

Alliance Rupture–Repair and Treatment Outcome in Youth Psychotherapy: A Systematic Review

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While extensive research has investigated alliance rupture–repair processes in adult psychotherapy, there is a need for a better understanding of rupture–repair and its association with outcome in child and adolescent psychotherapy. This study aims to fill this gap and provide the first systematic narrative synthesis of the existing empirical research on the association between alliance rupture–repair processes and therapeutic outcomes among adolescents. This systematic review included six studies. The findings from these studies indicate that successful rupture–repair processes are associated with improved therapeutic outcomes and reduced dropout rates. These results should be interpreted with caution because of the limited number of studies, small sample sizes, methodological limitations, and observed heterogeneity. This review also highlights a significant research gap in child therapy on this topic. Despite these limitations, it underscores the association between successful rupture–repair and improved therapeutic outcomes and treatment retention, particularly in adolescent psychotherapy. Further research, especially in child therapy, is essential to deepen our understanding of this relationship.

Public Health Significance Statement

This review is the first to summarize the literature on how resolving alliance ruptures affects outcomes in child and adolescent psychotherapy. Although research is limited, evidence indicates that resolving ruptures leads to better treatment outcomes, especially for adolescents. However, understanding in child therapy is still lacking because of limited studies. Further research is needed to guide clinical practice.

Keywords: alliance, rupture–repair, treatment outcome, child and adolescent psychotherapy, systematic review

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The therapeutic alliance, defined as the degree of collaboration between a therapist and client within an emotional bond (Bordin, 1979), has

consistently been shown to predict psychotherapy outcomes. This holds true across treatments for both adults (Flückiger et al., 2018) and

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Dhea Bengardi served as lead for formal analysis

and writing—original draft and contributed equally to conceptualization, data curation, methodology, and project administration. Catherine F. Eubanks contributed equally to supervision and writing—review and editing and served in a supporting role for conceptualization and methodology. Antonella Cirasola served as lead for conceptualization, formal analysis, methodology, project administration, supervision, and writing—review and editing.

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young people (Karver et al., 2018). As a result, the therapeutic alliance is widely regarded as one of the most important and integrative factors in psychotherapy. It has even been described as “the quintessential integrative variable” (Wolfe & Goldfried, 1988, p. 449), underscoring its relevance across various therapeutic approaches. This is because the alliance pertains to the therapeutic relationship, a key element in all therapy types, regardless of the therapist’s theoretical orientation or techniques (Flückiger et al., 2012). This consistency strengthens the alliance’s role as a transtheoretical factor essential to effective psychotherapy across diverse modalities.

Recent advances in alliance research, often referred to as the “second generation” of alliance studies, have built on early alliance research that established that the alliance is predictive of outcome and have provided deeper insight into how alliances develop, how ruptures occur, and how they are repaired. These studies now view the alliance as a dynamic, evolving process rather than a static variable. Research has highlighted that the alliance can experience temporary breakdowns or “ruptures” during therapy. If unresolved, these ruptures can impede treatment progress; however, when successfully addressed, they can actually lead to improved outcomes (Eubanks, Christopher Muran, & Safran, 2018).

Safran and Muran (2000) introduced the term “alliance rupture” to describe “the inevitable strains in the alliance . . . consisting either of disagreements about the tasks or goals of therapy or of problems in the bond dimension” (p. 16). While “rupture” usually suggests major conflict or breakdown, in alliance literature, it encompasses a range of alliance strains, which may not always carry negative implications (Safran & Muran, 1996, 2000). Ruptures in the therapeutic alliance are commonly classified as either withdrawal or confrontation types, although they may often involve elements of both.

Withdrawal ruptures involve “movements away” from therapy or the therapeutic relationship, reflecting emotional distancing or disengagement between the patient and the therapist. These may manifest as behaviors such as denial, minimal verbal responses, shifting topics, or intellectualizing issues to avoid emotional connection. In children and adolescents, withdrawal may also present as passive compliance—where the young person appears agreeable and cooperative, yet emotionally disengaged. For instance, a child might nod at the therapist’s suggestions or repeat what the therapist

says without genuine interest or understanding, possibly masking discomfort or uncertainty they do not feel safe expressing. In adolescents, this might take the form of noncommittal answers (“I don’t know,” “whatever”) or a polite but emotionally distant demeanor.

In contrast, confrontation ruptures represent “movements against” the therapeutic process or the therapeutic relationship itself, where the client and/or therapist challenge or oppose each other. These ruptures often reflect tension, frustration, or dissatisfaction and may involve direct resistance to the therapist’s interventions or to the therapy as a whole. In adolescent therapy, for example, a client may question the therapist’s competence, argue about the goals of treatment, or refuse to engage in certain therapeutic tasks. In younger children, confrontation may be expressed through behavioral disruptions, such as ignoring instructions, acting out, or refusing to participate, signaling opposition to the therapist’s efforts or the structure of the session.

Both types of ruptures, though disruptive, are seen as normal and even necessary parts of the therapeutic process. When addressed and repaired appropriately, they can strengthen the therapeutic alliance and contribute to more successful outcomes. A rupture is considered repaired when the emotional bond between the client and therapist is restored, and collaboration on therapy is resumed (Eubanks, Christopher Muran, & Safran, 2018). Based on research and clinical experience in adult psychotherapy, rupture–repair strategies are typically categorized into two types: immediate and exploratory (Eubanks, Christopher Muran, & Safran, 2018; Muran & Eubanks, 2020).

Immediate strategies aim to quickly restore the therapeutic alliance without delving deeply into the rupture’s underlying causes. These may include clarifying misunderstandings, renegotiating goals or tasks, explaining therapeutic choices, or helping the client refocus on treatment. The focus is on reducing emotional tension and reestablishing collaboration.

Exploratory strategies, by contrast, seek a deeper understanding of the rupture. They involve inviting clients to express their thoughts and feelings about the impasse, exploring underlying relational patterns or unmet needs, and offering the therapist’s reflections to promote mutual insight and connection.

