Alliance ruptures and rupture resolution in cognitive–behavior therapy:
A preliminary task analysis

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(Received 14 May 2007; revised 13 June 2008; accepted 16 June 2008)

Abstract
An initial ideal, rational model of alliance rupture and rupture resolution provided by cognitive–behavioral therapy (CBT) experts was assessed and compared with empirical observations of ruptures and their resolution in two cases of successful CBT. The initial rational model emphasized nondefensive acknowledgment and exploration of the rupture. Results indicated differences between what therapists think they should do to resolve ruptures and what they actually do and suggested that the rational model should be expanded to emphasize client validation and empowerment. Therapists’ ability to attend to ruptures emerged as an important clinical skill.

Keywords: brief psychotherapy, alliance; cognitive–behavioral therapy; integrative treatment models; process research; psychotherapist training/supervision/development; aptitude–treatment interaction research; helpful events

The alliance between client and therapist has long been considered essential to therapeutic progress across all therapies, including cognitive–behavioral therapy (CBT; Bordin, 1979; Krupnick et al., 1996; Lambert & Ogles, 2004; Safran & Muran, 1996; Waddington, 2002). Rector, Zuroff, and Segal (1999), for example, reported that changes in depressogenic cognitions could be predicted by clients’ ratings of agreement with the tasks and goals of therapy, two components of the alliance (Bordin, 1979; Horvath & Greenberg, 1989), and Treupka, Rees, Shapiro, Hardy, and Barkham (2004) found that outcome in CBT for depression was related both to therapist competence and alliance. We used task analysis (Greenberg, 1984) to examine alliance ruptures and rupture repair in two cases of CBT.

Alliance Ruptures
Seminal work on ruptures in the therapeutic alliances by Safran and Muran (1996) and colleagues (reviewed by Safran & Muran, 2000; Safran, Muran, Samstag, & Stevens, 2002) has allowed close examination of what in the broader psychotherapy literature used to be known as resistance. Safran and Muran (1996) define ruptures as “deteriorations in the relationship between therapist and patient” indicated by “patient behaviors or communications that are interpersonal markers indicating critical points in therapy for exploration” (p. 447). Hence, ruptures are points of emotional disconnection between client and therapist that create a negative shift in the quality of the therapeutic alliance.

The concept of ruptures encompasses events that vary in frequency, severity, intensity, and duration across treatment and across therapist–client dyads (Eames & Roth, 2000; Safran & Muran, 1996, 2000). They are important because they may impede progress and, if unresolved, may lead to premature treatment termination. They may also vary across different perspectives; therapists in the study by Eames and Roth (2000) reported ruptures in nearly half of sessions, whereas clients reported them in just under one fifth. Binder and Strupp (1997) described

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ISSN 1050-3307 print/ISSN 1468-4381 online © 2008 Society for Psychotherapy Research
DOI: 10.1080/10503300802291463
ruptures as episodes of covert or overt behavior that trap both participants in negative complementary interactions; this view highlights the importance of considering a rupture as an interactive process that involves both client and therapist contributions.

A central idea emerging from this work is the importance of therapists recognizing and acknowledging problems in the relationship. Safran, Crocker, McMain, and Murray (1990) suggested that the most consistent factor identified in integrative therapy as precipitating ruptures has been therapists’ failure to pay attention to strains in the alliance or to the client’s experience. Castonguay, Goldfried, Wiser, Raue, and Hughes (1996) suggested that ruptures resulted from therapists persisting with the application of technique regardless of client concerns.

