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## **The Influence of Anxiety Levels on Withdrawal Ruptures in the Therapeutic Alliance**

Gürster, Martin

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# Master Thesis

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## **The Influence of Anxiety Levels on Withdrawal Ruptures in the Therapeutic Alliance**

by

Martin Gürster

Student number: s4194381

E-mail: [m.gurster@umail.leidenuniv.nl](mailto:m.gurster@umail.leidenuniv.nl)

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## **Abstract**

This study aimed to examine the relationship between baseline anxiety levels, as measured by the Beck Anxiety Inventory (BAI), and the significance of withdrawal ruptures as well as the total number of withdrawal rupture markers during therapy sessions. Withdrawal ruptures, characterized by a client's disengagement from the therapeutic process, pose unique challenges for therapists as they impede the therapeutic progress. It was hypothesized that higher baseline anxiety levels would predict more significant withdrawal ruptures and markers thereof during therapy. Data was collected from 56 clients receiving integrative cognitive behavioral therapy (CBT) in a university outpatient clinic, with withdrawal ruptures coded using the Rupture Resolution Rating System (3RS). Contrary to expectations, the results of regression analyses indicated no significant relationship between baseline anxiety and withdrawal ruptures. This was also the case in the subset of patients who were diagnosed with an anxiety disorder. These findings challenge the assumption that anxiety levels directly influence withdrawal behaviors in therapy and suggest that other factors may be more critical in shaping withdrawal ruptures. The study's implications underscore the importance of therapist training in rupture-repair strategies and call for future research to explore other psychological and relational predictors of withdrawal behaviors in therapy.

*Keywords:* Therapeutic alliance, anxiety, withdrawal ruptures, Beck Anxiety Inventory

# **The Influence of Anxiety Levels on Withdrawal Ruptures in the Therapeutic Alliance**

In psychotherapy, the therapeutic alliance is fundamentally regarded as the working relationship between a therapist and their client, significantly influencing therapy outcomes (Flückiger et al., 2018). This alliance encompasses not only the emotional bond between the client and the therapist but also their agreement on therapeutic tasks and goals (Bordin, 1979). A strong therapeutic alliance is often predictive of positive treatment outcomes across various psychological disorders and therapeutic modalities (Flückiger et al., 2018). However, this alliance is not static, but rather characterized by rupture-repair episodes (Eubanks, Muran, et al., 2018). It can experience moments of strain or ruptures, which, if not effectively addressed, may impede therapeutic progress. Ruptures in the therapeutic alliance refer to tensions or breakdowns in collaboration between the therapist and client, manifesting as disagreements on therapy goals, tasks, or a deterioration in the emotional bond (Eubanks et al., 2015). These ruptures in the therapeutic alliance can be categorized into two main subtypes: Withdrawal ruptures and confrontation ruptures, with some instances presenting as mixed ruptures.

Withdrawal ruptures occur when the patient moves away from the therapist or the work of therapy. This can manifest as avoiding the therapist's questions, going silent, using vague or abstract language, or being overly deferential and pleasing. For instance, a patient might avoid engaging in meaningful conversation by shifting topics or telling irrelevant stories. These behaviors serve to distance the patient from the therapeutic process and hinder progress.

Confrontation ruptures, on the other hand, involve the patient moving against the therapist. This can include expressing anger or dissatisfaction in a non-collaborative manner, making demands of the therapist, or rejecting the therapist's interventions. For example, a patient might criticize the therapist's competence or express frustration with the therapy process in a hostile manner. These actions create conflict and strain within the therapeutic relationship, potentially leading to significant disruptions if not addressed.

Mixed ruptures contain elements of both withdrawal and confrontation. An example might be a patient who criticizes the therapist (a confrontational action) while simultaneously exhibiting nervous laughter or overly polite behavior (a withdrawal action).

Research has shown that these ruptures are not merely obstacles but can be opportunities for enhancing therapeutic efficacy if they are successfully resolved. Resolution of ruptures is therefore an essential process within therapy sessions, leading to significant improvements in the therapeutic relationship and therapy outcomes (Eubanks, Muran, et al., 2018). Given the pivotal role of the therapeutic alliance and the impact of its ruptures and resolutions, investigating these aspects in detail becomes crucial.

This relatively new area of research holds significant potential for improving therapy outcomes by providing insights into the dynamics that affect the therapeutic process. Understanding how and why ruptures occur and how they can be effectively resolved is crucial for enhancing therapeutic efficacy. This is particularly relevant for patients with high anxiety levels, whose conditions are often characterized by a general theme of avoidance (Dymond & Roche, 2009). These patients with heightened anxiety levels present a unique challenge in psychotherapy due to their tendency to also avoid conflict and confrontation (Davila & Beck, 2002). This tendency to avoid conflict may influence the nature of ruptures that occur in therapy. Specifically, patients with high anxiety levels might be more prone to withdrawal ruptures, as their avoidance behaviors could lead them to withdraw from the therapeutic process rather than confront it. In contrast, patients with lower anxiety levels might exhibit less withdrawal ruptures reflecting a different pattern of engagement with the therapeutic alliance.

The main Hypothesis of this investigation is: (H1) Patients with higher baseline anxiety levels are expected to exhibit more significant withdrawal ruptures and cause more withdrawal rupture markers during therapy sessions compared to those with lower anxiety levels.

To investigate this hypothesis further, the aim of this thesis is to explore the following research question: *Can anxiety scores at baseline predict the significance of withdrawal ruptures and the total number of withdrawal rupture markers during therapy sessions?*

This question will be explored with a main sample which contains patients with different psychological disorders and a subset of patients who specifically suffer from anxiety disorders.