Research in adult samples consistently shows that resolving alliance ruptures is linked to

positive therapy outcomes across various treatment modalities. Two meta-analyses of adult patients (Eubanks, Christopher Muran, & Safran, 2018; Safran et al., 2011) support this, with the most recent one analyzing 11 studies and 1,314 patients, finding a moderate effect size ($r = .29$). This indicates a significant correlation between successfully addressing ruptures and good therapy outcomes, such as symptom improvement and reduced premature termination. While caution is warranted because of variations in study designs and modest sample sizes, the second generation of alliance research underscores the importance of managing alliance ruptures for successful treatment outcomes. Consequently, repairing ruptures has been increasingly recognized as a promising evidence-based treatment approach (Norcross & Wampold, 2018).

Alliance Rupture–Repair in Child and Adolescent Therapy

Current research primarily focuses on understanding the relationship between alliance rupture–repair and therapy outcomes in adult psychotherapy, limiting our understanding of this dynamic in child and adolescent therapy. Since there is growing evidence highlighting the critical role of a strong and positive alliance for effective treatment in child and adolescent therapy (Bose et al., 2022; Karver et al., 2006, 2018; McLeod, 2011; Murphy & Hutton, 2018; Shirk & Karver, 2003; Shirk et al., 2011), it is reasonable to assume that the alliance rupture–repair processes can impact therapy outcomes in youth as well. Nevertheless, the unique developmental factors in this age group necessitate caution when applying findings from adult psychotherapy to youth settings (Cirasola & Midgley, 2023).

Engaging children and adolescents in therapy is crucial for building a strong therapeutic alliance (de Haan et al., 2013); yet, it poses distinct challenges. First, unlike adults, young people, especially children, are rarely self-referred, potentially affecting their engagement in and motivation for therapy. Second, the age gap between young clients and adult clinicians can create a more significant power imbalance than in adult therapy, which can lead to more tensions in the therapeutic relationship (Cirasola et al., 2022; Gulliver et al., 2010). Third, some young people, particularly younger ones, may have limited awareness of their issues and may struggle to understand the

therapeutic process (DiGiuseppe et al., 1996; Gulliver et al., 2010). Similarly, children’s cognitive development may hinder their comprehension of therapy tasks and goals (Shirk, 1988), complicating alliance formation and goal setting (Gulliver et al., 2010; Kazdin, 2003).

Adolescents, despite their greater cognitive abilities, may resist forming therapeutic bonds because of their desire for independence from adult authority figures. Additionally, adolescents’ intense emotions and risk-taking behaviors often raise safeguarding concerns, such as self-harm or risky relationships, which may require the therapist to breach confidentiality and involve caregivers or other professionals, sometimes against the young person’s wishes. This can strain the therapeutic relationship and create ruptures (Cirasola & Midgley, 2023). Moreover, therapy with young people often requires building alliances not just with the clients but also with their caregivers. The level of caregiver involvement can vary depending on the treatment and the child’s age, and discrepancies between the young person’s goals and their caregivers’ expectations can introduce further complexities and lead to ruptures in the therapeutic process.

These developmental considerations highlight the unique dynamics of forming alliances with young people, as well as the potential age-related factors that may contribute to ruptures. Therefore, it is crucial to approach alliance literature with an understanding of the distinct characteristics of children and adolescents (Sawyer et al., 2018) rather than assuming that findings from adult populations directly apply to this demographic. This emphasizes the need for further research specifically focused on children and adolescents to better understand the nuances of alliance formation and rupture in this context.

The Current Review

Although research on alliance rupture and repair in child and adolescent psychotherapy is still in its early stages, conducting a systematic review at this point can be valuable. A growing body of literature underscores the critical role of the therapeutic alliance in predicting treatment outcomes among young people (Karver et al., 2018; Shirk & Karver, 2003). Given that ruptures in the therapeutic relationship are often inevitable (Safran & Muran, 2000), understanding their nature, frequency, and impact is essential for

advancing both research and clinical practice. Synthesizing the existing—albeit limited—evidence can provide a valuable foundation for future work by consolidating current knowledge, identifying methodological and conceptual gaps, and informing the design of subsequent studies. As noted by [Petticrew and Roberts \(2008\)](#), systematic reviews serve a critical function even in emerging fields: they clarify the boundaries of current understanding, guide the allocation of research efforts, and help prevent unnecessary duplication. In this way, early synthesis efforts such as the present review can contribute meaningfully to the development of a more coherent and strategically directed research agenda in the area of alliance rupture and repair in youth psychotherapy.

This study aims to contribute to that effort by conducting a systematic narrative review of current evidence on the association between alliance rupture–repair processes and therapy outcomes in youth psychotherapy. Specifically, it seeks to address the question: To what extent is the repair of alliance ruptures associated with therapeutic effectiveness or efficacy in child and adolescent populations? While this review does not aim to offer definitive conclusions, it seeks to clarify the current state of the literature, assess methodological and conceptual strengths and limitations, and provide preliminary guidance for researchers and clinicians working in this developing area.

Method

This review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews (PRISMA) guidelines ([Page et al., 2021](#)). The review protocol was registered with Prospero (CRD42022361330).

Criteria for Considering Studies for This Review

As this marks the first review on the association between rupture–repair and treatment outcomes in child and adolescent psychotherapy, we employed broad inclusion criteria to comprehensively examine relevant studies. We thoroughly reviewed all relevant studies published up to March 2024. [Table 1](#) outlines the criteria we used to determine which studies were included and excluded in our systematic review. Given the early stage of research on alliance rupture–repair in child and adolescent psychotherapy, we adopted broader

inclusion criteria while still aligned with those used in adult meta-analyses. Specifically, we included studies that assessed both alliance ruptures (whether measured directly or indirectly) and treatment outcomes. Although our primary focus was on individuals under 18, we set an upper age limit of 24, consistent with the [World Health Organization’s \(2024\)](#) definition of “young people” as those aged 10–24. This broader definition, also supported by the [Lancet Child & Adolescent Health \(Sawyer et al., 2018\)](#), enabled the inclusion of mixed-age samples, provided that the majority of participants (at least 50%) were aged 18 or younger, and no participants were older than 24.

