Advanced CBT: Complexity and Process

THE TALKING THERAPIES UK PRACTITIONER SERIES



Advanced CBT: Complexity and Process

Comorbidity, rupture, schema-level work and the judgement calls protocols cannot make for you.

Advanced level · 14 hours of continuing professional development

TALKING THERAPIES UK

First edition · 2026

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First edition, 2026.

This manual accompanies the Advanced CBT: Complexity and Process course in the Talking Therapies UK Digital Classroom, from which its content is drawn and against which it is kept current.

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A note on the clinical material. Every case in this book is a fictional composite written for teaching. No real person appears in it, however disguised. Nothing here constitutes clinical supervision, and nothing in it replaces the judgement of a qualified practitioner working within their competence, their professional body's code and their local governance. Where guidance is cited it was current at the date of this edition; readers must check the standing of any guidance before relying on it.

Set in Poppins and Roboto, the Talking Therapies UK typefaces. Figures drawn by the Talking Therapies UK teaching-diagram engine.

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How to use this manual

Protocols are written for the client who attends with one problem, engages with homework and improves on schedule. Experienced practitioners know how rare that client is. This course is CBT at supervision level: the judgement calls that no manual can make for you, taught for clinicians who already practise the modality and now meet its limits.

The first module works where the protocol runs out. You will study comorbidity and the transdiagnostic processes, rumination, perfectionism, intolerance of uncertainty, that cut across diagnoses and explain why sequential single-disorder treatment so often stalls. You will work with rupture and repair as clinical material, and with therapy-interfering behaviour as something to be formulated rather than endured. The second module goes deeper still: schema-informed CBT and belief-level change for difficulties that survive symptom-level work, and an unflinching reading of what the outcome evidence does and does not actually establish.

This is demanding material, taught in four extended written lessons with key points, practice tasks pitched at case-formulation level, and a study tutor for the questions supervision would ask. Fourteen hours of CPD, around a year of access, a final assessment, and a personalised certificate on passing.

This manual is the written form of a course taught in the Talking Therapies UK Digital Classroom. It is set at advanced level and carries 14 hours of continuing professional development for practitioners who complete the accompanying course and its assessment.

It is written to be read in order. Each part opens with what it is for; each chapter teaches one idea to a working depth and closes with the points worth keeping and a practice task that converts reading into something you do. The tasks are the part most often skipped and the part that most reliably changes practice, and several of them are designed to be taken to supervision rather than completed alone.

The figures are teaching diagrams rather than decoration. Each is the conventional form of a model you will meet in the literature and in

supervision, drawn in one visual language across the whole series so that the shape of an idea is recognisable wherever it reappears.

Where a chapter draws on published work, the reference is named in the text and gathered in the further reading at the back. Terms of art are defined in the glossary, which is worth reading straight through once before you begin.

What this manual will leave you able to do

- Formulate complex, comorbid and long-standing difficulties where standard protocols fit poorly
- Work at the level of conditional rules and core beliefs, using continua, historical review and behavioural experiments
- Recognise and repair ruptures in the therapeutic relationship within a CBT frame
- Adapt CBT process and pacing for relational trauma, perfectionism and self-criticism
- Integrate imagery techniques and attention to process alongside protocol content
- Critically evaluate the CBT evidence base and its limits, and reason clearly about when to depart from protocol

PART 1

Transdiagnostic Foundations and Flexible Case Formulation

This module covers transdiagnostic processes, therapeutic ruptures, flexible stances, and modular treatment planning for complex presentations when standard protocols fall short.

CHAPTER 1

Comorbidity and transdiagnostic processes

The reality of contemporary clinical practice is that the client who presents with a single, neatly bounded diagnosis is the exception rather than the rule. Large-scale epidemiological surveys, such as the Adult Psychiatric Morbidity Survey (McManus et al., 2016) and the National Comorbidity Survey Replication (Kessler et al., 2005), consistently demonstrate that depressive episodes frequently co-occur with anxiety disorders, that anxiety disorders themselves frequently appear in clusters, and that substance misuse, insomnia and chronic physical illness are woven through the tapestry of emotional disturbance. The advanced therapist therefore begins by taking comorbidity seriously, not as a nuisance to be swept aside, but as a clue to the underlying maintenance economy that sustains distress.

