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When Therapy Stalls: Recognizing and Repairing Ruptures in the Therapeutic Alliance

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Narrative Clinical Review

Abstract—Psychotherapy can stall without open disagreement. A patient may become compliant, vague, late, intellectually busy, or quietly absent; another may challenge the therapist, the method, or the premise of treatment. These responses may mark a rupture in collaboration, but they may also express reasonable doubt, cultural difference, danger, or a treatment that does not fit. This narrative clinical review examines evidence available through 30 November 2023 on recognizing and responding to strains in the therapeutic alliance. It distinguishes withdrawal and confrontation markers, relates them to agreement on goals and tasks and to the emotional bond, and considers the limits of alliance questionnaires and observer ratings. Repair begins with curiosity about the patient's experience, a willingness to examine the therapist's contribution, and a concrete renegotiation of the work. Meta-analytic findings associate rupture resolution with better outcomes, while training studies remain relatively small and cannot show that every rupture should be preserved or repaired. Cultural humility, attention to power, and direct safety assessment are integral rather than supplementary. When treatment is ineffective, coercive, or unsafe, a good clinical response may be modification, consultation, referral, or an orderly ending. Repair is therefore not restoration of therapist authority. It is renewed, testable collaboration—or an honest recognition that collaboration cannot responsibly continue.

Index Terms—therapeutic alliance, alliance rupture, rupture repair, metacommunication, psychotherapy process, cultural humility

I. INTRODUCTION

Therapy sometimes loses movement before either participant says that anything is wrong. The patient brings less material, agrees too quickly, completes a form without conviction, or speaks fluently while remaining emotionally distant. In another room the strain is obvious: the therapist is challenged, an intervention is rejected, or the value of treatment is questioned. Both patterns can be uncomfortable, yet discomfort alone does not define a rupture. The clinically important event is a deterioration in collaboration around the relationship, its goals, or the work through which those goals are pursued.

The idea of a working alliance gives clinicians a useful map. Bordin described agreement on goals, agreement on tasks, and the bond that makes joint work possible, proposing that these elements apply across therapeutic schools (Bordin, 1979). A rupture can involve any one of them. A patient may trust the therapist yet see no purpose in an exposure exercise, accept the stated goal yet feel patronized by the way it is pursued, or understand the method while no longer feeling safe enough to use it.

Alliance quality is reliably associated with psychotherapy outcome across many studies, but the association should not be simplified into a command to maintain harmony (Flückiger et al., 2018). Stronger alliance ratings can partly reflect early improvement, stable patient or therapist characteristics, and the fit between treatment and person. Within-person analyses strengthen the case that changes in alliance can precede later symptom change, although they do not remove every alternative explanation (Falkenström et al., 2014; Zilcha-Mano, 2017). The alliance is clinically consequential and methodologically difficult.

Rupture work occupies that difficulty. It asks the therapist to notice a change without deciding its meaning in advance, to hear criticism without making the patient protect the clinician, and to examine whether the treatment itself needs to change. The objective is not agreement for its own sake. It is a relationship in which consequential disagreement can become usable information and in which a patient remains free to decline, leave, or seek a different form of care.

II. SCOPE AND REVIEW METHOD

This narrative clinical review considered literature publicly available through 30 November 2023, one month before the nominal issue date. Searches emphasized meta-analyses, systematic reviews, foundational alliance models,

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observational process studies, measurement research, therapist-training trials, and professional guidance relevant to risk, boundaries, and cultural responsiveness. Complete online-first reports available by the cutoff were eligible. No new systematic review or quantitative synthesis was undertaken.

The principal focus is individual adult psychotherapy. Findings from time-limited treatments and from research on personality disorders are included because much detailed rupture coding and training research has been conducted there. They should not be assumed to generalize unchanged to children, couples, families, groups, inpatient work, involuntary treatment, or every cultural setting. The underlying questions—whose goal is being pursued, what task is being asked of whom, and whether disagreement is safe—remain relevant across settings.

A rupture is used here for a clinically meaningful strain or breakdown in collaboration, not every pause, missed appointment, symptom fluctuation, or difference of opinion. The review also resists the opposite error of defining a rupture only when a patient protests explicitly. Withdrawal can hide dissatisfaction, fear, confusion, shame, hopelessness, or practical barriers. Formulation must distinguish among these possibilities rather than assigning a relational meaning from behavior alone.