The search strategy was formulated by combining keywords extracted from search strategies employed in previous reviews (e.g., [Eubanks, Christopher Muran, & Safran, 2018](#); [Safran et al., 2011](#)). [Table 2](#) provides an overview of the search terms and databases utilized. We also did some extra searching, which involved reaching out to important researchers in the field and looking through the reference lists of relevant articles and reviews.

The study selection adhered to PRISMA guidelines ([Page et al., 2021](#)). To ensure that the inclusion criteria were met, two MSc psychology students, including the Catherine F. Eubanks, independently reviewed titles, abstracts, and full texts. Their assessments showed a high level of agreement in study selection, with a kappa coefficient of .89. Regular meetings were also held between the two raters to systematically identify and resolve any observed discrepancies, with guidance from Dhea Bengardi. After completing the title and abstract screening, both the Dhea Bengardi and Catherine F. Eubanks participated in a secondary consistency check during the full-text screening phase. This ensured the consistent application of inclusion/exclusion criteria to identify eligible studies. Furthermore, both authors were involved in the quality assessment of the selected studies as outlined below.

Quality Assessment and Data Extraction

Adhering to the PRISMA guidelines, which underscore the importance of a thorough risk of bias assessment in systematic reviews ([Page et al., 2021](#)), we employed a standard quality assessment tool for evaluating research articles from [Qualyst \(Kmet et al., 2004\)](#). We chose

Table 1
Inclusion and Exclusion Criteria for the Systematic Review

Criterion	Description
	Inclusion criteria
Study focus	Primarily concerned with evaluating alliance rupture–resolution and outcomes, employing any design with quantitative measurement of both outcomes and alliance ruptures and resolutions.
Participant age	Studies with a majority of participants (>50%) aged between 3 and 19 years old, with none exceeding 24.
Intervention	Any psychological treatment related to child and adolescent psychotherapy, including family or group therapy.
Alliance rupture–resolution measures	Studies directly assessing alliance rupture and resolution using any type of measures. Studies not directly assessing alliance ruptures and resolutions but incorporating at least three alliance measurements to identify a V-shaped high–low high alliance pattern, indicative of potential alliance rupture and resolutions.
Outcome measure	Any outcomes related to any mental health condition or problem.
Language	English.
	Exclusion criteria
Method	Studies reporting only qualitative assessments of alliance and outcome, review articles, and meta-analyses.

this tool because it aligns with a previous systematic review and meta-analysis by Bose et al. (2022) on therapeutic alliance in psychosocial interventions for young people. It comprises 14 questions rated on a scale from 2 (*meets criteria*) to 0 (*does not meet criteria*), with higher scores indicating higher article quality. To assess study quality, we used the criteria established by Kmet et al. (2004). Scores above 75% were considered high quality, scores between 55% and 75% were deemed medium quality, and scores below 55% were classified as low quality. Dhea Bengardi and Catherine F. Eubanks independently evaluated the quality of the studies that met the inclusion criteria with the selected tool, demonstrating a high level of agreement: inter-class correlation coefficient (2, 2) = .88.

Following quality assessment, for each identified study, we extracted relevant information

focusing on methodology, sample characteristics (with emphasis on age and diagnosis), measurement methods (specifically detailing how therapeutic alliance, rupture, and resolutions were assessed), and outcomes or dropout rates.

Data Analysis

To synthesize the findings, we employed a narrative synthesis approach, as outlined by Popay et al. (2006). This method involves systematically describing and grouping the studies, followed by an in-depth analysis of the relationships and patterns within the data. We explored both the within-study findings and the relationships between different studies to provide a comprehensive overview of the current evidence on alliance ruptures and repairs in adolescent therapy. This approach allowed us to integrate diverse study

Table 2
Search Terms and Databases Searched

Search terms	Databases searched
(alliance* OR alliance pattern* OR rupture repair* OR rupture resolutions*)	PsycINFO
AND	Embase
(psychotherapy* OR child psychotherapy* OR adolescent psychotherapy* OR rupture resolutions*)	MEDLINE
AND	PubMed
(outcome*)	PsycArticles
	PsycNET

designs and provide a nuanced interpretation of the findings.

Results

Study Selection

Figure 1 illustrates the screening and selection process for this review. After title and abstract screening, 32 studies were assessed in full. Of these, only six met the inclusion criteria for the systematic review. Notably, all included studies focused on adolescent populations aged 11 and older; no studies involving children under the age of 11 met the criteria. One study involving younger children (Halfon et al., 2019) was initially considered but excluded, as it examined the trajectory of the therapeutic alliance in relation to outcomes without identifying rupture events or applying specific criteria for rupture–repair processes.

Quality Appraisal

Table 3 presents the overall and percentage scores for each study based on the selected

quality assessment measure (see Table S1 in the online supplemental materials for item-by-item quality scores). According to the cutoffs established by Kmet et al. (2004), three studies were classified as good quality, while three were categorized as medium to low quality.

