

## Repairing alliance ruptures in psychotherapy with adults: a scoping review

Alberto López-Vásquez,<sup>1-4,6</sup> Nicolás González-Araneda,<sup>1-3,5</sup> Stephanie Vaccarezza,<sup>1-3,6</sup> Catherine F. Eubanks,<sup>7</sup> Paula Errázuriz<sup>3,6,8</sup>

<sup>1</sup>Doctoral Program in Psychotherapy, Universidad de Chile, Santiago, Chile; <sup>2</sup>Doctoral Program in Psychotherapy, Pontificia Universidad Católica de Chile, Santiago, Chile; <sup>3</sup>Foundation for Research on Depression and Personality (MIDAP), Santiago, Chile; <sup>4</sup>Department of Psychology, School of Psychology, Universidad Diego Portales, Santiago, Chile; <sup>5</sup>Faculty of Behavioral and Social Sciences, University of Groningen, The Netherlands; <sup>6</sup>PsiConecta Mental Health NGO, Santiago, Chile; <sup>7</sup>Gordon F. Derner School of Psychology, Adelphi University, Garden City, NY, USA; <sup>8</sup>Department of Clinical Psychology, School of Psychology, Pontificia Universidad Católica de Chile, Santiago, Chile

### Abstract

Therapeutic alliance ruptures represent critical moments that, if properly addressed, may become opportunities for therapeutic change. Although various models and evidence exist regarding rupture repair, no prior scoping review has systematically mapped clinical recommendations using a replicable methodology. This review aimed to map clinical recommendations for repairing therapeutic alliance ruptures in psychotherapy with adults, focusing on therapist competencies, patient characteristics, and theoretical frameworks underpinning these recommendations. Following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) guidelines, articles were retrieved from Web of Science, PsycINFO, and Scopus, supplemented by secondary searches. Conceptual and empirical publications addressing rupture repair in individual psychotherapy with adults were included (n=25). The review maps two complementary sets of recommendations. Empirical studies appear to converge on strategies organized around rupture recognition, expressive repair (focused on exploring the rupture experience), and immediate repair (focused on corrective task and goal adjustments). Theoretical and conceptual contributions highlight the influence of cultural, contextual, and trauma-related factors on rupture and repair processes, emphasizing the need for sensitivity to patient-specific, cultural, and contextual factors. Overall, the findings suggest that the literature on rupture repair is evolving toward greater contextual sensitivity, with personalization and responsiveness emerging from an integrative reading of the findings as central challenges for clinical practice and future research.

**Key words:** therapeutic alliance, alliance ruptures, rupture-repair, training.

Correspondence to: Alberto López-Vásquez, School of Psychology, Universidad Diego Portales, Vergara 210, 8370067 Santiago, Chile.  
E-mail: alberto.lopez1@mail.udp.cl; alverlo.uchile@gmail.com

### Introduction

According to the model proposed by Bordin (1979), the therapeutic alliance has been conceptualized as a collaborative agreement between patient and therapist regarding therapy goals and tasks, sustained by an emotional bond of trust. The alliance is a robust predictor of treatment outcomes (Flückiger *et al.*, 2018). Patients who report a stronger alliance during treatment also tend to report better outcomes, a finding that remains consistent across diverse psychotherapeutic contexts (Flückiger *et al.*, 2020).

A rupture can be understood as a deterioration of the therapeutic alliance, which may manifest as disagreement or lack of collaboration on treatment goals or tasks, or relational tension affecting the bond between both members of the therapeutic dyad. The core of the disruption is represented by breakdowns in the way patients and therapists negotiate their respective needs and desires (Muran & Eubanks, 2020; Safran & Muran, 2000a). Ruptures are not limited

to abrupt or overt events, as they may also include more subtle signals, such as minor mismatches or covert tensions, which, if unrecognized, may compromise the therapeutic process.

While much of empirical and conceptual development in this area has been led by the Safran and Muran research program, these contributions have been complemented by other research groups who have developed related models of rupture resolution, some of which provide empirical support for Safran and Muran's expressive model. These include work with adolescents (Daly *et al.*, 2010), couple therapy (Swank & Wittenborn, 2013), and various therapeutic approaches such as psychodynamic (Agnew *et al.*, 1994) and integrative cognitive-analytic therapy (Bennett *et al.*, 2006), among others included in this review. In the present study, the conceptualization is primarily grounded in the Safran-Muran-Eubanks framework, given its central influence in the field.

Two types of rupture have been distinguished: *withdrawal ruptures* and *confrontation ruptures* (Harper, 1989; Safran & Muran,

2000a). The former involves movements away from the other or the therapeutic work, such as when a patient shows a compliant and appeasing attitude, for instance, by agreeing with the therapist while withholding disagreement or dissatisfaction, thereby denying an aspect of their own experience, or when a therapist changes the topic to avoid exploring certain issues in therapy. These withdrawal movements are often motivated by fear of compromising the therapeutic relationship and may represent efforts to protect the bond. Confrontation ruptures, in turn, are defined as movements against the other or the therapeutic work, such as when a patient seeks to control the therapist or hostilely rejects their ideas, or when a therapist complains about or criticizes their patient. These confrontations may reflect efforts to preserve autonomy at the expense of the bond.

Consistent with a relational perspective, Muran and Eubanks (2020) have emphasized that ruptures are not individual responses but co-constructed phenomena in dyadic interaction, so both therapists and patients can contribute to ruptures. This implies that ruptures may reflect differing perspectives, expectations, or interpretations between patient and therapist, which need to be negotiated within the therapeutic interaction.

Empirical research has shown that rupture repair presents significant challenges for psychotherapy. Unresolved ruptures are associated with poor treatment outcomes, whereas successfully repaired ruptures are significantly associated with positive outcomes (Eubanks, Muran, & Safran, 2018). Rupture repair allows the patient and therapist to renew or strengthen their emotional bond and restart collaboration on therapy tasks and goals (Eubanks, 2022; Eubanks & Muran, 2022; Safran & Muran, 2000a). Far from being obstacles, ruptures can represent opportunities to identify patients' dysfunctional interpersonal schemas (Safran & Kraus, 2014) and offer corrective emotional experiences (Christian *et al.*, 2012). For example, a patient who expects rejection when expressing dissatisfaction may, through repair, experience a different relational response that challenges their prior expectations. In this sense, repair is understood not only as a means to restore collaboration but also as a potential mechanism of change in itself (Eubanks, Sergi, Samstag, & Muran, 2021). When timely and sensitive, interventions during these difficult moments may allow patients to engage in new relational experiences that challenge prior expectations of rejection or misunderstanding, fostering emotional learning and the reorganization of interpersonal experience (Safran & Kraus, 2014).

Two main categories of repair strategies have been defined: immediate and expressive, both beginning with rupture recognition and culminating in the provision of a new relational experience (Muran & Eubanks, 2020). *Immediate repair strategies* refer to interventions that aim to promptly address alliance ruptures through corrective actions that bring treatment back on track. They typically involve two main pathways: addressing the rupture and refocusing treatment through interventions such as validating the patient's feelings or clarifying a misunderstanding (first pathway), and renegotiating therapeutic tasks or goals (second pathway). The *expressive strategy* involves shifting the session focus to exploring the rupture experience (third pathway), including the respective contributions of patient and therapist to gain a better understanding of their underlying needs, with *metacommunication* emphasized as the core technical principle for repair (Muran & Eubanks, 2020). This research program (Safran, Muran, Eubanks) has mainly focused on the exploratory approach to rupture resolution, although recent task analyses have generated a model for renegotiating therapeutic tasks or goals (Muran *et al.*, 2023).

The stage-process model (Muran & Eubanks, 2020; Safran &

Muran, 2000a) for rupture repair describes that in confrontation ruptures, exploring the rupture involves moving from exploring anger expressed by the patient toward the therapist to identifying disappointment with the therapist and then contacting underlying vulnerability, recognizing the need for affiliation. The repair process in withdrawal ruptures involves moving from exploring the patient's efforts to avoid direct interaction with the therapist to recognizing and helping the patient express more clearly what they truly need from the therapist, thereby contacting their need for autonomy.

