A Thematic Analysis of the Counselling Psychologist's Experience of Therapeutic Ruptures

Jordan William James Munn
15904646

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Prelude

Human beings are intricate and complex, and ruptures, well "it's just a big jumbled up mess that you're trying to tangle your way through". Therapeutic ruptures are "part in parcel" of the work we do as counselling psychologists and can act as a powerful tool through attaining a specific psychological sensitivity toward one's own countertransference, yet what we perceive to be rupture, may not be one at all. In more depth, ruptures may be the very essence of our client's therapeutic work, just as they may provide relief to our own central personal conflicts of interpersonal disconnection; there is no one answer. It is a human process that you struggle and wrestle with.

Jordan Munn, 2022

Abstract

This research explores the counselling psychologists lived experience of therapeutic ruptures with their clients. The relationship between therapist and client, referred to as the therapeutic relationship, represents *connection*, where participants work together collaboratively for the client's benefit. The therapeutic relationship is comprised of three interconnected components: the real relationship, the working alliance, and the transference/countertransference relationship. This research focuses on the working alliance between the therapist and client, an artifact which exists only when therapeutic work is being done. Therapeutic ruptures are breakdowns or tensions within the therapeutic relationship that result in *disconnection* and a loss of the collaborative nature of the relationship between therapist and client. While therapeutic ruptures are well documented, little is known about the counselling psychologists lived experience of therapeutic ruptures with their clients. To fill this gap in the literature, four registered counselling psychologists in Aotearoa, New Zealand, were interviewed and asked to describe their experience of a therapeutic rupture with one of their clients. Participants were asked to describe how they had identified the rupture, how it affected the therapeutic relationship, how they attempted to repair it, and if the rupture was resolved, how this occurred. Adopting an interpretive phenomenological approach, interviews were transcribed verbatim and analysed using a reflexive thematic analysis. Four primary themes emerged, *Therapists Clearly Identifying a Therapeutic Rupture, The Therapists Attempt at Repairing a Therapeutic Rupture, Resolving a Therapeutic Rupture and Understanding the Client*. The identification of therapeutic ruptures is not as explicit at it initially appeared. During the reparation phase, the therapist restores a collaborative connection between the therapeutic participants, yet innumerable realities within practice hinder the therapist's ability to repair a rupture event effectively. Successfully resolved ruptures are described as beautiful moments, but unresolved, the rupture begins to weigh on the mind of the therapist. Despite the outcome of the therapeutic rupture, there is always something to take away from each and every experience. Finally, underlying the entire rupture-repair process is the therapist's ability to understand their client, influencing the outcome of rupture events. This research may assist practising counselling psychologists to further their understanding of therapeutic ruptures and reflect upon their own processes and how they deal with therapeutic ruptures in practice. This research intended to aid psychology students as a foundation of knowledge and an introduction to the many complexities counselling psychologists experience within the clinical setting.

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Attestation of Authorship

In submitting this work, I declare that:

- This assessment has been produced by me and represents my own work
- Any work of another person is appropriately acknowledged and/or referenced
- This work did not involve any unauthorised collaboration
- This work has not previously been submitted by me or any other person/author, unless authorised
- I did not use any other unfair means to complete this work.
- I/we understand that the above obligations form a part of the University's regulations and that breaching them may result in disciplinary action.

Jordan William James Munn

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To my primary supervisor Dr Mark Thorpe, you have supported me in more ways than I can begin to articulate. Thank you for your ongoing support throughout our time together working on this research project. I want to highlight the times I simply needed to talk, where you took the time out of your busy day to listen to me and support me through this process. This year has been one of the most challenging yet satisfying years of my life, and I am incredibly excited for what the future holds.

To my friends and family, thank you all for your ongoing support and encouragement. It has been a year with many ups and downs; without you all, this would not have been possible.

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Chapter 1: Literature Review

The Therapeutic Relationship

The therapeutic relationship has been defined as "the feelings and attitudes counselling participants have towards one another and the manner in which these are communicated" (Gelso, 2013). Inspired by the practice of psychoanalyst Ralph Greenson (1967), Gelso and colleagues have enhanced essential principles within the therapeutic relationship to expand its scientific merit and adaptability to all theoretical approaches. In essence, independent of the therapist's theoretical approach, the tripartite model incorporates three interconnected components: the real relationship, the working alliance, and a transference configuration including client-therapist transference, or therapist-client countertransference. Greenson (2018) notes that the real relationship is a component of all human interactions, however, to illustrate the significance of the working alliance, I propose a quote by my supervisor Mark Thorpe "a fire ensues during a session, both individuals get up and exit the building, however, outside they walk and continue the session, this is their time". There is something sacred about the therapeutic space; it holds you, makes you feel safe, and allows you to open up about your inner experiences. The working alliance is a therapeutic artefact; the essence by which its existence is founded upon therapeutic work being done, examining the client's experiences, often from childhood, and understanding their contributions toward their current experience and actions (Freud, 1912). The fundamental key to the change process lies between the one who seeks change and the one who offers their service (Bordin, 1979). For the purpose of providing a conceptual framework for introducing the differences between various theories and psychotherapy, four notions are proposed:

1. All genres of psychotherapy have embedded working alliances and can be differentiated most meaningfully in terms of the kind of working alliance each requires.
2. The effectiveness of therapy is a function in part, if not entirely, of the strength of the working alliance.
3. Different approaches to psychotherapy are marked by the difference in the demands they make on client and therapist.
4. The strength of the working alliance is a function of the closeness of fit between the demands of the particular kind of working alliance and the personal characteristics of the patient and therapist

(Bordin, 1979).

When the client and therapist come together for the purpose of a working collaboration, central elements of an effective working alliance proposed by Bordin develop; (1 an agreement of goals are set (e.g. why are you here?), (2 therapeutic tasks or a series of therapeutic tasks are assigned and (3 an emotional bond cultivates. Although outside of my scope, it is important to briefly mention and address the impact

of cultural differences between client and therapist, as culture influences the experience a client and therapist may have with one another. Gender, race, and sexual orientation are components of the therapeutic dyad receiving attention regarding their impact on the therapeutic alliance (Schmidt, 2016). Oftentimes, clients feel more comfortable working with a therapist of the same gender but can eventually develop the same level of comfort with a therapist of the opposite gender once additional work has been completed to ensure a safe and comfortable space (Gehart & Lyle, 2004). Some systems, in most cases, match a therapeutic dyad based on the gender or preference of the client, enhancing the therapeutic relationship before the therapeutic process begins (Bhati, 2014). Geslo (2013) argues that the working alliance begins before the client and therapist make initial contact by fantasising. *How might a female therapist experience a therapeutic rupture with a male client whom they feel uncomfortable with?* Developing a collaborative and healthy alliance early on in therapy is critical for therapeutic success and is vital within all scopes of therapeutic approaches (Gelso, 2013).

Transference, deeply rooted in psychoanalysis, refers to a client's experience with their therapist that is driven by the client's own psychological framework and upbringing. The thoughts, feelings, and emotions experienced in early influential relationships are then unconsciously transferred onto the therapist (Jones, 2004). Similarly, countertransference is considered the therapist's transference to the client's transference. The construct is predicated on the therapist's capacity to recognise and regulate their own internal emotions and external reactions toward their client. If the therapist cannot manage their past and present relational conflicts, emotional turmoil seeps into the session and emerges behaviourally. However, when effectively managed, countertransference serves as a tool for understanding the client and the client's impact on others (Geslo, 2013).

An Interrelationship Between the Therapeutic Alliance and Ruptures

A *therapeutic rupture* is defined as a breakdown or tension within the collaborative relationship between client and therapist (Safran et al., 2011). Although rupture may imply an exaggerated breakdown in collaborative connection, ruptures vary in intensity, frequency, and duration, from minor tensions, which both client and therapist are superficially aware of, to severe breakdowns and misunderstandings adversely affecting collaboration, understanding, and communication. Within this complex and, at times, dysfunctional dance, it can be valuable to consider how disconnection occurs when determining whether or not a rupture has ensued. A therapist's ability to efficiently and accurately detect alliance ruptures is critical to engaging in the process of rupture reparation and a successful therapeutic outcome. Fundamentally, ruptures are an inevitability through and throughout the therapeutic process. In some cases, the formation of ruptures may increase the risk of early drop-out from treatment; however, the rupture-repair process in itself is critical, if not necessary, to successful therapeutic change (Geslo, 2013). Organised into two primary categories, ruptures can be identified as

either withdrawal or confrontation types, each eliciting different experiences within the therapist and client (Schenk et al., 2019). A withdrawal rupture marker manifests in the form of clients withdrawing or avoiding the therapist, their own feelings and emotions, or the treatment modality in order to maintain the relationship. Conversely, confrontational ruptures are characterised by a client's dissatisfaction being conveyed hostilely, attempting to control the therapist or situation (Safran et al., 2001).

Although ruptures may be perceived as one-sided in nature, it must be highlighted that all ruptures in any case within the therapeutic alliance are conceptualised as involving both client and therapist. During the process of rupture-repair, both withdrawal and confrontational events are handled in different manners (Coutinho et al., 2011). Withdrawal events require the therapist to empathically help the client explore their internal processes preventing the client from experiencing and expressing their genuine emotions; aiding the client in accepting and expressing their vulnerable feelings and deep-seated needs. By contrast, confrontational ruptures require the therapist to survive the client's hostile demeanour whilst managing their own countertransference so that the client may progress from anger and aggression to exploring their unexpressed emotions and needs. However, in reality, many alliance ruptures will present with both withdrawal and confrontational markers, requiring the therapist to bear the responsibility of monitoring their own emotional and behavioural reactions which arise in response to the client (Safran et al., 2011).

To elaborate further, psychoanalytic literature suggests two pillars that form the foundation for understanding the working alliance. One pillar stems from the work of Sterba (1934) in that the alliance itself is comprised of the therapist's "therapizing" side together with the rational ego of the client and that there is value within the therapeutic contract between the two (Menninger, 1958). The second pillar draws upon Zetzel's (1956) and Greenson's (1967) work, portraying the essence held within the real relationship during therapeutic work. Guided by Bordin's (1979) conceptualisation of the working alliance, fusing these contributions, difficulties within the therapeutic alliance arise from alliance tasks or goals, whilst other problems are related to the alliance's emotional bond (Eubanks, 2022). Ruptures influenced by alliance tasks or goals can be described as the therapist misapplying therapeutic techniques, being inflexible towards treatment models, using unsuitable interventions, misusing silence, or offering unwanted direction to clients (Gelso, 2013). In addition, therapists contribute toward ruptures related to the emotional bond of the alliance by being overly critical, distant, defensive, or lacking warmth and respect for patients. Furthermore, the initial condition of therapeutic work followed by the continuation of future therapy is the development of a therapeutic relationship rooted in key facilitative conditions suggested by Rogers (1957), namely, warmth, empathy, and congruence. *"If I can provide a certain type of relationship, the other person will discover within himself the capacity to use that relationship for growth and change, and personal development will occur"* (Rogers, 1961, p.

7). Therapists unable to adopt these key facilitative conditions starve their clients of the opportunity to feel safe to explore their thoughts, feelings, and emotions, further influencing a rupture event stemming from the alliance's emotional bond.