Given their more subtle nature which can manifest as silence, minimal responses, or overly compliant behavior, withdrawal ruptures are particularly challenging for therapists to perceive compared to confrontation ruptures which are more obvious (Kline et al., 2019). If therapists are not aware of ongoing withdrawal ruptures, these unaddressed issues can

undermine the therapeutic process and negatively influence the success of therapy. The lack of awareness and subsequent lack of intervention may prevent the necessary resolution of these ruptures, leading to stagnation or deterioration in the therapeutic alliance. If a correlation between high anxiety scores and increased withdrawal ruptures can be established, these findings could significantly impact clinical practice. Therapists would benefit from knowing that they need to be particularly vigilant for potential withdrawal ruptures in patients with high anxiety levels which would enable them to address ruptures more proactively and effectively, thereby improving therapeutic outcomes.

## **Method**

### **Participants**

This study's main sample consisted of the first 56 patients who were sequentially enrolled as part of a larger randomized controlled trial (RCT) at a university outpatient clinic in Europe (Caspar et al., 2022). Each participant received  $25 \pm 3$  sessions of integrative cognitive behavioral therapy (CBT). Of these, 13 patients (23.2%) completed their treatment earlier than planned due to significant clinical improvement, as determined in agreement with their therapists. The sample included 23 males (41.1%) and 33 females (58.9%), with a mean age of 31.07 years ( $SD = 10.33$ ). Diagnostic evaluations were performed by trained staff using the Structured Clinical Interview for DSM-IV-TR (First et al., 2002). Diagnoses were as follows: 29 patients (51.8%) had unipolar depression (ICD-10 codes F32, F33), four patients (7%) had dysthymia (ICD-10 code F34), and 23 patients (41.2%) had an anxiety disorder (ICD-10 codes F40, F41). The patients with an anxiety disorder were also used as a second sample to examine whether the results in this group differ from the more diverse main sample.

### **Therapists**

The therapy was provided by a total of 33 therapists, which included 10 therapists with completed postgraduate psychotherapy training and 23 therapists who had completed a minimum of one and a half years of postgraduate psychotherapy training. The therapist group comprised eight males (24.2%) and 25 females (75.8%), with an average age of 33.75 years ( $SD = 7.19$ ). These therapists self-selected into the treatment condition.

## **Study Design**

The sample of this study was drawn from a larger randomized controlled trial (RCT) that included two active treatment arms: CBT combined with emotion-focused therapy and CBT combined with self-regulation techniques. This current study was conducted as a longitudinal study utilizing a mixed design.

## **Procedure**

Participants received  $25 \pm 3$  sessions of integrative CBT, with each session video recorded for supervision and research purposes. In cases where videos were missing due to technical issues, the closest available session was used as a replacement. This occurred in 15 sessions. For the 13 patients who terminated therapy prematurely, the 24th session videos were unavailable. Ruptures and resolutions were coded by observers every 5 minutes during sessions 1, 8, 16, and 24 according to the Rupture Resolution Rating System 3RS (Eubanks et al., 2015). The quality of the therapeutic alliance and symptom severity were measured using self-report questionnaires administered after these sessions.

## **Measures**

### ***Rupture Resolution Rating System (3RS)***

The Rupture Resolution Rating System (Eubanks et al., 2015) is a coding framework used by observers to identify and rate alliance ruptures and resolution strategies during therapy sessions. Observers use this system to code seven markers indicative of withdrawal ruptures and confrontation ruptures, as well as ten different resolution strategies. They also provide global ratings for withdrawal ruptures, confrontation ruptures, and resolution strategies after viewing entire therapy sessions, based on the significance and effectiveness of these events. Ruptures are rated on a 5-point Likert scale from 1 (no significance) to 5 (high significance), while resolution effectiveness is rated from 1 (poor resolution/deteriorated alliance) to 5 (very good resolution/improved alliance). For this analysis only the average withdrawal significance over the four sessions and the total number of coded withdrawal rupture markers was used per participant. The 3RS has been demonstrated to be a reliable and valid tool for detecting alliance ruptures (Eubanks, Lubitz, et al., 2018).

### ***Beck Anxiety Inventory***

Anxiety levels were assessed using the Beck Anxiety Inventory (BAI) at the beginning of the therapy. The BAI is a 21-item self-report inventory that measures the severity of anxiety

symptoms on a 4-point Likert scale ranging from 0 (not at all) to 3 (severely). This inventory is widely used and has demonstrated high reliability and validity in clinical settings (Beck et al., 1988).

### **Statistical Analysis**

The primary objective of the statistical analysis was to determine whether anxiety levels, as measured by the Beck Anxiety Inventory (BAI), can predict the significance of withdrawal raptures and the total number of its markers during therapy sessions. A linear regression analysis was performed to assess this relationship, allowing for the use of baseline BAI scores as a predictor. A second statistical analysis was conducted specifically for the subset of patients with an anxiety disorder.

### **Descriptive Statistics**

Initially, descriptive statistics were calculated to provide an overview of the data. These included the mean and standard deviation of the BAI scores and the withdrawal rapture significance and total marker ratings.

### **Linear Regression**

A linear regression analysis was conducted to examine the relationship between baseline anxiety levels and the average significance of withdrawal raptures. Additionally, the relationship between baseline anxiety levels and the total number of withdrawal rapture markers was investigated. By using these two outcome measures an extensive understanding can be created regarding the significance of the withdrawal raptures as well as of the prevalence of withdrawal rapture markers.

*Independent Variable (Predictor):* Baseline BAI scores after session 1.

*Dependent Variable 1 (Outcome):* Average withdrawal rapture significance, which is rated on a Likert scale.

*Dependent Variable 2 (Outcome):* Total number of withdrawal rapture markers.