We acknowledge that in the rupture repair literature, several review articles have addressed rupture repair (*e.g.*, Eubanks, 2022; Muran *et al.*, 2021; Safran & Kraus, 2014) and two meta-analyses (Eubanks, Muran, & Safran, 2018; Safran *et al.*, 2011). However, to our knowledge, no reviews have systematically mapped the range and characteristics of available evidence using a rigorous and transparent methodology. A scoping review is particularly suited for this purpose, as it allows us to identify and map the types of evidence, clarify key concepts and definitions, examine how research has been conducted, and detect knowledge gaps in the field. A scoping review offers a comprehensive picture of the scope and focus of research on rupture repair, informing future studies and helping to refine questions for subsequent systematic reviews.

Furthermore, research on how patients and their characteristics contribute to alliance ruptures remains limited (Eubanks, Muran, & Safran, 2018). For instance, there is no consensus regarding the influence of specific patient characteristics on therapeutic alliance ruptures. Some studies suggest that factors such as psychological distress, demographic variables, chronicity of psychological problems, and diagnosis classifications do not predict ruptures (Tschuschke *et al.*, 2021). In contrast, other studies indicate that patient characteristics may influence the quality of the therapeutic alliance (Errázuriz *et al.*, 2014). Traits such as high impulsivity, emotional dysregulation, and lability – often observed in personality disorders – are associated with greater in-session, patient-reported rupture intensity (Tufekcioglu *et al.*, 2013). Additionally, the severity of childhood physical and emotional abuse and neglect has been linked to early difficulties in the alliance (Paivio & Patterson, 1999). These discrepancies may result from the heterogeneity of measurement methods used in the field. Nonetheless, they highlight the importance of further investigating how patient characteristics contribute to difficult moments in therapy. Therefore, considering patient characteristics appears relevant in studies of the therapeutic alliance (Wampold & Fluckiger, 2023).

The most recent meta-analysis shows that the association between rupture repair and outcome is not moderated by therapeutic approach (Eubanks, Muran, & Safran, 2018), suggesting that rupture repair is a transtheoretical change process (Eubanks, Sergi, Samstag, & Muran, 2021). However, a therapeutic factor may be common across multiple therapies but function differently in approaches such as cognitive-behavioral therapy (Huibers *et al.*, 2021). For this reason, it also seems important to consider the therapeutic approach in repair studies.

Taking these gaps in the research into account, the research question, following the Population-Concept-Context model (Aromataris *et al.*, 2024), is: What clinical recommendations are described in the scientific literature to repair therapeutic alliance ruptures in adult patients in the context of psychotherapy? From this general question, specific objectives emerge: i) to identify and describe therapist competencies and characteristics associated in the literature with successful repair processes; ii) to examine patient characteristics considered relevant by researchers when

formulating rupture repair recommendations; and iii) to examine the theoretical approaches framing clinical recommendations for rupture repair.

It is important to note that, consistent with the objective of a scoping review, the present study aims to map and systematize clinical recommendations reported in the literature, rather than to provide a synthesis of evidence-based guidelines. Given the nature of scoping reviews, which seek to capture the range of available knowledge on a topic, the literature may include different types of sources with varying levels of empirical support.

## Methods

This scoping review with a narrative synthesis follows the guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR; Tricco *et al.*, 2018). The review protocol was not registered; however, the complete PRISMA-ScR checklist and detailed search strategy are provided as *Supplementary Materials*.

### Search strategy

The search was conducted in July 2024. A systematic literature search was conducted in English in the following databases: Web of Science, PsycINFO, and Scopus. Search terms were developed by examining definitions and synonyms related to the two concepts of interest (rupture repair and psychotherapy) and by reviewing relevant articles in the field. After multiple tests, the search equation used for this review was as follows: (“rupture repair” OR “rupture resolutions” OR “rupture repair process” OR “alliance repair” OR “therapeutic alliance repair” OR “relationship repair” OR “therapeutic repair” OR repair\* OR “rupture resolution strategies”) AND (psychotherapy OR therapy OR treatment OR intervention OR “clinical practice” OR “psychotherapeutic treatment” OR “psychotherapeutic intervention” OR “psychotherapeutic process”). The search was conducted in titles, abstracts, and key words. To maximize comprehensiveness, the search was not limited to specific time periods.

### Eligibility criteria

An article was considered eligible for inclusion if it met the following criteria: i) published in English or Spanish; ii) theoretical/conceptual, or empirical in nature; iii) situated within the field of individual psychotherapy; iv) focused on adult patients; and v) provided recommendations for repairing therapeutic alliance ruptures, with full-text availability. Exclusion criteria were: i) literature reviews; ii) meta-analyses; iii) article commentaries; iv) theses; v) book chapters; and vi) book abstracts.

### Article selection and data extraction

Publications were managed through Rayyan, a platform that allows collaborative management and organization of systematic reviews with a reviewer pair. Duplicate records and articles from non-relevant fields of study were identified and removed.

To control bias, the first two authors (AL-V and NG-A) independently and blindly conducted both stages of article selection, each being unaware of the other’s decisions: i) screening based on title, abstract, and key words, and ii) eligibility assessment through full-text reading. Systematic meetings were held to resolve differences in the application of criteria. A more experienced researcher

(PE) supervised the process and was available to resolve any discrepancies in the reviewers’ decision criteria.

A secondary search was subsequently conducted by reviewing the reference lists of selected articles to identify the relevance of including additional publications meeting the eligibility criteria, leading to the inclusion of one new publication.

Regarding data extraction, the first author (AL-V) extracted the data into a spreadsheet, using a narrative, qualitative approach based on thematic organization of the extracted data. A subset of the extracted data was reviewed by a second author (NG-A) to ensure accuracy and consistency in the coding process. Extracted elements included bibliometric data (author, year, country, journal) and content data. Content elements included: type of publication; objective, methodology, and patient characteristics; therapeutic approach; inclusion of contributions from the Safran, Muran, and Eubanks program; repair strategy addressed (immediate or expressive); reference to the technical principle of metacommunication for repair; therapist attitude, characteristics, or essential skills; reference to nonverbal/paraverbal cues in repair; recommended repair strategy (if mentioned in a clinical example); theoretical-clinical implications of repair; repair obstacles; gaps in rupture repair research; clinical practice recommendations; source of recommendation; and other relevant results. These content elements were defined *a priori* based on the author’s familiarity with the literature and prior conceptual and non-systematic reviews in the field and were refined through discussion among the research team.

### Data analysis and synthesis

Following data extraction, a narrative qualitative synthesis was conducted, in which findings were organized into thematic domains aligned with the objectives of the review. Results are presented through a PRISMA flowchart of article search decisions (Figure 1). Regarding the research question, data were synthesized in a summary table and reported both quantitatively (percentages and frequencies) and narratively. Findings were grouped under the main conceptual categories used for data extraction (Aromataris *et al.*, 2024), in accordance with the objectives of this review. Finally, the review results will be presented through a narrative synthesis describing how the findings relate to the research question and objectives.

## Results

The results are presented at two complementary levels. First, a descriptive mapping of the literature is provided, including the characteristics of the included studies, their theoretical and clinical orientations, and the patient-related variables considered. Second, the clinical recommendations identified in the reviewed sources are synthesized. Given the heterogeneity of the literature, particular attention is paid to distinguishing between recommendations derived from empirical studies and those grounded primarily in theoretical or conceptual work.

### Article selection

The article selection process is presented in Figure 1. The database search strategy yielded 775 articles, which were reduced to 220 after removing duplicates and articles from an incorrect field of study (medicine). After applying the eligibility criteria, a total of 24 articles were included. Finally, a secondary search added one more article, resulting in 25 articles analyzed in the review (Table 1).