When a formulation reveals multiple diagnostic labels, the practitioner is faced with three strategic options, each of which must be articulated explicitly before a treatment plan can be constructed. The first option is the sequential protocol approach, in which one disorder is treated to a predefined criterion of response before the next protocol is introduced. This strategy preserves the fidelity of evidence-based manuals – for example, the Beck Depression Inventory-II guided protocol for major depressive disorder followed by the exposure-based protocol for social anxiety disorder – but it can be protracted, sometimes extending over many months or even years. Moreover, clinicians often find that gains achieved in the first phase erode while attention is diverted to the second, particularly when the disorders share common maintaining processes.

The second option is a transdiagnostic approach, which targets the shared substrate that cuts across diagnostic boundaries. The most extensively evaluated model is Barlow’s Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (Barlow et al., 2017). The Unified Protocol is built on a core set of modules that address neuroticism, experiential avoidance, emotion-driven behaviour, and maladaptive cognitive appraisals. By working through these modules in a single therapeutic arc, the therapist can

simultaneously attenuate the mechanisms that fuel depression, panic, generalised anxiety, obsessive-compulsive symptoms and related conditions. A meta-analysis of transdiagnostic treatments found that they outperformed control conditions and, in the few comparisons available, matched disorder-specific treatments for anxiety (Newby et al., 2015), and in a randomised equivalence trial the Unified Protocol was as effective as diagnosis-specific protocols for anxiety disorders (Barlow et al., 2017), while offering the pragmatic advantage of a single, coherent treatment trajectory.

The third option is a bespoke, formulation-driven plan. Here the therapist maps the individual's specific maintenance economy, identifies the processes that bear the greatest load, and orders interventions according to the hierarchy of leverage. This approach draws on the classic CBT formulation tradition articulated by Beck, Rush, Shaw and Emery (1979) and refined by contemporary scholars such as Kuyken, Padesky and Dudley (2009). The bespoke plan does not discard the utility of protocol-derived techniques; rather, it tailors their sequencing to the client's unique constellation of processes, allowing the therapist to intervene on the most potent driver of distress first, regardless of the diagnostic label attached to it.

Across these three options, a growing body of research points to the primacy of shared processes over categorical diagnoses. Rumination, defined by Nolen-Hoeksema (1991) as a repetitive, passive focus on symptoms of distress, has been implicated in the maintenance of depression, in worry, in the post-event processing of social anxiety and in anger, and it helps to explain why symptoms of depression and anxiety so often occur together (McLaughlin & Nolen-Hoeksema, 2011). Experiential avoidance, a central construct in Acceptance and Commitment Therapy (Hayes, Strosahl & Wilson, 1999), operates as a transdiagnostic driver of panic, substance misuse, and eating disorder behaviours. Intolerance of uncertainty, highlighted by Carleton (2016), underpins generalized anxiety, obsessive-compulsive checking, and health anxiety. Perfectionism, as delineated by Shafran, Cooper and Fairburn (2002), fuels eating pathology, depressive rumination and social anxiety. Self-criticism, captured in the Forms of Self-Criticising/Attacking and Self-Reassuring Scale (Gilbert et al., 2004), transforms ordinary setbacks into global self-condemnation, amplifying symptom severity across the mood-anxiety spectrum. In each case, the process cuts across diagnostic borders, suggesting that moving

the process may move a greater array of symptoms than treating any single disorder in isolation.

The advanced therapist therefore adopts a diagnostic-agnostic question: which single process, if altered, is likely to generate the greatest reduction in overall symptom burden? This “maximum leverage” inquiry is the fulcrum of formulation-driven planning. It requires the therapist to rank processes not by their theoretical elegance but by the empirical weight they carry in the client’s lived experience. The answer is never predetermined; it emerges from a careful synthesis of assessment data, behavioural observation, and collaborative hypothesis testing.