The regression tested whether higher BAI scores are associated with a greater significance of withdrawal raptures and a higher commonness of withdrawal rapture marker occurrence during therapy sessions.

## **Assumption Checks**

Before running the regression, the assumptions of linear regression were evaluated:

1. **Linearity:** The relationship between the BAI scores and withdrawal rupture significance as well as total withdrawal rupture markers were assessed to ensure it is linear.
2. **Normality of Residuals:** The distribution of the residuals was examined using visual methods (Q-Q plots).
3. **Homoscedasticity:** The variance of the residuals should be consistent across all levels of the independent variable, which was checked through residual plots.

## **Model Diagnostics**

The goodness of fit for the model was evaluated using the coefficient of determination ( $R^2$ ), which indicates the proportion of variance in the withdrawal rupture significance and the total number of withdrawal rupture markers that can be explained by the BAI scores. Additionally, the regression coefficients ( $\beta$ ), standard errors, t-values, and p-values are reported to determine the strength and significance of the relationship. This analysis provides insights into how anxiety levels as measured by the BAI influence the average significance of withdrawal raptures and the total number of withdrawal rupture markers in therapy sessions. By examining this relationship, the resulting data helps to clarify the impact of anxiety levels on therapeutic dynamics and potentially guide more tailored intervention strategies. Additionally, this analysis was also conducted in a subset of cases with an anxiety disorder to understand this specific group in more detail and see whether it differs from a more general population.

## **Ethics**

Ethical approval for the study, including the use of pre-existing data from therapy sessions for the secondary analysis, was already obtained from the ethics committee at the University of Leiden. This approval ensures that all research activities adhere to high ethical standards and comply with legal regulations. The ethics approval for the original study was provided by the Ethics Committee of the Canton Bern, KEK BE 168/15, which includes the consent of all participants.

## Results

### Relationship between baseline anxiety levels and the average significance of withdrawal ruptures in the main sample

#### *Descriptives for average withdrawal rupture significance in the main sample*

Table 1 provides the descriptive statistics for both the average significance of withdrawal ruptures and the baseline BAI scores.

**Table 1**

*Descriptive Statistics of Baseline BAI Scores and Average Withdrawal Rupture Significance in Main Sample*

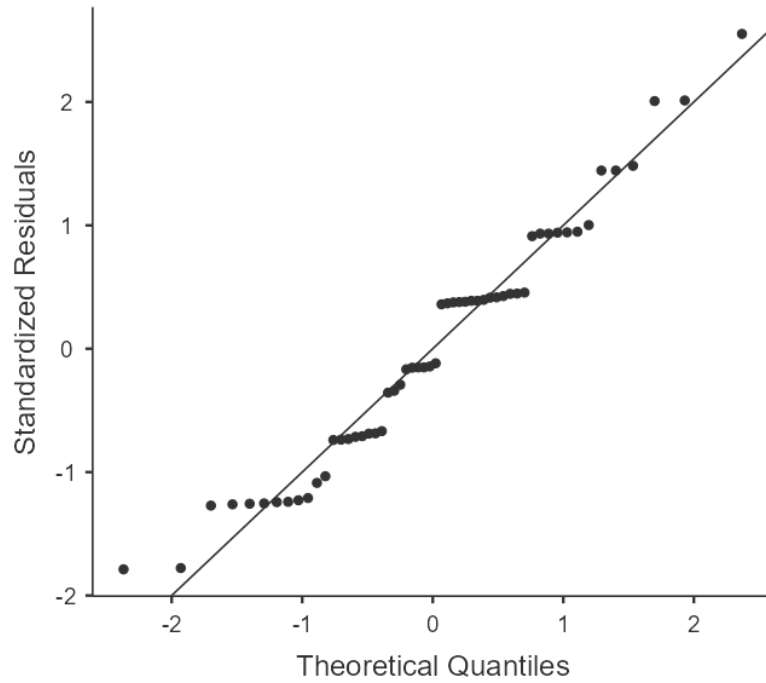
	Average WD Significance	BAI Baseline
N	56	56
Mean	1.82	18.6
Median	1.75	17.5
Standard deviation	0.459	10.2
Minimum	1.00	2
Maximum	3.00	44

#### *Assumption checks for average withdrawal rupture significance in the main sample*

Prior to the analysis, the assumptions of linear regression were evaluated. The Q-Q plot (Figure 1) indicated that the residuals were approximately normally distributed, with only slight deviations from normality at the extreme ends of the distribution.

**Figure 1**

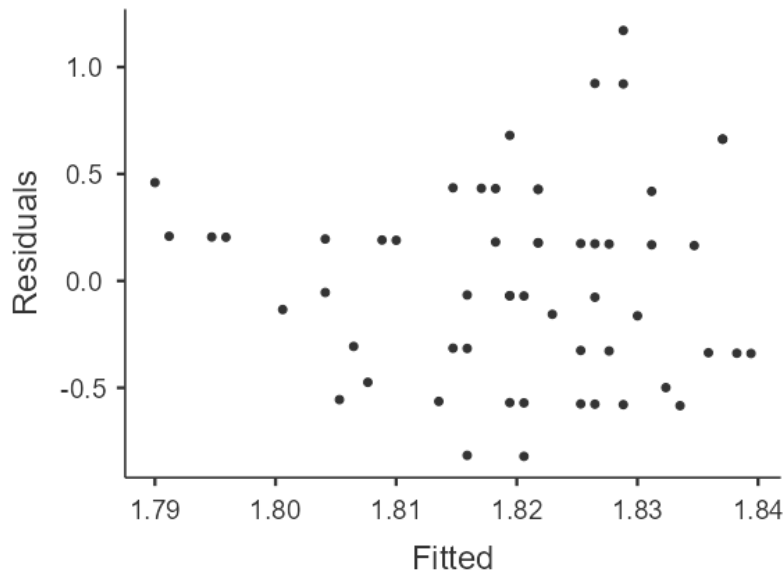
*Q-Q Plot of Residuals for Normality Check of Average Withdrawal Rupture Significance in Main Sample*



Additionally, the residuals vs. fitted values plot (Figure 2) revealed no clear pattern, suggesting that the assumptions of linearity and homoscedasticity were met. Residuals were randomly distributed around zero, further supporting the assumption of homoscedasticity.