**Table 1.** Overview of included articles.

Reference	Type of article/Method	Patient characteristics	Theoretical approach
Abbass & Town (2021)	Theoretical/conceptual (with vignettes)	57-year-old male: emotional detachment; narcissistic and avoidant personality disorder; substance use; childhood maltreatment	Short-term intensive psychodynamic psychotherapy
Aspland <i>et al.</i> (2008)	Empirical (mixed methods-task analysis)	2 patients: depression	Cognitive-behavioral therapy
Boritz <i>et al.</i> (2018)	Empirical (quantitative)	6 patients: borderline personality disorder (3 recovered, 3 non-recovered)	Dialectical behavior therapy
Cash <i>et al.</i> (2014)	Empirical (mixed methods-task analysis)	2 adults: borderline personality disorder	Cognitive-behavioral therapy
Coutinho <i>et al.</i> (2011)	Empirical (qualitative)	8 patients, personality disorders: borderline (3); histrionic (2); avoidant (1); paranoid (1); obsessive-compulsive (1)	Cognitive-behavioral therapy
Coutinho <i>et al.</i> (2010)	Case study	1 female patient; bipolar affective disorder; mood instability and interpersonal difficulties	Cognitive-behavioral therapy
David-Sela <i>et al.</i> (2020)	Theoretical/conceptual (with vignettes)	1 male patient: major depressive disorder	Psychodynamic therapy (core conflictual relationship theme)
Dolev-Amit <i>et al.</i> (2021)	Theoretical/conceptual (with vignettes)	1 patient: depression	Online psychotherapy Psychodynamic therapy (core conflictual relationship theme)
Eubanks, Burckell, & Goldfried (2018)	Empirical (quantitative)	6 cases, mixed presentations: depression; low self-confidence; relational distress; some without formal diagnosis	Different theoretical orientations
Gaztambide (2012)	Theoretical/conceptual (with vignettes)	1 female patient; migrant background	Relational psychoanalytic approach and culturally adapted evidence-based therapies
Haskayne <i>et al.</i> (2014)	Empirical (qualitative)	4 patients: depression (2); self-harm/low self-esteem (1); social anxiety with depression (1)	Psychodynamic therapy
Holmstrom <i>et al.</i> (2024)	Theoretical/conceptual (with vignettes)	1 clinical case: diagnosis not specified	Relational psychoanalytic therapy (self-determination theory)
Keenan <i>et al.</i> (2005)	Theoretical/conceptual (with vignettes)	8 clinical vignettes: intercultural therapeutic contexts	Multicultural approach
Kline <i>et al.</i> (2018)	Empirical (qualitative)	Not reported	Interpersonal psychodynamic approach
Kramer <i>et al.</i> (2014)	Case study (theory-building)	1 female patient: adjustment disorder with anxiety and depressive symptoms	Brief psychodynamic psychotherapy (focus on emotional processing)
Lawson <i>et al.</i> (2013)	Theoretical/conceptual (with vignettes)	1 female patient: complex trauma; history of childhood sexual abuse	Trauma-informed therapy
Markin & Coleman (2023)	Theoretical/conceptual (with vignettes)	2 female patients: racial trauma and birth-related trauma	Multicultural and attachment-based approach
Muran <i>et al.</i> (2023)	Empirical (mixed methods-task analysis)	6 clinical cases: cluster C or unspecified personality disorders; 87% with comorbid anxiety or mood disorders	Cognitive-behavioral therapy
Mylona <i>et al.</i> (2022)	Empirical (mixed methods)	1 male patient (27 years): negative thoughts; hopelessness; suicidal ideation	Psychoanalytic approach
Okamoto & Kazantzis (2021)	Theoretical/conceptual (with vignettes)	1 female patient: depression, generalized anxiety, and alcohol use disorder	Cognitive-behavioral therapy
Safran & Muran (2000b)	Theoretical/conceptual	Not specified	Relational and integrative approach
Safran & Muran (1996)	Empirical (mixed methods-task analysis)	29 patients: diagnosis not specified	Integrative cognitive therapy; interpersonal, experiential, and relational (psychoanalytic-informed) features
Walser & O'Connell (2021)	Theoretical/conceptual (with vignettes)	1 female patient: anxiety symptoms and relational difficulties (with daughter)	Acceptance and commitment therapy
Westerman & De Roten (2017)	Case study (theory-building)	1 female patient: adjustment disorder	Psychoanalytic therapy (interpersonal defense theory)
Yeo & Torres-Harding (2021)	Empirical (mixed methods)	128 participants: self-identified people of color reporting racial microaggressions in therapy	Multicultural approach

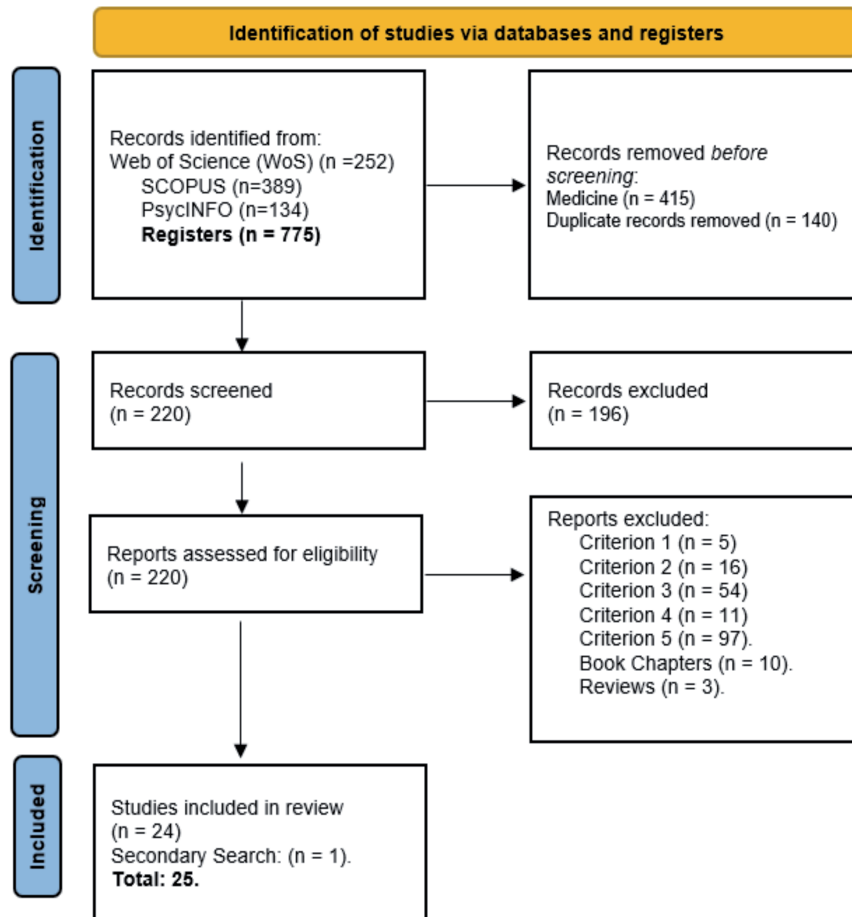


Figure 1. PRISMA flow diagram.

### Characteristics of included studies

The included articles were published between 1996 and 2024. Of the 25 articles, the majority originated from the United States (48%, n=12), three from Canada (12%), three from the UK (12%), two from Israel (8%), two from Portugal (8%), one from Switzerland (4%), one from Greece (4%), and one from Finland (4%). The journals with the highest frequency of publication were *Psychotherapy Research* (20%, n=5), *Psychotherapy* (16%, n=4), and *Journal of Clinical Psychology* (16%, n=4). The distribution of the selected studies by journal is shown in Table 2.

Regarding methodological design, most publications were empirical (56%, n=14; Aspland *et al.*, 2008; Boritz *et al.*, 2018; Cash *et al.*, 2014; Coutinho *et al.*, 2010; Coutinho *et al.*, 2011; Eubanks, Burckell, & Goldfried, 2018; Haskayne *et al.*, 2014; Kline *et al.*, 2018; Kramer *et al.*, 2014; Muran *et al.*, 2023; Mylona *et al.*, 2022; Safran & Muran, 1996; Westerman & De Roten, 2017; Yeo & Torres-Harding, 2021), while the remaining 44% (n=11; Abbass & Town, 2021; David-Sela *et al.*, 2020; Dolev-Amit *et al.*, 2021; Gaztambide, 2012; Holmstrom *et al.*, 2024; Keenan *et al.*, 2005; Lawson *et al.*, 2013; Markin & Coleman, 2023; Okamoto & Kazantzis, 2021; Safran & Muran, 2000b; Walser & O'Connell, 2021), were theoretical or conceptual in nature, often illustrated with clinical vignettes. Among the empirical studies, four followed a task analysis (28.6%; Aspland *et al.*, 2008; Cash *et al.*, 2014; Muran *et al.*,

2023; Safran & Muran, 1996), three were qualitative studies (21.4%; Coutinho *et al.*, 2011; Haskayne *et al.*, 2014; Kline *et al.*, 2018), three were case studies (21.4%; Coutinho *et al.*, 2010; Kramer *et al.*, 2014; Westerman & De Roten, 2017), two were quantitative studies (14.2%; Boritz *et al.*, 2018; Eubanks, Burckell, & Goldfried, 2018), and two were mixed-methods studies (14.2%; Mylona *et al.*, 2022; Yeo & Torres-Harding, 2021).