To illustrate the application of this reasoning, consider a 34-year-old woman, Maya, who presents with a primary complaint of low mood, chronic binge-eating, and an intense fear of social evaluation that has led her to avoid most gatherings for the past three years. On the PHQ-9 she scores a 16, indicating moderately severe depression; on the GAD-7 she records a 12, reflecting moderate anxiety; and on the Eating Disorder Examination-Questionnaire (EDE-Q) she reports weekly episodes of loss of control eating amounting to 1,500 kcal. A standard diagnostic formulation would assign her major depressive disorder, binge-eating disorder, and social anxiety disorder. A sequential protocol approach might begin with a CBT-depression protocol, then move to a CBT-eating disorder protocol, and finally to an exposure-based protocol for social anxiety – a trajectory that could easily exceed a year.

Maya’s formulation, however, reveals a different picture. She describes an inner critic that judges every perceived shortcoming against an unattainably high standard of performance. When she fails to meet these standards – for example, when she cannot deliver a flawless presentation at work – she enters a cycle of self-critical rumination that magnifies feelings of shame and hopelessness. The rumination fuels a depressive mood, which in turn lowers her motivation to engage in adaptive coping. To escape the distress, she turns to binge-eating, which provides temporary relief but subsequently reinforces the sense of failure because of the guilt that follows. The fear of social evaluation is maintained because any potential exposure threatens the critic’s verdict; avoidance therefore serves as a protective barrier against the anticipated self-condemnation.

In this formulation, the processes that appear most central are

perfectionistic standards, self-critical rumination, and binge-eating as an avoidance strategy. The therapist asks the pivotal question: which of these, if shifted, would most likely attenuate depression, anxiety and disordered eating simultaneously? The answer, derived from both the literature and Maya's own narrative, points to the perfectionism-self-criticism axis. Perfectionism has been measured since Frost, Marten, Lahart and Rosenblate (1990) developed their multidimensional scale, and a meta-analysis of ten longitudinal studies found that perfectionistic concerns predicted later depressive symptoms even after neuroticism was taken into account (Smith et al., 2016), while a major review of repetitive thought found that its unconstructive forms contribute to depression and anxiety (Watkins, 2008). By targeting perfectionistic beliefs and the accompanying self-critical inner dialogue, the therapist can simultaneously undercut the trigger for rumination, reduce the emotional intensity that drives binge-eating, and weaken the fear of negative evaluation.

The treatment plan therefore begins with a bespoke module that combines elements of cognitive restructuring (Beck, 1976) and compassionate mind training (Gilbert, 2009) aimed at dismantling perfectionistic standards and cultivating a kinder self-relating stance. The therapist works with Maya to identify automatic thoughts such as "If I am not perfect, I am worthless" and to test these against behavioural evidence. Simultaneously, a compassionate imagery exercise is introduced to develop an internal compassionate voice that can counter the self-critical commentator. Once a measurable shift in self-criticism is observed – for example, a reduction of 2 points on the inadequate-self subscale of the Forms of Self-Criticising/Attacking and Self-Reassuring Scale – the therapist monitors downstream effects on PHQ-9, GAD-7 and binge-eating frequency. In Maya's case, after eight sessions, her self-criticism score falls from 24 to 16, her PHQ-9 drops to 10, her GAD-7 to 7, and binge-eating episodes decline from weekly to fortnightly. The therapist then introduces exposure-based techniques to address residual social avoidance, now that the underlying fear is less amplified by self-critical rumination.

Contrast this with a client for whom the comorbidities are truly parallel rather than interlinked. Consider John, a 45-year-old man who presents with a specific phobia of elevators (diagnosed as a specific phobia) and a separate episode of major depressive disorder triggered by recent job loss. John's avoidance of elevators is confined to the physical context of buildings; his

depressive cognitions revolve around loss of identity and financial insecurity, with no evidence that the phobia fuels his low mood. In such a scenario, a sequential protocol – first a brief exposure-based protocol for the phobia, followed by a CBT-depression protocol – is the most efficient route. The phobia can be resolved within three to four sessions, providing John with an early success that bolsters motivation for the longer-term work on depression.