**Figure 2**

*Residuals vs. Fitted Values Plot for Linearity and Homoscedasticity Check of Average Withdrawal Rupture Significance in Main Sample*



***Linear regression analysis for average withdrawal rupture significance in the main sample***

A linear regression analysis was conducted to evaluate whether baseline anxiety levels after session 1 (measured by the Beck Anxiety Inventory, BAI) predicted the average significance of withdrawal ruptures during therapy sessions. The results of the regression analysis are summarized in Table 2. The model did not explain a significant amount of variance in withdrawal ruptures ( $R^2 = 0.00067$ ), suggesting that baseline anxiety levels are not a strong predictor of withdrawal rupture significance.

The regression coefficient for baseline BAI scores was non-significant ( $\beta = -0.026$ ,  $p = 0.849$ ), indicating that higher levels of anxiety were not associated with greater withdrawal rupture significance. Therefore, the hypothesis that higher baseline anxiety levels predict more significant withdrawal ruptures was not supported by the data.

**Table 2***Model Coefficients for Predicting Average Withdrawal Rupture Significance in Main Sample*

Predictor	Estimate	SE	t	p	Stand. Estimate	95% Confidence Interval	
						Lower	Upper
Intercept	1.84177	0.12986	14.183	< .001			
BAI Baseline	-0.00118	0.00615	-0.191	0.849	-0.0260	-0.299	0.247

### **Relationship between baseline anxiety levels and total number of withdrawal rupture markers in the main sample**

#### *Descriptives for total number of withdrawal rupture markers in the main sample*

Table 3 presents the descriptive statistics for both the total number of withdrawal rupture markers and the baseline BAI scores after the removal of outliers. Specifically, three cases were excluded from the analysis because their sessions were coded with a total of over 130 withdrawal rupture markers, which was substantially higher than the values observed for the rest of the sample. These extreme values were deemed unrepresentative and could have disproportionately influenced these specific results.

**Table 3**

*Descriptive Statistics of Baseline BAI Scores and Total Number of Withdrawal Rupture Markers in Main Sample*

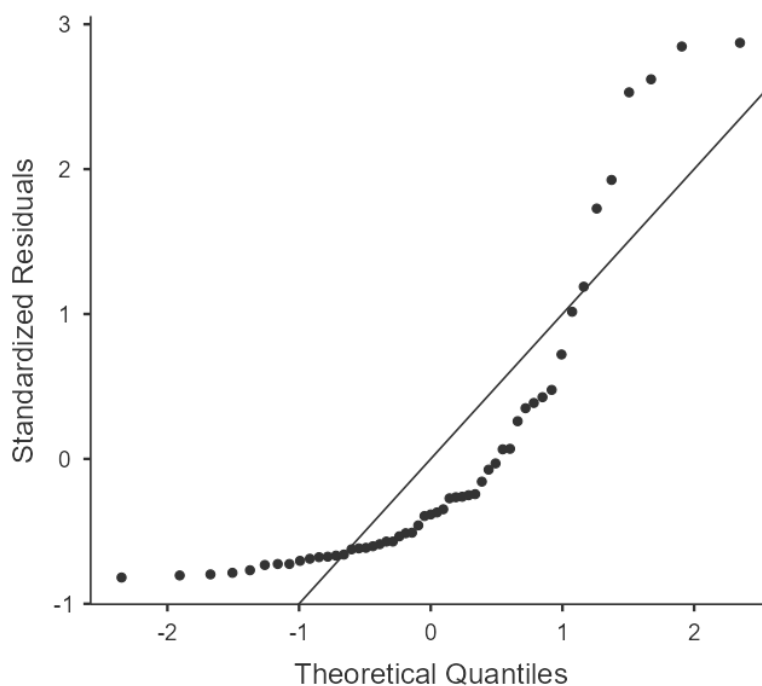
	Total # WD Markers	BAI Baseline
N	53	53
Mean	17.5	18.2
Median	9.00	17
Standard deviation	21.4	9.81
Minimum	0.00	2
Maximum	80.0	44

***Assumption checks for total number of withdrawal rupture markers in the main sample***

Prior to conducting the linear regression analysis, diagnostic plots were evaluated to assess the assumptions of linear regression. The Q-Q plot (Figure 3) demonstrated an improvement in the normality of residuals after the removal of outliers, with most residuals aligning closely with the diagonal line. However, some deviations were observed, indicating some skewness.