Another repeated theme is the suggestion that ruptures can have positive consequences if successfully resolved (Bennett, Parry, & Ryle, 2006; Muran, Safran, Samstag, & Winston, 2005; Rhodes, Hill, Thompson, & Elliott, 1994; Rice & Greenberg, 1984; Strauss et al., 2006). Binder and Strupp (1997) argued that a positive, effective alliance involves managing to negotiate and withstand ruptures and that resolving ruptures can lead to a stronger working alliance and a greater understanding of clients’ presenting problems. Conversely, therapists may overestimate their ability to establish and maintain good alliances, leading to negative consequences for treatment outcome. Binder and Strupp suggested that even highly trained therapists have difficulty managing their own involvement in interpersonal conflict. Failure to recognize markers of ruptures may result in their unwittingly exacerbating clients’ distress or frustration and not addressing significant issues. This, in turn, may initiate and maintain a negative cycle in which the rupture remains unresolved (Ackerman & Hilsenroth, 2001). Joyce, Duncan, and Piper (1993) observed that therapists in brief dynamic therapies often did not appear to recognize clients’ dissatisfaction, which then contributed to the dyad’s difficulties.

The importance of therapists’ active responsiveness to ruptures is underscored by clients’ frequent reluctance to confront their therapists regarding alliance problems. Watson and Greenberg (2000), in their study of experiential therapy, suggested that ruptures may arise from clients feeling unsafe to explore their emotional experience with their therapist, questioning the purpose and value of therapy, or having different expectations of the therapist’s role in treatment. Rennie (1994) reported that, without an invitation to collaborate in treatment planning, clients in a variety of therapies, including client-centered therapy, reported they could not directly confront their therapist and, therefore, resorted to subtle, defensive maneuvers.

Within CBT there has also been increasing recognition that disruptions in the therapeutic relationship offer both threats to and opportunities for therapeutic gains (Leiper, 2000; Waddington, 2002). Castonguay et al. (1996) described ruptures in CBT that resulted from rigid adherence to a treatment model. The ruptures occurred when therapists responded to strains in the relationship by persisting dogmatically with the application of a therapeutic technique rather than exploring the client’s difficult emotional experience and its impact. Further, Castonguay et al. (2004) indicated that attending constructively to ruptures in CBT had a positive impact on outcome, and both Strauss et al. (2006) and Muran et al. (2005) similarly reported that addressing ruptures in cognitive therapy for borderline personality disorder predicted significant symptomatic improvement and reduced dropout.

**Task Analysis of Rupture-Repair Sequences**

Greenberg (1984) pioneered the use of task analysis for the intensive analysis of events in therapy; this has been further elaborated in Greenberg (2007). Greenberg and Foerster (1996) outlined six steps of analysis: (a) Select a specific type of problem-solving task and operationalize in-session markers; (b) devise a rational (ideal) analysis of how the problem might be solved using experts (i.e., identify a rationally derived range of strategies for problem solving); (c) carry out an empirical study of actual problem solving; (d) progressively correct the rational model using empirical data (i.e., form a rational-empirical model); (e) refine the model by successively completing rational and empirical analyses; (f) verify the model by comparing successful and unsuccessful problem-solving tasks to identify the impact on outcome (this stage was not included in current study). Thus, task analysis utilizes an observational, inductive, and iterative strategy in which investigators use observations of individuals performing tasks to progressively improve descriptions of how the task can best be performed. It is congruent with Rosenwald’s (1988) multiple-case study approach to research and Stiles’s (2005, 2007) theory-building case study approach. Confidence in the evolving model increases as the intensive observation yields multiple points of contact between the cases and the model under construction, analogous to multiple degrees of freedom in a hypothesis-testing approach (Campbell, 1979).
Safran and Muran (1996) used the task-analytic paradigm to study the resolution of withdrawal ruptures in integrative psychotherapy. Sessions were selected for analysis based on fluctuations in client and therapist ratings on the Working Alliance Inventory (Horvath & Greenberg, 1989). Safran and Muran (1996) developed a model, assessed its ability to distinguish resolved from unresolved events, and refined it further through two rational-empirical models. They then used the refined model to develop and evaluate treatment interventions. In their final rational-empirical analysis, Safran and Muran proposed three therapist interventions to facilitate resolution: attending to the rupture marker, exploring either rupture experience or avoidance, and finally validating self-assertion (Safran, Greenberg, & Rice, 1988). In their later model (Katzow & Safran, 2007; Safran & Muran, 2000), a further stage was added after attending to the rupture marker. This stage involves therapists recognizing the cognitive-interpersonal cycle that they and their patients are in, including their own feelings, and moving to stand outside of the cycle.