Recommendations are therefore graded in ordinary language. Meta-analytic associations and controlled training studies are described as evidence; moment-to-moment repair sequences derived from process research are treated as empirically informed practice; and decisions about respect, consent, confidentiality, and noncoercion also rest on professional ethics. An earlier JPPC article emphasized questions as interventions that alter therapeutic communication (Haverkampf, 2017). The present review extends that observation by asking when a question opens collaboration and when it becomes another demand that the patient accommodate the therapist.

III. THE ALLIANCE AS A WORKING ARRANGEMENT

Alliance language can become sentimental if the bond is separated from work. Warmth may coexist with a poorly chosen goal; technical competence may coexist with a task the patient never accepted. Bordin's formulation remains useful because it makes the relationship operational: what are we trying to change, what will each of us do, and what kind of connection permits that work (Bordin, 1979)? Goal consensus and collaboration show meaningful associations with outcome in meta-analysis, although measures and designs vary (Tryon et al., 2018).

The Working Alliance Inventory translated this model into ratings of bond, goals, and tasks (Horvath & Greenberg, 1989). Such measures can create a shared language, but a total score can conceal the problem that requires discussion. Two patients can record the same score because one doubts the goal and another feels personally unsafe. Item-level review, change across sessions, and the patient's own explanation are often more informative than treating a threshold as a diagnosis.

Alliance is also both a stable difference between dyads and a changing process within a dyad. A patient who generally trusts treatment may experience a sharp strain after a missed cultural cue; another may rate every session cautiously while collaboration is slowly strengthening. Research that separates between-patient differences from within-patient change suggests that alliance fluctuations carry information beyond prior symptom change, but causal interpretation remains contested (Falkenström et al., 2014; Zilcha-Mano, 2017). Clinically, the safest conclusion is to investigate movement rather than worship the score.

The agreement is unequal in role but should not be unilateral. The therapist controls access to expertise, records, institutional language, fees, scheduling, and sometimes reports that affect liberty, employment, or benefits. The patient supplies intimate information and lives with the consequences of the plan. Collaboration does not erase this asymmetry. It requires the person with professional power to make goals, methods, uncertainty, alternatives, and limits sufficiently explicit that consent can remain active rather than ceremonial.

A working arrangement is revisable. New diagnostic information, adverse effects, a change in risk, financial pressure, or a patient's changing priorities may make an earlier task inappropriate. Renegotiation is not evidence that the original formulation was fraudulent. It is evidence that treatment is responsive to information. Conversely, repeated reframing that leaves the therapist's preferred method untouched is not meaningful negotiation. The revised plan must be visible in what happens next.

Contemporary alliance theory increasingly treats collaboration as an emergent, negotiated process rather than a therapeutic ingredient that can be poured into treatment at a fixed dose (Muran, 2022). That shift is clinically useful when it discourages static labels such as a “good alliance” and keeps attention on what the two participants can and cannot do together in the present phase of care.

IV. WHAT COUNTS AS A RUPTURE

Safran, Muran, and colleagues conceptualized ruptures as tensions or breakdowns in collaboration that may be expressed through withdrawal or confrontation (Safran et al., 2011). The distinction describes movement, not personality. Withdrawal moves away from a feeling, task, therapist, or treatment; confrontation moves against or seeks control over some part of the interaction. The same person may shift rapidly between the two, and an apparently calm exchange can contain both.

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Ordinary disagreement is not automatically a rupture. A patient can reject an interpretation while remaining engaged, and a therapist can recommend a treatment the patient declines without the relationship failing. Indeed, direct disagreement may demonstrate a sufficiently secure alliance. A rupture becomes more likely when collaboration narrows: one participant cannot express what matters, the other's response makes expression less safe, or goals and tasks continue as though assent were present when it is not.

Nor is every apparent marker relational in origin. Silence may allow thought, accommodate language processing, or reflect fatigue. Missed homework may follow executive difficulty, poverty, caregiving, an inaccessible task, or a realistic fear. Anger may be a proportionate response to disrespect. Coding systems identify behavior that warrants attention; they do not settle why it occurred. The meaning must be developed with the patient and, where relevant, with knowledge of context.

Process studies in time-limited psychotherapy found that the intensity and resolution of early ruptures were related to session quality and some outcomes, but these were not simple experimental tests of a repair technique (Muran et al., 2009). Meta-analysis subsequently found a moderate association between successful rupture resolution and outcome, with a small literature and variation in how repair was defined (Eubanks et al., 2018). The appropriate clinical stance is alertness with humility: ruptures matter, yet neither a marker nor a repaired score proves a mechanism.

