, Minor misattunements, Alliance-shattering problem, Dramatic disconnect, Small misunderstanding, Major breakdowns of collaborative relationship, Minor breakdowns of collaborative relationship, Substantial deterioration in alliance, Worse than usual alliance, Dips in alliance, Quick decline in alliance, Fluctuation in alliance, Negative shifts in quality.
Behavioural Components of Rupture	Opportunity for Change	Impasses, Ambivalence, Challenges, Misattunement, Therapist's minimal response**,** Difficulty versus disagreement, Persisting with therapeutic activity, Focus on risk.
	Rupture Characteristics	Confrontation ruptures, Direct manner, Expressed anger, Expressed dissatisfaction, Hostile manner, Verbal disengagement, Withdrawal ruptures, Direct expression, Indirectly expressed, Attacking the therapist, Confrontation ruptures, Minimal response from the patient, Avoidance**,** Masking real experience, Movements away, Shutting down the work**,** Attacking behaviours, Complaining, Confrontation ruptures, Controlling behaviours**,** Criticism, Movements against, Pushing back**,** Direct expression of negative feelings, Discontent, Resistance**,** Hiding dissatisfaction, Attempts to control the therapist, Expressed anger**,** Combination of withdrawal and confrontation.

Relational Dynamics of Rupture

This selective code explores the overall impact of ruptures on the therapeutic alliance, as well as the nature and intensity of the rupture on the client-therapist relationship.

Impact on the Therapeutic Relationship

This axial code focuses on rupture definitions in CBT literature that define rupture by its consequence on the client-therapist relationship. Here, ruptures are conceptualised by how they negatively impact the emotional bond and collaboration between the client and therapist. Across the literature, ruptures are consistently defined as challenges affecting both immediate therapeutic engagement and long-term treatment outcomes (Bordin, 1979; Muran & Eubanks, 2020; Safran et al., 2011, as cited in Lipner et al., 2021; Muran et al., 2022; Rubel et al., 2018; Urmanche et al., 2021a). Specifically, the literature highlights that ruptures manifest as disagreements on the core components of the therapeutic relationship: agreement on goals and tasks, and the therapeutic bond, components that are fundamental to CBT's collaborative framework (Babl et al., 2022; Eubanks et al., 2018a; Safran & Muran, 2000, as cited in Zlotnick et al., 2020). Ultimately, this leads to reduced engagement and higher dropout rates (Babl et al., 2024; Cirasola et al., 2022; Eubanks et al., 2017; Humer et al., 2021; Luong et al., 2020; Strauss et al., 2006; Urmanche et al., 2021a).

While the terminology used in these articles varies, such as "strains", "impasses", "resistance", and "weakening" (Bordin, 1994; Elkind, 1992; Leahy, 1993, as cited in Cash et al., 2013), the underlying theme is clear: ruptures are defined as factors that undermine the core components of the therapeutic alliance. This suggests that ruptures within the CBT framework are not simply isolated disruptions but reflect deeper relational challenges, such as misalignment in treatment goals, tasks, or the therapeutic bond. This understanding of rupture shifts the focus from viewing ruptures as singular incidents to understanding them as signs of underlying relational dynamics that influence the therapeutic process.

Nature and intensity of ruptures

This axial code examines the literature on the variability of ruptures, emphasising that ruptures are not binary but exist on a spectrum. While ruptures are commonly viewed as significant deteriorations in the therapeutic alliance (Humer et al., 2021; Luong et al., 2020), Falkenström et al. (2013) suggest that any changes that represent a diminishing of the status quo can be seen as a rupture. So while "rupture" elicits thoughts of severe incidents, small changes can also be seen as ruptures. This is highlighted in literature where ruptures are described as minor shifts, misalignments, or subtle tensions in the therapeutic alliance (Eubanks et al., 2018a; Lipner et al., 2021; Okamoto & Kazantzis, 2021; Safran & Muran,

1996, as cited in O'Keeffe et al., 2020; Strauss et al., 2006; Zlotnick et al., 2020). Stricker (2013) adds that while some ruptures can be dramatic, most manifest in more subtle ways, which are often overlooked in the moment. However, if left unaddressed, they may escalate into more substantial issues. This challenges the conventional view of ruptures as severe and underscores the importance of recognising minor disruptions in the therapeutic process.

Furthermore, research highlights that the therapeutic relationship is dynamic, fluctuating between collaboration and rupture throughout the therapeutic process (e.g., McLaughlin et al., 2014; Safran & Muran, 2000, as cited in Stevens et al., 2007). These fluctuations can arise from various factors, such as the materialisation of negative feelings or mistakes. Ultimately, this understanding of ruptures suggests that with the CBT framework, ruptures are defined as varying degrees of disruption, ranging from subtle to more substantial disruptions in the therapeutic relationship.

Behavioural Components of Rupture

This selective code highlights two key aspects of alliance ruptures: Rupture Characteristics: Confrontation vs. Withdrawal, which are client behaviours signalling relational rifts, and Opportunity for Change, where ruptures can create chances to improve the therapeutic alliance.