Study Characteristics

Table 4 provides a comprehensive summary of the characteristics of all included studies. The six identified studies collectively involved 5,723 participants, with sample sizes ranging widely from 1 to 5,640 ($M = 953.8$, $SD = 2,295.8$). These studies were published between 2010 and 2024, with the majority (85.7%) published after 2017. Participant ages ranged from 11 to 24 years old. The majority focused on adolescents aged 11–19, with one study also including a few young adults up to 24 (Daly et al., 2010). Among the studies involving adolescents, the majority (66.67%, $n = 4$) were from the United Kingdom, with one each from Australia and the United States. This imbalance

Figure 1
Flow of Studies Through the Review

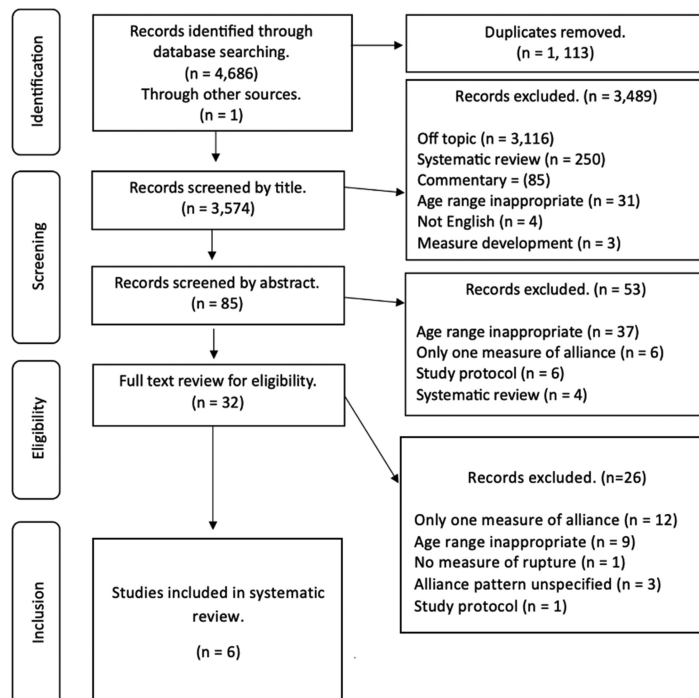


Table 3

Sum, Total Possible Sum, and Percentage Score for Quality Assessment of Studies

Article	Sum	Total possible sum	Percentage score
Cirasola et al. (2022)	17	20	85
Cirasola et al. (2024)	17	20	85
Daly et al. (2010)	13	23	56.52
Gersh et al. (2017)	15	24	62.5
Luebcke (2020)	20	22	90.9
O’Keeffe et al. (2020)	17	24	70.83

leans heavily toward Western, predominantly English-speaking countries.

Treatment and Problem Type

A diverse array of treatments was employed across the studies, with most incorporating multiple treatment types. The therapies used were primarily psychodynamic ($n = 3$), followed by counseling/supportive treatment ($n = 3$), cognitive analytic therapy (CAT; $n = 2$), and cognitive behavioral therapy (CBT; $n = 1$).

Regarding mental health issues, three studies (42.9%) focused on depressed adolescents, two studies (28.6%) examined adolescents with emerging borderline personality disorder (BPD), and one study (14.3%) investigated substance-related issues.

Measurement Type

The methods for assessing alliance rupture–repair vary, employing both direct and indirect approaches. Direct methods use tools specifically designed to identify alliance ruptures and resolutions during sessions. These include direct inquiries with clients and/or therapists immediately after sessions using questionnaires or observer-based measurements applied to session recordings or transcripts.

Indirect methods, on the other hand, involve administering alliance questionnaires at the end of sessions or at selected intervals throughout therapy to track changes in alliance scores over time. A decrease in the alliance score meeting specific criteria (e.g., exceeding a certain magnitude or falling below a cutoff score) indicates a rupture, while a subsequent increase suggests repair (Lipner et al., 2023; Strauss et al., 2006). These methods focus on overall trends across sessions, overlooking the within-session processes

of rupture–repair (Falkenström & Larsson, 2017; Stevens et al., 2007).

Five of the six studies measured rupture–repair using direct methods, specifically observer-rated measures applied to session recordings or transcripts. Four studies used the Rupture Resolution Rating System (Eubanks et al., 2019), a widely recognized and validated tool in adult literature for assessing alliance rupture and resolution. The remaining study (Daly et al., 2010) used an ad hoc quantitative observer-rated process measure, making its validity difficult to ascertain.

Luebcke (2020) was the only study included in this review that assessed alliance ruptures indirectly by using repeated measures of the therapeutic alliance and applying predefined cutoff criteria to identify rupture and repair episodes. Specifically, the study employed the Session Rating Scale (SRS; Miller & Duncan, 2004), a measure less commonly used in alliance research but designed to be developmentally appropriate for adolescents (Bose et al., 2022; Karver et al., 2018). The SRS was administered at the end of each session, assessing both alliance fluctuations and employing specific criteria for identifying alliance rupture and resolution. Specifically, rupture was defined as a minimum 1-point decrease from the previous SRS score, while resolution was defined as a minimum 1-point increase. These criteria align with those used in the adult literature but with different alliance measures (Safran et al., 2011).

Regarding outcome measures, five studies evaluated symptom severity or overall well-being at the end of treatment using various relevant instruments. Most studies relied on client self-reports for outcomes, with the exceptions being Daly et al. (2010), which used therapist-reported outcomes. Additionally, two studies reported on both outcomes and treatment retention (Cirasola et al., 2024; Luebcke, 2020). Only one study (O’Keeffe et al., 2020) focused solely on treatment retention without assessing symptom severity.

Systematic Narrative Review

The limited number of studies and the variability in both client profiles and therapeutic approaches posed challenges in identifying specific patterns. However, we categorized studies by the types of issues addressed, focusing on depression, emerging BPD, and substance-related

Table 4
Summary of Studies

Article	Problem type	Age	N	Treatment type	Alliance measure	Alliance informant	Alliance measurement timing	Rupture–repair measurement	Rupture–repair measure	Rupture–repair informant	Rupture–repair measurement timing	Outcome measure	Country
Cirasola et al. (2022)	Depression	14	1	STPP	WAI-S, WAI-O-S	Client, therapist, observer	WAI-S: 6, 12, 36 weeks postrandomization; WAI-O-S: all sessions (24)	Direct	3RS	Observer	All sessions (24)	MFQ	United Kingdom
Cirasola et al. (2024)	Depression	17	1	STPP	WAI-S	Client, therapist	6, 12, 36 weeks post randomization	Direct	3RS	Observer	All sessions (7)	MFQ	United Kingdom
Daly et al. (2010)	BPD	15–18 (SD = 0.84)	5	CAT, GCC	ARM, SEQ	Client	Sessions 3, 12, and 20	Direct	Ad hoc quantitative observer-rated measure	Observer	Sessions 3, 12, and 20	CGI-I	United Kingdom
Gersh et al. (2017)	BPD	15–24 (M = 18.20, SD = 2.81)	44	CAT, supportive treatment	NA	NA	End of each session (16 in total)	Direct	3RS, Observer-based rating procedure	Observer	51 CAT, 23 befriending	BPDSI, SAS–S	Australia
Luebecke (2020)	Substance abuse	13–19	5,640	Counseling	SRS	Client	End of each session	Indirect	NA	NA	NA	ORS	United States
O’Keefe et al. (2020)	Depression	11–17	35	BPI, CBT, STPP	WAI-O	Observer	Two sessions per client (early and late)	Direct	3RS	Observer	Two (an early and a late session)	Dropout rate	United Kingdom