V. WITHDRAWAL AND CONFRONTATION MARKERS

Withdrawal markers are easily rewarded by busy services. A patient who says that everything is fine, accepts the agenda, and causes no delay can appear highly engaged. Yet minimal answers, deferential agreement, abrupt topic changes, abstract storytelling, or repeated failure to enact an agreed task may signal that direct dissent feels costly. The clinician listens for a loss of specificity and vitality rather than assuming that quietness itself is pathological.

Confrontation markers are more visible and can activate the therapist's wish to defend competence. Complaints about fees, diagnosis, lateness, homework, empathy, or progress may be expressed sharply. Some are rupture communications; others are straightforward service complaints or accurate descriptions of harm. A useful first response does not require deciding which. It acknowledges the content, slows the exchange, and asks what effect the event had on the patient's willingness to continue.

The categories are not moral opposites. Withdrawal is not good behavior, and confrontation is not resistance. Each may protect agency or connection under conditions where open, vulnerable speech feels unsafe. The Rupture Resolution Rating System formalizes multiple markers and resolution strategies for observer coding, improving research precision while still requiring inference from interaction (Eubanks et al., 2019). In ordinary practice, the categories should widen observation, not turn a session into covert surveillance.

A marker becomes clinically useful when it leads to a question that can be refused. The therapist might notice that the conversation became more general after a proposal, or that a task was challenged more strongly than usual. The observation is offered tentatively and tied to the work: whether something did not fit, whether the therapist missed a concern, and whether it would help to stay with the moment. The patient may correct the hypothesis. That correction is information, not a failed intervention.

Table 1. Rupture markers are prompts for inquiry, not conclusions

Observed change	Possible rupture meaning	Important alternatives	Opening response
Minimal or overly agreeable replies	Withdrawal from dissent or vulnerable affect	Thinking time, language, fatigue, preference	Name the change tentatively and allow no answer
Topic shift or abstract storytelling	Movement away from a painful relational moment	Association, cognitive style, unclear question	Return to the transition and ask what was happening
Homework repeatedly not attempted	Disengagement from task or goal	Executive load, danger, cost, task too large	Recheck purpose, feasibility, and genuine agreement
Criticism of therapist or method	Confrontation around bond, task, or goal	Accurate complaint, ordinary disagreement	Receive content before explaining intention
Threat to quit or abrupt ending	Escalated strain or bid for agency	Logistics, treatment failure, unsafe care	Clarify choice, safety, alternatives, and what remains unresolved

VI. DETECTING AND MEASURING STRAIN

Therapists do not have privileged access to how patients experience them. Client, therapist, and observer ratings overlap imperfectly, and the perspective most predictive of outcome can depend on timing and method. A clinician's confidence that the alliance is sound may therefore be reassuring but insufficient. Routine, low-burden invitations to evaluate fit can make dissatisfaction more speakable before it appears as dropout.

Alliance questionnaires offer one route. They are most useful when framed as aids to conversation rather than evaluations the patient must help the therapist pass. Privacy of completion, clear explanation of use, and a nondefensive response to low ratings affect validity. If every low score produces a prolonged inquiry, patients may learn to rate generously to protect session time. If ratings disappear into the record, measurement becomes extractive.

Observer systems such as the 3RS identify withdrawal, confrontation, therapist contributions, and resolution behavior

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from recordings (Eubanks et al., 2019). They are valuable for research, training, and detailed supervision. They are resource-intensive and do not turn inference into fact. Recording also changes privacy obligations; specific consent, secure storage, access limits, and an alternative for patients who decline are part of the intervention's ethics.

Symptom and functioning measures provide a different signal. Progress feedback has, on average, small beneficial effects and may be particularly useful when a patient is not improving, although effects vary across systems and implementation (Shimokawa et al., 2010; de Jong et al., 2021). A flat or worsening trajectory should prompt review of risk, diagnosis, treatment dose, practical barriers, and method as well as alliance. Lack of progress is not proof of a hidden relational conflict.

The most sensitive measure may be a specific conversation. Rather than asking only whether the session was helpful, the therapist can ask which part felt least relevant, where the patient held back, what the therapist misunderstood, and whether the current goal still belongs to the patient. Haverkampf's discussion of therapeutic questions is pertinent here: the form of a question changes what can be communicated (Haverkampf, 2017). An invitation ceases to be feedback-friendly when disagreement is subtly debated away.