Rupture Characteristics: Confrontation vs. Withdrawal

This axial code reviews the literature on how rupture in the therapeutic alliance can manifest in various behaviours. Based on the behaviour, ruptures are broadly categorised into confrontation and withdrawal (Satir et al., 2011). A confrontation rupture is described as the client moving against the therapist (Eubanks et al., 2018a; Muran et al., 2022). This movement against the therapist is overtly negative and can take the form of expressed anger, frustration, criticism, hostility, or even attempts to control the therapist (Babl et al., 2024; Coutinho et al., 2014; Eubanks, 2022; Eubanks et al., 2018a; Muran et al., 2022; Safran & Muran, 2000, as cited in O'Keeffe et al., 2020). According to Muran et al. (2022), confrontation ruptures show attempts of the client to define themself at the cost of the connection with the therapist.

Conversely, withdrawal ruptures are movements away from the therapist (Eubanks et al., 2018a; Eubanks, 2022; Muran et al., 2022). This type of rupture may manifest as avoidance, disengagement, hiding negative feelings, or being extremely compliant (Babl et al., 2024; Eubanks et al., 2017; Eubanks et al., 2018a; Okamoto & Kazantzis, 2021). These ruptures are seen as attempts by the client to achieve a connection with the therapist at the cost of expressing their true self (Muran et al., 2022). The rupture in this case is subtle, as the

client struggles to recognise their feelings and subsequently express them during therapy (Eubanks et al., 2015, as cited in Babl et al., 2024).

Importantly, these two types of ruptures are not mutually exclusive (Safran & Muran, 2000, as cited in Okamoto & Kazantzis, 2021), which means they can co-exist within the therapeutic alliance. Both confrontation and withdrawal ruptures negatively impact the therapeutic alliance, leading to poorer treatment outcomes (Boritz et al., 2018, as cited in Okamoto & Kazantzis, 2021; Cash et al., 2013). However, confrontation ruptures occur less often than withdrawal ruptures (Lingiardi & Colli, 2015, as cited in O'Keeffe et al., 2020). Thus, these behaviours underscore the complexity of disruptions within the therapeutic alliance, indicating that ruptures are not solely emotional or cognitive but can also manifest in observable client behaviours. In sum, ruptures in the CBT framework are additionally understood as behavioural responses that signal rifts in the client-therapist relationship.

Opportunity for Change

This axial code focuses on literature that views rupture as a signal for change and adaptation to optimise the therapeutic relationship. Several scholars highlight this perspective, with Safran and Muran (2000) suggesting that ruptures offer a unique potential for therapeutic growth by providing key moments to address and resolve underlying interpersonal schemata (as cited in Ackerman & Hilsenroth, 2003). Similarly, other researchers (e.g., Aspland et al., 2008; Leiper, 2000; Waddington, 2002, as cited in Cash et al., 2013) similarly argue that ruptures present opportunities for deeper therapeutic inquiry.

This perspective implies that ruptures cue therapists to adjust their approach, whether in relational or technical contributions (Colli & Lingiardi, 2017, as cited in O'Keeffe et al., 2020). Relational contributions refer to therapists' behaviours that negatively impact the therapeutic alliance, such as displaying criticism, offering minimal responses or lacking warmth (Ackerman & Hilsenroth, 2001; Colli et al., 2019; Colli & Lingiardi, 2017, as cited in O'Keeffe et al., 2020). Ruptures can also occur when therapists inadvertently confirm a client's dysfunctional beliefs, by triggering their core interpersonal about themselves and the world (Muran, 2002, as cited in Strauss et al., 2006; Ngai et al., 2013). This is particularly relevant for clients with personality disorders (Coutinho et al., 2014, as cited in Eubanks, 2022; Knox, 2019; Tufekcioglu et al., 2013, as cited in Gersh et al., 2016). In contrast, technical contributions occur when therapists misuse therapeutic techniques. Rigidly following treatment protocols and using inappropriate interventions are common practices that can cause a rift in the therapeutic alliance (Ackerman & Hilsenroth, 2001; Colli & Lingiardi, 2017; Piper et al., 1999, as cited in O'Keeffe et al., 2020). Castonguay et al. (2004)

caution that persisting with these misapplied therapeutic interventions can diminish the therapeutic alliance and hinder progress. These behaviours create a disconnect that leads to ruptures.

However, reframing ruptures as opportunities for adaptation allows therapists to recognise them as requests for change from the client. These moments have the potential to not only restore the therapeutic relationship but also improve the previous level of the alliance between the client and therapist (Safran & Muran, 2000, as cited in Ruben et al., 2018). For this reason, Tee and Kazantzis (2011) emphasise the importance of distinguishing between collaboration difficulties and outright disagreements (as cited in Muran et al., 2022). This distinction is essential, as well-managed disagreements can contribute to successful collaboration, provided the alliance remains undamaged (Muran et al., 2022). Therefore, understanding the factors contributing to ruptures enables therapists to better navigate and resolve them (Cirasola & Midgley, 2023). This demonstrates that ruptures and repair are interdependent processes, with ruptures providing the context for repair. Thus, within the CBT framework, ruptures are furthermore understood as catalysts for change that emerge in moments of therapeutic misalignment.