The third scenario illustrates a middle ground where both transdiagnostic and bespoke strategies have merit. Sarah, a 28-year-old graduate student, meets criteria for generalised anxiety disorder, obsessive-compulsive disorder (checking rituals), and moderate depressive symptoms. Her assessment highlights intolerance of uncertainty as a core driver that fuels both her worry and her compulsive checking, while rumination sustains her depressive mood. Here the Unified Protocol offers a structured, evidence-based pathway that addresses intolerance of uncertainty, emotional avoidance and rumination within a single treatment arc. Yet the therapist may still augment the protocol with a bespoke module that targets Sarah's perfectionistic academic standards, a process that lies outside the standard Unified Protocol sequence but is clearly a high-leverage target in her formulation.

The lesson for the advanced practitioner is that the decision between sequential, transdiagnostic and bespoke approaches is not a matter of personal preference but a clinical judgement grounded in formulation. The therapist must first conduct a comprehensive assessment that includes diagnostic interviews, validated self-report measures (PHQ-9, GAD-7, EDE-Q, Forms of Self-Criticising/Attacking and Self-Reassuring Scale, Intolerance of Uncertainty Scale), and behavioural observation. From this data, a process hierarchy is constructed, explicitly ranking each maintaining factor by its estimated load-bearing capacity. The hierarchy is then shared with the client, inviting collaborative verification and ensuring that the client understands why a particular process has been selected as the point of maximum leverage.

In practice, the therapist writes the hierarchy on a visible sheet of paper or a shared digital document, for example: 1. Perfectionistic self-standards › 2. Self-critical rumination › 3. Binge-eating as avoidance › 4. Social avoidance. The therapist then states, "If we can loosen the grip of perfectionism, the

self-criticism that follows will lose its fuel, and the binge-eating and social avoidance are likely to diminish as a result." This transparent articulation not only aligns treatment with the client's lived experience but also provides a clear metric for progress: a reduction in the top-ranked process should be accompanied by measurable change across the secondary symptoms.

Outcome monitoring therefore adopts a multi-modal approach. Symptom measures (PHQ-9, GAD-7, disorder-specific scales) are administered at regular intervals, while process measures (e.g., the Perseverative Thinking Questionnaire for rumination, the Acceptance and Action Questionnaire for experiential avoidance) are tracked to confirm that the hypothesised lever is moving. When the data reveal that the targeted process is not shifting as expected, the therapist revisits the formulation, considers alternative high-leverage processes, and adjusts the intervention sequence accordingly. This iterative, data-informed stance embodies the spirit of advanced CBT: not a rigid adherence to protocol, but a flexible, evidence-based orchestration of techniques aimed at the most potent maintaining mechanisms.

The evidence base supporting this formulation-driven, process-focused stance continues to expand. Network approaches to psychopathology (Borsboom, 2017; Fried & Cramer, 2017) propose that symptoms are interconnected and that some, more central than others, may hold a network in place. If interventions target the central nodes, the model predicts cascading reductions in peripheral symptoms, although this has yet to be shown convincingly in treatment trials. Moreover, trials of transdiagnostic interventions, such as the Unified Protocol and emotion regulation therapy for generalised anxiety disorder with and without depression (Mennin et al., 2018), have begun to test whether change in process variables mediates symptom improvement, which would reinforce the clinical logic of the maximum-leverage question.

In summary, the advanced therapist confronting comorbidity must move beyond the simplistic notion that each diagnosis requires its own discrete protocol. The practitioner must first acknowledge the prevalence of overlapping disorders, then articulate three strategic pathways – sequential protocols, transdiagnostic modules, and bespoke formulation-driven plans – and finally apply a rigorous, data-guided process hierarchy to identify the single process whose modification promises the greatest overall symptom

relief. The concrete example of Maya illustrates how a bespoke focus on perfectionism and self-criticism can simultaneously attenuate depression, anxiety and binge-eating, while the contrasting cases of John and Sarah demonstrate when sequential or transdiagnostic routes are more appropriate. The disciplined habit of writing the process hierarchy, naming the predicted point of maximum leverage, sharing it with the client, and letting outcome data adjudicate the hypothesis is the hallmark of advanced CBT practice. It is not the accumulation of more manuals that defines expertise, but the capacity to discern, articulate and intervene upon the shared processes that truly drive distress across diagnostic boundaries.