Note. STPP = short-term psychoanalytic psychotherapy; WAI-S = Working Alliance Inventory–Short form; WAI-O-S = Working Alliance Inventory Observer version–short form; 3RS = Rupture Resolution Rating; MFQ = Mood and Feelings Questionnaire; BPD = borderline personality disorder; CAT = cognitive analytic therapy; GCC = good clinical care; ARM = Agnew Relationship Measure; SEQ = Session Alliance Questionnaire; CGI-I = Clinical Global Impression–Improvement Scale; NA = not applicable; BPDSI = Borderline Personality Disorder Severity Index; Social Adjustment Scale–Self Report; SAS-S = Social Adjustment Scale–Self Report; SRS = Session Rating Scale; ORS = Outcome Rating Scale; BPI = brief psychosocial intervention; CBT = cognitive behavioral therapy.

issues. We also provide an overview of the types and frequencies of therapeutic ruptures identified in the selected studies (see Table 5). Of the six studies reviewed, five directly quantified and assessed rupture instances within sessions, revealing a high occurrence of ruptures across diverse treatment approaches. In contrast, the one study that assessed ruptures indirectly reported a lower frequency. This discrepancy could be because of the limitations of indirect assessments, which prevent a detailed examination of within-session fluctuations in the alliance.

Of the five studies that directly assessed alliance ruptures, three differentiated between rupture types, with withdrawal ruptures being most common. These studies focused on adolescents with depression (Cirasola et al., 2022, 2024; O’Keeffe et al., 2020). The study by Gersh et al. (2017), which looked at adolescents with BPD symptoms, did not specify rupture types but noted a trend: early sessions had more withdrawal ruptures, while later sessions saw an increase in confrontation ruptures. This shift from withdrawal to confrontation may reflect a repair process, as suggested by Safran and Muran’s (2000) model, which links resolving withdrawal to promoting self-assertion and more direct expression of concerns. However, more research is needed to confirm this pattern, and this interpretation remains speculative.

Depression

All three studies focusing on adolescents with depression found positive associations

between resolved ruptures and both symptom improvements and treatment retention. Conversely, unresolved ruptures were linked to poorer outcomes and higher dropout rates. Specifically, Cirasola et al. (2022, 2024) conducted two single-case studies on adolescents undergoing short-term psychoanalytic psychotherapy. One study demonstrated positive outcomes with symptom improvement (Cirasola et al., 2022), whereas the other found no symptom improvement, resulting in participant dropout (Cirasola et al., 2024). Both studies assessed rupture-resolutions in all sessions and reported frequent rupture occurrences within and across sessions. However, in the case with a positive outcome, more ruptures were successfully resolved, whereas unresolved ruptures were prevalent in the dropout case with poor outcomes. This suggests that resolving ruptures may contribute to successful outcomes and treatment retention in youth psychotherapy for depression. However, the single-case design and cross-sectional data limit our ability to draw causal inferences about the relationship between rupture-resolution and outcomes. Nevertheless, qualitative analysis of interviews with clients and therapists in both cases supports the interpretation of these findings. In the case with a positive outcome, both parties emphasized the crucial role of the therapeutic relationship in treatment engagement and outcome, highlighting the importance of resolving the issues they encountered (Cirasola et al., 2022). In contrast, in the dropout case, both

Table 5
Frequency of Ruptures

Study	Participant (<i>n</i>)	Sessions (<i>n</i>)	Rupture measure	Frequency of ruptures
Cirasola et al. (2022)	1	24	Direct 3RS	100% of sessions ($M = 11.4$ per session) 83.2% withdrawal 16.8% Confrontation
Cirasola et al. (2024)	1	7	Direct 3RS	100% of sessions ($M = 22$ per session) 66% withdrawal
Daly et al. (2010)	5	5	Direct ad hoc observer-rated measure	100% of sessions ($M = 11.4$ per session)
Gersh et al. (2017)	44	74	Direct 3RS	53% of sessions
O’Keeffe et al. (2020)	35	70	Direct 3RS	100% of cases Confrontation ($M = 1.9$, $SD = 2.94$ per session) Withdrawal ($M = 7.33$, $SD = 5.27$ per session)
Luebecke (2020)	5,640	49,931	Indirect SRS	48% of cases 11.04% of sessions

Note. The study of Halfon et al. (2019) was excluded because of a lack of rupture frequency data. 3RS = Rupture Resolution Rating; SRS = Session Rating Scale.

the patient and therapist reported challenges in their relationship and acknowledged that these difficulties may have contributed to the client's decision to discontinue treatment (Cirasola et al., 2024).