Repair strategies in CBT

During the analysis process, numerous open codes were identified and categorised into six axial codes: Alliance Assessment tools, Change Detection Mechanisms, Empathy and Collaborative Skills, Corrective Emotional and Relational Repair Techniques, Alliance-Focused Training and Supervision, and Adaptive Strategies. Subsequently, these axial codes were grouped into the following three selective codes: Assessment and Detection Tools, Repair Skills, and Repair Training. Table 4 summarises the selective, axial, and open codes. The subsequent section elaborates on the definitions of each selective and axial code.

Table 4

Overview of Selective, Axial, and Open Codes for Repair Strategies in CBT

Selective code	Axial code	Open code
Assessment and Detection Tools	Alliance Assessment tools	Working Alliance Inventory (WAI), Rupture, Empathy Scale (ES), Agnew Relationship Measure (ARM), Observer-based ratings, Indirect self-report methods, Measurements of ruptures, Indirect measures of ruptures, Assessment.

	Change Detection Mechanisms	Resolution Rating Scale (3RS), Collaborative Interactions Scale (CIS), Session by session assessment, Post-session assessment, Moment to moment assessment, Control charts, Multiple time point assessments, Person specific estimates, Statistical analysis, Pre-session to post-session assessment, Change detection, Deviations from treatment, Patterns.
Repair Skills	Empathy and Collaborative Skills	Thought and feeling empathy, Disarming technique, Inquiry, Three listening skills, Stroking, "I feel" statements, self-expression, Therapist's empathy, Awareness of shifts, Recognition of mistakes, Use of empathy, Direct validation, Validation of feelings, Collaborative repair, Collaborative empiricism, Re-establishment of collaboration, Re-establishment of understanding and mutual respect, Collaborative exploration, Sharing decision-making, Inviting feedback, Exercise responsiveness to feedback, Use of emotion.
	Corrective Emotional and Relational Repair Techniques	Corrective emotional experience, Expressive resolution strategies, Corrective or differential learning experience, Self-assertion, Clarification of interpersonal schemas, Validation strategies, Clarification of unmet needs, Explicit acknowledgement, Implicit acknowledgement, Recognition of the expression of implicit need, Acknowledgement of rupture, Direct resolution strategies, Indirect resolution strategies, No explicit acknowledgement of rupture, Corrective repair experience.
Repair Training	Alliance-Focused Training and Supervision	Integration of repair training in CBT, Mindfulness training, AFT as a CBT enhancement, Awareness of patients with interpersonal problems, Awareness of discrepancies in reporting, Self-practice, Self-reflection, Alliance-focused treatment, Recognition of therapist and client contributions. Supervisory tasks, Videotape analysis, Group supervision, Rupture resolution focused supervision, Exploration of therapist's contribution, Rupture repair model for child and adolescent psychotherapy, Awareness-oriented roleplays, Exploration of alternative viewpoints,
	Adaptive Strategies	Rupture recognition training, Awareness of ruptures, Identification of ruptures, Addressing of ruptures, Rupture detection, Exploration of rupture,

Exploration of avoidance, Exploration of rupture experience, Track A - Non-exploratory approach, Track B - exploratory approach, Incorporation of repair strategies, Rupture recognition as part of therapy manuals, Attention to alliance.

Assessment and Detection Tools

The selective code Assessment and Detection Tools focus on the methodological tracking of the alliance and identification of changes in the therapeutic relationship. The tools discussed in the axial codes allow therapists to assess the therapeutic relationship based on feedback and provide therapists with methods for identifying ruptures during and across multiple sessions.

Alliance Assessment Tools

This axial code addresses assessment tools that can be systematically used to track changes in therapeutic relationships. Regular session-by-session assessments allow therapists to detect early signs of rupture, often evident through shifts in alliance scores and specific observer-based ratings. A primary assessment tool for detecting and addressing ruptures is known as the Working Alliance Inventory (WAI), where declines in WAI scores reported by clients between sessions have been shown to indicate potential disruptions in the therapeutic relationship (Eubanks et al., 2018b; Haugen et al., 2017; Larsson et al., 2018, as cited in Humer et al., 2021). The WAI also helps therapists track returns to pre-rupture levels, which may indicate successful repair (Larsson et al., 2018; Stevens et al., 2007, as cited in Zlotnick et al., 2020). Additionally, the Empathy Scale (ES) is a self-administered session-by-session assessment tool completed by clients after each session, allowing therapists to monitor and address alliance changes (Burns, 1989; Burns & Auerbach, 1996, as cited in Constantino et al., 2008). This tool enables therapists to track and quickly address dips in the alliance based on changes in ES scores (Constantino et al., 2008). In brief, assessment tools like the WAI and ES offer indirect opportunities to resolve ruptures. Together, these tools promote timely identification, structured resolution, and consistent alliance monitoring, which promotes a more adaptive treatment approach.