Table 2. Complementary ways to detect a treatment impasse

Source	What it can show	What it may miss	Responsible use
Patient alliance rating	Experienced bond, goal and task fit	Reasons for a score; fear of offending	Review change and selected items collaboratively
Therapist rating	Clinician's sense of engagement and strain	Patient's private experience; therapist blind spots	Compare perspectives without privileging either
Observer coding or recording	Specific interaction markers and sequences	Unrecorded context; meaning known only to participants	Use with consent in training or supervision
Outcome and functioning measures	Progress, deterioration, and domain-specific change	Why change occurred; relationship quality	Trigger broad formulation and risk review
Direct session inquiry	Meaning, preference, and proposed correction	What still feels unsafe to say	Ask specifically, receive the answer, revisit over time

VII. FROM MARKER TO COLLABORATIVE INQUIRY

The first task after noticing strain is often regulation, especially the therapist's. A critical remark can produce shame, urgency, irritation, or a rapid explanatory monologue. A withdrawn response can invite harder questioning or premature reassurance. If the clinician acts from that pressure, the attempted repair may repeat the original problem. A brief pause, slower speech, and an internal acknowledgment of uncertainty create room for a different response.

An observation should be proximal and modest. “We seemed to lose each other when I suggested the exercise” is easier to examine than “You are withdrawing because closeness is frightening.” The first identifies a shared moment and leaves causation open. The second may eventually become a hypothesis, but offered too early it requires the patient to accept both the therapist's theory and the therapist's innocence.

Receiving content precedes clarifying intention. If a patient says that an interpretation felt dismissive, the therapist can first establish what was dismissed and what effect followed. Explaining that the intention was supportive may later matter, but intention does not erase impact. Where the therapist recognizes an error, a concise acknowledgment is stronger than a confession that requires reassurance. Responsibility is expressed in changed conduct.

The inquiry should also preserve ordinary choice. Some patients do not wish to analyze every interpersonal moment and may experience repeated metacommunication as intrusive. A therapist can offer the option to return later, ask whether a practical change would be enough, or accept that the patient prefers a more structured focus. Responsiveness includes knowing when not to deepen.

Before leaving the rupture, the dyad needs a small, observable experiment. The agreed change might concern pace, wording, accessibility, homework size, session structure, contact policy, or whether a disputed intervention is paused. Therapist and patient can name what each will do, what would suggest renewed collaboration, and when the change will be reviewed. This protects rupture work from becoming an indefinite inquiry in which the patient repeatedly explains distress while treatment remains unchanged. It also permits a patient who does not want extended relational discussion to evaluate a practical correction. If the experiment fails, the result is information about fit, not evidence that the patient resisted repair. Meta-analysis associates successful resolution with better outcomes but does not establish a universal sequence, so changed conduct and subsequent experience carry more weight than whether the conversation resembled an ideal repair model (Eubanks et al., 2018).

A brief repair conversation

- Notice: describe the specific change without assigning motive.
- Invite: ask whether something in the interaction or task did not fit.
- Receive: summarize the patient's meaning before explaining your own.
- Own: acknowledge any error or contribution without seeking reassurance.
- Renegotiate: agree one visible change in goal, task, pace, or boundary.
- Revisit: ask later whether the change restored useful collaboration.

Haverkampf, C. J. (2023). When Therapy Stalls: Recognizing and Repairing Ruptures in the Therapeutic Alliance. J Psychiatry Psychotherapy Communication, 2023 Dec 31;12(4):111-120

VIII. METACOMMUNICATION AND THE WORK OF REPAIR

Metacommunication means speaking about what is happening between patient and therapist while it is happening or soon afterward. In rupture work it can transform an enacted conflict into shared observation. Safran and colleagues describe strategies that begin with recognition, exploration of the patient's experience, and attention to underlying wishes or fears before a new way of relating is attempted (Safran et al., 2011). The sequence is a guide, not a script.

Withdrawal often requires permission for agency. The therapist may invite the patient to notice what made disagreement hard, while guarding against turning the invitation into another demand for emotional exposure. Confrontation often requires the therapist to tolerate anger long enough to hear the threatened need—perhaps respect, clarity, competence, autonomy, or protection. In both patterns, repair moves from marker to experience and then to a revised interaction.