### Theoretical and clinical approaches

Most articles adhered to a psychodynamic approach (40%, n=10), including intensive short-term psychodynamic therapy, core conflictual relationship theme method, relational psychoanalysis, interpersonal defense theory, brief psychodynamic therapy (with a focus on emotional processing), and self-determination theory. Within this approach, one article addressed online therapy and another culturally adapted therapy.

Next, the cognitive/cognitive-behavioral approach represented 36% (n=9), including cognitive-behavioral therapy, dialectical behavior therapy, integrative cognitive therapy, and acceptance and commitment therapy.

Three articles were approached from a multicultural perspective (12%), one of which also included an attachment perspective. Two articles were described from an integrative relational perspective or by therapists from diverse theoretical orientations without specifica-

**Table 2.** Distribution of selected studies by journal.

Journal	Frequency (n)	Percentage (%)
Psychotherapy Research	5	20
Psychotherapy	4	16
Journal of Clinical Psychology	4	16
Counselling Psychology Quarterly	2	8
Journal of Psychotherapy Integration	1	4
Journal of Consulting and Clinical Psychology	1	4
Journal of Personality Disorders	1	4
Journal of Clinical Social Work	1	4
Journal of Contemporary Psychotherapy	1	4
Psychoanalytic Psychology	1	4
Counselling and Psychotherapy Research	1	4
Professional Psychology, Research and Practice	1	4
Revista Argentina de Clínica Psicológica	1	4
British Journal of Psychotherapy	1	4
Total	25	100

tion (8%). Finally, one article had a trauma-informed approach (4%).

All included studies (100%) referenced the Safran and Muran Research Program (2000a).

### Reported patient characteristics

Across the 14 empirical studies, a total of 195 participants were included. Of these, 128 participants corresponded to the study by Yeo and Torres-Harding (2021), which did not report any specific clinical diagnoses but described all participants as patients from minority groups. As shown in Table 3, the remaining empirical studies reported a variety of patient diagnoses. It should be noted that these figures reflect the frequency with which diagnoses were reported across a small and methodologically heterogeneous set of studies, rather than the prevalence or representativeness of these clinical populations in the rupture-repair literature. Personality disorders were the most frequently described ( $n=22$ ). Depressive disorders were reported in six cases, while single instances of social anxiety with depression, bipolar affective disorder, and adjustment disorder with anxiety and depressive symptoms were also identified. For the majority of patients ( $n=163$ ), most of whom were from the Yeo and Torres-Harding (2021) study, no specific diagnosis was reported.

Task analysis studies that developed models for rupture resolution included two patients with depression (Aspland *et al.*, 2008), two adults with borderline personality disorder (Cash *et al.*, 2014), and six patients with Cluster C or unspecified personality disorders, 87% of whom had a comorbid Axis I disorder (anxiety or mood; Muran *et al.*, 2023). One publication (Safran & Muran, 1996) did not provide detailed clinical diagnoses for the 29 participating patients.

Among the theoretical publications that included clinical case vignettes, the authors described patients as presenting multiple relevant characteristics. These included migration backgrounds, interpersonal difficulties, histories of complex trauma, experiences of sexual abuse, racial trauma, childbirth-related trauma, and suicidal ideation.

It is important to note that most empirical studies described patient populations in terms of diagnostic categories or demographic characteristics, without specifying how these characteristics modify repair strategies. Publications that moved beyond population description to propose functional implications for rupture repair were primarily theoretical and conceptual contributions, including proposals regarding patients with complex trauma histories (Lawson *et al.*, 2013), patients from ethnic minority back-

**Table 3.** Reporting of patient diagnoses in empirical studies.

Diagnosis	Frequency of reporting (n)
Personality disorders	22: borderline (11); histrionic (2); avoidant (1); paranoid (1); obsessive-compulsive (1); cluster C (6)
Depression	6
Social anxiety and depression	1
Bipolar affective disorder	1
Adjustment disorder	1
Adjustment disorder (with anxiety and depression)	1
No diagnosis reported	163
Total participants	195

grounds experiencing cultural rupture (Gaztambide, 2012; Keenan *et al.*, 2005; Yeo & Torres-Harding, 2021), and patients experiencing gendered racial trauma (Markin & Coleman, 2023). These contributions suggest that certain patient characteristics may shape not only the emergence of ruptures but also the emphasis and form of repair interventions. However, these proposals remain primarily grounded in theoretical and clinical reasoning and require empirical examination to assess their validity across diverse clinical contexts. The functional implications of these patient characteristics for rupture repair are discussed in the following section on theoretical and conceptual contributions, where proposals regarding specific populations are examined in greater detail.

Alongside patient characteristics, therapist-related variables constitute another dimension of sample description in the included publications. Therapist-related variables were not systematically extracted as sample descriptors in this review, as the data extraction framework focused on patient characteristics and therapist competencies as reflected in clinical recommendations. Where available in the included studies, some information on therapists indicated variability in experience, ranging from trainees in supervised practice (Kline *et al.*, 2018) to experienced clinicians and expert-nominated practitioners (Eubanks, Burckell, & Goldfried, 2018). Some studies included therapists from diverse theoretical orientations (Eubanks, Burckell, & Goldfried, 2018; Safran & Muran, 1996), while others specified adherence to a single therapeutic model. However, given the absence of a systematic extraction of therapist characteristics, these aspects are not synthesized in the present review. This represents a limitation of the current data extraction framework, and future scoping reviews may benefit from incorporating therapist variables more explicitly as sample descriptors.

## Clinical recommendations for repairing ruptures

The following sections present the clinical recommendations identified in the reviewed literature. In line with the aims of this scoping review, and given the heterogeneity of the included publications, these recommendations are organized according to their source. Specifically, a distinction is made between those derived from empirical studies and those grounded primarily in theoretical or conceptual work. This distinction aims to clarify the nature of the evidence informing these recommendations and to avoid conflating contributions with different levels of empirical support. An overview of the identified recommendations, organized by domain and source type, is presented in Table 4.

### Recommendations derived from empirical studies

Empirical studies highlight the importance of therapists recognizing the occurrence of alliance ruptures (Boritz *et al.*, 2018; Kline *et al.*, 2018; Muran *et al.*, 2023; Yeo & Torres-Harding, 2021). This requires therapists to maintain ongoing, moment-to-moment awareness of the quality of the alliance during the session (Coutinho *et al.*, 2010; Eubanks, Burckell, & Goldfried, 2018; Mylona *et al.*, 2022). This is particularly relevant for identifying subtle signs of withdrawal ruptures (Boritz *et al.*, 2018; Eubanks, Burckell, & Goldfried, 2018; Kline *et al.*, 2018), which may go unnoticed even by experienced therapists, for example, when clients appear superficially compliant or engaged while withholding disagreement, or when they become silent or disengaged during the session.

Empirical findings suggest that rupture repair does not neces-

sarily require explicit acknowledgment by the therapist (Aspland *et al.*, 2008; Cash *et al.*, 2014; Westerman & De Roten, 2017). Instead, repair may occur through shifts in therapeutic focus or modifications of tasks to better align with the patient's needs (Aspland *et al.*, 2008; Cash *et al.*, 2014). Regardless of whether the rupture is addressed explicitly or implicitly (Boritz *et al.*, 2018; Muran *et al.*, 2023), successful repair appears to depend on the therapist's capacity to identify and respond to what is most salient for the patient (Coutinho *et al.*, 2010).

The literature also underscores the role of therapist training in developing competencies for rupture recognition and repair (Eubanks, Burckell, & Goldfried, 2018). Recommended approaches include extensive practice and supervision focused on rupture and repair (Coutinho *et al.*, 2011), video-based analysis of clinical interactions, role-playing, and mindfulness-based practices (Eubanks, Burckell, & Goldfried, 2018).