Change Detection Mechanisms

This axial code discusses alliance change detection mechanisms. Eubanks-Carter et al. (2010) assert that detection methods are classified into within-session and between-session

methods (as cited in Lipner et al., 2021). Within-session methods are used to assess the therapeutic relationship from moment to moment during the session. Tools like the Rupture Rating Scale (3RS) and the Collaborative Interaction Scale (CIS) can be employed to monitor the occurrence of ruptures (Eubanks et al., 2018b; Colli & Lingiardi, 2009, as cited in Lipner et al., 2021). The 3RS and the CIS are valuable observer-based tools for repair strategies (Colli & Lingiardi, 2009, as cited in Lipner et al., 2021; Urmanche et al., 2021a). The 3RS categorises ruptures into two main types: confrontation and withdrawal ruptures, using five-minute intervals to assess seven client behaviours that are associated with ruptures and ten therapist strategies for resolution, rating each on a Likert scale to measure their effect on the therapeutic relationship (Urmanche et al., 2021a). At the same time, the CIS specifically evaluates collaborative behaviours, which are central to the working alliance (Lipner et al., 2021).

Between-session methods, however, use post-session measures to monitor shifts in the therapeutic relationship. Such post-session measures include control charts which plot alliance scores against the number of sessions to make a visual representation of the changes over time (Eubanks-Carter et al., 2012; Pande et al., 2000, as cited in Lipner et al., 2021). According to Eubanks-Carter et al. (2012), a rupture can be identified when the alliance score declines to a point lower than the control limit, as this implies a deviation from the status quo. Lipner et al. (2021) highlight the benefit of using control charts, arguing that they offer person-specific estimates, which makes them invaluable in visualising the therapeutic alliance's progression over some time. Although the benefits of control charts are clear, control charts appear to be less reliable in detecting ruptures resolved within the same session. In addition to control charts, the Reliable Change Index (RCI), a statistical tool, is suggested to enhance the WAI's precision by distinguishing minor fluctuations from significant disruptions (Jacobson & Truax, 1991; Stiles et al., 2004, as cited in Humer et al., 2021).

Repair Skills

This selective code refers to the therapist's ability to address ruptures in the therapeutic relationship. It focuses on techniques that support the restoration of trust, understanding, and connection. The axial codes that fall under Repair Skills are discussed below.

Empathy and Collaborative Skills

This category encompasses a range of therapeutic techniques that use empathy and cooperation to foster a strong therapeutic bond. It is rooted in client-centred therapy

principles, which emphasise empathy and understanding (Rogers, 1957, as cited in Castonguay et al., 2004). Three core listening skills are at the core of this approach: thought and feeling empathy, inquiry, and disarming technique (Burns, 1989, as cited in Castonguay et al., 2004). As Castonguay et al. (2004) describe, thought and feeling empathy is rephrasing the client's complaints or negative feelings. They describe inquiry as involving probing the client with questions to gain insight into their negative feelings towards the therapist or therapy. It is important to take a gentle approach while probing, not to interrogate the client. Finally, disarming techniques are described as requiring the therapist to consider the truths in the client's criticism, regardless of how unfounded they may seem to the therapist. By validating the client's experiences, these techniques aim to defuse defensive responses and promote open dialogue. Muran et al. (2022) support this assertion, stating that simple clarifications of intentions and validations of feelings lead to a corrective experience, resulting in the re-attunement of the therapeutic relationship.

Furthermore, self-expression skills are also said to play an important role in repairing ruptures. According to Castonguay et al. (2004), the use of "I feel" statements and stroking was popularised by Burns (1989), these are statements in which the therapist tactfully expresses their feelings for the client in moments of tension (Castonguay et al., 2004). The goal here is to make the client feel heard and understood, encouraging the client to re-engage with the therapeutic process (Castonguay et al., 2004). Building on the ideas of Burns (1989), Safran and colleagues (Safran & Degal,1990; Safran & Muran, 2000, 2006) have emphasised the significance of the therapist's cognisance of changes in the quality of the alliance, their empathy, and their willingness to explore their contribution to the ruptures (as cited in Constantino et al., 2008). These actions serve as a corrective interpersonal experience that is centred on openness rather than defensiveness (Constantino et al., 2008).

Additionally, the concept of collaborative repair has been well documented in CBT. The goal of such repair techniques is to assist in re-establishing the collaborative bond and help the client manage interpersonal difficulties both within and outside therapy (Catonguay et al., 2004). The techniques of acceptance, which involve the direct validation of the client's feelings and an empathetic response to their expression of worry, are a good example of collaborative repair (Catonguay et al., 2004). Other techniques include collaborative empiricism, collaborative exploration, and inviting feedback. By allowing clients to share in decision-making and give feedback, therapists enhance the client's sense of agency and, subsequently, the therapeutic relationship (Eubanks, 2022; Okamoto & Kazantzis, 2021).

