

“A Portfolio on the
Therapeutic Relationship,
Therapeutic Ruptures and Repairs,
and Counselling Psychology”

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City University Declaration

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Section A:

Preface

Title:

**“A Presentation of the Various
Components of the Portfolio”**

Preface to Portfolio

This portfolio is comprised of three distinct, yet intertwined pieces of work; a critical literature review, an original piece of research, and a client case study. A pertinent thread running throughout the portfolio and tying its various pieces together is the primacy of the therapeutic relationship, in its various forms and textures. The critical literature review explores the concept of the therapeutic alliance, in terms of its definition, conceptualisation, measurement and therapeutic implications. Consequently, the research thesis investigates ruptures in the therapeutic alliance, as experienced, understood and processed by counselling psychologists of various therapeutic orientations. Lastly, the case study is concerned with the presentation and exploration of the therapeutic journey with a client, whereby the therapeutic relationship constituted the cornerstone of the therapeutic work and change.

1. Critical Literature Review

The portfolio opens with a literature review which aims to examine and critically evaluate the concept of the therapeutic alliance in psychotherapy theory, research and practice. The construct of the alliance holds particular theoretical and practical significance for counselling psychologists, who are expected to demonstrate an understanding of the therapeutic relationship and alliance as conceptualised in different models (HCPC, 2015), as well as the ability to engage in relational practice (BPS, 2015). The critical literature review therefore opens with an examination of the concept of the therapeutic alliance as defined and conceptualised in the major schools of psychotherapy. Core alliance measures are also presented and critically evaluated in relation to their methodological rigour and usefulness in alliance research and practice. The relationship between the therapeutic alliance and outcome is critically reflected upon, whilst giving thorough consideration to therapist, client and interactive factors impacting the development and maintenance of the therapeutic alliance, thus possibly mediating and/ or moderating the relationship between alliance and treatment outcome. Contemporary re-conceptualisations and critiques of alliance theory and research are in turn thoroughly examined and critically discussed. Taking into account the primacy of the therapeutic relationship in Counselling Psychology (BPS, 2005), this sections concludes with a presentation of the therapeutic implications of alliance theory and research for practitioner psychologists in general and counselling psychologists in particular, irrespective of their therapeutic orientation. In general lines, it is postulated that a solid therapeutic alliance is fundamental for successful treatment process and outcome. Counselling psychologists are therefore urged to carefully foster, develop and maintain strong alliances, as well as to tailor them to clients' individual preferences, styles and needs (Norcross, 2011).

It is hoped that this section succeeds in critically analysing and evaluating psychological research (HCPC, 2015), in ways that can meaningfully inform professional practice.

2. Research

This part of the portfolio consists of an original piece of research, which aims to investigate counselling psychologists' subjective experiences and sense-making processes of therapeutic ruptures, as well as their unique ways of managing and overcoming them. Taking into account the unequivocal relationship between a positive therapeutic alliance and successful treatment outcome, the research study attempts to shed light onto the ways through which counselling psychologists may maximise their ability to reflect upon and successfully manage ruptures in the therapeutic alliance, in order to enhance their therapeutic skills and efficacy, optimise treatment outcome and ultimately promote clients' well-being. In line with the humanistic and relational value base of Counselling Psychology, which privileges and emphasises subjectivity, phenomenology and meaning (BPS, 2005, 2015), the present study espouses a constructivist-interpretivist stance. Consequently, it seeks to explore and illuminate participants' subjective lived experiences, unique meaning-making processes and idiosyncratic ways of managing therapeutic ruptures and resolutions. Data was collected through semi-structured interviews and analysed using the qualitative methodology of Interpretative Phenomenological Analysis (IPA). The analysis revealed that participating counselling psychologists understood ruptures as essentially co-constructed and co-experienced by both members of the therapeutic dyad. Although undoubtedly uncomfortable and potentially threatening, ruptures were also perceived as essentially beneficial to the therapeutic endeavour, if and when resolved successfully. The analysis is discussed in relation to existing literature and the implications for the practice, training, and research of Counselling Psychology are highlighted. The study concludes by emphasising the fundamentally subjective and intersubjective nature of human experience, a value highly endorsed within the discipline and clinical practice of Counselling Psychology (BPS, 2005). The current study hopefully demonstrates the researcher's ability to understand a variety of research methodologies and designs, as well as to initiate, design, and conduct psychological research (HCPC, 2015), whilst taking into thorough consideration the ethical issues involved in the conduct of research with human participants (BPS, 2010).