Agnew, Harper, Shapiro, and Barkham (1994) reported a task analysis of rupture resolution in a single good-outcome case of psychodynamic-interpersonal (PI) psychotherapy. Sessions were selected for intensive analysis using fluctuations in the client and therapist ratings on the Agnew Relationship Measure (ARM; Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998). Agnew et al. (1994) looked for markers of confrontation challenges in the identified sessions using Harper’s (1994) coding system. In an intensive and iterative analysis, they developed narrative summaries of therapist and client task performances leading to resolution. In their resultant rational-empirical model, Agnew et al. (1994) described five stages following the rupture marker: acknowledgment, negotiation, exploration, consensus and renegotiation, enhanced exploration, and new styles of testing.

By contrast, Bennett et al. (2006) used a task analytic approach to study alliance-threatening transference enactments by clients drawn from a large-scale research project studying cognitive-analytic therapy with borderline personality disorder. Qualitative analyses were completed on four cases, containing 107 alliance-threatening transference enactments. Their refined performance model of enactment resolution broadly comprised the stages of acknowledgment, exploration, linking and explanation, negotiation, consensus, getting in touch with role positions, further explanation, and development of exits or aims and closure.

Current Study: Task Analysis of Ruptures and Rupture Resolution in CBT

Following the work by Safran and Muran (1996) on integrative psychotherapy, Agnew et al. (1994) on PI psychotherapy, and Bennett et al. (2006) on cognitive-analytic therapy, we used task analysis to construct a model of rupture and rupture repair in successful cases of CBT. Although familiar with and acknowledging previous models, we aimed to examine whether we would find similar results within a different therapeutic approach. We first constructed a rational model based on consultation with CBT experts, and we revised it based on intensive empirical observation of two selected cases in which clear ruptures occurred. Ours was a preliminary study that focused on comparing the initial rational model of a rupture-repair sequence, with the subsequent empirical model observed in a limited number of successful cases, and did not progress to the verification stage. Nor was the study designed to distinguish between resolved and unresolved ruptures.

Method

Rational Analysis

Participants. A rational model of rupture-repair sequences in CBT was constructed by Susan Llewelyn and Helen Aspland in collaboration with four internationally recognized expert British CBT therapists, all of whom had extensive experience of CBT and a long-standing interest in engaging clients with complex psychological difficulties.

Procedure. The expert therapists were given examples and the definition of a rupture as an emotional disconnection creating a negative shift in the quality of the therapeutic alliance. They were asked to engage in a thought experiment, an empathic creative process, imagining how they would proceed upon becoming aware of a rupture. They were asked to draw on their clinical knowledge but were not asked about their familiarity with theory or with existing models of rupture repair. Systematic questioning was used to explicate their clinical assumptions and understandings about rupture recognition and resolution. Using their responses together with principles drawn from CBT literature (A. T. Beck & Emery, 1985; J. S. Beck, 1995; Moorey, 1996; Wells, 1997), the investigators constructed a provisional map of the rupture-repair sequence, which was then circulated to the experts for comment and modification. After modification, the model was confirmed by all four experts.
Empirical Analysis

Data source. The study used rupture-repair sequences identified in the CBT of two clients seen in the Second Sheffield Psychotherapy Project (SPP2; Shapiro et al., 1994). In SPP2, 117 depressed, white-collar clients were randomized to either eight or 16 sessions of either CBT or PI psychotherapy for depression. Outcome was assessed by a battery of standard measures, including the Beck Depression Inventory (BDI; A. T. Beck, Ward, Mendelson, Mock, & Erbaugh, 1961).