Corrective Emotional and Relational Repair Techniques

This axial code can be defined as a set of therapeutic techniques that use empathy, understanding and cooperation to repair ruptures in the therapeutic relationship. These techniques, grounded in emotional validation and relational re-attunement, provide clients with corrective experiences that can reshape maladaptive interpersonal patterns. Validation plays a crucial role in this process by addressing disruptions with empathy, recognising the client's perspective, and fostering a space where they feel understood (Castonguay et al., 2004; Eubanks et al., 2017; Muran et al., 2022). Validation can take two forms: explicit, where the disruption is directly acknowledged, or implicit, where the client's feelings are subtly affirmed without formally discussing the rupture (Eubanks et al., 2017; Steindl et al., 2023). Okamoto and Kazantzis (2021) assert that perspective-taking empathy is essential for CBT's collaborative nature, helping reduce defensiveness and facilitate openness when ruptures activate dysfunctional interpersonal beliefs. Linehan (1997) further highlights that, at the minimum, validation should involve attentiveness, focus and active listening (as cited in Okamoto and Kazantzis, 2021). Additionally, therapists may also work on clarifying the client's interpersonal schemas or beliefs, which could be contributing to the rupture (Eubanks, 2022). Encouraging self-assertion and allowing clients to express their emotions openly can help clarify unmet needs (Cash et al., 2013; Muran et al., 2022).

Repair Training

This selective code focuses on strategies that equip therapists to navigate and repair ruptures in the therapeutic relationship. It incorporates experiential and reflective approaches and emphasises flexibility in applying the different strategies. This selective code represents strategies that aim to improve the therapist's ability to maintain the alliance when challenges arise.

Alliance-Focused Training and Supervision

This axial code focuses on a therapeutic training approach, Alliance-Focused Training (AFT), designed to improve the quality of the therapeutic relationship. AFT has been shown to enhance the therapeutic relationship significantly. This training incorporates mindfulness techniques, awareness-focused role-play, and video analysis to help therapists effectively repair ruptures in the therapeutic alliance (Urmanche et al., 2021b). Delivered in weekly 75-minute group sessions, AFT combines experiential learning with self-exploration and can be used as a standalone approach or with other therapeutic approaches. The mindfulness training teaches therapists to observe their thoughts non-judgementally, promoting emotional

regulation and greater self-awareness. In addition, role-playing and video analysis allow therapists to observe and address their emotional responses to ruptures by identifying and analysing rupture moments (Eubanks et al., 2017). Research by Muran et al. (2018) found that AFT improves the interpersonal approaches of therapists by encouraging more expressiveness, affirming words, and collaboration (as cited in Urmanche et al., 2021b). According to Urmanche et al. (2021b), AFT also enhances therapists' ability to engage in meta-communication, facilitating negotiation during therapeutic ruptures.

Adaptive Strategies

This axial code centres on two adaptable repair approaches, the non-exploratory and exploratory approach, for rupture repair. These approaches are also often referred to as expressive and immediate strategies. According to Eubanks (2022), research has indicated that training in rupture repair enhances the therapist's ability to manage ruptures, resulting in positive treatment outcomes. Muran et al. (2022) state that non-exploratory approaches focus on problem-solving, a direct and practical approach where ruptures are identified, and an agreement is immediately reached on how to address the issue. This strategy prioritises resolving issues efficiently without delving into the underlying causes but rather focusing on a solution that ensures the therapeutic process can resume without any further disruption (Muran et al., 2022). Eubanks et al. (2018a) add that they focus on resuming or modifying interrupted tasks. Non-exploratory approaches could be helpful in contexts where immediate, practical solutions, like adjusting treatment tasks, are needed to address a client's reluctance or resistance to a particular task .

In contrast, exploratory approaches involve an investigative approach, where the therapist and client collaboratively explore the underlying issues contributing to the rupture and work together to explore alternative strategies to resolve the issues (Muran et al., 2022). It involves identifying and understanding the emotional and cognitive barriers affecting the therapeutic relationship. Eubanks et al. (2017) state that this approach reorients the session toward the rupture and addresses the underlying issues. While Non-exploratory approaches are suited for situations requiring a more immediate resolution, exploratory approaches are helpful when a more in-depth exploration of the rupture's root causes is needed. This could be scenarios where addressing the root causes could lead to long-term healing and improved collaboration. According to Muran et al. (2022), empirical research has shown that the two tracks are best seen as complementary. It is up to therapists to gauge which track is the most appropriate based on the scenario. Ultimately, the flexibility to move between non-

exploratory approaches and exploratory strategies gives therapists the agency to tailor their repair strategy to each rupture's unique dynamics, ensuring that immediate resolution and in-depth exploration are integrated into the therapeutic process as needed.

Discussion

This literature review aimed to provide a comprehensive understanding of how ruptures are conceptualised within CBT frameworks and to identify CBT repair strategies by synthesising existing literature through a grounded theory methodology. The review sought to answer two key research questions: *(1) How are ruptures understood within CBT frameworks? (2) What repair strategies for therapeutic ruptures emerge from CBT literature?* Following the analysis of a diverse range of studies, several important findings emerged. These findings are discussed below.