A concrete renegotiation distinguishes repair from a moving conversation. If homework felt infantilizing, the patient and therapist may redesign the task and agree how its usefulness will be judged. If diagnostic language felt imposed, they can record uncertainty and review what the label changes. If lateness by the therapist damaged trust, an apology matters, but so does reliable timekeeping. The new agreement must be capable of succeeding or failing in observable practice.

Qualitative research shows that patients and therapists can experience the same rupture differently, including differences in when it began and whether it was repaired (Coutinho et al., 2011). Asking the patient whether the conversation helped is therefore necessary. A therapist may feel relief after explaining an error while the patient feels that criticism was absorbed but nothing changed. Repair is not complete because tension left the therapist's body.

Meta-analysis links successful resolution with better outcomes, and specific repair efforts appear preferable to continuing technique unchanged through a significant strain (Eubanks et al., 2018). Yet the literature does not establish one sequence for every therapy. Some repairs are quiet: a slower pace, clearer rationale, different seating, a changed pronoun, an accessible format, or more accurate follow-through. The relevant criterion is renewed capacity to work, not performance of relational depth.

IX. THE THERAPIST'S CONTRIBUTION AND EMOTIONAL PRESSURE

Rupture models are sometimes misused to locate the problem in the patient's interpersonal pattern. The therapist also brings expectations, attachment strategies, cultural assumptions, institutional loyalties, fatigue, and preferred techniques. A patient who resists may be protecting treatment from a premature intervention. The question "What is this patient doing?" needs a companion: "What am I doing, inviting, avoiding, or making difficult to say?"

Countertransference is clinically relevant when the therapist's reactions narrow perception or action. Meta-analytic work associates effective management of countertransference with better outcome, although the evidence base includes varied definitions and designs (Hayes et al., 2018). Management does not mean emotional absence. It means noticing reactions, understanding their possible sources, and choosing a response that serves the patient's work rather than discharging the clinician's discomfort.

Common pressures include proving that the treatment is valid, restoring warmth quickly, becoming unusually permissive after criticism, or withdrawing emotionally from a patient perceived as rejecting. Each can create false repair. The therapist may agree to a change that cannot be sustained, disclose too much to demonstrate humanity, or use formulation language to regain authority. Supervision is especially valuable when the clinician feels certain that the patient is the sole cause of the impasse.

An apology is indicated when there has been a recognizable error or harm. It should name the action, acknowledge likely impact, avoid excuses, and state what will change. Broad self-condemnation burdens the patient with the therapist's recovery; a qualified apology—"I am sorry you felt that way"—denies responsibility. When facts or meanings remain uncertain, the therapist can still acknowledge the experience and commit to investigating it without falsely admitting what did not occur.

Therapist fallibility should be discussable from the beginning. Explaining that feedback is expected, that misunderstandings can occur, and that alternatives can be considered may reduce the cost of later dissent. Such preparation cannot guarantee candor; power remains. It does, however, create a reference point the patient can invoke when the therapist's actual behavior drifts from the stated collaborative stance.

X. CULTURE, IDENTITY, AND POWER

A rupture cannot be understood outside the meanings available in a patient's social world. Eye contact, emotional directness, family obligation, authority, privacy, gendered speech, spirituality, disability, and help-seeking carry different expectations across communities and individuals. A therapist who treats one local norm as neutral may code difference as avoidance or noncompliance. Cultural formulation begins with inquiry into meaning and consequence, not a list of presumed group traits.

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Cultural humility emphasizes an other-oriented stance, awareness of limits, and attention to power rather than a claim of achieved competence (Hook et al., 2013). Client perceptions of multicultural orientation have been associated with therapeutic process, and the broader framework highlights cultural humility, opportunities to discuss identity, and the handling of cultural material (Owen et al., 2011; Davis et al., 2018). These findings are largely correlational and cannot prescribe a single way to broach difference.

Silence around identity is not necessarily neutral. In cross-racial therapy, satisfied and dissatisfied clients have described how therapists' responsiveness, cultural knowledge, errors, and willingness to discuss difference shaped the relationship (Chang & Berk, 2009). A patient may withdraw after a microaggression because challenging a clinician feels unsafe, or confront because previous polite efforts were missed. The same marker has a different history when professional authority is joined to societal power.

Repair requires specificity. The therapist can ask what was assumed, how the remark landed, and what recognition or change is needed. Seeking a cultural tutorial from the injured patient adds labor; displaying newly acquired knowledge can recentre the therapist. Consultation, reading, and supervision should occur outside the session, while the patient retains control over what personal meaning is explored inside it.