The fundamental idea underlying rupture-repair is that the client experiences problems within the working alliance due to their own unresolved relational conflicts and the empathic inadequacies of the therapist (Gelso, 2013). Whilst the union of therapeutic participants transpires these two factors become increasingly meaningful and complex. As therapists attempt to address the client's troubles, they must also wrestle with their defences. Recently, two main arguments have emerged supporting the notion of 'rupture-repair'. Firstly, if a rupture impairs the therapeutic dyad's capacity to communicate and share collaboratively in mutual trust and understanding, the conflict must be resolved for the dyad to continue its therapeutic work. Secondly, a rupture serves value in identifying and acknowledging the patient's emotionally-charged beliefs. Working through a rupture collaboratively with a therapist who role-models adaptive interpersonal skills provides the patient with a corrective experience, broadening their understanding in negotiating their own relational conflicts (Eubanks, 2022).

Understanding the common signs of alliance ruptures naturally highlights fundamental rupture-repair approaches therapists may employ, where specific interventions can initially be classified into either direct or indirect strategies (Safran et al., 2011). Direct interventions related to task or goal orientated ruptures can involve providing the client with rationale (e.g. reiterating treatment reasoning) or microprocessing tasks (e.g. utilising therapeutic exercises to help clients understand the core principles of therapeutic change) whilst also providing the opportunity for client's to explore their own core interpersonal themes (e.g. a client who neglects cognitive behavioural therapy assignments between sessions, may have issues with being controlled). Contrarily, indirect rupture strategies require the therapist to implicitly change the task or goal and reframe the meaning of the task or goal. Direct strategies linked to alliance ruptures rooted in the emotional bond include explicitly clarifying any misunderstandings the client may have and exploring the client's core interpersonal themes. Finally, indirect interventions related to the emotional bond feature strategies such as empathetic characterisation and providing the client with a corrective emotional experience (Safran & Muran, 2000). Metacommunication is also a process in which the therapist removes themselves from the dysfunctional dance and invites the client to step back and examine what is currently occurring between them. This process requires the therapist to identify and express their own inner experiences of the client or, in other cases, focus on their perception of what the client may be feeling. The therapist utilises their experiences or perceptions as a point of departure for the purpose of collaborative exploration. Fundamentally, ruptures are inevitable throughout the therapeutic process and, in some circumstances,

may increase the risk of early withdrawal from treatment; however, resolution and comprehension of a rupture event are essential, if not necessary, to successful therapeutic change (Geslo, 2013).

The Therapists Experience of Therapeutic Ruptures

Encounters with the world in which we entitle our experience are deeply entrenched within our everyday language, and that the possibility of explaining such a concept is difficult at best, and at worst, can be entirely impossible (Karbonowska, 2015). To grasp an understanding of the therapist's experience of therapeutic ruptures, the therapist's observations, perceptions, bodily awareness, memories, fantasies, emotions, feelings, desires, actions, and thoughts will be considered. Ruptures within the therapeutic alliance are moments where the process of therapeutic collaboration between client and therapist is interrupted (Safran & Muran, 2000). Such moments within the therapeutic space must be explored as they allow therapists at all levels to reflect upon and learn how to negotiate the demands of the self, alongside others in an environment where interpersonal relatedness is compromised (Safran & Segal, 1990). Attempting to delve deeper into the dysfunctional dance of disconnection, several studies have utilized task-analysis as a method to examine the processes underlying rupture-repair (Cash et al., 2014). Fundamentally, task analysis is used to break down complex tasks, such as the process of rupture-repair, into palatable sequences of smaller steps or actions (Carlisle, 1983). In application, external observers watch and analyse successful and unsuccessful therapy sessions to determine whether rupture markers, were present, whether the therapist recognized the markers, and what efforts were taken to resolve the rupture. One significant strength task analysis pose is its ability to capture moment-by-moment details illustrating how the rupture process unfolds. For example, Safran and Muran's (1996) influential work on ruptures utilised task analysis to generate a model that identifies three sequential therapist interventions; (1) attending to the rupture marker, (2) exploring the rupture experience/avoidance, and (3) exploration of the clients underlying wants and needs. Although task analysis proves valuable superficially, the inherent limitation lies within the observer's inability to account for the inner experiences of the therapist (Kline et al., 2019).

Why is it important to account for the therapist's inner experiences? Firstly, Safran and Muran (2000) emphasise the importance of understanding how therapists process their own feelings and emotions before intervening in a rupture event so that the intervention does not appear defensive. Secondly, although task analysis captures moment-by-moment details about a therapist's rupture-repair intervention, it does not capture why the therapist has chosen to take such steps. Furthermore, during an empirical analysis, Aspland et al. (2008) find significant differences between what therapists implement during a rupture event and what they innately believe they should do. Ruptures were found to occur primarily due to task and goal disagreements negatively affecting the therapeutic alliance. For example, a therapist suggests building up strength for relaxation in the occupational environment,

whereas the client wanted to explore their marriage difficulties. Due to the therapist's inattentiveness towards the client's needs, withdrawal markers were present in the form of the client providing short responses. When indirect rupture interventions are utilised, Safran and Muran (2000) suggest it may be beneficial for therapists to be silent in formulating their understanding of the rupture event. The therapist in this example had implicitly shifted the clients focus back to their marriage difficulties where the client appeared to be reengaged. The covert nature of the task change approach adopted in reparation of this rupture, demonstrates the therapist's internal formulation or decision to refocus, however, this cannot be verified as therapists were not interviewed in this study. Therefore, examining a therapist's inner experience may provide insight into their decision-making processes and illuminate reasons for subsequent discrepancies between their thoughts and actions.

Despite current literature examining the therapist's experiences of alliance ruptures being dominated by the registered and trainee psychotherapist, alongside the clinical psychologist's position, this unique knowledge may form the foundation of the counselling psychologist's experience (Coutinho et al., 2011; Schmidt, 2016; Kline et al., 2019). In brief, the discipline of counselling psychology adopts an integrative stance in understanding psychological functioning. That is, counselling psychologists consider the clients inner workings, interpersonal relationships, alongside the impact of structural factors (socio-political, socio-cultural, & political factors) in determining one's psychological well-being (du Prees & Goedeke, 2013). Moving away from the medical model of assessment, counselling psychology's strength lies within the recognition of the latter two aspects of an individual's psychological functioning, informing the implementation of intervention modalities. According to du Prees and Goedeke (2013), one of the most predominant distinctions of counselling psychology is the emphasis and inclusion of self-reflective practice, including personal development, and supervision. *How might this distinction play a role in how a counselling psychologist experiences a therapeutic rupture?*

In apprehension of the therapist's experience of rupture events, three phases are proposed: recognition, reparation, and resolution (Schmidt, 2016). At first glance, during the recognition phase of rupture events, mental health professionals (e.g., social workers, counsellors, marriage and family psychologists, clinical psychologists, and psychotherapists) interviewed by Schmidt (2016) report observing their client's shifting in mood, affect, and responsiveness. The most common characteristics observed in recognising a rupture are when clients express emotions such as anger, emotional invalidation, rage, and sadness. Mental health professionals had also recognised rupture events manifesting through the client's behaviour which included clients displaying a decrease in commitment to therapy (e.g., arriving late to a session, cancelling or missing sessions), providing minimal responses

in session, exaggerated compliance, complaints against therapist to supervisors, and questions surrounding the therapist's integrity.

Although the study provides insight into the therapist's superficial experience of recognising a rupture event, it does not account for their inner world. Digging deeper, Kline et al. (2019), investigating the experiences of trainee psychotherapists during rupture events, report that some therapists felt nervous and worrisome going into a session and were fundamentally "bracing for impact" for what they had predicted to be a challenging session. Conversely, some therapists were unaware of the tension building within the therapeutic relationship "I felt calm and was fully engaged", thus the rupture had come as a surprise, proving problematic, as detecting ruptures is essential in the rupture-repair process (Chen et al., 2018).

As the essence of human nature is innately intricate and profound, disconnection between individuals can become particularly complex when interpersonal relatedness is compromised. Although at times uncomfortable, the reparation of such disconnect allows clients to work through their interpersonal issues, thus enhancing therapeutic outcomes by demonstrating the integrity and strength within the therapeutic relationship through the process of coming back together again (Eubanks et al., 2018). The most common modalities trainee psychotherapists utilised in repairing rupture events were metacommunication and immediacy, naming the rupture with the client and providing time for the dyad to understand what had happened within the rupture event (Kline et al., 2019). Both trainee psychotherapists and clinical psychologists would also promote the client's interpersonal patterns and how the rupture within the session could be connected to similar situations in their personal life, ultimately disrupting the recurrent pattern (Coutinho et al., 2011; Schmidt, 2016). Furthermore, an important aspect Rogers (1961) highlights within the therapeutic relationship is the idea of the relationship between client and therapist being the therapy. Considering so, clinical psychologists were seen to support and reassure their clients as a form of intervention, emphasising that the therapeutic space was secure and safe even though clients were distancing themselves (Coutinho et al., 2011).

In some cases, therapists had recognised their own contributions towards rupture events, which is in line with Coutinho et al. (2011) findings. For example, during withdrawal and confrontational ruptures, clinical psychologists report experiencing feelings of confusion, guilt, and incompetency (e.g., "I was not being a good therapist") whilst also expressing feelings of not knowing what to do in the moment (e.g., "I didn't know where to go from there"). Aspland et al. (2008) findings were also evident where therapists report experiencing a dichotomy between interventions, wanting to ask painful questions, and not wanting to hurt the client's feelings. Consequently, during these difficult and tense times, a therapist

reported how the dichotomy affected their inner experience; "I withdrew, I cut the conversation short in order to not deal with that again" (Coutinho et al., 2011).

In contrast, positive experiences consisted of therapeutic work becoming more productive. For example, a therapist reports their sessions feeling more real, as reparation had heightened the dyad's feelings associated with the rupture event, leading to discussions surrounding misperceptions, miscommunications, client interpersonal relational issues, and configurations of transference (Kline et al. 2019; Schmidt, 2016). A therapist also reported the reparation process as a transformative experience for not only the client but also themselves; "We have become closer because we're more open and honest with each other … so it feels like our relationship has improved." Interestingly, the therapist's energy level also seemed to play a pivotal role in their experience of ruptures. For example, during a withdrawal rupture, a therapist reported feeling comfortable and close to their client, as they were not too tired, and any information presented was valuable in understanding their functioning. In contrast, during a confrontational rupture, feelings of being less present in the interaction occurred as a therapist reported feeling tired, and only half their attention was focused on their client's experience. Subsequently, the therapist felt guilty and incompetent, stating, *"I was feeling angry with myself because I hurt and disappointed the client"*. (Coutinho et al., 2011, p. 533).

Finally, assuming ruptures are an inevitability within therapeutic work, there is significance within ruptures being resolved for the continuation of therapeutic work alongside successful therapeutic change (Coutinho et al., 2011). According to Schmidt (2016), therapists could not provide many examples encapsulating the last phase, resolution. It is reasonable to believe therapists are not going above and beyond to reduce the probability of future ruptures, possibly due to unavoidable occurrences. It may also be possible that therapists are afraid of the client's response regarding modifications to the alliance or the therapist themselves to create a stronger bond. Nonetheless, the underrepresentation of the resolution stage may lie within its preventative nature, whereby ruptures in itself are inevitable and necessary for therapeutic change. Once a rupture has been detected and repaired, therapists may underestimate the significance of resolution due to the disruption in therapeutic work no longer being imminently distressing. However, the most common form of resolution was the collaborative effort between the dyad to re-establish or review therapeutic tasks and goals, realigning the treatment strategy to fit the client's needs better, and determining different approaches in the event a rupture occurs in future sessions. Overall, resolutions of the rupture always involve restoring the client's sense of power and control within the therapeutic relationship through the promotion of partnership; "*Okay, I'm going to do this with you."* (Kline et al., 2016, p. 1093).