Furthermore, O'Keeffe et al. (2020) mirrored these results in another study investigating the link between alliance rupture–repair and treatment retention in depressed adolescents receiving short-term psychoanalytic psychotherapy, CBT, or brief psychosocial intervention. They examined early and late sessions rupture–resolution in 35 adolescents, distinguishing between those who completed treatment ($n = 14$) and those who ended therapy prematurely without the therapist's agreement ($n = 21$). Among the latter, 14 were “dissatisfied” dropouts, who reported in posttreatment interviews that they were unhappy with their treatment, and seven were “got-what-they-needed” dropouts, who reported in posttreatment interviews that they felt they achieved their goals in therapy. The results showed similar ratings of alliance and rupture–repair between completers and “got-what-they-needed” dropouts. Compared to completers, dissatisfied dropouts had poorer alliance ratings in both early (mean alliance difference = -0.29 , 95% confidence interval [CI] = $[-9.69, 9.12]$) and late (mean alliance difference = -14.14 , 95% CI = $[-21.01, -7.27]$) sessions. Dissatisfied dropouts also experienced more frequent ruptures, with higher odds of confrontation ruptures (odds ratio [OR] = 6.44 , 95% CI = $[1.42, 29.19]$) and withdrawal ruptures (OR = 6.85 , 95% CI = $[1.49, 31.46]$). Additionally, they had more unresolved ruptures, both in early (OR = 0.07 , 95% CI = $[0.01, 0.40]$) and late (OR = 0.02 , 95% CI = $[0.0009, 0.17]$) sessions, suggesting that disengagement can contribute to therapy dropout.

Overall, the results of these studies seem to indicate the importance of addressing alliance ruptures to improve outcomes with adolescents with depression, particularly in terms of treatment retention. However, caution is needed because of the small number of studies, all of which are subsets of the improving mood with psychoanalytic and cognitive therapies trial (Goodyer et al., 2017), although they use different data sets.

Emerging BPD

Two studies involved young people exhibiting emerging BPD, and they both found that successful

repairs of ruptures were associated with improved therapeutic outcomes (Daly et al., 2010; Gersh et al., 2017). Gersh et al. (2017) examined the relationship between alliance rupture–repair processes and treatment outcomes, as well as whether these processes differed between CAT ($n = 21$) and befriending ($n = 23$), a basic supportive therapy, in a sample of 44 adolescents with BPD. Ruptures were assessed early in treatment for both groups and again later in treatment for the CAT group only. The findings showed no significant differences in the frequency of ruptures between the two therapies. However, ruptures occurring early in treatment were linked to poorer social functioning outcomes ($r = .32$, $p < .05$), while greater resolution of ruptures later in therapy was associated with a reduction in BPD symptoms ($r = .67$, $p < .05$). The authors concluded that alliance ruptures are particularly challenging in the early stages of therapy with adolescents with BPD but can serve as opportunities for therapeutic growth when effectively resolved later in treatment.

Daly et al. (2010) primarily aimed to evaluate a nine-stage model of rupture–resolution in CAT for adolescents with BPD symptoms. The study also examined the relationship between alliance rupture–resolution and two factors: (a) session quality, classified as good or poor based on two client process measures and (b) treatment outcomes, assessed by therapists at the end of treatment using the Clinical Global Impression–Improvement Scale (Zaider et al., 2003). The study involved a small sample of five adolescents.

The findings suggested that more ruptures were fully resolved in sessions rated as good compared to those rated as poor, although this trend did not reach statistical significance. However, a significant relationship was identified between positive treatment outcomes and sessions where ruptures were resolved or partially resolved, while unresolved ruptures were linked to less favorable outcomes.

Despite their valuable insights, these studies are limited by small sample sizes and the use of basic statistical analyses that did not account for the nested data structure (clients within therapists), warranting cautious interpretation.

Substance-Related Issues and/or Externalizing Behaviors

Luebcke (2020) was the sole study to examine alliance rupture–repair among military adolescents

undergoing therapy for substance-related issues, encompassing personal substance abuse, parental substance abuse, and associated risk factors such as psychological distress and externalizing behaviors. This study indirectly assessed alliance rupture–resolution using the SRS with specified cutoff criteria in a large sample ($n = 5,640$). The study categorized clients into three groups: (a) no rupture, (b) rupture–repair, or (c) rupture nonrepair. The research aimed to analyze alliance–outcome relationships across rupture conditions and investigate the impact of rupture conditions on outcome and premature therapy termination. The results showed that clients coded as rupture–repair experienced significantly greater positive change in well-being, using the Outcome Rating Scale (Miller & Duncan, 2004) compared to those with no rupture ($p = .027$, $d = 0.083$) or rupture nonrepair ($p < .001$, $d = 0.27$). Clients in the rupture nonrepair category were also more likely to terminate therapy prematurely and attended fewer sessions compared to rupture–repair clients, $\chi^2(1) = 16.70$, $p < .001$. Among rupture–repair clients, repairs were more likely to occur in the early therapy sessions than in later ones, $\chi^2(1) = 66.27$, $p < .001$. They also investigated the connection between rupture–repair status and premature termination from therapy and found that adolescents who experienced unresolved ruptures were 1.93 times more likely to end therapy prematurely compared to those whose ruptures were successfully repaired.

The link between resolving ruptures and both treatment retention and outcomes might be particularly significant for this target group. Previous research has shown a weaker alliance–outcome association in adults (Flückiger et al., 2018) and adolescents (Shelef et al., 2005; Tetzlaff et al., 2005) with substance abuse compared to those with other mental health issues. However, it is worth noting that this difference may stem from how ruptures and outcomes are measured, which widely differ across studies. For instance, some studies focus on overall well-being, while others specifically assess substance abuse outcomes. Given the challenges of engaging adolescents with substance abuse, clinicians working with this population may need to prioritize the effective resolution of ruptures to support better outcomes.

These findings align with other studies in this review, particularly regarding the link between

unrepaired ruptures and dropout among adolescents. However, Luebecke (2020) stands out because of its unique characteristics: it had a larger sample size, used an indirect measure of alliance ruptures, and focused on U.S. military adolescents with substance-related issues. Given these distinct factors—such as the potential influence of deployment on the participants (Milburn & Lightfoot, 2013)—caution is needed when generalizing these results to other populations.

In summary, although based on a small number of studies, the available evidence suggests a possible association between the repair of alliance ruptures and improved treatment outcomes, including enhanced retention in youth therapy. This potential link may extend across various diagnoses and therapeutic approaches represented in the studies included in this review. However, further research is clearly needed to confirm, refine, and contextualize these preliminary findings.