Power also includes diagnosis, compulsory care, immigration status, disability assessment, financial dependency, and digital access. In such settings, saying “you are free to disagree” may be formally true and practically incomplete. The clinician should state what choices are real, what information will be recorded or shared, and what consequences are outside the therapist's control. Transparency does not equalize power, but concealed power is harder to negotiate.

Table 3. Cultural and power-sensitive rupture review

Question	Risk if overlooked	Clinician action
Whose communication norm was treated as neutral?	Difference is mislabeled as withdrawal or hostility	Ask about intended meaning and preferred form of dialogue
What identities or social realities were missed?	Invalidation, stereotype, or forced education	Acknowledge the omission; learn outside the session
What material power does the clinician hold?	Apparent consent masks fear of consequences	State choices, records, reporting duties, and limits plainly
Who is carrying the work of repair?	Patient must soothe or teach the therapist	Take responsibility and use supervision or consultation
What change would be observable?	Warm words replace changed practice	Agree a specific adjustment and review its effect

XI. TECHNIQUE, DIAGNOSIS, AND SETTING

Rupture repair is not an alternative school of therapy placed above technique. A well-supported intervention may still need a clear rationale, shared goal, and adaptation to the patient. Conversely, a strong bond does not make an ineffective or contraindicated method acceptable. Research on the alliance supports responsive delivery, not the abandonment of treatment models whenever discomfort appears (Flückiger et al., 2018; Baier et al., 2020).

Some tasks are expected to evoke anxiety or ambivalence. Exposure, behavioral activation, trauma-focused work, and discussions of substance use can feel difficult precisely because they approach what has been avoided. The clinician distinguishes productive difficulty from a rupture by examining agreement, understanding, safety, and learning. If the patient understands the rationale, chooses the task, and can modify pace, distress need not indicate relational failure. If refusal is argued away, the method has lost its collaborative basis.

Diagnosis can organize care and also become a rupture site. A patient may hear a label as explanation, accusation, stigma, or threat to identity. The therapist should ask what the diagnosis means to the person, describe uncertainty and alternatives, and specify what treatment decision it informs. Disagreement about a label does not automatically show lack of insight; it may reveal a different account of context or a justified concern about consequences.

Settings change what repair can accomplish. Brief services may have little time, inpatient units may involve coercion, and public clinics may restrict clinician choice. Online treatment can make withdrawal harder to read and practical disruption easier to misinterpret. The therapist should name structural constraints rather than personalizing them. Repair may involve advocacy or a change in service pathway, not only a better conversation inside an unchanged system.

Alliance-focused training has shown that relational skills can be taught through video review, awareness work, and role-play, and one small controlled study found effects on process and outcome in a specific CBT protocol for patients with personality disorders (Eubanks-Carter et al., 2015; Muran et al., 2018). This evidence is encouraging but narrow. It does not license an untrained clinician to improvise intensive relational work beyond competence or to claim that every stalled treatment is cured by metacommunication.

XII. SAFETY, BOUNDARIES, AND UNSAFE TREATMENT

A rupture conversation never replaces direct safety assessment. Sudden withdrawal, missed sessions, hopelessness, anger, or a wish to end treatment may coincide with self-harm risk, violence, intoxication, abuse, mania,

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psychosis, or medical deterioration. The clinician asks about risk plainly and follows the relevant care pathway. Guidance on self-harm emphasizes psychosocial assessment, collaborative care, and safety planning rather than risk scales used as predictive verdicts (National Institute for Health and Care Excellence, 2022).

Safety also includes the treatment relationship. Sexualized behavior, coercive contact, financial exploitation, retaliatory documentation, breaches of confidentiality, and pressure to remain with a clinician are not ordinary alliance tensions to be repaired privately. Professional boundaries protect the patient and define the purpose of contact. Where a serious boundary concern arises, consultation, safeguarding, formal complaint routes, transfer, or regulatory processes may be required. The therapist's wish to preserve the alliance does not supersede accountability.

A patient may reasonably decide that treatment is unsafe or ineffective. Interpreting departure as enactment can reproduce coercion, especially when the clinician controls the record. The therapist can offer a final review, describe options, provide clinically necessary continuity information with consent or lawful authority, and document the patient's stated reasons accurately. The invitation must remain an invitation. Refusal of a final session is not evidence that the ending was clinically wrong.