Chapter 2: Purpose

Aims of the study

This research aims to explicate the counselling psychologist's experience of therapeutic ruptures within the therapeutic alliance with their clients. The research will initially gather a detailed account of the counselling psychologist's own experience of a therapeutic rupture with one of their clients. Secondly, the research will seek a deeper understanding of how the counselling psychologist identifies a therapeutic rupture and how they attend to it. Finally, if the rupture was resolved, how and what effect the rupture and repair had on the counselling psychologist and the therapy.

Personal reflexivity and the choice of research topic

Prior to the commencement of this research project, I was torn between topics that have in some ways saved me and those that delve deeper into the depths of my pain. Naïve to the world of counselling psychology, I was determined to research mindfulness inventions and how they have saved my life, considering the reality in which I was raised. However, the complexities within my mind overshadowed the beauty of mindfulness; the secret to living an authentic life inadvertently gifted me with momentary silence to listen and breathe. From the cultivated peace within, extensive conversations with my supervisor, and sleepless nights of reflection, my research topic emerged.

As I was raised *"in-between"* two different environments with two different perspectives on the world, interpersonal relationships throughout my life have been infused and pervaded with disconnection and rupture. From an early age, talk therapy has, in some respect, been a part of who I am, yet I never felt accepted or understood throughout the process. There is an aspect of me that does not want others to feel rejected or misunderstood, yet there is a fragment deep within that does. The therapeutic relationship represents *connection* between the therapist and client, a relationship that is in some ways sacred, a space in which clients who are deeply hurt tentatively seek in hopes of healing their suffering (Kottler, 2017). As a novice therapist, it is difficult to comprehend that ruptures, the very source of my pain, is 'part in parcel' of therapeutic success. Attaining in-depth accounts of a counselling psychologist's experience in recognising, repairing, and resolving ruptures could aid in evolving our understanding of therapeutic ruptures and how they perhaps allow insight into one's suffering. *"When another person makes you suffer, it is because he suffers deeply within himself, and his suffering is spilling over. He does not need punishment; he needs help. That's the message he is sending"* Thich Nhat Hanh (Thorpe, 2021, p. 9).

Reflecting upon my assumptions about the world and knowledge, I believe reality, as we know it to be, is constructed intersubjectively, formed socially and experientially through meaning and understanding.

What we have not learnt on our own through our experiences, senses, and intuitions, we learn from other human beings. Fundamentally, our knowledge is bound by the fact that we cannot separate ourselves from the information and experiences we know. In essence, we understand the world based on how we understand ourselves and others in the world. Therefore, based on my assumptions of the world, knowledge, and the study's aims, a qualitative scope is the most appropriate approach to employ. Qualitative research has also been closely linked with research and practice in counselling psychology (Thorpe, 2013), a career I intimately pursue. The alternative research method to traditional psychological methodology offers the potential to investigate the complexities and multifaceted nature of human phenomena (Morrow, 2007), the central theme of counselling psychology (Rennie, 1994; Williams & Hill, 2001). Paraphrasing McLeod's (2011) statement on qualitative research, it is suggested that the practice of qualitative research; finding meaning and understanding how meaning in the social realm has been formed, is in harmony with conducting psychological therapy itself. That is, to make new meaning, gain insight, understand, and discover how a client's personal meaning has been constructed.

Psychological therapy is a journey into the unknown. Clients bring to us overwhelming and emotionally charged content that we cannot hold at times (Kottler, 2017). Therapists need to find ways in which to live with the uncertainty and ambiguity inherent in the therapeutic relationship. In the same light, qualitative research requires one to leave the security of the known, maintain optimal distance from the data, and resist the temptation of premature closure (Thorpe, 2013). Inspired by the wise words of Winnicott (1949, p. 70), qualitative research is, in some respect, an attempt by the researcher to understand, resolve, and live with the uncertainty of a central personal conflict. This work represents an attempt on my behalf to wrestle with, understand, and tolerate the ambiguity of a deep-seated issue that has caused nothing but suffering in my life; interpersonal disconnection.

Chapter 3: Methodology and Method

Design

This study strives to reveal the counselling psychologists experience of therapeutic ruptures within the working alliance with their clients. An interpretative phenomenological analysis (IPA) approach was employed as it provides in-depth examinations of personal lived experience (Smith et al., 2009). Influenced by the work of Husserl, phenomenology strives to account for an individual's lived experience in its own right, rather than that of a pre-existing theoretical framework. IPA recognizes that examining human experience is an interpretive endeavor; humans are sense making organisms. Therefore, the researcher adopts the role of attempting to make sense of the participant trying to make sense of their experience of therapeutic ruptures with one of their clients (Smith et al., 2009). Whilst the researcher attempts to access the participants inner-world, access depends greatly upon the researcher's own conceptions, and highlights the universal inclination towards self-reflection. IPA is idiographic in nature, focusing on the individuals experience, and emphasises the uniqueness of such (Briggs, 2010). As the aim of the current study was to explicate the counselling psychologists experience of therapeutic rupture with their clients, IPA was recognized as appropriate to be used as an analytical tool.

Participants

According to Pietkiewicz and Smith (2012), when utilising an IPA approach, it is inappropriate to consider random or representative sampling as so few participants are interviewed; participants are selected purposely. Therefore, in accordance with IPA theoretical underpinnings, this study utilized a purposive sampling method to recruit participants, where the researcher's primary supervisor selected appropriate participants of a defined group with relevance and personal significance. The eligibility criteria are for the research subjects to be registered, practising counselling psychologists in New Zealand.

Ethical considerations

Prior to the recruitment of participants, AUT Human Ethics Committee granted ethical approval. The counselling psychologists who volunteered to participate were sent an information sheet, outlining the study's purpose, procedure, as well as the participants commitment, rights, and support. The information sheet outlined that all identifiable information would be removed, and pseudonyms of the participants choice would be used when referred to in the study.

Data collection

An IPA researcher's primary concern during data collection is to obtain rich, in-depth accounts of the participants lived experience. Thus, open-ended, semi-structured, one on one interviews were used. Semi-structured interviews enable the researcher and the participant to converse in real time. They also provide enough room and flexibility for new and unanticipated difficulties to surface, which the researcher may investigate further with more questions (Pietkiewicz and Smith, 2012). Seven open-ended questions were initially formulated and concentrated on exploration of mental phenomena including the participants observations, perceptions, interpretations, bodily awareness, memories, fantasies, emotions, feelings, desires, actions, and thoughts. The researcher and each of the four participants engaged in single one to one interview: each lasting approximately 60 minutes.

Data analysis

A reflexive thematic analysis method was employed to identify, analyse, and report patterns within the data formulated by the participants experiences. This method organizes, and describes the data collected in rich detail, whilst also posing as a more accessible form of analysis for researchers like myself, early in their qualitative research career (Braun and Clarke, 2006). It is important to mention that the themes emerging from the data do not simply 'reside' within the participants discourse but reside within the mind of the researcher. Interpretations of themes and patterns were critically discussed between the primary researcher and supervisor. This reflexive approach offered opportunities to facilitate and develop new insight. Although this theoretical approach limits the richness in detail of the data, it provides a more detailed analysis on specific aspects of the data such as the recognition, reparation, and resolution of therapeutic ruptures from the counselling psychologist's perspective (Braun and Clarke, 2006). Guided by Braun and Clarke's (2006) proposed 'six phases' of analysis, the listening and transcription of audiotaped interviews were analyzed.

1. **Familiarization:** Becoming familiar with interview transcripts (reading and re-reading) and generating ideas on the essence of the data, and what stands out; forming the foundation for the rest of the analysis.

2. **Coding:** Developing initial codes from the data with the research questions in mind. This process involves highlighting sections of data and generating 'codes' describing their content.

3. **Generating Themes:** This phase consists of collating initial codes into potential themes that capture the significance within the data.

4. **Review Themes:** Modifying and developing themes, ensuring they are useful and representative of the data.

5. **Defining Themes:** This stage involves the formulation of what each theme means and how the themes encapsulate the data.

6. **Write-up:** The final phase includes selecting quotes that entail the essence of the participants reported experiences and comparing the findings to existing literature.

Chapter 4: Results

This chapter presents the themes and sub-themes derived from the participant interviews. Data analysis revealed four primary themes and subsequent sub-themes which have been summarized below in Table 1.

Table 1: Summary of Themes

Primary Themes	Sub-Themes
Therapists Clearly Identifying a Therapeutic Rupture – "*Now we are in the midst of a real rupture"*	Discomfort in the countertransference *It's pretty easy to identify*
The Therapists Attempt at Repairing a Therapeutic Rupture – *"I'd like to help everyone, but I can't"*	Realities of practice *I didn't really get anywhere with most of that*
Resolving a Therapeutic Rupture – "*It was a big learning curve for me"*	*It was a beautiful moment* *Is the family, okay?* *So that's one change*
Understanding the Client	

Theme 1: Therapists Clearly Identifying a Therapeutic Rupture – "*Now we are in the midst of a real rupture"*

Drawing upon a quote from participant 4, the true essence underlying the identification phase of a therapeutic rupture is revealed. As the therapist becomes psychologically attuned toward their own countertransference and are able to attentively observe the clients non-verbal and verbal behaviours, the therapist begins to recognize they are now in the midst of a therapeutic rupture.

Discomfort in the countertransference - The therapist's ability to use countertransference as a tool in the identification phase of therapeutic ruptures.

"I have been empathetic to him, but I haven't… I've not been expressive enough for him… it's being like in a field of landmines and I'm kind of stuck there and I go almost quite dumb or quite numb. It's almost like no matter what I say here, I'm going to step on a landmine and therefore I don't. I don't say anything and I'm kind of frozen and that's when I know we are in the midst of a real rupture". (Participant 4)

The quote above exemplifies the therapist's inner thoughts and felt discomfort, comparing their rupture identification experience to being in a field of landmines, not knowing where to go or how to proceed. The therapist is in conflict with not being empathic or expressive enough for their client, recognizing their own contribution towards the rupture. In anticipation of stepping on a landmine [saying the wrong thing to the client] the therapist feels inadequate, numb, and locked in a frozen state. In recognition of their own countertransference, the therapist realizes, they are now in the midst of a real rupture.

However, as participant 4 says below, it is important to understand that it takes time, experience, and supervision to become aware of their own countertransference.

"For a while, we were in it repeatedly, we'd have kind of good points and would cycle back to this experience, and this went on probably all that year. Then I got some supervision about it and there was a real breakthrough moment". (Participant 4)

Below participant 3 reinforces the idea that the therapist's countertransference; their reaction to the client's transference can be used as important information. In this case, the identification of ruptures.

"If we get to the place, where we're really skillful, we can kind of use our own reaction as some really important information" (Participant 3)

Although the therapists countertransference can be utilized as important information in identifying therapeutic ruptures, the quote below by participant 2 demonstrates a different side; a side that causes the therapist discomfort.

"So, the earliest identification I had of it was as I was talking to her about not making another appointment… it was part of that conversation that I didn't sort of feel completely right or sit right with me… I reassured myself with "she's got a case manager and a good relationship with the case manager". There was a feeling like I'm pushing her aside" (Participant 2)

As the therapist sits with the feeling of pushing their client aside in the quote above, recognising they are in the midst of a rupture, it appears the therapist may be experiencing guilt. Consequently, the

therapist reassures themselves that the client has a case manager they can go to if the relationship does not work in therapy.