Discussion

To our knowledge, this systematic review represents the first attempt to synthesize studies examining the relationship between rupture–repair processes and treatment outcomes in psychotherapy with young people. Despite the use of broad inclusion criteria, only six studies met the requirements for inclusion, all of which involved adolescent samples. The review was unable to evaluate the relationship between rupture–repair processes in child psychotherapy because of the lack of available studies focusing on children under the age of 11. While preliminary, the findings from the included studies suggest a generally positive association between successful rupture–repair and improved treatment outcomes—such as symptom reduction and treatment retention—in youth psychotherapy, across a range of therapeutic modalities and clinical populations.

These findings align with meta-analyses on alliance rupture–repair and outcomes in adult populations (Eubanks, Christopher Muran, & Safran, 2018; Safran et al., 2011). Notably, consistent with the adult literature (Muran et al., 2023), one study (Luebecke, 2020) found better treatment outcomes when ruptures occurred but were subsequently resolved compared to cases without ruptures. This might suggest that ruptures themselves are not inherently problematic;

instead, their successful resolution may have a critical role in determining treatment effectiveness across different therapy approaches. In response to our research question, the consistency of findings suggests that in youth, the resolution of ruptures is associated with more positive treatment outcomes.

Direct measures may offer a more nuanced understanding of moment-to-moment shifts in alliance dynamics during therapy sessions. This may help explain the relatively high frequency of ruptures observed in the adolescent studies included in this review, particularly the prevalence of withdrawal-type ruptures. Notably, the only study that utilized an indirect assessment method reported a lower incidence of ruptures. This aligns with findings in the adult literature, suggesting that indirect methods may underestimate the occurrence of alliance ruptures (Coutinho et al., 2014; Eubanks, Christopher Muran, & Safran, 2018). Another key finding from this review is the predominant use of direct measures to assess alliance ruptures in the included studies, which contrasts with the adult literature, where indirect methods are more commonly used (Eubanks, Christopher Muran, & Safran, 2018).

However, it is also important to consider the alternative possibility that observer-based measures of alliance rupture and repair may overestimate the occurrence of ruptures. To comprehensively capture the nuanced landscape of alliance dynamics, employing a combination of both direct and indirect methods is recommended. This dual-method approach, supplemented by qualitative data obtained through postsession or posttherapy interviews with both patients and therapists, can offer a multiperspective and more accurate depiction of the alliance's fluctuations within and across therapy sessions. This becomes particularly crucial when working with young people, given the distinct challenges in assessing their unique therapeutic needs.

The prevalence of withdrawal ruptures in youth psychotherapy might underscore a specific area needing therapeutic attention when working with this age group. Unlike confrontation ruptures, which involve explicit complaints and are thus easier to identify, withdrawal ruptures, because of their subtle nature, can be more challenging to detect (Eubanks et al., 2023; Eubanks, Burckell, & Goldfried, 2018). For example, behaviors aimed at appeasement, often indicative of withdrawal, might mistakenly be seen as signs of a good alliance, thus masking underlying

issues. This emphasizes the necessity for youth therapists to undergo comprehensive training, enabling them to skillfully identify and address even minor tensions within the therapeutic relationship.

However, the prevalence of withdrawal rupture may also be attributed to the characteristics of the adolescents predominantly featured in this review, such as those experiencing depression. It is possible that adolescents with depression exhibit withdrawal behaviors more frequently, thus influencing the prevalence of this rupture type in the research findings. Importantly, although more readily identifiable, confrontation ruptures also pose a significant concern for therapists working with adolescents. These ruptures can occur when adolescents disclose risky behaviors while insisting on confidentiality or express dissatisfaction with therapy progress or the therapist's approach. Such situations often trigger intense emotions in both the adolescent and the therapist. As a result, the therapist is confronted with the demanding task of adeptly handling these emotions and pressures while also repairing the rupture.

A potential pattern identified in this review is the increased frequency of confrontation ruptures in adolescents with BPD, especially toward the end of treatment. However, because of the limited number of studies, it remains unclear whether this pattern is specific to adolescents with BPD or if it applies to other mental health conditions as well. Future research should investigate the type, frequency, and impact of ruptures across different adolescent populations with a range of mental health issues to better understand the dynamics of rupture-resolution in this demographic.

Notably, children aged 10 and under were significantly underrepresented in the studies included in this review. The only study that came close to meeting the inclusion criteria was Halfon et al. (2019). While it examined alliance trajectories and found that both average alliance strength and a U-shaped pattern predicted improvements in teacher-reported outcomes—suggesting possible mid-treatment ruptures and subsequent repairs—it did not directly assess ruptures using defined criteria. As a result, no conclusions can be drawn about rupture-repair processes in child therapy. This highlights a clear gap in the literature and the need for further research in this area.

Supporting this need, a recent study by [Gürdilek et al. \(2025\)](#) directly assessed alliance ruptures in children and found them to be common, reinforcing the importance of understanding how such ruptures may influence treatment outcomes in younger populations. However, the study did not examine the link between rupture–repair processes and treatment outcomes, and therefore could not be included in this review. The scarcity of studies focusing on children aged 10 and under poses challenges in fully understanding how rupture–repair dynamics affect therapeutic outcomes in this age group. In addition to the relative newness of rupture research, various unique factors may contribute to this scarcity. First, a direct measure to assess alliance rupture with children is lacking. The therapeutic interactions with children often encompass nonverbal communication, play, and expressive modalities. Conventional alliance measures, primarily reliant on verbal communication, may be inadequate for capturing the nuanced dynamics of the therapeutic relationship with children, hindering research focused on ruptures in this age group. Adopting measures aligned with children’s developmental stages is an essential step for a more comprehensive understanding of alliance dynamics.