How ruptures are understood within CBT frameworks

The review revealed that ruptures within CBT frameworks are conceptualised through four key themes: *Impact on the Therapeutic Relationship, Nature and Intensity of Rupture, Rupture Characteristics: Confrontation vs. Withdrawal, and Opportunity for Change*. First, numerous studies, including Babl et al. (2022) and Eubanks et al. (2018a), define ruptures in terms of their impact on the therapeutic relationship. These ruptures are seen as disruptions to the core components of the therapeutic relationship; agreement on goals and tasks, and the client-therapist bond. Second, ruptures are also defined by intensity and the degree to which they affect the therapeutic process, with studies such as Falkenström et al. (2013), Humer et al. (2021), Luong et al. (2020), and Zlotnick et al. (2020) indicating that ruptures range from minor disruptions to more dramatic breaks, also involving fluctuations in the client-therapist relationship. These first two dimensions of ruptures are categorised under the selective code *Relational Dynamics of Rupture*, highlighting that these definitions focus on the relational aspects of rupture.

The final two axial codes pertain to the *Behavioural Components of Rupture*, which focus on the specific behaviours associated with ruptures. The first axial code conceptualises ruptures as either confrontational or withdrawing. This categorisation is derived from the literature, which identifies ruptures as either overt expressions of conflict, such as anger or hostility towards the (Babl et al., 2024), or more subtle signs of dissatisfaction, such as avoidance or disengagement (Babl et al., 2024; Okamoto & Kazantzis, 2021). The second

axial code views rupture through the lens of these behaviours as signals that indicate the need for therapists to initiate change, either relationally or technically, to address the disruption in the therapeutic relationship (Ackerman & Hilsenroth, 2003; Cash et al., 2013). Therefore, this perspective views ruptures as opportunities for change, underscoring that ruptures are not fringe but critical moments that either weaken or strengthen the therapeutic relationship.

Taken together, an all-encompassing definition of rupture within CBT emerges from these four axial codes: *ruptures are opportunities for change that arise from varying degrees of disruptions in one or more core components of the therapeutic relationship, characterised by either confrontation or withdrawal behaviours*. This explicit positioning of ruptures as positive catalysts for change distinguishes the findings in this review from existing literature. While previous studies have primarily framed ruptures as disruption, challenges, or barriers to therapeutic progress, this review offers a unique, integrative perspective by reframing ruptures not only as obstacles but as potential sources of therapeutic growth. It contributes to a forward-looking, strengths-based approach to understanding ruptures, integrating earlier findings into a more comprehensive framework that acknowledges both the difficulties and potential benefits of ruptures in the therapeutic relationship.

Repair strategies for therapeutic ruptures within CBT frameworks

With this comprehensive understanding of how ruptures are conceptualised within CBT frameworks, attention now turns to repair strategies. Six specific repair strategies used in CBT were identified and subsequently categorised into three overarching themes: *Assessment and Detection Tools, Repair Skills, and Rupture Resolution Training*. These themes were further divided into actionable components: *Alliance Assessment Tools* and *Change Detection Mechanisms*, which are tools, such as the WAI and 3RS, that provide systematic feedback and early detection of alliance disruptions. *Empathy and Collaborative Skills*, and *Corrective Emotional and Relational Repair Techniques*, which are repair skills that emphasise empathy, validation, and collaboration, create corrective emotional and relational experiences that promote adaptive interpersonal dynamics. Lastly, *Alliance-Focused Training and Supervision*, and *Adaptive Strategies* are training programmes and guidelines that equip therapists with reflective and practical skills, promoting flexibility in addressing ruptures through exploratory or non-exploratory approaches.

These findings suggest that CBT employs a tiered approach to rupture repair, consisting of three key tiers: (1) Assessment and Detection: this tier focuses on early detection

and proactive monitoring to identify alliance ruptures before they escalate. Therapists make use of session-by-session tools (e.g., WAI and ES) and observer-based rating systems (e.g., 3RS and CIS) (Eubanks et al., 2018b; Urmanche et al., 2021a). This real-time feedback helps therapists adjust their approach to maintain a strong alliance. (2) Repair Skills: therapists can apply direct intervention techniques to resolve ruptures once a rupture is identified. This tier includes using collaborative and corrective repair strategies such as empathy-driven responses and validation strategies to rebuild the therapeutic bond (Castonguay et al., 2004; Okamoto & Kazantzis, 2021). (3) Repair training: therapists require training and skill development to handle ruptures effectively over time. Structured training programs, such as AFT, incorporate mindfulness techniques, role-playing, and reflection to enhance therapists' ability to navigate alliance ruptures (Urmanche et al., 2021b; Muran et al., 2022). This final tier involves equipping therapists with long-term strategies to effectively recognise, address, and prevent ruptures.

This tiered model underscores the importance of early detection, skill application, and long-term skill development. By integrating these elements, therapists effectively prevent, address, and repair alliance ruptures. The tiered framework for repair strategies identified in this review represents another significant contribution. The levels integrate various strategies into a pragmatic model for addressing alliance ruptures. The assessment and detection tier leverages tools like WAI and the 3RS for early detection of alliance ruptures. Repair skills, including empathy, collaboration and validation, align with CBT's emphasis on relational repair and corrective emotional experiences. Finally, repair training ensures that therapists are equipped to adapt to complex therapeutic challenges, promoting resilience and flexibility in dealing with ruptures. The strategies within this tiered approach are highlighted throughout existing CBT frameworks. For instance, Eubanks et al. (2017), Muran et al. (2022), and Urmanche et al. (2021b) emphasise the importance of training therapists to manage ruptures and promote applying therapeutic skills like empathy, validation and inquiry.