"It's pretty easy to identify" - The complexities within identifying therapeutic ruptures via client non-verbal and verbal behaviors; A juxtaposition.

"I think the first sign was seeing it in her, seeing her get up, seeing her body language change… just like this real little shift where she just got some tears in her eyes, and I saw her body go really tense. She was kind of answering questions really easily, and then after [rupture] it was kind of ask a question no response at all for a few minutes". (Participant 3)

In the example above, the therapist recognized they were in the midst of a rupture through the client's subtle shift in non-verbal behaviour followed by verbal withdrawal. This quote illustrates the therapist's attentiveness and awareness towards the identification of the rupture event.

Although it may seem easy to identify therapeutic ruptures based on the client's non-verbal and verbal behaviours, participant 3 highlights below the emotionally distressing complexities within a client's confrontational behaviour.

"It's pretty easy to identify it because it's clear from his being how he will either shut down in the session or he will become quite attacking towards me… putting me down and critiquing me… kind of calling out my limitations as a therapist, so it's very obvious. I'm here feeling actually quite incompetent… and I feel shame about that incompetency (Participant 3)

In contrast, the quote below exemplifies the therapist being completely unaware of their clients' dissociating behaviors during session as the therapist was experiencing varying levels of physical pain.

"So… the client identified it for me… I literally didn't even know because I was feeling sick with sore, really sore ears" (Participant 1)

Participant 1's quote above, highlights the importance of the therapist's ability to be in the present moment with their client, and how inattentiveness may result in a clients dissociating behaviour going unseen, resulting in a rupture event being missed.

In some cases, the identification phase of the rupture repair process is not as clear and defined as it may seem. The quote below demonstrates the overwhelming nature of rupture recognition in that there may not be simply one rupture marker, but many, as participant 2 said:

"I don't know if it was something on her face, or what message I felt she was getting?... It semi felt to me... I don't know, if this was me or her or countertransference or whatever". (Participant 2)

Theme 2: The Therapists Attempt at Repairing a Therapeutic Rupture – *"I'd like to help everyone, but I can't"*

Derived from a quote by participant 2, in a perfect world, therapists would like to help everyone that comes through their doors; yet they are only human. In reality there are innumerable personal and practical limitations, barriers, and expectations that influence their ability to repair therapeutic ruptures.

Realities of Practice - How the reality of clinical practice influences the counselling psychologist's ability to repair therapeutic ruptures.

"Unfortunately, there's time constraints with the DHB... I think I saw her for five sessions. I typically see people back-to-back one after the other… I don't always have as much time as I'd like pre [session] when that person's turning up to have a good think about what's happening and what I'd like to do, what's been working, what's not and I don't have a lot of time to debrief post [session] with myself. If there's any attempts, I guess validating that if she wanted to try and cut down it wasn't something she had to do on her own… So, there's more attending I can do, I probably didn't attend to it as well as I would have liked to. It is tricky. Again, with the time constraints that I have of being able to follow up as much as I'd like to do an intensive follow up of how things going. Yeah, perfect world. I'd love to be able to do at least three full on phone calls, messages, text". (Participant 2)

The quote above exemplifies the reality of working with clients within the context of the DHB and the difficulties associated with repairing a therapeutic rupture. In this case, the therapist is limited to only five sessions to understand, formulate, and support their clients' presenting issues. In addition, seeing back-to-back clients limits the therapist's ability to debrief and reflect upon the rupture event in depth, limiting to therapists' ability to attend to the rupture.

Furthermore, the quote below illustrates how the therapist navigates and rationalizes the constraints in which they are governed by:

"I recognize being able to be as good a therapist as I would like to be is not possible. The ideal time that I'd like to spend on formulating and planning and working out and mental debriefs of what I can do differently and then noting that and getting everything up to date. But I kind of figured that maybe I'll kind of rationalize in my head that there's maybe half or 3/4 of a job and that's better than the person having nothing at all. So, if I can at least give them a semi positive experience of being able to access some sort of psychology without too much of a wait list or things getting worse". (Participant 2)

In contrast, the quote below illustrates the realities of private practice.

"Because it's private practice, we can kind of do whatever we want. We can reduce the frequently, we can take a break and then you can come back or whatever. It's your space, and your kind of paying for it, so you know you can get what you want out of it". (Participant 3)

Although the quote below by participant 2 may portray a unique experience, there is a sense of indescribable pressure placed upon one therapist to perform.

"Unfortunately, there's one psychologist for the addiction service… and there's about a four month wait for adult mental health… that's not great, but if you want some psychology, then I'm it basically… there's pressure on me to try and be it for everybody, which is unrealistic as well, I guess. I'd like to be able to help everybody and I can't and not everybody's a good match for everybody as far as human beings. So, I may not be a good match for everybody". (Participant 2)

Furthermore, the quote below by participant 1 highlights the pressure of having dealt with their own problems in order to ensure the session is focussed on the client and not the therapist. However, there are circumstances in which honesty and an element of self-disclosure is required to attend to a therapeutic rupture.

"It's kind of tricky… it isn't my job to tell clients about my stuff, it's expected that I've dealt with all my stuff. I don't wanna burden the client with my problems you know… I'm on antibiotics and I've got pain in my ears and that was my rationale for not saying anything at first… however, you can at least say something… potentially *it's gonna cause a rupture if you are not honest about it." (Participant 1)*

"I didn't really get anywhere with most of that" - Counselling psychologist's utilizing therapeutic alliance intervention strategies to repair therapeutic ruptures; it is not as straight forward as it may seem.

As the therapeutic bond becomes strained, the therapist attempts to repair the rupture with an emphasis on *clarifying a misunderstanding* as participant 1 said:

"I owned it, I was able to say I am so sorry; I was happy to see you after all that time. And to be honest, I said, look, I had an ear infection last week and so when you came in and you were sort of standing 3 meters away from me, I didn't catch what you said, and I owned it and I said it's taught me a lesson". (Participant 1)

Below, participant 4 recognised the need to express themselves to their client, yet had to be very careful in not coming across as a victim. This quote demonstrates the complexities within using metacommunication as an intervention strategy, and how the therapist has identified their own feelings and used them as a point of departure for collaborative exploration, attempting to repair the rupture.

"I had to find a way to express my vulnerability with him… I had to be very careful not to come across from a victim perspective but to be really honest and vulnerable and show my humility just as a human being with him. I worked quite hard to get to a point where I could express to him this experience, I was having in the relationship to him. So basically I just expressed the process in a way and found words to express what was going on for me and to tie that back to him and his sense of isolation". (Participant 4)

The quote below displays the therapists attempt to repair the rupture via immediacy, inviting the client to look at what is going on in the moment between the therapeutic dyad. However, this attempt was unsuccessful where the therapist then moved toward clarifying any misunderstandings that may have occurred. As both attempts were ineffective in repairing the rupture, the therapist suggested a relaxation technique. This quote illustrates the difficulties within repairing therapeutic ruptures, and the reality in which therapists may experience.

"I can see that you're upset, you're feeling a little bit tense… I'm wondering what's going on for you? So, trying to kind of explore what was happening between us. Then it was me verbally trying to provide a lot of reassurance and kind of explain what I had seen and what I had meant, I didn't really get anywhere with most of that... and then it was, let's maybe just take a few really deep breaths together". (Participant 3)

Theme 3: Resolving a Therapeutic Rupture – "*It was a big learning curve for me*"

In some instances, the successful resolution of ruptures was described as a beautiful moment, yet the unsuccessful resolutions were the ones that seem to sit with the therapists a little more. Despite the outcome of the rupture event, there is always something to take away from each and every experience.

Resolved – *"It was a beautiful moment"*

On the surface, the quote below illustrates the therapists feeling of successfully resolving a therapeutic rupture.

"It was good… felt very gratifying, very gratifying" (Participant 1)

However, there is also another side to resolving therapeutic ruptures in which the therapist experiences a release from anxiety or stress. A rupture event can be at times distressing for both the client and the therapist. In resolution of such disconnection there is a sense of relief on the therapists part whereby collaboration is resumed and the work of therapy can continue as participant 1 says below:

"It was a relief" (Participant 1)

The quote below illustrates the power of physical touch and how a deep-felt experience *"a beautiful moment"* can not only resolve a therapeutic rupture, but can also deepen the therapeutic relationship.

"I offered him just to reach out and take my hand... I wanted him to have a deep-felt experience of me being with him that he could take away… he took my hand and then he just broke down in tears. It was so moving for me because I could feel the shift, you know, the change and the pureness of it. So now that we've broken through that rupture, it's significantly deepened. His awareness for himself and what happens but also deepened our work, and it's deepened the therapeutic relationship a lot. (Participant 4)

Unresolved – *"the ones that sit in the front of my head"*

"So most therapeutic ruptures… the ones that sit in the front of my head… are the ones that have not been successfully resolved or there's not at this point been a positive outcome. I guess I don't necessarily remember the successfully managed ruptures the same way as I do the unsuccessfully managed ones". (Participant 2)

The quote above embodies the essence of how an unresolved therapeutic rupture may sit in the mind of a therapist. It is likely therapists reflect upon unsuccessfully managed ruptures more than those with positive outcomes. It appears that therapists may feel a sense of disappointment or guilt perhaps, not being able to resolve the therapeutic rupture to restore collaborative connection.

Participant 3 reflects upon the experience of not resolving their therapeutic rupture below saying:

"It was really gutting that happened" (Participant 3)

As unresolved ruptures sit at the front of the therapist's mind reflecting in disappointment and disheartened about the unsuccessful outcome, sometimes there is simply no resolution; at times there is no light at the end of the tunnel and the therapist must sit with that discomfort and ambiguity, not knowing if their client or their client's family are okay. This is an experience that is part in parcel of the work counselling psychologist's do as participant 2 says:

"Sometimes… there is no resolution, and you just have to sit with the discomfort, it is what it is" (Participant 2)

"So that's one change"

In the quote below, participant 3 reflects upon their unsuccessful rupture resolution experience that has evoked a significant amount of emotional distress, and states that evening work is no longer an option.

"I was seeing her in the evenings after work late at night… just sort of meant that they were in my head a little bit more… this might sound like sort of a bizarre thing to learn, but… I don't do any evening work anymore, I just find that particularly difficult. So that's one change". (Participant 3)

It appears that the therapist reflects upon the experience as something that was particularly difficult professionally and perhaps even personally. The evening work may have begun to seep into the therapists personal life as quoted above.

"There's, how do I handle that in a different way?... do I need to do pre work?... Do I need to have a transition appointment or do that then book another appointment in? And then I can always swap that with a case manager if I need to, but they've got a time that they're gonna be here, or there's a commitment that we're going to have a chat if nothing else, just to have a formal handover. I guess that's the change in work that I'm looking at". (Participant 2)

The quote above illustrates the therapists inner conflicts in reflection of the unsuccessfully resolved therapeutic rupture. It appears the experience has influenced the therapist to step back, re-evaluate, and make the necessary adjustments for their future work.

In some circumstances, rupture events may pose as an opportunity to learn. In this case, the therapist has learnt if they are physically unwell, to make the client aware or to cancel the session completely as participant 1 below says:

"As I say, it was a big learning for me… if I've got something, some illness that might impact my ability to hear or see or whatever, then I need to be clear about that or maybe cancel my sessions for the day, you know?" (Participant 1)

On a deeper level, the quote below displays how influential rupture events can be on the therapist's personal and professional life.