Not every disclosure can remain confidential. Limits concerning imminent risk, safeguarding, court orders, team care, or insurer requirements should be explained before they become active and revisited when relevant. If information must be shared, the patient should ordinarily be told what will be communicated, to whom, and why, subject to safety and law. Surprising a patient with a previously obscured limit can itself produce a profound rupture.

Clinicians need a pathway for concerns about their own impairment or conduct. Fatigue, illness, substance use, grief, and organizational pressure can reduce responsiveness. Supervision and occupational support are not signs that the alliance has failed; they are protections for it. Ethical practice includes stepping back or arranging cover when the therapist cannot offer safe care.

XIII. WHEN REPAIR DOES NOT OCCUR

Some ruptures remain unresolved. The patient may not feel able to describe the problem, the therapist may not understand it, or the proposed change may fail. Other impasses reflect a method that is ineffective, an unchangeable service constraint, incompatible expectations, or harm serious enough that continued work is not appropriate. Persistence is not always therapeutic perseverance.

A structured review separates several questions. Is the target still important to the patient? Has there been meaningful change in symptoms or functioning? Is the treatment being delivered competently and at an adequate dose? Are practical barriers, diagnosis, medication effects, substance use, physical illness, or social danger obstructing progress? Does the patient want a different therapist, modality, or level of care? The answer may involve more than the relationship.

Dropout research shows that premature termination is common and varies with patient, therapist, treatment, and design factors (Swift & Greenberg, 2012). The label “dropout” is itself limited: some people leave because they improved, some because access ended, and some because care was poor. Services should seek reasons without blaming, offer routes back where appropriate, and analyze patterns across clinicians and groups rather than treating each departure as an isolated patient failure.

Referral can be a repair when it restores access to suitable care. It is harmful when used to remove a patient who criticized the therapist or when it occurs without continuity for someone at risk. A responsible referral names the clinical rationale, acknowledges the relationship, presents feasible alternatives, transfers information proportionately, and plans the interval. Where choice is constrained, that constraint should be said plainly.

An ending can also hold unresolved disagreement without manufacturing consensus. The therapist may summarize what each person understands differently, recognize what did not help, and document the patient's view. The patient does not owe gratitude or absolution. The clinical aim is a clear, safe transition and the preservation of future help-seeking where possible.

Unresolved work benefits from an explicit time horizon. Continuing for 'a little longer' without criteria can convert uncertainty into drift and make departure feel like failure. The patient and therapist can agree to a short review interval, identify one clinical outcome and one collaboration outcome, state which element of care will change, and decide in advance what would prompt consultation, a different method, referral, or ending. A trial is not a contract to remain: new risk, harm, intolerable burden, or loss of consent can bring review forward. Conversely, lack of rapid symptom change is not by itself proof that treatment failed when the agreed target reasonably requires time. The point is disciplined uncertainty—enough continuity to evaluate a credible adjustment, with enough exit clarity to prevent therapeutic hope from becoming indefinite exposure to ineffective care. Because reasons for termination vary, the patient's account of the decision should be sought and recorded without forcing a final explanatory session (Swift & Greenberg, 2012).

XIV. MONITORING, FEEDBACK, AND SUPERVISION

Monitoring after a repair asks whether work actually resumed. A brief plan may track the disputed task, one patient-

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defined outcome, symptoms or functioning, and the experience of collaboration. If the change was a slower pace, later review asks whether the patient could think and speak more freely. If the change was a different intervention, the review asks whether it addressed the shared goal. General warmth is not an adequate outcome measure.

Feedback systems can improve outcome modestly, especially when results reach the clinician and are used, but they are not self-executing (de Jong et al., 2021; Lambert & Shimokawa, 2011). A graph cannot decide whether deterioration reflects temporary activation, adverse treatment, external crisis, or measurement noise. It creates an obligation to look. Services should monitor who completes measures and who disappears from the data, since burden and digital exclusion can make the apparently measurable sample unrepresentative.

Supervision benefits from close review of sequence rather than global descriptions of a difficult patient. The therapist can identify the moment before the change, their internal reaction, what they said, the patient's response, and the alternative they now see. Video or audio can reveal timing and tone but requires consent and secure governance. Role-play allows the supervisor to test a concise acknowledgment or invitation before the therapist returns to the room.

Training should include receiving criticism, tolerating silence, apologizing, explaining limits, and recognizing cultural and power dynamics. Alliance-focused training explicitly develops awareness, affect regulation, and interpersonal sensitivity (Eubanks-Carter et al., 2015). The evidence does not yet establish the ideal dose or transfer across settings. Deliberate practice is still preferable to assuming that goodwill alone produces relational skill.