## Rupture repair strategies

Empirical studies described rupture repair strategies that can be broadly grouped into expressive strategies (Aspland *et al.*, 2008; Cash *et al.*, 2014; Haskayne *et al.*, 2014; Kramer *et al.*, 2014; Mylona *et al.*, 2022; Safran & Muran, 1996; Westerman & De Roten, 2017) and immediate strategies (Muran *et al.*, 2023). While some studies focus specifically on one of these domains, others describe the integration of both within the repair process (Coutinho *et al.*, 2010; Eubanks, Burckell, & Goldfried, 2018; Yeo & Torres-Harding, 2021). However, a subset of studies addressed rupture and repair processes without specifying distinct intervention strategies (Boritz *et al.*, 2018; Coutinho *et al.*, 2011; Kline *et al.*, 2018).

### Expressive repair strategies

Across empirical studies, expressive repair strategies emphasize the therapist's capacity to acknowledge their contribution to the rupture and assume responsibility within the therapeutic interaction (Aspland *et al.*, 2008; Coutinho *et al.*, 2010; Muran *et al.*, 2023; Safran & Muran, 1996; Yeo & Torres-Harding, 2021). This is closely linked to recognizing one's own limitations in the therapeutic process (Cash *et al.*, 2014).

These approaches also involve inviting patients to explore their immediate experience (Eubanks, Burckell, & Goldfried, 2018; Westerman & De Roten, 2017), particularly within the here-and-now of the therapeutic interaction (Mylona *et al.*, 2022; Safran & Muran, 1996), and encouraging feedback to facilitate a shared understanding of the rupture (Aspland *et al.*, 2008).

In addition, therapists are encouraged to support the expression of patients' concerns (Westerman & De Roten, 2017), negative emotions (Coutinho *et al.*, 2010; Kline *et al.*, 2018), and other primary experiences that may not be fully recognized (Safran & Muran, 1996), particularly those emerging in the context of the rupture (Cash *et al.*, 2014). Such processes may foster patients' capacity to articulate needs and assert themselves within the therapeutic relationship. Additionally, some studies describe the therapist's use of self-disclosure of their own emotional or internal responses in the context of the rupture as part of the repair process (Cash *et al.*, 2014; Coutinho *et al.*, 2010).

Studies highlight the importance of therapists validating patients' responses during the exploration of ruptures while maintaining a non-defensive stance (Aspland *et al.*, 2008; Eubanks, Burckell, & Goldfried, 2018; Muran *et al.*, 2023; Safran & Muran,

1996). Validation is described as involving openness to the patient's perspective and facilitating a collaborative understanding of the rupture. Additionally, a study suggests linking the rupture to recurring interpersonal patterns as part of the repair process (Coutinho *et al.*, 2010).

Repair processes may give rise to further tensions or additional ruptures within the therapeutic interaction (Muran *et al.*, 2023). Ruptures may also emerge in contexts where patients hold negative expectations about others. Therapists should therefore be prepared for rupture emergence, particularly when working with patients who hold negative expectations about others, such as anticipating criticism or invalidation (Muran *et al.*, 2023). Ruptures may also be more likely in long-term therapies (Haskayne *et al.*, 2014). Moreover, repair attempts may result in only partial resolutions, requiring continued exploration and iterative revisiting of the rupture (Cash *et al.*, 2014).

Therapeutic metacommunication is described as a central intervention in rupture repair processes (*e.g.*, Kramer *et al.*, 2014; Mylona *et al.*, 2022), although not all empirical studies explicitly use this term (*e.g.*, Aspland *et al.*, 2008; Cash *et al.*, 2014). It involves addressing the ongoing therapeutic interaction by making aspects of the relational process explicit during rupture exploration. In this context, therapists draw on their internal experiences to collaboratively explore the interpersonal dynamics unfolding in the here-and-now. Metacommunicative interventions may vary according to the type of rupture. In confrontation ruptures, therapists are encouraged to avoid complementary hostility and facilitate access to underlying vulnerable emotional experiences. In withdrawal ruptures, emphasis is placed on recognizing and addressing the rupture without dominating the patient, while supporting the emergence of more self-affirming desires (Coutinho *et al.*, 2011; Safran & Muran, 1996).

**Table 4.** Clinical recommendations for therapeutic alliance rupture repair: mapping across empirical studies and theoretical-conceptual contributions.

Domain	Clinical recommendation	Source type
Rupture recognition	Maintain ongoing, moment-to-moment awareness of alliance quality, attending particularly to subtle withdrawal signs ( <i>e.g.</i> , superficial compliance, silence, disengagement). Whether the rupture is addressed explicitly or implicitly, prioritize identifying and responding to what is most salient for the patient	Empirical and theoretical-conceptual
Immediate repair strategies	When rupture repair requires task-level adjustment, reformulate therapeutic tasks or clarify their rationale to enhance relevance for the patient. With highly reactive patients, negotiate goals and tasks collaboratively using less directive approaches. Maintain flexibility, as repair may unfold in multiple, non-linear ways rather than following a fixed progression	Empirical and theoretical-conceptual
Expressive repair strategy	Acknowledge your contribution to the rupture, assume responsibility, and recognize your own limitations within the therapeutic process	Empirical and theoretical-conceptual
Expressive repair strategy	Invite the patient to explore their immediate experience within the here-and-now of the interaction, and encourage feedback to facilitate a shared understanding of the rupture	Empirical and theoretical-conceptual
Expressive repair strategy	Support the expression of patients' concerns, negative emotions, and primary experiences; validate their responses while maintaining a non-defensive stance and openness to their perspective	Empirical and theoretical-conceptual
Expressive repair strategy	Invite the patient to link the rupture to recurrent interpersonal patterns, both within the therapeutic relationship and in their broader functioning, to support shared understanding and meaning-making	Empirical and theoretical-conceptual
Cultural and sociopolitical context	Recognize the patient's cultural worldview and attend to power asymmetries in the therapeutic encounter; acknowledge the limits of your own perspective and actively invite corrective feedback when misunderstandings arise	Theoretical-conceptual and empirical
Complex trauma context	Adopt a less hierarchical relational position that recognizes patients as experts in their own experience; pace interventions carefully using a "go slow" approach to help contain anxiety and promote emotional regulation	Theoretical-conceptual
Relational dynamics	Identify and work through repetitive relational patterns emerging within the therapeutic relationship; foster mentalizing capacities, remain aware of your own relational positioning, and avoid controlling interventions that may undermine the patient's self-regulation and autonomy	Theoretical-conceptual
Supportive strategies	Sustain collaboration through supportive strategies: express genuine interest, reinforce patient strengths, acknowledge coping efforts, and adapt communication through metaphors or references to prior therapeutic successes; remain attentive to affective processes during clinically sensitive phases such as termination	Theoretical-conceptual

This table maps clinical recommendations as reported in the reviewed literature and does not constitute a synthesis of evidence-based guidelines. Recommendations identified in empirical studies were derived from how authors interpreted and discussed their findings, rather than representing direct empirical results, and reflect heterogeneous designs, including task analyses, qualitative studies, case studies, and quantitative and mixed-methods investigations. Recommendations identified in theoretical and conceptual contributions represent clinically oriented proposals grounded in specific therapeutic frameworks or clinical populations; these require further empirical examination before their generalizability across diverse clinical contexts can be established. The recurrence of a recommendation across publications reflects its prominence within the rupture-repair discourse rather than its demonstrated clinical effectiveness.

## Immediate repair strategies

In contrast to expressive approaches, immediate repair strategies focus on adjusting the therapeutic task in response to the patient's concerns. These may include reformulating tasks or providing clearer rationales to enhance their relevance and meaning (Coutinho *et al.*, 2010; Muran *et al.*, 2023). In some cases, particularly when working with highly reactive patients, less directive approaches are described, involving the joint negotiation of the therapeutic goals and tasks (Muran *et al.*, 2023). Importantly, empirical findings suggest that rupture repair does not follow a fixed progression but may unfold in multiple non-linear ways (Muran *et al.*, 2023), highlighting the need for flexibility in the therapist's interventions.

## Recommendations derived from theoretical and conceptual work

The following recommendations are derived from theoretical and conceptual contributions and should be understood as clinically oriented proposals that extend the understanding of rupture repair processes, rather than as empirically established findings. Many of these works are grounded in specific therapeutic frameworks or focus on particular clinical populations, highlighting the role of cultural and racial dynamics, trauma-related processes, and broader contextual factors shaping the therapeutic relationship. While these contributions enrich the conceptualization of rupture and repair, they are not uniformly supported by empirical evidence and therefore require further empirical examination to assess their generalizability across clinical contexts. Accordingly, this section aims to map conceptually grounded proposals rather than to establish evidence-based recommendations, and these should be interpreted with caution, particularly when considering their transferability to diverse therapeutic settings or patient populations.