"I think I've experienced the biggest change myself personally and professionally from working with him. He has been such a teacher to me in terms of how it works and what's really changed for me, I am much more aware now about the types of clients and their needs. Rather than coming from a head based like kind of logical perspective like to really drop down into my heart, like into my humanity and just be much more emotive and work from that relational perspective and just be much more real." (Participant 4)

Through the process of coming back together with their client, the therapist has become significantly more sensitive toward their clients and their needs. Furthermore, it is possible, the therapist was initially

afraid of "*dropping down into their heart"* to be more real, and it was safer to take a logical perspective with clients. Yet, through experiencing the rupture event, the therapist had realized or was placed in the position to take a leap of faith and be more emotive and more real; a complete shift in perspective profoundly influencing their personal and professional life.

Theme 4: Understanding the Client

Beneath the dysfunctional dance of therapeutic ruptures, lays the therapist's ability to *'live in the skin of their clients'* and hold a unique sensitivity toward the client's personality structure; the client's history, presenting problems, the dynamic within the room, and an attuned reflexivity towards their own countertransference. From the data, the recognition, reparation, and resolution phases of therapeutic ruptures were significantly influenced by the therapist's understanding of their client, and an example can be seen below.

"She was coerced into leaving her son behind, and at the time she thought it was temporary… there's a lot of self-blame on her responsibility for that happening… drinking up to two bottles of wine a day. So, I said, look, it's really hard for me to work with you if you're still drinking 2 bottles of wine every single night. And so, she said, I can stop and do it on my own. Where the rupture occurred, I think I said to her I won't make another appointment with you; I will discuss this with the case manager and see if we can work out a plan".
(Participant 2)

Interpreting the quote above, the client was coerced into leaving her son behind where there is a deep-felt sense of self-blame, drinking two bottles of wine per day to cope with the pain. Whilst considering the context in which the therapist finds themselves in, the suffocating pressure and time constraints may have inhibited their ability to understand their client further than what is presented on the surface. Although the client's coping behaviour is maladaptive and risky, it is only a symptom on the surface for the pain beneath. Rather than trying to explore and understand the client's inner pain, the therapist was focused on the drinking behaviour, threatening to give up on the client if the drinking behaviour did not reduce significantly. Furthermore, it appears the therapist's refusal to book future appointments reinforces the idea that the therapist has indeed given up, just like the client had given up her son. The client ultimately withdraws from the therapist and the service itself. In any case, the therapist was limited in their understanding of the client, negatively impairing the rupture repair process.

"And then when I saw that she was upset, I guess my thinking was immediately she's perceived that as a rejection because, you know, she's had this rejection from her partner and many other people in her life. I guess that instinct of trying to clarify what I meant and provide a lot of reassurance and you know, again recognition that this was like probably her secure attachment, her safe space… but I do think that conversation would have impacted our relationship. So, I gave her lots of options, like meet next week or take a break of any, any length of time that you

like or not book another session. And you know, you can e-mail me when you've had a think or not. We took a three-week break… that was what she asked for specifically. So we went into a lockdown. I offered her something online and she said no… we came out of the lockdown and I got in touch and offered her an appointment… she said actually, like she'd rather take a break (Participant 3)

As rejection has played a significant role within the client's life in the quote above, the therapist recognized immediately that what they had said had been interpreted by the client as rejection. In reflection, it appears that the therapist had realized they were the clients only secure attachment and safe place, but the rupture event had ultimately compromised their therapeutic relationship. It seems apparent that the therapist's realization was too late, and the client withdrew. As the client felt rejected and unwanted, the various options proposed by the therapist had further exacerbated these feelings. Once New Zealand came out of lockdown, it appears the rupture had ended the therapeutic relationship as the client did not return to therapy.

"She's a very tricky, super sensitive client… So in a way it didn't surprise me that this happened. When you've been sexually abused, you don't trust anyone. Trust is something that is very hard earned and when you lose the trust it can take a while for them to build it up again. In recognition of the rupture, *she knew that I wasn't gonna bite her head off… but I think because I owned it and because I gave her quite a valid reason it was obvious I wasn't just making it up". (Participant 1)*

The quote above exemplifies the therapists understanding of the therapeutic rupture in terms of the clients history and personality structure. As the therapist recognises the client's tricky and sensitive nature alongside her traumatic past, the rupture event came as no surprise. Although the client had identified the therapeutic rupture, this very act displays the trust embedded within the therapeutic relationship and how that trust was a pillar for the client to lean on in not only being courageous enough to raise the issue, but to also trust the therapists truth, and resolve the therapeutic rupture successfully.

"His mother is quite narcissistic and has been very critical to him and his life. When he came to therapy with me… in some ways I and how I am, represented a lot of commonalities between him and his mother… Quite often what happens is when I try to be empathetic towards him, he dismisses it… or he has become quite confrontational, putting me down and critiquing, kind of calling out my limitations… So basically I just expressed the process in a way and found words to express what was going on for me and tied that back to him and his sense of isolation… this was the essence of his work, this was the essence of what was happening for him in his life and other relationships. It's deepened the therapeutic relationship a lot". (Participant 4)

Interestingly, the therapist recognizes the parallel between the client/mother relationship and how the therapeutic relationship between client and therapist shares similarities. As the therapist tries to

empathize with the client, the attempt is quickly dismissed or met with confrontation just as the client's mother may have dismissed or confronted her son. With time and supervision, the therapist perhaps became aware of the clients need for a sense of love, affection, and humility. Through this understanding, the therapist attempts to express their feelings in how the client is making them feel, tying them back to the way in which the client is feeling; isolated, shameful, incompetent, and abandoned. As the therapist holds this unique understanding of the client's personality structure, the therapist recognized that the rupture process itself; disconnecting from the therapist just as the client had disconnected from his mother and coming back together again, was the very essence of the client's therapeutic work. In resolution of the rupture event, the therapeutic relationship deepened significantly where the dyad can now explore together on a greater level.

Chapter 5: Discussion

This research aimed to explicate the counselling psychologists lived experience of therapeutic ruptures within the therapeutic alliance with their clients. A reflexive thematic analysis method was utilised to identify, analyse, and report patterns within the data formulated by the therapists lived experiences. This method was employed to add depth and richness to the existing literature by revealing the many complexities within the rupture-repair process, namely the identification, reparation, and resolution phases. This chapter will discuss and compare the emergent themes to the existing literature, after which the limitations, implications for practice, and suggestions for future research will be reflected upon.

Four primary themes emerged from the therapist's lived experiences: Therapists Clearly Identifying a Therapeutic Rupture – *"Now we are in the midst of a real rupture"*, The Therapists Attempt at Repairing a Therapeutic Rupture – *"I'd like to help everyone, but I can't"*, Resolving a Therapeutic Rupture – *"It was a big learning curve for me"*, and Understanding the Client. The first three themes (identification, reparation, resolution) will be discussed individually to illustrate each rupture phase. The final influential theme (understanding the client) will be discussed illustrating how it forms the basis of the entire rupture-repair process.

Identification

Decades of literature on the therapeutic rupture demonstrate that the therapeutic relationship and the therapist themselves have a significant effect on treatment success (Ackerman & Hilsenroth, 2003; Horvath et al., 2011; Wampold, 2015). Consistent with these findings, empirical research conducted by Talbot et al. (2019) propose that the therapist's ability to identify therapeutic ruptures accurately and efficiently is required to engage in the rupture repair process. Similarly, this was evident in the findings of this study; however, it is not as straightforward as it may seem. Similar to the findings of Schmidt (2016), during the identification phase, therapist's spoke about noticing their client's non-verbal (e.g. tears in the client's eyes, client's body became tense) and verbal behaviours (e.g. client providing minimal responses in session, client putting therapist down and calling out their limitations) in recognising a rupture event was taking place. These findings are in line with the conclusions of Schenk et al. (2019), stating that ruptures manifest through the client's either becoming withdrawn or confrontational toward the therapist, illustrating that a high level of attentiveness and awareness by the therapist is required during the identification phase of the rupture.

Whilst identifying therapeutic ruptures may seem explicit through the observation and recognition of client markers, sitting beneath the superficial layer of rupture identification is a complex and emotionally distressing reality. For example, one therapist reported feeling sick and experiencing physical pain that interfered with their ability to become aware of their client's dissociative behaviours.

Similar to the findings of Chen et al. (2018), the client identified the rupture coming as a shock to the therapist. Although therapists work in a culture of one-way caring (Guy, 2000), in which they are expected to be empathic, compassionate, and patient toward their client without expectation of receiving such care in return. This example identifies the significance embedded within the therapist's ability to hold a balanced awareness of their clients behaviours, while simultaneously recognising their own needs and interfering factors. Suppose a factor is interfering with the therapist's ability to be present with their client (e.g. feeling sick), especially in identifying a therapeutic rupture. In that case, it is the therapist's responsibility to monitor rupture signals from both the client and themselves, as left unnoticed, may potentially harm the therapeutic relationship, reduce treatment benefits, and encourage early client dropout (Talbot et al., 2019).

In more depth, as therapists begin to confront therapeutic ruptures, they tend to experience difficult emotional responses as part of their countertransference (Safran et al., 2011). It is well documented that some therapists are better than others in countertransference management; however, some authors have proposed that the therapist's self-awareness of their own emotional reactions allows for an enhanced sensitivity toward the identification of ruptures (Van Wagoner et al., 1991; Talbot et al., 2019); a phenomenon observed throughout this study. Therapist's spoke about getting to a place where they are skilful enough to use their countertransference as necessary information. For example, a therapist compared their rupture identification experience to being in a field of landmines as their client would behave in a hostile and confrontational manner. Eubanks-Carter et al. (2015) suggest that the therapist's awareness towards their emotional reactions leads them to become psychologically attuned to shifts that take place within the therapeutic relationship in the present moment. As the therapist reflected upon their experience, no matter what they said, how they said it, or if they were being empathic or expressive enough toward their client, they felt inadequate, numb, and locked in a frozen state. In addition to supervisory support, time, and experience in sitting with the discomfort in the countertransference, the therapist realised they were now in the midst of a rupture.

One unique finding within this study reveals a side to countertransference that brings about actual emotional discomfort for the therapist. Although the therapist's countertransference can be used to identify therapeutic ruptures (Van Wagoner et al., 1991; Talbot et al., 2019), it is important to recognise that the therapist is human. Therefore, as therapists sit with their countertransference and experience feelings such as inadequacy, numbness, or guilt, how might these feelings begin to affect the therapist, personally, if not professionally? To illustrate this notion, a quote will be used from therapist 2 below.

"So, the earliest identification I had of it was as I was talking to her about not making another appointment… it was part of that conversation that I didn't sort of feel completely right or sit right with me… I reassured myself

with "she's got a case manager and a good relationship with the case manager". There was a feeling like I'm pushing her aside" (Therapist 2).