**Figure 3**

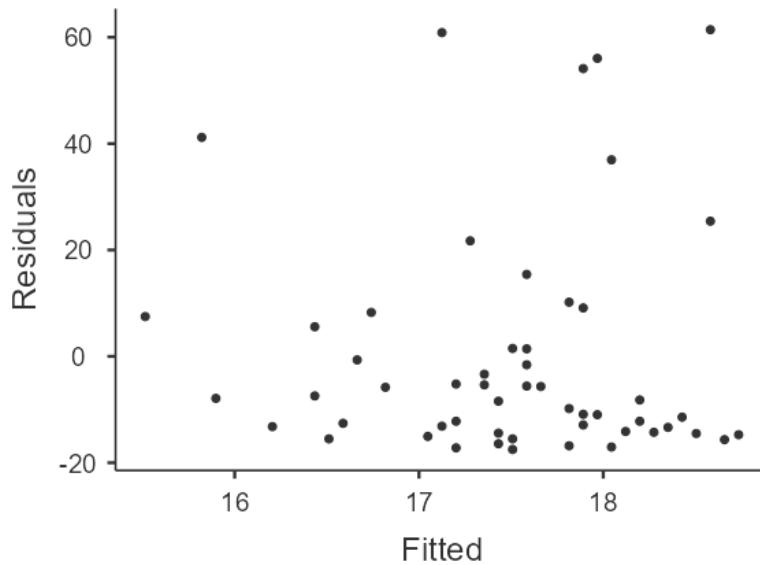
*Q-Q Plot of Residuals for Normality Check of Total Number of Withdrawal Rupture Markers in Main Sample*



The residuals versus fitted values plot (Figure 4) showed a random scatter of residuals around zero, with no discernible pattern, indicating that the linearity assumption was met. A slight increase in the spread of residuals with fitted values was observed, suggesting mild heteroscedasticity. Despite these minor deviations, the assumptions of linear regression were considered sufficiently met for this analysis.

**Figure 4**

*Residuals vs. Fitted Values Plot for Linearity and Homoscedasticity Check of Total Number of Withdrawal Rupture Markers in Main Sample*



***Linear regression analysis for total number of withdrawal rupture markers in the main sample***

A linear regression analysis was conducted to examine the relationship between "BAI Baseline" scores and "Total # WD Markers." The results are summarized in Table 4. The model yielded an  $R^2$  value of 0.00124, indicating that the BAI baseline value accounted for only 0.12% of the variance in the total number of withdrawal rupture markers. This suggests that the predictive ability of this model was negligible.

**Table 4**

*Model Coefficients for Predicting Total Number of Withdrawal Rupture Markers in Main Sample*

Predictor	Estimate	SE	t	p	Stand. Estimate	95% Confidence Interval	
						Lower	Upper
Intercept	18.8879	6.304	2.996	0.004			
BAI Baseline	-0.0767	0.305	-0.251	0.803	-0.0352	-0.316	0.246

## **Relationship between baseline anxiety levels and the average significance of withdrawal ruptures in the anxiety subset of cases**

### *Descriptives for average withdrawal rupture significance in the anxiety subset of cases*

Table 5 displays the descriptive statistics for baseline anxiety levels and average withdrawal rupture significance for the subset of patients with an anxiety disorder

**Table 5**

*Descriptive Statistics of Baseline BAI Scores and Average Withdrawal Rupture Significance in Anxiety Subset of Cases*

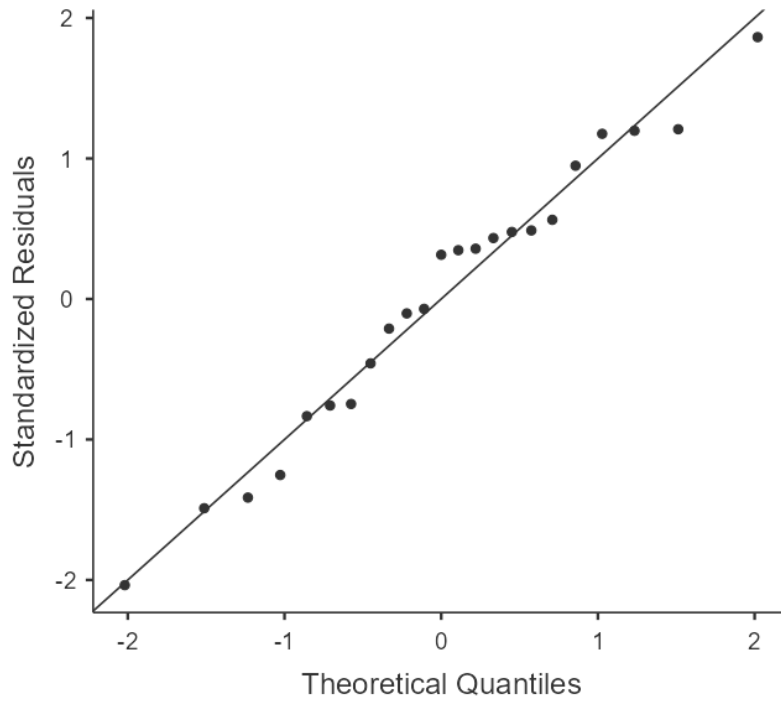
	<b>Average WD Significance</b>	<b>BAI Baseline</b>
N	23	23
Mean	1.82	28.0
Median	2.00	27
Standard deviation	0.389	7.85
Minimum	1.00	19
Maximum	2.50	44

### *Assumption checks for average withdrawal rupture significance in the anxiety subset of cases*

To ensure the appropriateness of the linear regression analysis, assumption checks were conducted. The Q-Q plot of the residuals (Figure 5) confirmed that the residuals were approximately normally distributed, as they aligned closely with the diagonal line.