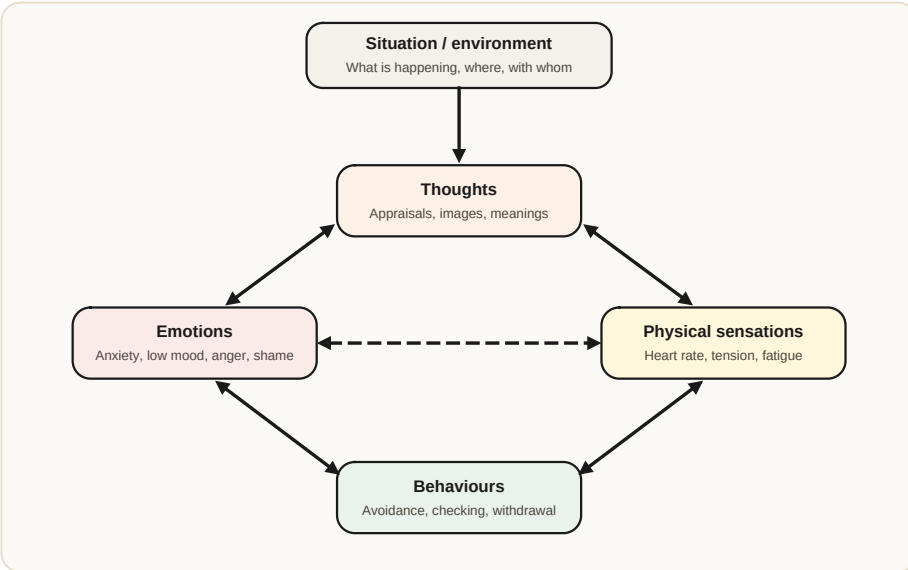


FIGURE 1.1 The five areas model

Greenberger and Padesky's five areas ("hot cross bun") model: a situation is processed through thoughts, emotions, physical sensations and behaviours, and every element influences every other. Change introduced at any point, most often at thoughts or behaviours, alters the whole system.

Points worth keeping

- Options: sequential protocols, transdiagnostic work, bespoke formulation
- Shared processes (rumination, avoidance, self-criticism) often outrank diagnoses
- Ask: which single process, if moved, moves the most symptoms

PRACTICE TASK

For a client with depression, GAD and health anxiety, name the one process you would target first and defend the choice in two sentences.

CHAPTER 2

Rupture, repair and therapy-interfering behaviour

The phenomenon of therapeutic rupture and its repair occupies a central place in the contemporary understanding of cognitive-behavioural therapy (CBT) as a relational process, even though the original research was cultivated in a psychodynamic tradition. Safran and Muran's seminal work on rupture-repair cycles, later integrated with Bordin's working- alliance model, provides a conceptual scaffold that is entirely compatible with the collaborative-empiricist stance of CBT. In the advanced practice context, clinicians must be able to detect two distinct rupture patterns – confrontation ruptures and withdrawal ruptures – appreciate their prognostic significance, and intervene with repair strategies that are themselves CBT interventions. Moreover, behaviours that appear to interfere with therapy, such as chronic lateness, repeated cancellations, or pervasive "I don't know" responses, should be approached through functional analysis rather than through a confrontational stance.

A confrontation rupture is overt. The client openly challenges the therapist's competence, the relevance of the treatment model, the prescribed homework, or the therapist's interpretation of the case formulation. The session may become tense, with the client's tone sharpening, a sudden increase in resistance, or a direct accusation that the therapist is "pushing too hard." In contrast, a withdrawal rupture is covert and often masquerades as compliance. The client may appear to acquiesce, complete worksheets, and verbalise agreement, yet the quality of the interaction is marked by a subtle disengagement. In CBT this is especially insidious because the therapist's procedural checklist – attendance, homework completion, and symptom rating – can be misread as evidence of a strong alliance, while the client's authentic engagement has already receded. Research on alliance ruptures, much of it by Safran, Muran and their colleagues, suggests that unrepaired ruptures of either type undermine treatment, and a meta-analysis found a moderate association between the resolution of ruptures and better outcomes (Eubanks, Muran & Safran, 2018). Repair is therefore best treated as a core competence rather than an optional skill.