The version of CBT in SSP2 study was a manualized multimodal method, similar to, but somewhat more behavioral in emphasis than, Beck’s cognitive therapy. Therapists used anxiety-control training, cognitive restructuring, self-management, and a job-strain package. Therapist adherence to the model was high, and clear discrimination was found between CBT and PI treatments. Both therapists in this study were experienced male clinical psychologists (Hardy, Shapiro, Stiles, & Barkham, 1998; Shapiro et al., 1994).

Alliance measure. Clients completed the ARM (Agnew-Davies et al., 1998) after each session to measure the alliance. This is a 28-item self-report instrument on which respondents rate agreement with each item on Likert scales. Based on the work of Bordin (1979) core alliance index is calculated as the mean of the items on three factor-based subscales: Bond, Partnership, and Confidence (Stiles et al., 2004). Evidence of the internal consistency and validity of the ARM has been reported elsewhere (Agnew-Davies et al., 1998; Stiles et al., 2002). Ethical approval for the study was obtained from local National Health Service ethics committees.

Selection of cases and sessions for analysis. The cases used for intensive analysis were two of the six SPP2 cases receiving CBT whose ARM scores contained rupture-repair sequences, as identified by Stiles et al. (2004). Clients were chosen because they experienced good outcomes as defined by changes on the BDI. One of the clients, Annie, a 59-year-old married woman, had a BDI score of 30 at pretherapy screening, 8 at posttreatment, and 10 at 1-year follow-up. Her presenting problems were feeling constantly frightened, difficulty relaxing, and negative beliefs that she would ever be able to “pull it together.” She also reported being distant from others, including her husband. The second client, Frank, a 45-year-old married man, had a BDI score of 22 at pretherapy screening, 1 at posttreatment, and 1 at the 1-year follow-up. Before treatment, he reported being anxious about work, having a poor relationship with his manager, feeling depressed, having low motivation, and being concerned about his work performance.

Two sessions per client were selected for analysis: the rupture session, when the ARM score dropped, and the repair session, when it recovered. For Annie, these were Sessions 4 and 5 and for Frank, Sessions 3 and 4. These clients’ ARM scores for the prerupture, rupture, and repair sessions, as well as their average ARM scores, are shown in Table I.

Safran and Muran (2000) and Harper (1994) suggested that ruptures comprise both a misunderstanding event (the precipitating context) and client rupture marker behaviors, which may be classified as either withdrawal (e.g., disengagement, minimal responding) or confrontation (e.g., disagreement or challenge). Safran and Muran (2000) suggested that markers of ruptures in CBT in particular may be subtle, such as overcompliance or withdrawal. Rupture markers used in this study were confrontation, withdrawal, or overcompliance. Rhodes et al. (1994) described rupture resolution or repair as the process of re-engagement in the task of therapy without assuming that this would always require an explicit statement of understanding or recognition of the rupture. Re-engagement was used as the repair marker in this study.

Analytic procedure. Three steps were taken:

1. Transcripts of the targeted sessions were read closely, and all potential rupture and repair markers were identified and classified by Susan Llewelyn and Helen Aspland. The majority (87%) of identified ruptures had withdrawal or disengagement markers, and in several instances re-engagement was followed within

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<th>ARM score</th>
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<td>Annie</td>
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Table I. Agnew Relationship Measure (ARM) Scores
minutes by another rupture; these were assessed separately.

2. All consensually identified therapist and client behaviors pertaining to the rupture and resolution attempts were scrutinized for their structure and characteristics, including duration, therapist and client response, and extent of subsequent engagement (see later examples).

3. Empirical results were compared with the rational model, resulting in construction of a rational-empirical model (see Greenberg, 2007, for a full outline of the task analysis procedure).

Results

Rational Analysis

The consensus expert-derived rational rupture-resolution model is shown in Figure I. Seven stages were identified. It was proposed that once the marker is noticed, the therapist needs to review it internally, evaluating the intensity and significance of the rupture and deciding on possible action (note that it would not be possible to observe this part of the process because it is internal to the therapist). If indicated, the therapist should decide whether or not to act, acknowledge the rupture marker, seek client feedback, and explore the rupture. This exploration might include therapist acknowledgment of a contribution to the rupture or validation of the client’s experience. Unless there is a straightforward misunderstanding, this should then lead to an examination of links to other instances within or outside therapy and to the formulation. Finally, there should be negotiation or collaborative agreement on how to proceed, possible revision of the formulation, or revision to the current task. The process of resolution might involve cycling within and between stages.