**Figure 5**

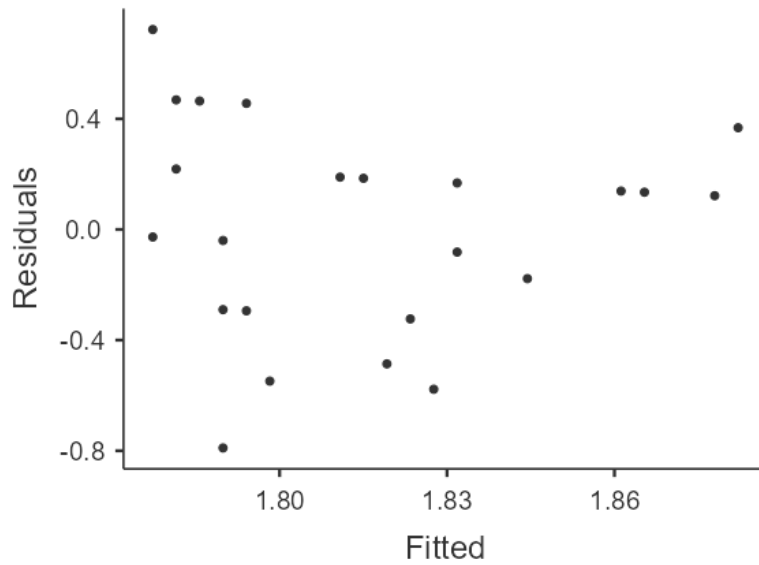
*Q-Q Plot of Residuals for Normality Check of Average Withdrawal Rupture Significance in Anxiety Subset of Cases*



The residuals vs. fitted values plot (Figure 6) showed a random distribution of residuals around zero, indicating that the assumptions of linearity and homoscedasticity were met.

**Figure 6**

*Residuals vs. Fitted Values Plot for Linearity and Homoscedasticity Check of Average Withdrawal Rupture Significance in Anxiety Subset of Cases*



***Linear regression analysis for average withdrawal rupture significance in the anxiety subset of cases***

The model did not explain a significant amount of variance in withdrawal rupture significance ( $R^2 = 0.00716$ ,  $p = 0.701$ ). The regression results are summarized in Table 6 and indicate a very weak and non-significant positive relationship between baseline anxiety and withdrawal rupture significance.

**Table 6**

*Model Coefficients for Predicting Average Withdrawal Rupture Significance in Anxiety Subset of Cases*

Predictor	Estimate	SE	t	p	Stand. Estimate	95% Confidence Interval	
						Lower	Upper
Intercept	1.69756	0.3135	5.414	< .001			
BAI Baseline	0.00420	0.0108	0.389	0.701	0.0846	-0.368 0.537	

## **Relationship between baseline anxiety levels and total number of withdrawal rupture markers in the anxiety subset of cases**

### *Descriptives for total number of withdrawal rupture markers in the anxiety subset of cases*

Table 7 displays the descriptive statistics for baseline anxiety levels and total number of withdrawal rupture markers for the subset of patients with an anxiety disorder. Two outliers were removed for the same reasons mentioned in the main sample.

**Table 7**

### *Descriptive Statistics of Baseline BAI Scores and Total Number of Withdrawal Rupture Markers in Anxiety Subset of Cases*

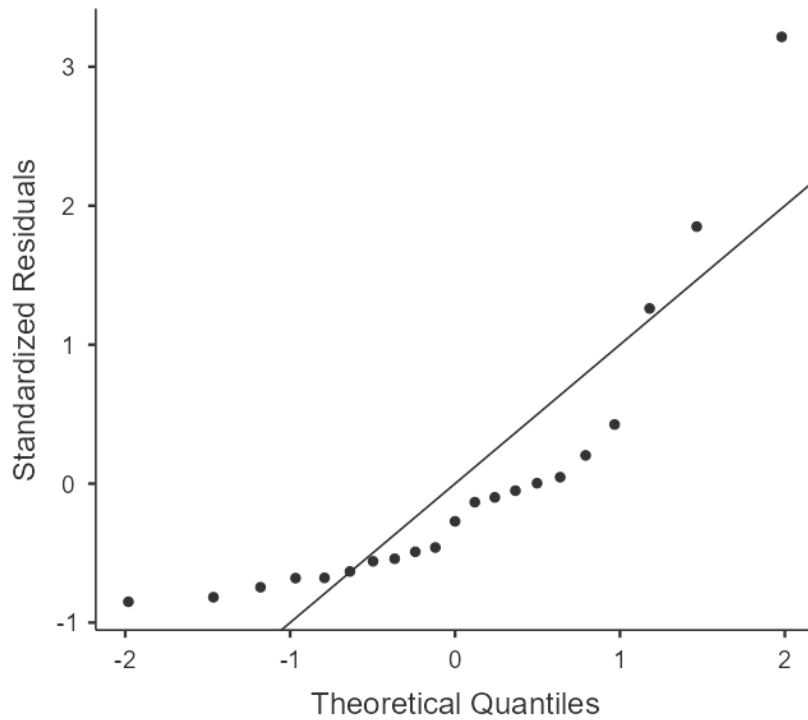
	<b>Total # WD Markers</b>	<b>BAI Baseline</b>
N	21	21
Mean	16.6	27.8
Median	11.0	27
Standard deviation	19.8	7.24
Minimum	0.00	19
Maximum	78.0	44

### *Assumption checks for total number of withdrawal rupture markers in the anxiety subset of cases*

The Q-Q plot (Figure 7) revealed some deviation from normality. However, the majority of residuals aligned somewhat with the line, indicating an acceptable level of normality for the regression analysis.