Among the clinical recommendations, a foundational element concerns the recognition of rupture processes. Within this body of work, identifying the occurrence of a rupture is emphasized as a necessary precondition for any repair attempt (Gaztambide, 2012; Lawson *et al.*, 2013; Okamoto & Kazantzis, 2021; Walser & O'Connell, 2021). These contributions, drawing on prior empirical work, also refer to commonly described repair strategies, including immediate and expressive interventions. From this perspective, rupture recognition is understood as a clinically informed competence that requires familiarity with rupture markers (Gaztambide, 2012; Okamoto & Kazantzis, 2021).

Across these contributions, rupture repair is consistently framed as a process embedded within broader cultural and sociopolitical contexts that shape both the therapeutic relationship and the meanings attributed to distress. From this perspective, effective repair involves recognizing the patient's cultural worldview, particularly when this differs from that of the therapist, and attending to power asymmetries that may emerge in the therapeutic encounter (Gaztambide, 2012; Markin & Coleman, 2023). This includes adopting a stance of openness to uncertainty, acknowledging the limits of one's own perspective, and actively inviting patients to provide corrective feedback when misunderstandings arise. Within this framework, patients' experiences and symptoms are understood not as individual deficits but as meaningful responses to contextual and often traumatic conditions, positioning rupture repair as a process that fosters collaboration, empowerment, and agency (Markin & Coleman, 2023).

A related line of work emphasizes the importance of the therapist's relational stance, particularly in contexts involving complex

trauma. Here, rupture repair is facilitated by adopting a less hierarchical position that recognizes patients as experts in their own experience, thereby reducing relational tension and facilitating a more collaborative process (Lawson *et al.*, 2013). This stance is closely linked to the regulation of emotional intensity within the therapeutic relationship, highlighting the clinical value of pacing interventions carefully and conveying a "go slow" approach that may help contain anxiety and promote emotional regulation.

Beyond these considerations, theoretical contributions converge on the understanding of rupture repair as an ongoing relational process that requires sustained attention to both interpersonal patterns and the patient's affective experience. Central to this perspective is the identification and working through of repetitive relational dynamics that may emerge within the therapeutic relationship, while maintaining a collaborative stance (Abbass & Town, 2021; Holmstrom *et al.*, 2024). This involves fostering mentalizing capacities, remaining aware of one's relational positioning, and avoiding controlling interventions that may undermine self-regulation and psychological change (Holmstrom *et al.*, 2024).

Within this process, interventions are oriented toward supporting core psychological needs such as attachment, competence, and autonomy while facilitating emotional engagement and strengthening the therapeutic bond (Dolev-Amit *et al.*, 2021; Holmstrom *et al.*, 2024).

Indirect supportive strategies, including the expression of genuine interest, the reinforcement of patients' strengths, and the acknowledgment of their efforts in coping with distress, are highlighted as ways of sustaining collaboration (Dolev-Amit *et al.*, 2021). Similarly, adapting communication to the patient's experiential world through the use of metaphors or by drawing on prior therapeutic successes may enhance accessibility and engagement, particularly when working with complex or emotionally charged material (David-Sela *et al.*, 2020). These contributions also underscore the importance of attending to affective processes across the course of therapy, especially during clinically sensitive phases such as termination, where unresolved emotional dynamics and potential regression may emerge (David-Sela *et al.*, 2020).

Across therapeutic orientations, rupture repair is conceptualized as a collaborative process that involves addressing relational dynamics and disagreement while fostering the therapeutic bond. From a psychodynamic perspective, this includes the exploration of defensive patterns that may interfere with treatment (Abbass & Town, 2021). In cognitive-behavioral approaches, dialogical strategies such as Socratic dialogue and shared decision-making are emphasized as a means of facilitating perspective-taking and promoting patient involvement in the repair process (Okamoto & Kazantzis, 2021). Similarly, third-wave approaches conceptualize ruptures as opportunities for learning and transformation, contributing to psychological flexibility (Walser & O'Connell, 2021), for instance, by helping patients shift from rigid or avoidant responding toward more flexible engagement with in-session experiences. Ongoing clinical attunement is required to evaluate whether interventions facilitate or constrain therapeutic inquiry, underscoring that rupture resolution is a dynamic and continuously negotiated process within the therapeutic relationship (Holmstrom *et al.*, 2024).

## Therapist characteristics in rupture repair: conceptual perspectives

Theoretical and clinical contributions describe therapist characteristics that are proposed as relevant for rupture repair processes. While some of these characteristics also appear in empirical

studies, they are most systematically elaborated in theoretical and conceptual contributions. These characteristics can be broadly organized into four interrelated domains: therapists' relational stance, their emotional and regulatory capacities, their reflexivity and positioning within the therapeutic relationship, and their sensitivity to nonverbal and paraverbal processes. At the level of relational stance, therapists engaged in rupture repair are described in the literature as curious, engaged, self-aware, and reflective, demonstrating an active interest in rupture experiences and maintaining a stance of openness and collaborative inquiry (David-Sela *et al.*, 2020; Gaztambide, 2012; Lawson *et al.*, 2013; Okamoto & Kazantzis, 2021; Walser & O'Connell, 2021). This relational stance is further characterized by a non-judgmental and non-blaming attitude, marked by compassion and openness to the patient's perspective (Safran & Muran, 2000b; Walser & O'Connell, 2021). This stance is further described as involving the patient in collaborative dialogue and shared decision-making (Okamoto & Kazantzis, 2021), thereby fostering a sense of joint engagement in the therapeutic process (Dolev-Amit *et al.*, 2021). This relational stance has been described as fostering a sense of trust and safety within the therapeutic relationship (Markin & Coleman, 2023). Therapists are portrayed as conveying credibility and reliability (Keenan *et al.*, 2005), as well as demonstrating genuine respect and care, which may support the patient's engagement with previously avoided or distressing experiences (Dolev-Amit *et al.*, 2021). They are further described as maintaining a present-focused stance, remaining emotionally available while witnessing and tolerating difficult moments within the therapeutic encounter (Holmstrom *et al.*, 2024). Notably, in the specific context of telepsychotherapy with depressed clients, a more active therapeutic stance has been proposed as relevant, particularly to support the patient's sense of the therapist's presence (Dolev-Amit *et al.*, 2021).

Regarding emotional and regulatory capacities, the theoretical literature emphasizes empathy and emotional attunement as central features of therapists addressing rupture repair (Gaztambide, 2012; Keenan *et al.*, 2005; Lawson *et al.*, 2013; Safran & Muran, 2000b; Walser & O'Connell, 2021). These capacities are described as involving responsiveness to the patient's experience and the ability to validate emotional states (Safran & Muran, 2000b), while minimizing defensive reactions on the part of the therapist (Gaztambide, 2012; Safran & Muran, 2000b; Walser & O'Connell, 2021). Additional characteristics are proposed in the literature as relevant for rupture repair, including emotional sensitivity, flexibility (Walser & O'Connell, 2021), and persistence (Abbass & Town, 2021).

Regarding reflexivity and positioning, therapists are described as capable of recognizing their own errors and limitations and of addressing these within the therapeutic process with humility (Gaztambide, 2012; Safran & Muran, 2000b). This stance is further emphasized in relation to cultural responsiveness, highlighting the importance of acknowledging potential misunderstandings or limitations when they involve aspects of the patient's cultural identity (Markin & Coleman, 2023).

Sensitivity to nonverbal and paraverbal processes constitutes another domain of therapists' involvement in rupture repair. These cues may be used as a basis for exploring rupture experiences, for example, by explicitly referring to observable aspects of the interaction (Abbass & Town, 2021). In intercultural contexts, micro-ruptures may emerge from differing interpretations of nonverbal communication, highlighting the importance of sensitivity to these processes (Keenan *et al.*, 2005). In some clinical contexts, attention

to voice changes, eye movements, acoustic shifts, and gaze avoidance has been proposed as relevant for identifying withdrawal ruptures (Dolev-Amit *et al.*, 2021). The limited attention to these processes in the reviewed literature may reflect the predominantly verbal and text-based orientation of the included publications, rather than their clinical relevance.