Empirical Analysis

Number of rupture and resolution episodes. We identified 24 rupture episodes and attempts at resolution during the four sessions we studied. Fourteen instances were identified in Annie’s two sessions, 10 of which occurred in the rupture session and four in the repair session. In Frank’s therapy, 10 rupture episodes were found: seven in the rupture session and three in the repair session.

Rupture episodes during the rupture sessions. In all rupture episodes identified in the rupture sessions, therapists followed their own agenda and did not overtly validate the clients’ viewpoint. Rupture episodes tended to happen in quick succession and were characterized by client withdrawal, passive concession, or disengagement. On only three occasions did one client (Frank) tentatively challenge the relevance of what the therapist was pursuing. Attempts at resolution were partial and involved both participants trying to re-engage in the task by going over similar ground, apparently agreeing, or changing the topic. For example, early in Session 4, Annie identified her domestic situation as difficult and was eager to discuss it. The therapist, however, had been pursuing the task of reviewing Annie’s use of relaxation, which had been prescribed the preceding week as homework. The third rupture episode of the session occurred when the therapist attempted to find examples of when Annie had felt tense at work. In response to Annie’s denial of a problem there, the therapist re-explained the rationale and continued to pursue the task. Annie’s withdrawal and minimal responding marked the rupture:

Therapist: So are there any situations at work that get you a bit wound up, get you a bit tense?

Annie: Not—not at the moment, not that . . .

Therapist: Not a lot just a—just a bit . . . not the very worst situation you are facing at the moment so as to get the idea and build up the strength for relaxation. So you see what I mean?

Annie: Mm.

Therapist: Fine . . . You need some other things and we’ll work out what to help you with those pressures. But in the meantime the skill of relaxation is something that we could begin to develop as a . . . something to help you to cope with tension and pressure.

Annie: Mm.

The therapist then continued pressing for an example, which Annie finally provided, although repeating that this was not a problem and that she now felt more confident at work. The therapist briefly praised Annie for this and the discussion moved on. However, the issue was not fully resolved, recurring several minutes later, with an essentially similar rupture:

Therapist: Yeah, well, remember I’m still talking about relaxation. I know that’s not the whole of your life, but so I’m still talking about relaxation and what I’m looking for is a situation that makes you tense . . .
Annie: You mean at work?

Therapist: Well, I was thinking of work because that was kind of...it was safe because it was so distinct from the home situation that bothers you a lot. It doesn’t have to be at work but as I...that was...that was why I was looking for something at work to keep it separate from home at the moment.

Annie: (8-s pause) No, I can’t think of...I can’t think of one at work lately.

Annie did not effectively re-engage in therapy until the therapist addressed Annie’s concerns by inquiring about her home situation.

Similar instances were found in Frank’s therapy. For example, following a discussion of Frank’s
difficulties unwinding after work, he identified his main problem as sleeping. The first rupture episode occurred when the therapist suggested a strategy to address the disengaging difficulty and directed Frank toward that, indicating that it was a more important goal than sleeping. In particular, the therapist suggested a technique for excluding work-related thoughts. During this, Frank responded minimally and eventually tentatively challenged the task:

Therapist: There’s some genuine thing here to be concerned about. And I think the issue is . . . is not so much actually one doesn’t want to spend time thinking about these things at all . . . This is about getting some boundaries. This is what is more important than anything.

Frank: Great.

Therapist: How . . . how does . . .

Frank: The thought that comes to my mind as you were saying that is “Impossible.”