Second, child therapy often involves parental involvement, necessitating alliance measures that can effectively capture the diverse types of alliances present in sessions. This may complicate the conceptualization of alliance ruptures as the relationship is not only with the client themselves. Some interventions targeted at children target the parent exclusively ([James et al., 2020](#)), and thus, rupture research in child psychotherapy may need to incorporate these features. There are some initial studies into the therapeutic alliance between child, parent, and therapist ([Malhotra & Chauhan, 2020](#)). These suggest that the alliance between caregiver and therapist influences that of the child and therapist, thus adding an additional layer to the rupture dynamics.

Third, the concept of “rupture” may require careful reconsideration in the context of child psychotherapy, as children are likely to express dissatisfaction or disengagement in ways that differ from those of adolescents or adults. It remains unclear whether existing conceptualizations of rupture types—such as withdrawal and confrontation—are fully applicable to younger children. Notably, the only available study that

directly measured alliance ruptures in a child population found withdrawal ruptures to be particularly prominent ([Gürdilek et al., 2025](#)). However, this study did not examine the link between rupture–repair processes and treatment outcomes. Overall, further research is needed to address these conceptual and methodological challenges and to deepen our understanding of how alliance rupture and repair function in child therapy. This is particularly crucial as qualitative research supports the significance of this relationship in child therapy. For example, one study suggests that adopting a child-centered, playful approach fosters affection and trust, leading to emotional changes, and deeper therapist–child bonds, resulting in more profound changes ([Núñez et al., 2022](#)). Given the potential importance of understanding the role of alliance rupture and resolution in child therapy, further exploration of this relationship is warranted.

Diversity Considerations

The studies in our systematic review did not explicitly explore how diversity influences alliance ruptures. While the existing literature ([Muran, 2007](#)) acknowledges that differences in gender, race, religion, sexual orientation, and socioeconomic status between patients and therapists may contribute to ruptures, systematic research on these factors is lacking. Additionally, all adolescent-focused studies in our review originated from Western, mostly English-speaking, cultural contexts, which limit the generalizability of the findings to other cultural contexts. This limited representation underscores the need for broader geographical diversity to gain a more comprehensive understanding of cultural influences on the relationship between alliance rupture–resolutions and therapy outcomes in child and adolescent psychotherapy.

Strengths, Limitations, and Future Research Directions

The findings of this review should be considered within the context of several limitations. One limitation concerns the generalizability of the results. Despite using broad inclusion criteria, our review identified only a limited number of studies. Furthermore, substantial heterogeneity was observed among the identified studies, stemming from differences in therapeutic modalities,

populations, and outcomes. This variability, coupled with the small sample size, challenges the broad applicability of our findings. Additionally, our review's generalizability is limited by its exclusive focus on English-language studies, potentially overlooking diverse cultural contexts and introducing bias. Moreover, the presence of publication bias may impact the results, as studies with significant findings are more likely to be published. This bias could skew the perceived strength of the relationship between rupture–resolution and outcomes. Therefore, caution is warranted when interpreting the results of this review.

However, this review also boasts several strengths, including being the first comprehensive exploration of the association between alliance rupture and resolution in youth psychotherapy. Furthermore, the utilization of the Qualyst tool (Kmet et al., 2004) adds a layer of strength to the review's methodology. Additionally, the involvement of two independent raters in study identification and assessment serves as another strength, adding an extra layer of reliability to the review process.

The limited number of studies identified in this review highlights the need for further research into the relationship between alliance rupture–repair and treatment outcomes in youth psychotherapy, particularly with children. In youth populations, additional studies with larger sample sizes are needed to strengthen and extend current findings, which are often limited by small samples and reduced statistical power. Future research should also aim to include more diverse participants—across ethnicity, socioeconomic status, gender identity, and clinical profiles—to enhance generalizability. Applying advanced statistical methods, such as multilevel modeling or structural equation modeling, can better account for the nested nature of psychotherapy data (e.g., sessions within clients and clients within therapists). Longitudinal designs using session-by-session alliance measures, or experience sampling methods, could offer valuable insights into how rupture–repair processes unfold over time and relate to treatment outcomes. These methodological advances would help build a more robust and nuanced understanding of alliance dynamics in adolescent psychotherapy. Due to the small number of available studies and variability in sample sizes, a comprehensive answer to our research question could not be established. Once the field has advanced

sufficiently, a meta-analysis could provide a more robust, quantitative assessment of the relationship between alliance rupture–repair and treatment outcomes.

This review also underscores a critical gap in the literature: the absence of research on rupture–repair processes and their connection to outcomes in child psychotherapy. It would be valuable to better understand how alliance ruptures are expressed in younger children, whether these differ from other age groups, and how they may influence therapeutic outcomes. This line of inquiry could benefit from adapting and validating existing rupture measures for use with children or from developing new age-appropriate assessment tools.

Finally, more attention should be given to rupture–repair processes in therapeutic contexts involving multiple alliance relationships. Finally, more attention should be given to rupture–repair processes in therapeutic contexts involving multiple alliance relationships. In parent-led or caregiver-assisted interventions, for example, future research could examine how a caregiver's presence shapes rupture–repair dynamics and their links to treatment outcomes. This raises important questions about whether ruptures with the therapist, caregiver, or both affect engagement and efficacy differently and how repair processes unfold across these relationships. Exploring these dynamics could inform more nuanced clinical strategies—helping therapists navigate and coordinate repair efforts across parties to strengthen outcomes and therapeutic engagement.

Conclusion

In conclusion, our systematic review points to the potential role of recognizing and addressing therapeutic ruptures to enhance treatment effectiveness and engagement with young people. The findings support the value of successful rupture–repair processes in promoting positive treatment outcomes, such as symptom reduction and treatment retention. However, the limited number of studies and notable methodological constraints restrict the strength and generalizability of these conclusions. A key takeaway from this review is the glaring research gap in child therapy. This lack of data leaves many unanswered questions about the nature, frequency, and impact of therapeutic ruptures in younger children, pointing to several areas of focus for future

research. Although the field is not yet sufficiently developed to draw meaningful conclusions about the relationship between rupture–repair processes and outcomes in child and adolescent psychotherapy, we hope this review serves as a starting point to encourage researchers to advance this important area of inquiry, given its potential clinical implications.

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