### Research gaps reported in the included literature

The following research gaps were identified as reported by the authors of the included publications. These gaps reflect the perspectives of individual contributions and should be interpreted as reported observations rather than as consolidated findings of the present review.

The authors have highlighted the need for further theoretical and empirical work to clarify what constitutes a withdrawal rupture (Eubanks, Burckell, & Goldfried, 2018). A more focused analysis on the nonverbal domain of communication during rupture repair has also been proposed (Holmstrom *et al.*, 2024; Mylona *et al.*, 2022). In addition, some studies emphasize the need to improve understanding of therapist responsiveness in the rupture resolution process (Boritz *et al.*, 2018), as well as to examine rupture repair in cases of unsuccessful therapy (Aspland *et al.*, 2008).

A number of publications have pointed to the importance of investigating repair methodologies for specific patient populations (Coutinho *et al.*, 2010; Coutinho *et al.*, 2011; Eubanks, Burckell, & Goldfried, 2018; Westerman & De Roten, 2017). In this regard, some authors note a lack of empirical evidence regarding effective strategies for repairing cultural ruptures (Gaztambide, 2012; Yeo & Torres-Harding, 2021). Relatedly, several studies suggest the need to examine responsive rupture repair in the context of patient and therapist cultural identities, as well as power differences (Muran *et al.*, 2023), and to explore how therapist and patient attributes may influence the repair process in such contexts (Yeo & Torres-Harding, 2021).

Further research has been proposed on the relationship therapist variables (*e.g.*, attachment style) and patient variables (*e.g.*, psychopathology and attachment style), as well as their interaction, in relation to the experience and management of ruptures (Kline *et al.*, 2018). Some studies also suggest the need for more detailed investigation into whether focusing on affective experience is important for resolving ruptures with patients diagnosed with borderline personality disorder (Cash *et al.*, 2014). Additionally, the potential impact of rupture processes on the therapist's alliance with their supervisor (Kline *et al.*, 2018), as well as supervisors' experiences of alliance ruptures (Coutinho *et al.*, 2011), has been identified as an area requiring further exploration. Research on psychotherapy with patients who have histories of complex trauma has also been highlighted as a relevant area for further study (Lawson *et al.*, 2013).

Finally, the authors have suggested the need for studies with larger qualitative samples exploring rupture and repair experiences from both patient and therapist perspectives during individual and group therapy contexts (Haskayne *et al.*, 2014).

### Discussion

This scoping review aimed to map clinical recommendations for repairing therapeutic alliance ruptures with adult patients, identifying therapist competencies, patient characteristics, and theoretical frameworks associated with rupture repair processes. The findings highlight the ongoing influence of the foundational contributions of

Safran and Muran (2000a), as well as more recent developments by Muran and Eubanks (2020), and are discussed below in relation to each of the review's specific objectives.

Across the reviewed literature, the recognition of ruptures emerges as a recurrent theme that appears to constitute a foundational step preceding any repair attempt. Empirical studies suggest that this recognition does not necessarily require explicit acknowledgment within the session. These observations suggest that rupture recognition may involve a relational competence requiring ongoing attunement to the patient's moment-to-moment experience, one that may benefit from explicit attention in therapist training.

With respect to the clinical recommendations identified, the reviewed studies frequently referred to strategies that are captured within the Rupture Resolution Rating System (3RS; Eubanks & Muran, 2022). Given that these strategies were identified across heterogeneous publications spanning different theoretical orientations and methodological designs, the 3RS may be considered a useful reference framework for organizing psychotherapy research and informing clinical reflection, rather than a set of universally applicable guidelines. At the same time, its prominence in the present review should be interpreted in light of the conceptual starting point of this study, which is grounded in the Safran-Muran-Eubanks tradition. Accordingly, it is not surprising that the identified strategies largely reflect the language and framing of this particular research program.

With respect to the first objective – identifying therapist competencies and characteristics associated with successful repair processes – the reviewed literature describes a constellation of interrelated capacities that appear relevant to rupture repair, organized around four domains: relational stance, emotional and regulatory capacities, reflexivity and positioning, and sensitivity to nonverbal and paraverbal processes. Across these domains, a recurring emphasis on relational attitudes, such as curiosity, empathy, humility, and reflexivity, suggests that rupture repair may require sustained attunement to the patient's experience that goes beyond the technical application of strategies. It is important to note, however, that these characteristics are derived primarily from theoretical and conceptual contributions and should be understood as clinically oriented proposals rather than empirically validated competencies. Moreover, as one empirical study suggests, these therapist qualities may prove insufficient in certain clinical contexts, particularly when working with patients from minority backgrounds who have experienced racial microaggressions (Yeo & Torres-Harding, 2021), pointing to the need for greater specification of how these competencies operate across diverse clinical populations.

These findings point to several directions for therapist training. Reviewed publications suggest that rupture recognition and repair competencies may benefit from explicit training approaches, including supervision focused on rupture and repair processes (Coutinho *et al.*, 2011), video-based analysis of clinical interactions, role-playing, and mindfulness-based practices (Eubanks, Burckell, & Goldfried, 2018), as explicit training in the detection of rupture markers and the flexible use of repair strategies may enhance clinicians' sensitivity to critical moments in treatment (Muran *et al.*, 2018). Training programs may also benefit from emphasizing that repair is not solely the therapist's responsibility, but an inherently bidirectional process in which the patient's active participation plays a meaningful role.

Regarding the second specific objective – examining patient characteristics considered relevant when formulating rupture repair recommendations – general repair frameworks appear potentially relevant across clinical populations, although their applicability may

require adaptation depending on patient characteristics and contextual factors. Within the empirical literature, the most frequently represented groups were patients diagnosed with personality disorders, particularly borderline personality disorder, and depressive disorders. A substantial proportion of the included empirical studies, however, did not report specific diagnoses. Theoretical and conceptual contributions, by contrast, described a considerably broader range of patient characteristics, including relational difficulties, histories of complex trauma, childhood maltreatment, substance use problems, migration backgrounds, intercultural contexts, racial trauma, birth-related trauma, and suicidal ideation. One contribution also addressed the specific context of telepsychotherapy, highlighting how the clinical setting itself may shape the emergence and repair of ruptures. These observations suggest that certain subgroups may warrant particular attention in future research. For instance, patients with histories of complex trauma or those from migrant backgrounds exposed to cultural microaggressions have begun to receive some consideration in the rupture-repair literature, though the empirical basis for population-specific adaptations remains limited. Other populations, such as patients with substance use disorders, have been scarcely addressed, representing a gap that future studies may benefit from exploring. As noted in the results, the literature remains predominantly therapist-centered in its conceptualization of rupture repair, and patient contributions to the repair process are rarely examined systematically. Patients' responses may facilitate, hinder, or reshape the course of repair (Muran & Eubanks, 2020), yet these processes remain largely underexplored empirically. Importantly, the reviewed empirical studies do not systematically examine how such patient contributions operate at a functional level within rupture repair, nor do they consistently link patient characteristics to differential repair strategies. This limits the extent to which patient-side processes can be synthesized in the present review and underscores a significant gap in the literature. Future empirical research may help address this gap, particularly with the revised version of the 3RS (Eubanks & Muran, 2022), which incorporates patient repair strategies and may facilitate a more systematic examination of patient contributions.

Regarding the third specific objective – examining the theoretical approaches framing clinical recommendations for rupture repair – the reviewed literature reflects a notable diversity of orientations. The included publications adhered primarily to psychodynamic approaches (40%), followed by cognitive and cognitive-behavioral frameworks (36%), with smaller proportions representing integrative, multicultural, and trauma-informed perspectives. This pattern may be consistent with the characterization of alliance rupture repair as a transtheoretical process (Eubanks *et al.*, 2023), in the sense that certain recurrent strategies and principles appear across differently oriented publications. However, this recurrence should be interpreted cautiously, given the shared theoretical lineage of the included publications and the terminological boundaries of the search strategy. These recurrent patterns do not constitute evidence of a universally applicable framework, nor do they imply functional equivalence in the implementation, underlying mechanisms, or clinical timing of repair strategies across psychotherapy models. Rather, they reflect themes that appear with some consistency within this terminologically bounded *corpus*.