The therapist began exploring Frank’s reservations, and Frank described previous failed experiences in pursuing similar strategies, before attempting to redirect the discussion to his sleeping difficulties. The therapist responded by re-explaining the rationale for the disengaging task and pursuing ways of completing it. This resulted in a further rupture and repetition of the pattern whereby the therapist presented a solution, not accepted by the client, to a problem that the client has not considered central.

Rupture episodes during the repair sessions. For both clients, there were fewer than half as many ruptures in their repair session as their rupture session, and when they occurred, rupture episodes were much more effectively resolved. Although continuing to pursue their own tasks, therapists in the repair session worked more explicitly toward client engagement, initially by summarizing and exploring clients’ accounts following the rupture episode while also checking clients’ understanding. The clients then started to participate more fully and became increasingly confident in expressing reservations or their wish to pursue another task. This then led to revisions in the therapists’ approach and the adoption of a more collaborative interaction.

For example, early in her repair session, Annie and her therapist began discussing the pros and cons sheet on her marriage previously assigned as homework. Annie reported satisfaction that “I’ve managed to pull out what I feel are the important things that need to be discussed.” The therapist then disagreed, suggesting that because Annie had experienced a reasonable week at home, this could have biased her list positively. A rupture episode occurred when Annie demurred and the therapist reiterated his perception of the task, leading, as before, to minimal responding and withdrawal. For the first time in these two sessions, however, the therapist next valued and then explored Annie’s contribution:

Therapist: So what—what’s excellent about this is that we’ve got a list here of propositions that we’re not just talking about “Should I stay or should I go?” We’re talking in much more detail . . . it’s much easier to evaluate them.

Annie: I’ve not done it in enough depth.

Therapist: What do you mean by that?

Annie: Because there are . . . there are other reasons why I should go.

Therapist: Other reasons why you should go?

Annie: And I did . . . I spent, you know, quite some time on it and as I say, I’ve—I’ve thought about it and thought about it, er, a lot . . . er, but I am just not— I’m not happy there.

At this point the therapist validated Annie’s struggle and suggested he could understand some of the reasons why, despite extensive deliberations, she may have decided to stay in an unhappy marriage. She responded well to this and elaborated further on her dilemmas.

A similar example occurred in Frank’s therapy. Before the second rupture episode in the repair session, Frank and the therapist were discussing Frank’s conflictual relationship with his manager, and the therapist suggested a cognitive solution of thinking differently about the manager. Frank expressed reservations, but the therapist continued, suggesting how Frank could manage the situation more effectively. The rupture was marked by Frank’s minimal response throughout and finally by a mild challenge. The therapist did not at first validate this, instead effectively rebuking him:

Frank: Interesting hypothesis. Er (4-s pause) . . . don’t . . . don’t know whether it’s possible to put into . . . into practice as easily as it . . . as it sounds because . . .

Therapist: Nothing is easy.

Frank then expanded his reservations further, elaborating his experiences with the manager. This
time, however, the therapist validated his reservations, using Frank’s own metaphor to describe the manager (“a wet blanket”), and adopted a more collaborative tone:

Therapist: Okay, which of those two do you think would be easier for us to tackle?

Frank: The easiest is sorting the problem that he’s just around the department and not, but this is not the most important I would surmise, possibly wrongly, as if we can cure or come up with suggestions to deal with the difficult, the...the feeling that there is a “wet blanket” will just disappear.

Therapist: Okay, shall we have a ... crack then at prioritizing the ... interaction ones?

Frank: Yes, yes. I think that would be ... be more beneficial, yes.

These results suggest that a key step toward resolution of these ruptures appears to have been switching focus to issues more salient to clients. It is not possible to assess whether therapists had been internally reviewing, evaluating, or linking the rupture to the formulation before the switch.

Rational-Empirical Comparison

The next stage was construction of a rational-empirical model, that is, a revised model of observed rupture resolution performances. Each of the 24 resolution attempts was iteratively compared with the rational model and to the other 23 observed performances. This process produced the rational-empirical model shown in Figure II, based on the “researchers’ cumulative understanding of these comparisons” (Harper, 1994, p. 254).