In the quote above, the therapist looks to be experiencing guilt whilst they sit with the feeling of pushing their client aside and recognise they are now in the midst of a rupture. Although they have successfully identified the rupture, the guilt which they feel is uncomfortable. Consequently, the therapist reassures themselves that the client has a case manager they may turn to if the therapeutic alliance fails during therapy. The therapists self-reassurance demonstrates a genuine human concern toward their client to ensure their own piece of mind that their client will be okay if their therapeutic alliance were to discontinue. Fundamentally, countertransference can be used to identify therapeutic ruptures and has displayed efficacy throughout this study. However, with countertransference comes real human feelings that may cause the therapist actual discomfort. *Is it essential to debrief or seek supervisory support in sitting with the discomfort?*

Reparation

Once a therapeutic rupture has been identified, it is the therapist's responsibility to take the necessary measures to restore connection within the therapeutic relationship. Although challenging at times, the act of restoring connection between the therapeutic dyad helps clients work through their interpersonal issues, thus improving therapeutic outcomes by demonstrating the integrity and strength within the therapeutic relationship through the process of coming back together again (Eubanks et al., 2018). Similar to the findings of Kline et al. (2019), metacommunication, immediacy, and clarifying misunderstandings were the therapist's most commonly used interventions to repair therapeutic ruptures. However, this study highlights the complexities of utilising such modalities and the need for therapists to take caution when repairing therapeutic ruptures. To exemplify, a quote by therapist 4 will be used below to illustrate the complexities of using metacommunication.

"I had to find a way to express my vulnerability with him… I had to be very careful not to come across from a victim perspective but to be really honest and vulnerable and show my humility just as a human being with him. I worked quite hard to get to a point where I could express to him this experience, I was having in the relationship to him. I get frozen and numb and what I'm realising is that when I go frozen and numb and I don't have the words to express this to you, you experience me as being cold and aloof and you feel isolated and abandoned by me. So basically I just expressed the process in a way and found words to express what was going on for me and to tie that back to him and his sense of isolation". (Therapist 4)

In the quote above, the therapist expressed their vulnerability to the client in a way which ties both therapist's experiences together into one therapeutic experience. Because the therapist felt frozen and numb, they were unable to find the words to express their experience. Consequently, the client

experienced the therapist as being cold and aloof, resulting in the client feeling isolated and abandoned. In an attempt to step back from the dysfunctional dance, the therapist communicated the process that had transpired by identifying and expressing their own feelings as a point of departure to repair the relational disconnection between the therapeutic dyad. The rupture repair intervention may not have been effective if the therapist had only identified their own feelings, neglecting to tie the experience back to the client. In one instance, a therapist attempted to repair a rupture via immediacy, inviting the client to look at what is happening in the moment between the therapeutic dyad. This attempt was unsuccessful, and the therapist then moved toward clarifying any misunderstandings that may have occurred. Unfortunately, as both attempts were ineffective in repairing the rupture, the therapist suggested a relaxation technique. This finding from the study portrays the reality of practice, where rupture repair interventions are employed, yet nothing seems to be effective in repairing the alliance rupture. This is an experience that may evoke feelings of hopelessness or inadequacy within the therapist (Werbart et al., 2020); *how might the therapist proceed?*

With the exception of attachment patterns, and the therapist's ability to identify and repair ruptures, no literature was found which discusses how the reality of practice hinders the therapist's ability to repair therapeutic ruptures (Miller- Bottome et al., 2018; Walser & O'Connell, 2021). However, this study found that therapists practicing in the context of the District Health Board, experience various limitations and barriers that hinder their ability to repair therapeutic ruptures. For example, a therapist spoke about being limited in the number of sessions they had with their clients (e.g. five sessions) to understand, formulate, and offer support for their client's presenting problems. If a rupture occurs during these five sessions, *how might a therapist navigate the rupture-repair process while also providing adequate support for their client's needs considering the time constraints?* Additionally, the therapist said they were seeing back-to-back clients, one after the other limiting their ability to debrief and reflect upon the rupture event in depth, hindering their ability to effectively repair the therapeutic rupture. In contrast, the data suggests that therapists working in private practice have significantly more time, space, and freedom to work with their clients, as therapist 3 says below:

"Because it's private practice, we can kind of do whatever we want. We can reduce the frequently, we can take a break and then you can come back or whatever. It's your space, and your kind of paying for it, so you know you can get what you want out of it". (Therapist 3)

Furthermore, the data suggests there is an underlying expectation for all therapists to have dealt with their own problems to ensure the therapy session is focused primarily on the client and not the therapist. In reality, therapists are humans too, and deal with the inevitabilities of life just as clients do. To illustrate, a therapist said they were unable to hear their client clearly due to illness, causing a rupture

between the two therapeutic therapists. Initially, the therapist did not want to burden the client with their problems of being sick, yet through honesty/self-disclosure, the therapist had clarified the misunderstanding (e.g. I could not hear you because I was sick) repairing the rupture event. In reflection, there is a fine line between appropriately using honesty, just as therapist 4 had used metacommunication, and burdening the client with their problems. Finally, I would like to highlight a significant yet upsetting finding within this study that illustrates a sense of indescribable pressure placed upon one therapist to perform. Therapist 2 states below:

"Unfortunately, there's one therapist for the addiction service… and there's about a four month wait for adult mental health… that's not great, but if you want some psychology, then I'm it basically… there's pressure on me to try and be it for everybody, which is unrealistic as well, I guess. I'd like to be able to help everybody and I can't and not everybody's a good match for everybody as far as human beings. So, I may not be a good match for everybody". (Therapist 2)

Although the experience described above may be unique, I would like to emphasise one specific point that may be relevant to all therapists at all levels. Considering the limitations, barriers, and expectations of this situation, how might one therapist, with a four-month waitlist and an insurmountable amount of pressure trying to be *it* for everybody, adequately support their client's needs, let alone effectively repair a therapeutic rupture?

Resolution

It is important that therapeutic ruptures are resolved, not only for the client, allowing for the continuation of therapy to occur but also for the therapist (Coutinho et al., 2011). This study shares similar findings to Schmidt (2016) in that therapists discussed different approaches with their clients to mitigate future therapeutic rupture of the same nature. An example from the study to illustrate this finding can be drawn from a quote by therapist 1 below:

"As I say, it was a big learning for me… if I've got something, some illness that might impact my ability to hear or see or whatever, then I need to be clear about that or maybe cancel my sessions for the day, you know?" (Therapist 1)

The quote above illustrates the approaches therapist 1 has decided to take in the event they are physically unwell in the future to avoid a similar rupture. However, that is the extent to which the findings of this study within the resolution stage are similar to the existing literature. As this study aimed to explicate the counselling therapists lived experience, the findings of this study provide a unique insight into the inner world of the counselling therapist during rupture events that are both

resolved and unresolved. Therapists who successfully resolved their therapeutic rupture with their client expressed feeling good and gratifying. However, there is also another side to the resolution of ruptures in which therapists expressed feeling a sense of relief. As both client and therapist negotiate clearer goals of therapy or experience a strain in their bond, the strength and integrity of the therapeutic relationship, alongside the client's trust, is in question (Goldsmith, 2015; Eubanks et al., 2018). There is a sense of relief on the therapist's side when such disconnection is resolved, as therapeutic collaboration may continue.

Interestingly, discussions surrounding physical touch in psychotherapy are difficult, as conversations begin to arise about the confusion of touch, the therapist's lack of experience, misunderstandings between therapist and client, fears of sexual provocation, and physical aggression (Westland, 2011). Yet, the literature on physical touch in psychotherapeutic settings demonstrates various reasons for its inclusion and has shown utility for clients who are emotionally and physiologically dysregulated, aggressive, emotionally defended, and traumatised (Westland, 2011). In line with this study, physical touch in psychotherapy has been seen to deepen the experience of the therapeutic relationship (Older, 1982; Cornell, 1998) and can be illustrated by a quote from therapist 4 below:

"I offered him to reach out and take my hand... I wanted him to have a deep-felt experience of me being with him that he could take away… he took my hand and then he just broke down in tears. It was so moving for me because I could feel the shift, you know, the change and the pureness of it. So now that we've broken through that rupture, it's significantly deepened. His awareness for himself and what happens but also deepened our work, and it's deepened the therapeutic relationship a lot. (Therapist 4)

Unresolved ruptures have been associated with poor alliance connection, the therapist's inability to acknowledge the rupture, conflicting agreements about therapeutic goals, and transference issues (Haskanye et al., 2014). Although this study does not offer insight into the factors associated to unresolved ruptures, therapists spoke about therapeutic ruptures, especially those that are unsuccessful, as the ones that sit in the front of their heads the most, reflecting upon the experience as *"gutting"* that it happened. According to Vaish et al. (2008), there is considerable research pertaining to the asymmetry in how people utilise positive vs. negative information to make sense of their world. Specifically, people tend to exhibit a proclivity toward attending to, learning from, and using negative information substantially more than positive information across various psychological situations and tasks. Therapists likely reflect upon unsuccessfully managed ruptures more than those with positive outcomes due to the negative feelings the rupture experience may evoke. Perhaps therapists feel a sense of disappointment or guilt, unable to resolve the therapeutic rupture to restore the collaborative connection between the therapeutic therapists. Whilst unresolved ruptures sit in the front of the therapist's mind;

sometimes there is simply no resolution. Ultimately, the therapist must sit with that discomfort and ambiguity, not knowing if their client or their client's family are okay. This is an experience that is part in parcel of the work counselling therapists do, as therapist 2 says:

"Sometimes… there is no resolution, and you just have to sit with the discomfort, it is what it is."
(Therapist 2)

The study also found that no matter the outcome of the rupture event, there was always something to take away from each experience. Whether the therapist attends regular personal psychotherapy, engages in psychological workshops to enhance self-development, or keeps up to date with the latest evidence-based practice, the therapist's career is a lifelong journey of education and learning (Beidas & Kendall, 2010; Åstrand & Sandell, 2018). In the same light, the findings of this study suggest that therapeutic ruptures, irrespective of the outcome, have a profound effect on the therapist's personal and professional life. On the surface, an unsuccessful rupture resolution influenced a therapist to acknowledge that evening work was no longer suitable. Through experiencing the emotionally distressing nature of rupture events (Eubanks et al., 2018), the therapist recognised that working during the evening may have begun to seep into their personal life, realising it was time for a change.

The study also found that unsuccessfully resolved ruptures evoked a process of reflection within the therapist, as therapist 2 says below:

"There's, how do I handle that in a different way?... do I need to do pre work?... Do I need to have a transition appointment or do that then book another appointment in? And then I can always swap that with a case manager if I need to, but they've got a time that they're gonna be here, or there's a commitment that we're going to have a chat if nothing else, just to have a formal handover. I guess that's the change in work that I'm looking at". (Therapist 2)

The quote above illustrates an experience that all therapists may encounter at one point or another in the event a rupture is unsuccessfully resolved. The experience influenced the therapist to step back, re-evaluate, and make the necessary adjustments to their future work.

On a deeper level, a therapist reflects upon their successful rupture resolution as an experience that profoundly impacted their life. Therapist 2 says below:

"I think I've experienced the biggest change myself personally and professionally from working with him. He has been such a teacher to me in terms of how it works and what's really changed for me, I am much more aware now about the types of clients and their needs. Rather than coming from a head based like kind of logical perspective

like to really drop down into my heart, like into my humanity and just be much more emotive and work from that relational perspective and just be much more real." (Therapist 4)

Coutinho et al. (2011) found that as the therapist confronts difficult and tense times within the rupture process, there is a dichotomy within. The quote above illustrates the therapist's dichotomy between taking a safer, more logical route to resolution (e.g. not getting too close to the client, offering to change therapeutic goals) and adopting a more relational perspective. Initially apprehensive, the therapist realised or was placed in the position to take a leap of faith and be more emotive and authentic. By coming back together with their client and adopting a more relational approach, the therapist says they have become significantly more sensitive toward their other clients alongside their needs.