This review adds nuance by organising these strategies into a tiered framework, offering more explicit guidance on when and how to apply the specific strategies. This framework could serve as a foundation for training aspiring CBT practitioners by integrating it into their curricula and continuing educational programmes. Furthermore, the insights could enhance therapy protocols and support clinical supervision.

Limitations and Future Research Directions

While this review provides valuable insights, it is not without limitations. A key limitation is using a single researcher for coding and analysis, which introduces interpretative bias. As Walsh et al. (2015) note, single-researcher analysis increases the risk of subjective interpretations and misclassification of themes. The absence of multiple coders also prevents triangulation, compromising the reliability and objectivity of the findings.

Furthermore, relying solely on existing literature may have limited the identification of repair strategies that emerge in real-world circumstances. The absence of primary research, such as therapist interviews or observational studies, reduces the ability to capture practical applications of these strategies. This increases the risk of bias and leads to questions about the generalisability of the findings.

To address this review's limitations, future studies should extend the research to multiple coders to ensure inter-coder reliability. This would increase the objectivity of data analysis and help validate the findings. Moreover, it would encourage triangulation across coders, providing a more robust and reliable interpretation of rupture and repair themes.

In addition, given the reliance on secondary literature, future research should consider employing mixed methods, such as observational studies or clinical trials, to capture real-world data on how repair strategies are used in clinical practice. This would provide a more nuanced understanding of the practical application and effectiveness of these strategies in therapy.

Conclusion

This review reframes ruptures in CBT as transformative opportunities rather than mere setbacks. While previous research has acknowledged the potential for growth following rupture, this review offers a more explicit and integrated conceptualisation of rupture, synthesising relational dynamics and behavioural components of ruptures into a cohesive framework. Additionally, the findings highlight a structured yet adaptive tiered approach to rupture repair, emphasising early detection, intervention, and long-term skill development. These insights underscore the critical role of rupture repair in strengthening the therapeutic alliance and improving treatment outcomes. Ultimately, this review contributes to research and clinical practice by offering a refined conceptualisation of ruptures and a practical framework to inform therapist training and enhance therapeutic practices for clients and therapists.

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Appendix

Table 5

Results of included studies discussing rupture and/or repair in therapeutic relationships

Author, Year	Study Design	Key findings	
		Rupture	Repair
Ackerman & Hilsenroth, (2003)	Literature review	Ruptures in the therapeutic alliance can be seen as valuable opportunities for growth.	N.A.
Babl et al. (2022)	Longitudinal study with mixed design	Rupture is conceptualised as a lack of agreement on therapeutic goals and tasks or a strain in the emotional bond between the therapist and client.	Repair is focused on strengthening the emotional bond and collaboration between the therapist and client.
Babl et al. (2024)	Secondary data analysis of Randomised Controlled Trial	Ruptures in the therapeutic relationship, manifesting as overt conflict or subtle disengagement, can negatively affect the alliance and treatment outcomes.	N.A.
Cash et al. (2013)	Quantitative approach	Ruptures in the therapeutic alliance, though detrimental to the therapeutic goals and outcomes, can serve as an opportunity for deeper therapeutic exploration by fostering client self-assertion and clarifying unmet needs.	N.A.
Castonguay et al. (2004)	Quasi-experimental design	N.A.	Repair involves addressing therapeutic ruptures through empathy, validation, and techniques like inquiry to foster clients' re-engagement and strengthen the alliance.
Cirasola et al. (2022)	Longitudinal mixed methods Single-case approach	Therapeutic ruptures reduce treatment efficacy and increase dropout rates.	N.A.

		However, understanding rupture resolution has the potential to enhance therapeutic outcomes.	
Cirasola & Midgley (2023)	Literature review	N.A.	Repair is possible when there is an understanding of what contributed to the rupture.
Constantino et al. (2008)	Randomised Controlled Trial	N.A.	The importance of monitoring the therapeutic alliance, showing empathy, and analysing the therapist's contribution are highlighted as repair strategies.
Eubanks (2022)	Literature review	N.A.	Repair training is highlighted as an effective way of improving therapists' abilities to manage alliance ruptures. Collaboration techniques like inviting feedback and clarifying interpersonal schemas strengthen the alliance.
Eubanks et al. (2018b)	Validation study	N.A.	Assessment tools like the 3RS and WAI provide valuable insights to examine the therapeutic alliance and predict dropouts.
Eubanks et al. (2017)	Qualitative study, expert consensus methodology	N.A.	Therapist training to enhance skills in recognising and resolving ruptures, including video analysis, validation and empathy improves therapeutic outcomes by fostering understanding and collaboration.
Eubanks et al. (2018a)	Meta-analysis	Alliance ruptures fall under two categories: confrontation (over movements against the therapist) or withdrawal ruptures (subtle movements away from the therapist).	Repair strategies can be direct or indirect. Direct repair strategies explicitly address ruptures, while indirect strategies resolve the rupture without explicit acknowledgement.