The most substantial change from the initial rational model was that therapists and clients did not explicitly acknowledge that the ruptures had occurred. Therapists did not acknowledge their own contribution to the rupture or discuss this collaboratively, nor were links to the formulation made explicitly. Clients re-engaged with therapy only when the topic under discussion shifted toward their own concerns. Recognition that a rupture had taken place took some time, and an effective change in therapists’ approach occurred only after a number of ruptures and resolution attempts. The lack of verbal acknowledgment of the rupture meant that explicit mutual exploration of this was not feasible. No empirical support was found for the proposed stage in which therapist and client agreed to monitor similar events as an ongoing task of therapy (cf. Figure I). Instead, therapists eventually changed their approach, attending to clients’ experience through summarizing, exploring, and validating. The changed approach did seem to lead to the successful restoration of the collaborative relationship, as suggested by the rational model, via encouragement of active participation, valuing the client, and seeking feedback.

As Figure II shows, the restoration process played a more significant role than envisaged in the rational model. The absence of an explicit acknowledgment stage entailed other significant differences, including the absence of explicit changes to the formulation or open discussion of this by the dyad (although possibly this process occurred in private in the therapist’s conceptualization).

Discussion

The ruptures observed in our empirical analysis appeared to arise primarily from unvoiced disagreements about the tasks and goals of therapy, which then negatively affected the therapeutic alliance. For both Annie and Frank, difficulties arose from their therapists initially appearing inattentive to their experiences or to the immediate significance of an issue for them. As observed by Castonguay et al. (1996) in other cases of CBT, ruptures in this study became manifest primarily in clients seeking to avoid tasks or becoming unresponsive to therapists’ interventions. Notably, in both dyads, negative complementary interactions then took place. Progress toward successful resolution appears to have been facilitated only by therapists changing their behavior to focus on issues salient to the clients. By being more collaborative, the therapists thus avoided perpetuating these complementary interactions.

Our findings provide some support for Castonguay et al.’s (1996) suggestion that ruptures result from therapists persisting with the application of technique irrespective of client concern. Our observations are also consistent with the model proposed by Safran and Muran (1996), who suggested that rupture repair can be effected if the recurrence of repetitive relational patterns are addressed. Moves toward resolution by these CBT therapists appeared to be helped by therapists changing their behavior and encouraging clients to engage by acting in a more helpful, collaborative style of interacting, thereby providing “a new constructive interpersonal experience that will modify their maladaptive interpersonal schema” (Safran & Muran, 1996, p. 447).

There were a number of interesting differences between the rational and the rational-empirical model. In contrast to both Safran and Muran’s
model and the rational model, the revised model
did not, for a number of possible reasons, include
overt recognition or discussion of the rupture itself.
First, processes of recognition and reformulation
may have occurred silently in the therapists’ own
understanding of the case, although these could not
be directly observed or easily inferred by an
observer. Thus, the first stages of the ideal model
(the internal review process and decision to act) and
Safran and Muran’s model were, in effect, system-
atically excluded from our revised model by the
empirical phase of the task-analytic method (i.e., we
did not investigate therapists’ accounts). Second,
possibly the predominance of withdrawal and hence
largely covert ruptures, rather than confrontation
and hence more overt ruptures, in our sample may
help to explain the lack of explicit discussion. Third,
perhaps a somewhat different model of rupture
repair may operate in at least some forms of CBT.
Possibly the therapists in this study were following
the more behaviorally oriented approach used in the
Sheffield study rather than current CBT best
practice, which recommends clear and explicit
recognition of the process, including difficulties.
Finally, it may be that, in practice, the covert
management of ruptures is more common, espe-
cially when they are not overt ruptures, as was
predominantly the case here. Even in their more
relationally oriented approach, Safran and Muran
(2000) suggested that “it may be preferable (at least

Figure II. The revised rupture repair model.
initially) for the therapist to be silent and formulate his or her understanding to him- or herself, since any overt interpretation runs the risk of being defensively motivated if the therapist has not adequately processed his or her own feelings” (p. 107). Such a view is consistent with Binder and Strupp (1997), who note the frequent occurrence of therapist difficulty in recognizing their own contribution to interpersonal conflict. Alternatively, the therapists may have considered that overt discussion might distract from the need to change focus, which Safran and Muran (2000) suggest is best effected by changing tasks or goals. The change of approach seen in Annie’s and Frank’s therapists during the repair session may demonstrate internal reformulation or a decision to refocus, although this cannot be verified because therapists were not interviewed about this.