Understanding the Client

Evidence suggests that the strength of the therapeutic relationship is the strongest predictor of psychotherapeutic outcomes (Safran et al., 2011). However, regardless of the therapist's intent or expertise, a strong therapeutic relationship will experience times of rupture; as Pinsof (1995) suggests, these crises are not just common but inevitable. The existing literature on therapeutic ruptures demonstrates various ways in which therapists can identify (e.g. observe client verbal and non-verbal behaviour), repair (e.g. metacommunication), and resolve (e.g. discuss future approaches with the client) therapeutic ruptures, however, this study ventures further by surfacing the importance of the therapist's ability to understand their client; the foundation of the entire rupture-repair process. Beneath the dysfunctional dance of therapeutic ruptures lies the therapist's ability to *live in the skin of their clients* and hold a unique sensitivity toward the client's personality structure; the client's history, presenting problems, the dynamic within the room, and an attuned reflexivity towards their own countertransference. This study found that the therapist's understanding of their client significantly influenced the outcome of the rupture-repair process.

According to Rogers (1975), empathy is one of the most delicate yet effective ways in which therapists can understand their clients and monitor the effecting changes in personality and behaviour. To be with a client empathically means entering their private perceptual reality and feeling completely at ease within it. Living in the client's skin involves an attuned sensitivity toward the client's labyrinth of felt meanings, moving within it without judgement, sensing meanings of which the client is superficially aware of, and communicating these senses about elements of which the client is fearful. From the data, all therapists in this study understood their client, but to varying degrees. To demonstrate how the therapist's ability to understand their clients influences the outcome of the rupture-repair process, quotes by therapists will be interpreted and discussed. The quote by therapist 2 below is an example about how the therapist fails to fully understand their client and its effect on the rupture.

"She was coerced into leaving her son behind, and at the time she thought it was temporary… there's a lot of self-blame on her responsibility for that happening… drinking up to two bottles of wine a day. So, I said, look, it's really hard for me to work with you if you're still drinking 2 bottles of wine every single night. And so, she said, I can stop and do it on my own. Where the rupture occurred, I think I said to her I won't make another appointment with you; I will discuss this with the case manager and see if we can work out a plan". (Therapist 2)

In the quote above, therapist 2 recognises that their client was coerced into leaving her son behind and was drinking up to two bottles of wine per day to cope with a deep-felt sense of self-blame. Rather than exploring and understanding the client's deep-felt sense of self-blame and what it means to her, the therapist focused on the drinking behaviour, threatening to give up on the client if the drinking behaviour did not reduce significantly. Perhaps this reaction could be understood as poorly managed countertransference hindering the therapists ability to empathise with their client. Although the client's maladaptive coping behaviour poses a significant risk, it is not the whole story. It is the therapist's responsibility to look beyond the seen, to analyse, interpret, and understand more than what may be evident, and to decode the meaning behind the client's presenting problems (Matthews, 2008). In considering the therapists unique circumstance (e.g. only available therapist in service, time constraints, 4-month waitlist), it becomes difficult to imagine how they may understand their client further than what is presented on the surface. In light of the therapist's lack of understanding toward their client, the therapists refusal to book future appointments reinforces the idea that the therapist has indeed given up, just like the client had given up her son. The client ultimately withdrew from the therapist and the service itself. Suppose the therapist understood the magnitude of their client's deep-felt sense of self-blame for leaving their child. In that case, they might have recognised the value in booking another session which the client may have interpreted as *"I understand you are hurting, I am here for you, I will not leave you"*.

Below is a quote by therapist 3 who failed to understand the depth of their clients felt rejection:

"And then when I saw that she was upset, I guess my thinking was immediately she's perceived that as a rejection because, you know, she's had this rejection from her partner and many other people in her life. I guess that instinct of trying to clarify what I meant and provide a lot of reassurance and you know, again recognition that this was like probably her secure attachment, her safe space… but I do think that conversation would have impacted our relationship. So, I gave her lots of options, like meeting next week or take a break of any, any length of time that you like or not book another session. And you know, you can e-mail me when you've had a thing or not. We took a three-week break… that was what she asked for specifically. So we went into a lockdown. I offered her something online and she said no… we came out of the lockdown and I got in touch and offered her an appointment… she said actually, like she'd rather take a break (Therapist 3)

As rejection has played a significant role in the client's life, as quoted above, the therapist recognised immediately that what they had said had been interpreted by the client as rejection. Attempting to repair the rupture, therapist 3 says:

"I can see that you're upset, you're feeling a little bit tense… I'm wondering what's going on for you? So, trying to kind of explore what was happening between us. Then it was me verbally trying to provide a lot of reassurance and kind of explain what I had seen and what I had meant, I didn't really get anywhere with most of that... and then it was, let's maybe just take a few really deep breaths together". (Therapist 3)

The quote above illustrates the difficulties in repairing therapeutic ruptures and highlights the importance of therapists understanding their clients. If the therapist understood the depth of the client's felt rejection, they may have been more careful with the language they used. As the therapist reflects upon the experience, they realise they were the client's only secure attachment and safe place, but the rupture event had ultimately compromised their therapeutic relationship. It seems apparent that the therapist's realisation was too late, and the client withdrew; *You reject me here; I will reject you by taking a 3-week break*. As the client felt rejected and unwanted, the various options proposed by the therapist following the unsuccessful rupture repairs, further exacerbated these feelings; *If the therapist wanted me, they would explicitly tell me to come back*. Although the therapist was not bound by any limitations or time constraints, unfortunately, as the therapist was unable to empathise the depth of their client's felt rejection, once New Zealand came out of lockdown, it appears the rupture had ended the therapeutic relationship as the client did not return to therapy.

In contrast to the unsuccessfully resolved therapeutic ruptures above, therapist 1 says below:

"She's a very tricky, super sensitive client… So in a way it didn't surprise me that this happened. When you've been sexually abused, you don't trust anyone. Trust is something that is very hard earned and when you lose the trust it can take a while for them to build it up again. In recognition of the rupture, she knew that I wasn't gonna bite her head off… but I think because I owned it and because I gave her quite a valid reason it was obvious I wasn't just making it up". (Therapist 1)

The quote above exemplifies the therapist's understanding of the therapeutic rupture in terms of the client's history and personality structure. As the therapist understands the client's tricky and sensitive nature alongside her traumatic past, the rupture event was simply an inevitability waiting to occur. Although the client had identified the therapeutic rupture, coming as a shock to the therapist, this very act displays the trust embedded within the therapeutic relationship (e.g. “she knew I wasn't gonna bite her head off”) and how that trust was a pillar for the client to lean on to identify the rupture. Because the therapist understood their clients tricky past pervaded with sexual abuse, the therapist recognised

the value of trust within their therapeutic relationship. Thus, the therapist owned their mistake, not only resolving the rupture, but reinforcing the trust embedded within the therapeutic relationship with their client.

Below is a quote by therapist 4 who understood their client by identifying the parallel in the relationship between the client and his mother and the client and the therapist.

"His mother is quite narcissistic and has been very critical to him and his life. When he came to therapy with me… in some ways I, and how I am, represented a lot of commonalities between him and his mother… Quite often what happens is when I try to be empathetic towards him, he dismisses it… or he has become quite confrontational, putting me down and critiquing, kind of calling out my limitations… So basically I just expressed the process in a way and found words to express what was going on for me and tied that back to him and his sense of isolation… this was the essence of his work, this was the essence of what was happening for him in his life and other relationships. It's deepened the therapeutic relationship a lot". (Therapist 4)

The identification of such a parallel process highlights not only the depth but also the sensitivity the therapist has towards understanding their client. As the therapist tries to empathise with the client, the attempt is quickly dismissed or met with confrontation (rupture), just as the client's mother may have dismissed or confronted her son. With time, experience and supervision, the therapist became aware of the client's need for love, affection, and humility. Through this understanding, the therapist attempts to repair the rupture by expressing their feelings about how the client is making them feel (metacommunication), tying them back to how the client is feeling; isolated, shameful, incompetent and abandoned. As the therapist holds this unique understanding of the client's interpersonal difficulty, the therapist attempted to repair the rupture by:

"I offered him to reach out and take my hand... I wanted him to have a deep-felt experience of me being with him that he could take away… he took my hand and then he just broke down in tears. It was so moving for me because I could feel the shift, you know, the change and the pureness of it. So now that we've broken through that rupture, it's significantly deepened. His awareness for himself and what happens but also deepened our work, and it's deepened the therapeutic relationship a lot. (Therapist 4)

The therapist understood how deeply the feelings of isolation, shamefulness, incompetency and abandonment effected their client. Through the act of physical touch, the therapist represented a symbolic mothering, connecting with the clients “child within” and it’s suffering (Jacoby, 1986). The rupture process itself; the client disconnecting from the therapist (mother figure) just as the client had disconnected from his mother and coming back together again was the essence of the client's therapeutic

work. Following the resolution of the therapeutic rupture, there was a significant deepening of the therapeutic relationship allowing the therapeutic therapists to explore the client's life in greater depth.

Limitations and Reflections

The research findings of this study should be interpreted with caution in light of the study's limitations. Firstly, considering the study is an honours dissertation, the depth and richness of the research are restricted to various time and resource constraints, resulting in smaller sample sizes than recommended to reach adequate data saturation (Braun & Clarke, 2013). Thus, the limited sample size of four participants makes it difficult to determine the study's validity and interpretive power, restricting the generalisability of the findings to broader populations. Furthermore, considering the data's highly complex theoretical and clinical nature, the time and resource constraints limited the researcher's ability to wrestle with the conflicting ideas emerging from the study's findings. In a perfect world, additional time and supervisory support, may have aided the researcher in uncovering the deeper meanings within the participant's lived experiences.

Another potential limitation is the researcher's data collection process. The interviews were conducted via Microsoft teams due to the participant's busy time schedules and ease of use. However, technical difficulties arose in some instances where participants' screens had frozen, and important data was missed. According to Krouwel et al. (2019), in-person research interviews are marginally superior to online interviews in that interviewees say more, increasing the richness of the data. However, weighing up the time and resource constraints may justify using online interviews with a qualitative research study. It must also be stressed that my personal connection to the essence of this research, as discussed in chapter 2, may have influenced the study's conclusions. Due to my personal experience with interpersonal disconnection, it is essential to recognise that within the confines of an interpretative phenomenological paradigm, I am value bound and cannot remove myself from the research itself, requiring a high level of reflexivity (Pring, 2015). Upon such a realisation, a reflexivity journal was used throughout the research process to ensure the participants lived experience was the essence of the study's findings rather than my own. In addition to following Braun and Clarke's (2006) recommended decision-making process, all transcripts and themes were discussed between the researcher and supervisor to reduce the effect of my lived experience of interpersonal disconnection interfering unduly with the findings of this study, illustrating the importance of supervisory support.