Repair in CBT is not a peripheral relational technique; it is an embodiment of the therapy's own epistemic stance. The therapist first notices a deviation from the expected pattern – for instance, a sudden drop in the client's self-rating on the PHQ-9, an unexpected increase in the GAD-7, or a marked shift in the client's affect during a session. The therapist then names the observation without attributing blame, framing it as a hypothesis about the therapeutic interaction. A typical repair utterance might be: "I have noticed that after we explored the belief that 'I must be perfect to be valued', you have been quieter and have not completed the thought record we planned. I wonder whether something about that experiment felt uncomfortable for you." This formulation accomplishes three things. First, it signals the therapist's willingness to examine their own contribution, aligning with the CBT principle that the therapist's interventions are hypotheses to be tested. Second, it invites the client to disconfirm or confirm the therapist's conjecture, thereby re-establishing collaborative empiricism. Third, it creates a concrete behavioural target – the completion of the thought record – that can be monitored in subsequent sessions.

The repair process itself can be modelled on the classic CBT cycle of case formulation, hypothesis testing, and data-driven revision. The therapist treats the rupture as a data point that either supports or challenges the existing formulation of the client's maintaining factors. For example, a client who habitually withdraws in the face of perceived criticism may be maintaining avoidance of emotional experience, a pattern that can be captured in the formulation as "avoidance of affective processing maintains depressive cognitions." When a withdrawal rupture emerges, the therapist can explicitly link the rupture to the formulation: "It seems that when we approached the memory of your father's criticism, you stopped filling out the exposure worksheet. This fits with the idea that you tend to avoid situations that might trigger strong emotions." The repair then becomes an opportunity to test the formulation in real time, perhaps by designing a graded exposure to the emotional content, thereby turning the relational difficulty into therapeutic material.

Therapy-interfering behaviours (TIBs) – such as chronic lateness, repeated cancellations, crisis-of-the-week presentations, or pervasive "I don't know" replies – are often perceived by novice clinicians as obstacles that must be overcome through persuasion or confrontation. In advanced CBT, however, TIBs are conceptualised as behaviours that serve a function within the

client's broader behavioural repertoire. A functional analysis of a TIB mirrors the analysis applied to any other symptom. The analyst identifies antecedents (what precedes the behaviour), the function (what the behaviour achieves for the client), and consequences (what maintains the behaviour). By situating the TIB within the case formulation, the therapist can address it without resorting to a power struggle.

Consider a client who habitually arrives ten minutes late to each session after a particularly emotionally charged exposure exercise. A functional analysis might reveal that the client's lateness follows sessions in which they have been asked to confront a feared memory, and that the lateness serves to provide a temporal buffer in which the client can engage in self-soothing behaviours (e.g., scrolling through social media). The consequence of this pattern is that the therapist's agenda is truncated, and the client avoids the immediate post-exposure processing that is crucial for consolidation of learning. The therapist can then formulate the TIB as "post-exposure avoidance behaviour" and propose a collaborative experiment: "Would you be willing to set an alarm for five minutes after the session ends, so that we can briefly discuss how you felt after the exposure before you attend to other activities?" This approach respects the client's autonomy, retains the collaborative stance, and directly tests the hypothesis that the lateness is maintaining avoidance.