Falkenström et al. (2013)	Longitudinal study with multilevel modelling	Rupture is any change that disrupts the established therapeutic status quo.	
Gersh et al. (2016)	Randomised controlled trial with repeated measures and process-outcome analyses.	When the therapist confirms the dysfunctional beliefs of clients with personality disorders, ruptures may occur.	N.A.
Humer et al. (2021)	Randomised controlled trial	N.A.	Assessment tools like the Working Alliance Inventory (WAI), supplemented by statistical tools like the Reliable Change Index (RCI) improve the detection of ruptures.
Knox (2019)	Literature review	Clients with personality disorders often exhibit dysfunctional behaviours that make them particularly susceptible to therapeutic ruptures.	N.A.
Lipner et al. (2021)	Randomised controlled trial	Ruptures can range from subtle misalignments to more severe strains. Through repair, rupture can lead to therapeutic growth.	Tools like the Rupture Rating Scale (3RS) and Collaborative Interaction Scale (CIS) are helpful in monitoring and detecting alliance ruptures.
Luong et al. (2020)	Systematic review	Ruptures are significant deterioration in the alliance and often result in early termination of the treatment.	N.A.
McLaughlin et al. (2014)	Randomised controlled trial	Research shows that alliances can shift between cooperation and conflict.	N.A.
Muran et al. (2022)	Mixed methods approach, qualitative study, randomised controlled trial	Ruptures are distinguished into two groups: Confrontation and withdrawal rupture. Confrontation ruptures are movements against the therapist characterised by asserting self-definition (for example, expressing anger). Withdrawal ruptures are movements away from the therapist (for example, avoiding tasks).	Therapeutic ruptures can be managed properly by applying empathy and validation techniques to rebuild the therapeutic relationship.

Ngai et al. (2013)	Randomised controlled trial	The confirmation of dysfunctional beliefs of clients can be a contributing factor to therapeutic ruptures.	N.A.
Okamoto & Kazantzis (2021)	Qualitative approach	Rupture also includes minor tensions in the alliance. Confrontation and withdrawal ruptures are two types of ruptures, and they can simultaneously exist within the therapeutic relationship.	Incorporating collaboration shared decision-making, and feedback-giving can help promote the client's agency, improving the alliance.
O'Keeffe et al. (2020)	Randomised controlled trial	Therapeutic rupture can take a subtle or overt form, such as confrontation or withdrawal, and both negatively impact treatment outcomes. Notably, withdrawal ruptures tend to occur more frequently. These ruptures can stem from the therapist's relational or technical contributing factors (e.g., criticism) or strict adherence to the treatment protocols.	N.A.
Rubel et al. (2018)	Quantitative approach	Ruptures in the therapeutic relationship negatively impact the collaboration and emotional bond. However, although ruptures can hinder the therapeutic process, they also have the potential to encourage growth once they are properly repaired.	N.A.
Satir et al. (2011)	Single-case experimental design	Ruptures, which present as either confrontation or withdrawal, are defined by their effect on the therapeutic alliance. When effectively repaired, ruptures can improve the alliance.	N.A.
Steindl et al. (2023)	Case study-based qualitative analysis	N.A.	Validation of the client's feelings is a repair strategy that is either explicit or implicit.

Stevens et al. (2007)	Randomised controlled trial	The therapeutic alliance is dynamic, characterised by periods of collaboration and rupture.	The Working Alliance Inventory (WAI) can be useful for tracking dynamic alliance changes and signalling ruptures and repairs.
Strauss et al. (2006)	Non-randomised open trial design	Ruptures increase the likelihood of early termination. They may include minor tensions that occur when clients have dysfunctional interpersonal beliefs.	N.A.
Stricker (2013)	Case study, qualitative approach	Ruptures can take a subtle or dramatic form. However, subtle ruptures are more common than dramatic ruptures.	N.A.
Urmanche et al. (2021a)	Mixed-methods, qualitative and quantitative approach	Ruptures negatively affect collaboration and emotional bonds between the therapist and clients, leading to increased dropout rates.	Observer-based tools like 3RS categorise ruptures into confrontation and withdrawal ruptures, evaluate the repair strategies, and provide a structure to assess and address ruptures.
Urmanche et al. (2021b)	Quantitative approach, correlational analysis	N.A.	Affective-Focused Therapy (AFT) enhances the therapist's ability to repair ruptures in the alliance. It incorporates mindfulness, role-playing, and video analysis to help therapists improve their expressiveness and communication skills.
Zlotnick et al. (2020)	Quantitative approach	Ruptures can manifest as significant strains or minor tensions that disrupt the therapeutic process.	Effective tools like the Working Alliance Inventory (WAI) are instrumental in monitoring alliance changes and recognising returns to pre-rupture levels.