This characterization finds partial support in the present review, while also highlighting that the extent to which alliance ruptures repair functions as a transtheoretical corrective experience drawing on multiple traditions (Eubanks, Sergi, Samstag, & Muran, 2021) across diverse clinical and cultural contexts remains an open empir-

ical question. Recognizing these recurrent patterns does not eliminate the need for theoretical specificity or personalization; rather, it underscores that their clinical relevance depends on context-sensitive adaptation within each therapeutic framework.

Building on the patterns identified across the three objectives, and drawing on conceptual frameworks from the broader psychotherapy literature, the notions of personalization (Harnas *et al.*, 2024) and responsiveness (Eubanks, Sergi, & Muran, 2021) emerge as particularly relevant integrative lenses for interpreting the findings of this review. While these concepts extend beyond the directly mapped evidence, they offer a clinically meaningful framework for understanding how the recurrent strategies identified in the literature may be implemented in practice.

Rupture repair strategies may be understood as forming a recurrent set of themes within the literature, yet their effective implementation appears to depend on sensitivity to the specific clinical, relational, and cultural context of each patient. Personalization involves integrating these recurrently described strategies with systematic adaptations that address the unique ways in which ruptures are experienced and expressed, as well as the patient's individual needs and preferences. This underscores the need for therapists not only to embody general attitudes but also to cultivate flexibility and attunement to the meanings that ruptures may carry for different patients. Responsiveness, defined as the mutual influence between patient and therapist in a constant ebb and flow of behaviors shaped by the emerging therapeutic context (Stiles *et al.*, 1998), emphasizes the therapist's capacity to notice contextual shifts and adjust interventions accordingly. In this context, difficulties in responsiveness are often implicated in the emergence of ruptures, while repair processes appear to depend on the therapist's ability to remain attuned and flexibly select interventions that resonate with the relational needs of the dyad (Eubanks, Sergi, & Muran, 2021). Thus, rupture repair can be understood less as the application of predefined steps and more as an ongoing process of adjustment that demands sustained attunement to the patient's relational experience.

This attunement becomes especially critical in the clinical contexts highlighted in this review, including therapeutic relationships marked by cultural differences, histories of discrimination, or chronic trauma, where withdrawal ruptures may be particularly difficult to detect. Several empirical studies in this review identified behavioral markers of withdrawal ruptures, such as superficial compliance, deferential responses, and apparent engagement that masks underlying disconnection (Boritz *et al.*, 2018; Eubanks, Burckell, & Goldfried, 2018; Safran & Muran, 1996). In patients with histories of complex trauma, these same behaviors may simultaneously function as learned survival strategies. While this perspective is not directly derived from the mapped findings, it offers a clinically meaningful hypothesis that may help interpret patterns observed in the literature. Drawing on neurobiological research, the *appeasement response* (Bailey *et al.*, 2023) describes a co-regulation mechanism through which trauma survivors may appear emotionally connected and compliant in contexts of power asymmetry, as a means of adapting to threatening relational situations. In the therapeutic space, this response may be replicated in behaviors that closely resemble withdrawal rupture markers, such as deferential or appeasing behaviors and the masking of genuine experience. This overlap suggests that what a therapist may interpret as a strong alliance or cooperative engagement could, in some cases, reflect a withdrawal rupture shaped by trauma-related survival responses, making these ruptures particularly difficult to detect.

The clinical implications of this overlap are significant: if these

behaviors go unrecognized as rupture markers, the therapeutic relationship may deteriorate silently (López-Vásquez *et al.*, 2024). In these populations, where relational insecurity and mistrust may lead patients to adopt cautious or guarded positions, and where verbal reports may not fully reflect their internal experience, training therapists to recognize nonverbal signs of withdrawal may be especially helpful. Continuous monitoring of the therapist's own emotional responses also appears relevant for accurately perceiving these signals and guiding the repair process.

Consistent with the gaps identified in the reviewed publications, the review also highlighted the limited attention given to nonverbal and paraverbal dimensions in rupture repair processes more broadly. Most publications have focused on verbal exchanges and explicit therapist interventions, while only a few have emphasized how facial expressions, vocal quality, or prosodic variations may contribute to recognizing and resolving tensions within the alliance. In this regard, micro-analytical research has examined mutual regulation between patient and therapist at verbal and nonverbal levels, showing how these relational patterns may influence the emergence of ruptures and their possible pathways of resolution (Altimir & Valdés-Sánchez, 2020; Martínez *et al.*, 2014). Further development of this line of inquiry, integrating verbal, nonverbal, and physiological data, could provide clinicians with more nuanced tools for attending to the relational dynamics of rupture and repair and contribute to a more comprehensive understanding of the co-constructed nature of therapeutic change (Cunningham *et al.*, 2023).

Regarding future directions, it is important to advance research that deepens understanding of the patients' active role in repairs, develops specific adaptations of strategies for clinical subpopulations, and evaluates the effectiveness of teaching these resources in training and supervision programs. Such lines of inquiry may contribute to strengthening the theoretical field and informing clinical practice.

## Strengths and limitations

Among the strengths of this review is the integration of literature from different sources – conceptual, qualitative and quantitative empirical, and mixed-methods – allowing for a broad and panoramic view of the field, based on a replicable review methodology (Tricco *et al.*, 2018).

Some limitations must also be acknowledged. First, our search strategy prioritized literature explicitly using *rupture-repair* terminology. Consequently, this review primarily maps the discourse associated with this dominant conceptual lineage (Safran, Muran, Eubanks) and may have excluded studies addressing related clinical phenomena under different terms, such as alliance strain, impasses, misattunements, disruptions, enactments, misunderstandings, or negotiation failures (Muran, 2019). The search was conducted in July 2024 and reflects the timeframe in which the review was originally developed; as such, more recent publications are not included. Thus, while the review captures the rupture-repair discourse, it does not aim to provide exhaustive coverage of all clinically relevant work on therapeutic alliance challenges or repair processes. Second, the included publications are methodologically heterogeneous, comprising single-case studies, qualitative investigations, task analyses, and quantitative studies with varying sample sizes. These approaches differ substantially in their forms of measurement, levels of operationalization of rupture and repair processes, and sources of variability, which limits the comparability of findings across studies. Third, in line with the methodological framework of scoping reviews and PRISMA-ScR guidance, sources of evidence were not

critically appraised, as these reviews are typically conducted to provide an overview of the available literature regardless of methodological quality or risk of bias (Tricco *et al.*, 2018). Consequently, the recurrence of certain recommendations across publications should not be interpreted as an indicator of evidentiary strength or clinical effectiveness, but rather as reflecting dominant or recurrent themes within the literature. Fourth, a central aspect of this review is that it does not focus exclusively on empirical findings, but rather on how the literature formulated clinical recommendations. The recommendations identified reflect an interpretative level of analysis, in which authors translate empirical results, theoretical frameworks, and clinical experience into practice-oriented guidance. While many recommendations are derived from empirical studies, their degree of empirical grounding varies considerably across publications, and in some cases, they may extend beyond the data presented. Accordingly, the recommendations included in this review should not be interpreted as having equivalent evidentiary weight nor as representing standardized or validated clinical guidelines. The findings are intended to map the rupture-repair discourse and to identify recurrent clinical themes, rather than to establish a hierarchy of evidence-based recommendations.

## Conclusions

This review maps a heterogeneous body of literature on therapeutic alliance rupture repair, reflecting variability in methodological approaches and theoretical orientations. Within the empirical literature, the recognition of ruptures emerges as a recurrent and foundational recommendation. Detecting subtle signs of disengagement or tension within the dyad may constitute a core clinical competence that calls for explicit attention in therapist training and supervision.

While theoretical models have outlined how patients' characteristics, such as histories of complex trauma, cultural diversity, migration status, racial trauma, and the context of telepsychotherapy, shape the experience of rupture, empirical research is still needed to examine how these factors influence repair processes in practice. Addressing this gap will require methodological refinement and the integration of cultural and contextual dimensions into the study of therapeutic interaction.

Overall, many context-specific recommendations remain grounded in theoretical and conceptual contributions and require further empirical examination. At the same time, the findings highlight personalization and responsiveness as central challenges for the field, as it continues to move toward greater contextual sensitivity. Future developments in rupture and repair research will depend on the capacity to integrate this framework with a nuanced understanding of patient diversity and emerging clinical contexts.

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*Online supplementary material:*

*Supplementary Text 1. Final search strategy.*

*Supplementary Table 1. PRISMA-ScR checklist.*

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