**Figure 7**

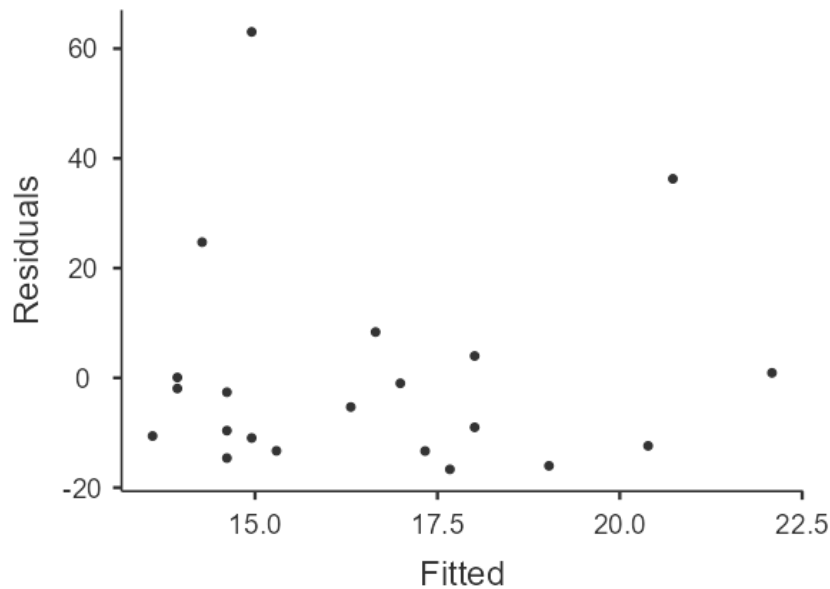
*Q-Q Plot of Residuals for Normality Check of Total Number of Withdrawal Rupture Markers in Anxiety Subset of Cases*



The residuals vs. fitted values plot (Figure 8) displayed a random scatter of residuals around zero, suggesting that the linearity assumption was met. However, the presence of a few extreme values in the residuals indicates slight heteroscedasticity. Despite these minor deviations, the assumptions were deemed sufficiently met for the analysis.

**Figure 8**

*Residuals vs. Fitted Values Plot for Linearity and Homoscedasticity Check of Total Number of Withdrawal Rupture Markers in Anxiety Subset of Cases*



***Linear regression analysis for total number of withdrawal rupture markers in the anxiety subset of cases***

The regression results are summarized in Table 8. The model accounted for only 1.55% of the variance in the total number of withdrawal rupture markers ( $R^2 = 0.0155$ ), indicating a negligible predictive ability.

**Table 8**

*Model Coefficients for Predicting Total Number of Withdrawal Rupture Markers in Anxiety Subset of Cases*

Predictor	Estimate	SE	t	p	Stand. Estimate	95% Confidence Interval	
						Lower	Upper
Intercept	7.143	17.804	0.401	0.693			
BAI Baseline	0.340	0.622	0.546	0.591	0.124	-0.352	0.601

In summary, the results indicate that baseline anxiety levels, as measured by the BAI, do not significantly predict the significance of withdrawal ruptures or the total number of withdrawal rupture markers in therapy sessions. This applies to a general patient population as well as patients with an anxiety disorder.

## **Discussion**

This study aimed to investigate the relationship between baseline anxiety levels, as measured by the Beck Anxiety Inventory (BAI), and the average significance of withdrawal ruptures as well as the total number of withdrawal rupture markers during therapy sessions. The central hypothesis H1 proposed that individuals with higher baseline anxiety would experience more significant withdrawal ruptures and a higher number of withdrawal rupture markers due to the well-documented link between anxiety and avoidance behaviors (Dymond & Roche, 2009). However, the findings did not support this hypothesis. The results revealed no significant association between baseline anxiety levels and the significance of withdrawal ruptures or the frequency of withdrawal rupture markers. This result was also found in the subset of patients with an anxiety diagnosis.

These findings challenge the assumption that anxiety levels, particularly as measured by the BAI, play a substantial role in predicting withdrawal behaviors during therapy. This also seems to hold true in patients diagnosed with an anxiety disorder. The absence of a significant relationship suggests that high anxiety levels may not manifest as withdrawal ruptures in the rather structured environment of integrative cognitive behavioral therapy (CBT) as it was conducted in this study. CBT-based therapy sessions are typically highly structured and directive, which may limit the opportunity for the subtle disengagement that characterizes withdrawal ruptures (Brewin, 1996; McGinn & Sanderson, 2001).

Alternatively, it is possible that other factors, such as the quality of the therapeutic relationship, the therapist's interventions, or even the client's personality traits, may be more relevant in predicting withdrawal ruptures (Barber et al., 2007; Bucher et al., 2019; Marziali & Alexander, 1991). High anxiety levels may not directly translate into the specific avoidance behaviors often associated with withdrawal, such as going silent or disengaging from therapeutic tasks. This raises the possibility that withdrawal ruptures are more likely influenced by complex psychological or relational dynamics, rather than anxiety levels alone.

These findings diverge from some previous research that has identified a strong relationship between high anxiety levels and avoidance behaviors in various contexts (Davila & Beck, 2002; Dymond & Roche, 2009). However, much of that research has focused on general avoidance behaviors in social or everyday contexts, rather than within the therapeutic setting. Avoidance behaviors outside of therapy are often more reactive and unstructured, such as avoiding social interactions or stressful situations. In contrast, withdrawal ruptures within therapy involve a more subtle disengagement from the therapeutic process, which might not be solely driven by anxiety. Withdrawal behaviors in therapy may be more closely linked to interpersonal avoidance or specific relational dynamics, rather than generalized anxiety symptoms, which are the primary focus of the BAI. For instance, a client's discomfort with intimacy or vulnerability in the therapeutic setting, rather than their overall anxiety level, could be a more accurate predictor of withdrawal ruptures. This aligns with the idea that the context of the therapeutic relationship - including the emotional and relational factors - plays a more pivotal role in therapeutic ruptures than general symptoms of anxiety (Safran & Kraus, 2014). In that case, the Beck Anxiety Inventory (BAI), while a reliable and widely used measure of anxiety, may not capture the specific forms of anxiety that are most relevant to withdrawal ruptures in therapy. The BAI focuses primarily on somatic symptoms of anxiety (e.g., heart palpitations, dizziness), which may not fully reflect the psychological avoidance behaviors that contribute to withdrawal ruptures. Interpersonal anxiety or therapy-specific anxieties, such as fear of vulnerability or fear of emotional closeness, may play a larger role in predicting withdrawal ruptures. Using a more specialized anxiety measure, such as the Liebowitz Social Anxiety Scale (Heimberg et al., 1999), which assesses both social avoidance and fear, might yield different results in future studies.