At service level, repeated low alliance ratings or disproportionate dropout among particular groups should trigger examination of access, language, discrimination, scheduling, cost, and clinician behavior. Individual repair cannot compensate indefinitely for a hostile system. Aggregate review must protect confidentiality and avoid turning patient feedback into punitive ranking that encourages therapists to seek high scores rather than honest data.

Monitoring should include delayed and opportunity costs. A patient may report that a repair conversation felt respectful yet later avoid a topic, attend less reliably, complete an unwanted task, or conclude that criticism changes words but not practice. Review therefore asks not only whether tension fell, but what became easier or harder to say and do afterward. The therapist can compare the agreed change with subsequent sessions, invite correction in a low-burden form, and notice whether the patient is now protecting the clinician from another discussion. Measures can help locate change, but item scores should be read alongside attendance, functioning, adverse effects, and the patient's narrative rather than converted into a relational verdict (de Jong et al., 2021). When progress and alliance signals diverge, supervision should preserve both possibilities: effective treatment can still be delivered coercively, and a warm relationship can coexist with little clinical benefit. The task is to explain the divergence and alter care where warranted, not select the measure that best reassures the service.

XV. LIMITATIONS OF THE EVIDENCE

Alliance research is large, but rupture research is comparatively small. Studies use different definitions: observer-coded markers within a session, sudden changes in questionnaire scores, patient-reported critical incidents, or researcher-identified resolution episodes. These methods do not capture the same event. Meta-analytic association between repair and outcome is clinically suggestive, yet it cannot show that a particular repair caused improvement in every case (Eubanks et al., 2018).

Samples are often drawn from specialist clinics, time-limited therapy, and patients willing to be recorded. Detailed studies of personality-disorder treatment have generated valuable models but may overrepresent certain interpersonal patterns and therapist training contexts. Cultural, racialized, disabled, older, and economically marginalized patients remain insufficiently represented in many process datasets. Measures developed in one language and clinical culture may not travel without changed meaning.

Alliance ratings are vulnerable to common-method effects, reverse causation, and stable dyad characteristics. Sophisticated longitudinal methods improve inference but do not randomize a relationship (Zilcha-Mano, 2017; Baier et al., 2020). Training trials are few and small. Research rarely measures harms of attempted repair, such as pressure to disclose, prolonged ineffective treatment, or a therapist using relational language to neutralize a complaint.

Future research needs preregistered definitions, repeated patient-centered measurement, observer and participant perspectives, and explicit reporting of adverse events and repair failures. Studies should examine rupture work across therapies, remote and hybrid care, compulsory settings, and culturally diverse services. Outcomes should include retention, functioning, trust in future care, and whether the patient experienced greater agency—not only symptom score and therapist-rated resolution.

XVI. CONCLUSION

When therapy stalls, the visible behavior is only the beginning of formulation. Withdrawal and confrontation can signal a strain in bond, goals, or tasks, but they can also reflect thinking style, practical constraint, justified disagreement,

Haverkampf, C. J. (2023). When Therapy Stalls: Recognizing and Repairing Ruptures in the Therapeutic Alliance. J Psychiatry Psychotherapy Communication, 2023 Dec 31;12(4):111-120

cultural difference, failed treatment, or danger. A marker warrants curiosity, not a verdict.

Repair is a disciplined form of communication. The therapist notices a specific change, invites the patient's meaning, receives impact before defending intention, examines personal and institutional contribution, and renegotiates something that can be observed. Measures and feedback can support this work, while supervision provides a place to think when shame, urgency, or certainty has narrowed the therapist's view.

The alliance is not preserved by keeping a patient agreeable. It is strengthened when consequential dissent can alter the work. Sometimes the responsible outcome is renewed collaboration; sometimes it is consultation, a different method, referral, complaint, or ending. The measure of repair is not restored authority or comfort. It is whether treatment again becomes safe, chosen, intelligible, and useful.

XVII. CONFLICTS OF INTEREST AND DISCLOSURES

Conflicts of interest—The author developed and writes about Communication-Focused Therapy (CFT). Where CFT is discussed, it is presented as a formulation perspective and not as a substitute for established assessment, evidence-based treatment, or independent replication. No other conflict of interest was reported.

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Patient material—No identifiable patient material is presented. Any brief examples are generic composites created to illustrate clinical reasoning and are not case reports.

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