A concrete worked example illustrates the integration of rupture detection, repair, and functional analysis of a TIB. Sarah, a 34-year-old accountant, presented with generalised anxiety (GAD-7 score 15) and perfectionistic beliefs about work performance. The therapist's formulation identified a cycle of "excessive checking" and "post-event rumination" that maintained her anxiety. Over the first six sessions, Sarah completed weekly thought records and engaged in behavioural experiments targeting her checking behaviours. In session seven, Sarah arrived five minutes early but, after a brief check-in, she said, "I'm not sure I want to do the exposure we planned today." She then offered a vague alternative: "Maybe we could just talk about how the day went." The therapist noted a withdrawal rupture – Sarah's overt compliance with the appointment but covert avoidance of the planned exposure. The therapist responded, "I hear that you are feeling hesitant about the exposure we scheduled. I wonder whether the idea of confronting the 'messy' part of your workday feels threatening for you." Sarah disclosed that she feared that if she failed the exposure, it would confirm her belief

that she is incompetent. The therapist then linked this disclosure to the formulation: “Your fear of confirming the ‘I must be perfect’ belief appears to be driving the avoidance of the exposure.” The repair involved treating the therapist’s own suggestion as a hypothesis: “If we proceed with a brief, low-intensity exposure – for example, writing a short email without checking it twice – we can test whether the feared outcome actually occurs.” The therapist also identified a concurrent TIB: Sarah’s pattern of “I don’t know” responses, which functioned to avoid committing to any behavioural experiment. A functional analysis revealed that the “I don’t know” reply followed moments when the therapist introduced a new task, and that it served to maintain the status quo of perfectionism. The therapist collaboratively reframed the response: “When you say ‘I don’t know,’ it may be a way of protecting yourself from the possibility of error. Let us treat that as a data point and explore what would happen if you tried the task, even if the outcome is uncertain.” Sarah agreed to a micro-exposure, completed the email, and reported a modest increase in anxiety (SUDS 5) that dropped to 2 within ten minutes. The session data were recorded, the formulation updated, and the rupture repaired. Over the next three sessions, Sarah’s attendance improved, her PHQ-9 score fell from 14 to 8, and her GAD-7 reduced to 9, illustrating how the repair of a withdrawal rupture and the functional handling of a TIB can catalyse therapeutic change.

In practice, the therapist must embed systematic monitoring of the alliance and of potential ruptures into every session. The use of brief alliance measures – such as the Working Alliance Inventory – at the close of each session, combined with a simple feedback question (“Is there anything about today’s session that felt unhelpful or confusing for you?”) provides the data needed to detect subtle withdrawal patterns. When a rupture is suspected, the therapist should move towards it with curiosity, employing the same collaborative empiricism that underpins all CBT interventions. The therapist’s stance is one of humility: treating the therapeutic relationship itself as a hypothesis to be tested, naming one’s own contribution, and inviting the client to disconfirm the hypothesis.

The overarching principle for advanced CBT practitioners is that the therapeutic relationship is not a peripheral backdrop but the very medium in which cognitive-behavioural techniques are enacted. Rupture and repair are not merely relational phenomena; they are integral to the process of hypothesis testing, data collection, and formulation revision.

Therapy-interfering behaviours, when approached through functional analysis, become additional data points that enrich the case formulation rather than obstacles that must be eliminated. By consistently applying these principles – detecting both confrontation and withdrawal ruptures, repairing them through collaborative hypothesis testing, and functionally analysing any interfering behaviours – clinicians can transform moments of relational strain into opportunities for therapeutic growth, thereby ensuring that the protocol does not merely run out, but is continually revitalised by the lived experience of the client and therapist together.

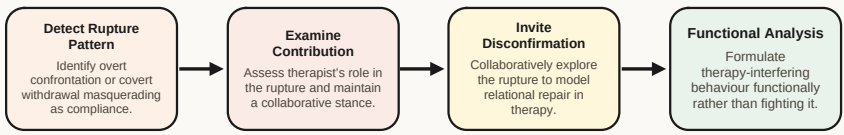


FIGURE 2.1 Rupture and Repair Process

Detect rupture types and use collaborative repair as an active intervention. Functional analysis replaces confrontation for interfering behaviours.

Points worth keeping

- Withdrawal ruptures masquerade as compliance; both rupture types predict poor outcome unless repaired
- Repair models the therapy: examine your contribution, invite disconfirmation
- Therapy-interfering behaviour is formulated functionally, not fought

PRACTICE TASK

Recall (anonymised) a moment of client withdrawal you may have read as agreement. Write the alternative reading and what repair would have sounded like.