Implications for Practice

Although this study supports the existing literature surrounding the identification, reparation, and resolution phases of therapeutic ruptures, the findings of this study also surface the many complexities therapists experience in clinical practice. Although identifying ruptures may seem straightforward on

the surface, therapists must hold a balanced awareness of their client's behaviours whilst simultaneously recognising their own needs and interfering factors. Ideally, therapists can get to a place where their countertransference can be used as a tool to identify ruptures, yet through this modality comes real human feelings that may cause the therapist actual discomfort. During the reparation phase, it is the therapist's responsibility to take the necessary steps to restore collaborative connection within the therapeutic relationship; however, there are various realities within practice that hinder the therapist's ability to repair therapeutic ruptures effectively. Finally, in resolving a rupture, no matter the outcome, beautiful or emotionally distressing, there is always something to take away from every experience. Underlying the entire rupture-repair process is the therapist's ability to experientially understand the client, influencing the outcome of the rupture-repair process. This research may assist psychologists at all levels in understanding the process of therapeutic ruptures whilst highlighting the many complexities embedded within the process. It is hoped that this research inspires registered psychologists to reflect upon their own processes of dealing with therapeutic ruptures and to recognise the influence that understanding their client has on the outcome of therapeutic ruptures. For aspiring psychologists like myself, this research is intended to aid as a foundation of knowledge regarding therapeutic ruptures, and an introduction to the many complexities counselling psychologists experience in the clinical setting.

Future Research

This study has surfaced many complexities within the rupture repair process counselling psychologists experience in clinical practice and has expanded this field of research. There are many avenues in which future research may take, such as therapeutic ruptures and the transference/countertransference relationship, hindering factors to repairing ruptures, and the effect of the counselling psychologists' theoretical approach on therapeutic ruptures. However, there are moments within the findings of this research that therapists acted before they could think or feel, affecting the outcome of the rupture repair process. Therapists may have increased the likelihood of the rupture event successfully resolving through practicing mindfulness. Although mindfulness can be described in many ways, a consistent component underpinning the process by which we process and restore ourselves is *attention*. The primary focus of mindfulness is to bring one's complete attention to the present experiential moment and focus one's attention in a particular way on purpose, non-judgmentally (Marlatt & Kristeller, 1999; Kabat-Zinn, 1994). Mindfulness has been applied in psychology to help clients manage emotional discomfort and maladaptive behaviours, yet it is not exclusively a means for relaxation or mood management (Kabat-Zinn, 1994). *Mindfulness* is a mental training tool that holds power to lessen one's cognitive sensitivity to reactive modes of feeling, thinking, and behaving (Bishop et al., 2004). To illustrate the significance of mindfulness in the context of therapeutic ruptures, a quote by therapist 2 will be used below to exemplify the utility of being mindful in moments of emotional discomfort.

"She was coerced into leaving her son behind, and at the time she thought it was temporary… there's a lot of self-blame on her responsibility for that happening… drinking up to two bottles of wine a day. So, I said, look, it's really hard for me to work with you if you're still drinking 2 bottles of wine every single night. And so, she said, I can stop and do it on my own. Where the rupture occurred, I think I said to her I won't make another appointment with you; I will discuss this with the case manager and see if we can work out a plan". (Therapist 2)

In the quote above, the therapist is frustrated and possibly angry with their client for not cutting down on their excessive drinking behaviour and immediately acts out by refusing to book another appointment. In this moment, the therapist could have been more mindful, sitting with the feelings of frustration and anger rather than acting out defensively. The therapist could have sat with themselves and asked; *why do I feel frustrated and angry with this client at this time of the therapy? S*itting with the emotional discomfort in the present moment without judgement may have surfaced their true feelings of rejection and possible abandonment as the client refuses to reduce their drinking behaviour. The therapist's awareness and understanding of such feelings may have given them insight into how the client may feel, aiding in the resolution of their rupture and thus deepening the therapeutic relationship.

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Appendices

Appendix One: Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

28 July 2022

Project Title

A Thematic Analysis of the Counselling Psychologist's Experience of Therapeutic Ruptures

An Invitation

Kia Ora, my name is Jordan Munn, and I would like to invite you to participate in my research regarding therapeutic ruptures, which is part of my Bachelor of Health Science (Honours) degree at Auckland University of Technology.

What is the purpose of this research?

This research aims to explicate the counselling psychologist's experience of a therapeutic rupture within the therapeutic alliance with one their clients. The research will initially gather a detailed account of the counselling psychologist's experience of the therapeutic rupture with one of their clients. It will then seek to gain a deeper understanding of how the counselling psychologist identified the therapeutic rupture. Finally, if the rupture was resolved within the therapeutic relationship, how and what effect did the rupture and repair have on the counselling psychologist and the therapy itself. This research also fulfils the requirements of a Bachelor of Health Science (Honours) degree, and the findings of this research may be used for academic publications and presentations.

How was I identified and why am I being invited to participate in this research?

You have been identified by my supervisor (Dr Mark Thorpe) as a potential participant as you are currently a New Zealand registered and practising counselling psychologist. I would like to interview individuals who have experience with disconnection within the therapeutic relationship and invite you to participate in this research if you are interested in sharing your unique experience of a therapeutic rupture with one of your clients.

How do I agree to participate in this research?

If you are willing to take part in this research, please email me, and I will then send you a consent form and the questions I will ask during the interview. Your participation in this research is voluntary (it is

your choice), and whether or not you choose to participate will neither advantage nor disadvantage you. You can withdraw from the study at any time. If you choose to withdraw from the study you will be offered the choice between having any of your identifiable removed, or allowing it to continue to be used in the research. Removal of your data may not be possible once the findings have been produced.

What will happen in this research?

Your participation in this research entails an interview with me that will be conducted in English and will take approximately 60 minutes to complete. The interview will be audio-taped and transcribed verbatim. With your permission, I may take notes during your interview, which you can also view at any time during the interview process. The interview will either take place face-to-face at the AUT North Shore campus or, depending on COVID-19 restrictions, via zoom/Microsoft teams. The transcript of your interview will be accessible for review, and you may alter or withdraw any sections of the transcript at any time before data analysis begins. If you choose to withdraw from the study you will be offered the choice between having any of your identifiable removed, or allowing it to continue to be used in the research. Removal of your data may not be possible once the findings have been produced.

What are the discomforts and risks?

Participants in the study will be registered counselling psychologists with their own mandated, regular clinical supervision. In the unlikely event of the participating psychologists being provoked by the interview material, they have the additional opportunity of seeking debriefing through the AUT Counselling Clinic.

How will these discomforts and risks be alleviated?

AUT Student Counselling and Mental Health is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9998.
- let the receptionist know that you are a research participant and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

What are the benefits?

Participants will have the opportunity to share their experiences of a therapeutic rupture during psychological therapy with one of their clients. The participant will also be able to describe how they had identified the rupture, how it affected their therapeutic relationship, and if the rupture was resolved how resolution occurred. Attaining in-depth accounts of a counselling psychologists experience in identifying, reflecting, and repairing ruptures, could aid in evolving our understanding of therapeutic ruptures and how they perhaps allow insight into one's suffering.

This study will not only provide a greater understanding into therapeutic ruptures within the counselling psychology context, but will also contribute toward the researchers Bachelor of Health Science Honours qualification. As the researcher aims to progress towards a Bachelor of Health Science Master's degree in 2023, the research field, interview process, and overall research process will offer a unique opportunity for learning and skill development vital to future practice.

Considering relevant literature surrounding a therapists experience of therapeutic ruptures has been conducted on primarily psychotherapists and clinical psychologists, this study offers exclusive insight into a counselling psychologists perspective. Finally, this particularly unique knowledge surrounding disconnection is invaluable to not only all therapists at all level, but also the primary researchers life.

How will my privacy be protected and confidentiality upheld?

Your personal contact information will only be available to me as the researcher in order for us to keep in contact. The substance of the interview will be securely stored on an external hard drive in a locked cabinet in a locked room at my residence. After six years, the interview transcripts (e.g. audiotapes and electronic transcripts) will be destroyed. Your identity will be concealed throughout the research process, including any personally identifying information, and pseudonyms ,of your choice, will be used throughout the final report.

What are the costs of participating in this research?

The cost of participation may involve travelling to AUT North Shore campus and approximately 60 minutes of your time.

What opportunity do I have to consider this invitation?

You will have two weeks from the time you receive this information sheet to examine this invitation and declare your interest in participating in this research. Please contact me via email if you are interested.

Will I receive feedback on the results of this research?

If you are interested in receiving the results of this research, a summary will be provided to you.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Mark Thorpe, mark.thorpe@aut.ac.nz, (+649) 921 9999 ext. 7786.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz*, (+649) 921 9999 ext. 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Jordan Munn (Bachelor of Health Science (Honours) student, Department of Health Sciences) Email: sqs3879@aut.ac.nz

Project Supervisor Contact Details:

Dr. Mark Thorpe (senior lecturer from the School of Public Health and Psychosocial Studies, Department of Health Sciences) Email: mark.thorpe@aut.ac.nz Tel: +64 9 921 9999 ext. 7786

Approved by the Auckland University of Technology Ethics Committee on 7/09/2022, AUTEC Reference number 22/221.

Appendix Two: Consent Form

Consent Form

Project title: ***A Thematic Analysis of the Counselling Psychologist's Experience of Therapeutic Ruptures***

Project Supervisor: ***Dr Mark Thorpe***

Researcher: ***Jordan Munn***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 28 July 2022
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participants signature :

.....……

Participants name :

.....……

Participants Contact Details (if appropriate) :

……..

Date :

***Approved by the Auckland University of Technology Ethics Committee* 7/09/22 *AUTEC Reference number* 22/221**

Note: The Participant should retain a copy of this form.

Appendix Three: Interview Schedule

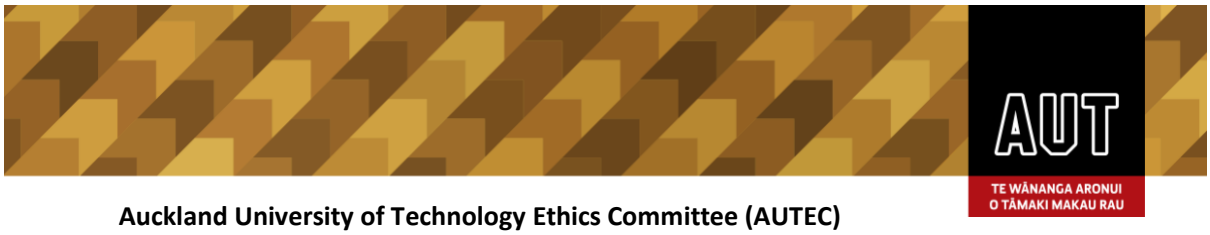
Interview Questions

Thank you for agreeing to participate in this research. The aim of the study is to shed some light on the counselling psychologists' experience of ruptures within the therapeutic relationship with their clients.

In preparation for the interview, please could you think about the following questions which will be asked in the interview.

- Please select a particular therapeutic rupture you have experienced during psychological therapy with one client. Describe your own experience, as the therapist, of the rupture as accurately and in as much detail as possible.
- How did you identify the therapeutic rupture? Please provide as much detail as possible.
- Describe your experience of identifying the rupture.
- How did the rupture affect the therapeutic relationship and the work of therapy?
- How did you attend to/repair the rupture?
- If the rupture was resolved, please describe how this occurred.
- Do you have anything else to add?

Appendix Four: AUTEC Ethics Approval Letter



Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

7 September 2022

Mark Thorpe
Faculty of Health and Environmental Sciences

Dear Mark

Re Ethics Application: **22/221 A Thematic Analysis of the Counselling Psychologist's Experience of Therapeutic Ruptures**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 7 September 2025.

Non-Standard Conditions of Approval

1. Please send through the room number for the data and Consent Form storage

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be reviewed by AUTEC before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.
8. AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics.

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: sqs3879@aut.ac.nz