The use of summarizing, exploring, and validating seen in these cases converges with recommendations by Rhodes et al. (1994), Newman (1998), and Watson and Greenberg (2000) that, on noticing a rupture, therapists should become more empathic and responsive, use reflection, and encourage clients to express their concerns rather than continuing with technical intervention. Our observations also converge with those by Castonguay et al. (2004) and Muran et al. (2005) in proposing the beneficial effects of systematically addressing ruptures using strategies such as validation and acceptance of responsibility for ruptures rather than more standard CBT techniques. The current empirical analysis also highlighted the interactive nature of rupture and rupture resolution suggested by Safran and Muran: The clients clearly worked hard to repeatedly provide their therapists with indicators of their needs. The role of the “heroic client” and their drive to make therapy effective, including resolving alliance ruptures, should not be underestimated (Duncan & Miller, 2000).

Our observations emphasize the concern that therapists may interpret clients’ negative reactions or withdrawals personally and respond with anxiety, redoubling efforts to apply a theoretically correct technique. Such a concentration on task rather than process seems likely to perpetuate the rupture. Instead, CBT therapists should attend to process issues in much more detail in training and practice. We note that the therapeutic strategies needed to resolve a rupture in CBT are entirely consistent with good CBT practice, namely summarizing, exploring, validating, collaborating, and seeking feedback (A. T. Beck & Emery, 1985).

**Limitations**

First, we did not examine the extent to which our experts, when constructing the rational model, were familiar with, and hence influenced by, existing models of rupture repair. It was notable that the rational model was not explicitly cognitive in nature. Next, our identification of rupture episodes was qualitative, in the absence of any established method of rupture identification in CBT. Only audiotapes were available, and videotaped recordings might have provided further useful information. Next, we acknowledge that studying only two therapeutic dyads is appropriate for theory-building case study research (Rosenwald, 1988; Stiles, 2005), but, of course, rupture and repair may take other forms in other CBT dyads. It is also unlikely that we have sampled all ways of resolving ruptures. Another limitation is that both our cases had successful outcomes, so there are no comparisons with rupture resolution sequences in unsuccessful cases. Nevertheless, as noted previously, the proposed CBT rupture-repair model shares aspects with models derived within other approaches, including integrative therapy (Safran & Muran, 1996), psychodynamic therapy (Agnew et al., 1994), and cognitive analytic therapy (Bennett et al., 2006).

Finally, the current study represents an initial attempt. Refinements based on further cases can increase confidence in and generality of the model. Future work might include operationalization of each stage of the preliminary model and testing it in other clinical samples to determine which stages of rupture-repair sequences could be identified reliably (Safran et al., 1988). Hypotheses derived from the model could be tested: For example, rupture-repair sequences consistent with this model should appear more frequently in good-outcome cases compared with poorer outcome cases (see Greenberg, 2007).

**Summary**

This study provided a preliminary task analytic comparison of CBT experts’ concepts of rupture and rupture resolution with rupture and repair observed in the clinical practice of CBT. The rational model of resolution as provided by CBT experts was only partially confirmed in practice. There appeared to be some differences between what therapists think they should do to resolve ruptures and what they actually do, particularly the lack of implementation of the consensus expectation that the rupture should be explicitly acknowledged.
The processes of nondefensive exploration, validation, and client empowerment, however, were confirmed as appearing significant in resolving therapeutic difficulties and in maintaining the quality of the therapeutic alliance.

References