Another possibility is that personality factors or individual differences in therapeutic engagement play a more significant role than anxiety in withdrawal ruptures. Clients with certain personality traits, such as high neuroticism or avoidant attachment styles, may be more prone to withdrawing from therapy, regardless of their baseline anxiety levels (Bucher et al., 2019). In contrast, clients who are more therapeutically engaged or have a higher tolerance for discomfort in therapy may be less likely to withdraw, even if they have high levels of anxiety.

## **Strengths and Limitations**

### ***Strengths***

One of the major strengths of this study was the use of well-established, validated measures. The Beck Anxiety Inventory (BAI) provided a robust and reliable assessment of participants' anxiety levels, while the Rupture Resolution Rating System (3RS) effectively captured the occurrence and significance of withdrawal ruptures during therapy sessions. Both tools have been validated in clinical settings and widely used in psychotherapeutic research, ensuring that the measurements of anxiety and withdrawal ruptures were accurate and reliable (Beck et al., 1988; Eubanks, Lubitz, et al., 2018).

Another strength of this study is its focus on a real-world clinical setting. The data were collected during actual therapy sessions in a university outpatient clinic as part of an ongoing randomized controlled trial. This increases the external validity of the findings, meaning the results are more likely to reflect what happens in typical therapeutic environments, as opposed to controlled laboratory settings.

### ***Limitations***

Although the main sample of 56 participants provided sufficient data for the analysis, the sample size may have limited the statistical power of the study. This is especially a problem for the smaller subset of patients with an anxiety diagnosis. A larger sample could potentially have revealed smaller or more nuanced effects of anxiety on withdrawal ruptures that were not detectable in this analysis. This should be considered when generalizing the results to broader populations.

The study relied exclusively on the BAI to assess anxiety, which primarily measures somatic symptoms of anxiety. While this is a well-validated tool, it may not fully capture the interpersonal aspects of anxiety, such as fear of vulnerability or emotional closeness, which could be more relevant to understanding withdrawal ruptures in therapy. Using additional measures, such as those that assess social anxiety or attachment-related fears, might provide a more comprehensive view of anxiety's role in therapeutic ruptures.

The findings are based on data collected from integrative cognitive behavioral therapy sessions, a fairly structured and directive approach. While this modality is effective for many psychological issues, it may not allow for the same occurrence or detection of withdrawal

ruptures as other, more exploratory approaches like psychodynamic therapy. As a result, the findings may not generalize to all therapeutic modalities.

### **Clinical and Practical Implications**

The findings of this study have important clinical and practical implications, particularly for therapists working with a diverse population of clients. Understanding that anxiety levels, at least as measured by the BAI, do not significantly predict withdrawal ruptures can help inform therapeutic approaches.

First, the lack of a significant association between baseline anxiety and withdrawal ruptures suggests that therapists should not assume that clients with high anxiety scores on the BAI are more prone to withdrawal behaviors. Instead, therapists should remain vigilant for signs of withdrawal ruptures in all clients, regardless of their anxiety levels. Withdrawal ruptures are subtle and may otherwise go unnoticed, leading to unresolved tensions in the therapeutic alliance if not addressed.

Second, the study highlights the importance of therapist training in recognizing and addressing withdrawal ruptures, even when they are not immediately apparent. Training programs should emphasize rupture-repair strategies, such as metacommunication and validation techniques, which can help therapists more effectively manage these ruptures. Proactively addressing withdrawal behaviors can prevent therapeutic stagnation and improve overall outcomes.

Lastly, these findings can help therapists better tailor their interventions for clients with high anxiety. Since withdrawal ruptures were not specifically tied to anxiety levels in this study, therapists might focus more on building trust and safety in the therapeutic relationship, which may help reduce the likelihood of withdrawal behaviors overall. By fostering stronger alliances, therapists can support clients in remaining engaged in therapy, regardless of their anxiety levels.

### **Suggestions for Future Research**

While this study contributes to our understanding of withdrawal ruptures in therapy, several areas remain open for future exploration. The following suggestions for future research aim to build on the current findings and address the limitations of the study.

Future studies should focus more specifically on patients with an anxiety disorder and investigate the role of different types of anxiety - such as social anxiety or interpersonal fear -

in withdrawal ruptures. By using a broader range of anxiety measures, including tools like the Liebowitz Social Anxiety Scale, and a larger study population, researchers could gain a more nuanced understanding of how various forms of anxiety influence therapeutic ruptures.

Given that this study focused on integrative cognitive behavioral therapy, future research should explore whether the findings hold true in other therapeutic approaches, such as psychodynamic therapy, systemic therapy, or humanistic approaches. These modalities, which often place more emphasis on exploration and emotional processing, may produce different patterns of withdrawal ruptures and therapeutic outcomes (Baardseth et al., 2013).

### **Conclusion**

This study aimed to explore whether baseline anxiety levels could predict the significance of withdrawal ruptures and the amount of withdrawal rupture markers in therapy sessions, addressing the broader question of how anxiety might influence the therapeutic process. Contrary to the initial hypothesis, the findings revealed no significant relationship between baseline anxiety levels and withdrawal ruptures. This was also the case in the subset of patients diagnosed with an anxiety disorder. These results challenge the assumption that anxiety, particularly as measured by the Beck Anxiety Inventory (BAI), plays a direct role in driving withdrawal rupture behaviors during therapy. This seems to be the case regardless of whether a patient is diagnosed with an anxiety disorder or not.

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