3. Professional Practice

The portfolio concludes with a case study, which aims to demonstrate my ability to engage in self-reflective, competent, and ethical professional practice. This particular case has been chosen as it represents a good example of my preferred way of working with clients. More importantly, it has been one of the most challenging, yet rewarding, cases I have encountered

in my professional practice, which has been instrumental in my maturation, learning, growth and development as a counselling psychologist. This case study therefore constitutes a vivid illustration of my engagement in integrative and relational work with clients, and is demonstrative of my ability to generalise, synthesise, and critically apply prior knowledge and experience (HCPC, 2015), in a way that respects and privileges the dynamic and relational nature of human experience (BPS, 2015). This piece of work opens with a detailed assessment of the client's presenting problems, followed by a presentation of a thorough case formulation and treatment plan tailored to the client's emotional and psychological difficulties, and drawing from different models of therapy that best correspond to the client's preferences and needs (BPS, 2015; HCPC, 2015; NICE, 2011). Consequently, the main implemented interventions and core therapeutic processes are presented and critically discussed, in an attempt to demonstrate my professional competence in employing a variety of evidence-based and practice-based interventions, as appropriate to the client's problems and needs, and whilst honouring the unique and intersubjective human nature of the therapeutic encounter (BPS, 2015). Particular emphasis is paid on reflection upon the therapeutic process and relationship (HCPC, 2015), as it evolved and matured throughout the therapeutic journey. In addition, contextual and ethical issues are thoroughly addressed in an attempt to demonstrate my ability to practice ethically and competently, whilst demonstrating awareness of and sensitivity towards the client's socio-cultural context framing his subjective experience and presenting difficulties (BPS, 2010; HCPC, 2015). Lastly, difficulties encountered in the work with this client, as well as the constructive role of supervision in overcoming them are critically reflected upon, hopefully highlighting my ability to engage in self-reflective practice (BPS, 2005, 2010; HCPC, 2015).

Due to the revealing, intimate and sensitive material included in the case study, as well as in line with the BPS's Code of Human Research Ethics (2010) recommendations, this piece of work (and its associated appendices) has been removed from the final submission of the portfolio. Despite having obtained the client's informed consent, it has been decided that the short-term benefits of this particular case study do not outweigh the possible future risks of harm, in terms of the ethical implications involved, such as compromising the client's confidentiality and anonymity or inducing to the client psychological discomfort or anxiety in the long run (see BPS, 2010). However, the main headings of the case study are included in the Table of Contents, in order to provide the reader with a richer and fuller picture of this particular component of the submitted portfolio.

Overall, the portfolio represents my personal and professional identity, values and worldviews as a human being, as well as a practitioner counselling psychologist. The main theme that ties the various components of the portfolio together is the primary significance

and transformational nature of the therapeutic relationship in professional practice. In a sense, the portfolio ultimately pays tribute to the subjectivity and intersubjectivity of human experience, as unfolded, lived and experienced within the context of the therapeutic encounter. The pieces of work included in this portfolio hopefully demonstrate my ability to embrace a ‘scientist-practitioner’ and a ‘reflective-practitioner’ model of research and clinical practice, which marries “...the scientific demand for rigorous empirical inquiry with a firm value base grounded in the primacy of the counselling/psychotherapeutic relationship” (BPS, 2005, p.1).

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Section B:
Critical Literature Review

Title:
**“The Therapeutic Alliance:
Definitions, Reflections, and Therapeutic
Implications”**

Introduction

The present literature review aims to offer an in-depth examination and critical evaluation of the concept of the therapeutic alliance, as it has been historically unfolded in psychotherapy theory, research and practice. Definitions and conceptualisations of the alliance in the major schools of psychotherapy will be presented, and the relationship between the therapeutic alliance and treatment outcome will be critically discussed. Particular emphasis will be placed upon therapist and client factors that appear to impact the development and maintenance of the therapeutic alliance. Furthermore, contemporary advances in alliance theory and research will be presented and reflected upon, and the clinical implications for counselling psychologists will be highlighted and discussed.

One of the things that characterises and differentiates Counselling Psychology is its grounding on the primacy of the psychotherapeutic relationship that values both subjectivity and intersubjectivity, and acknowledges the contextual nature of human experiences and relationships (BPS, 2005). Counselling psychologists are required to demonstrate the ability to compare, contrast and critically evaluate different models of therapy, as well as to understand the ways the therapeutic relationship and the alliance are conceptualised in each therapy school (HCPC, 2015). The present critical review is therefore compatible with the main principles and values of Counselling Psychology, whilst the topic under investigation holds significant therapeutic implications that are directly relevant and can be implemented into counselling psychologists' clinical practice regardless of their theoretical orientation.

Over the last four decades both researchers and practitioners have demonstrated an immense and sustained interest in the therapeutic alliance, which is reflected in the numerous publications that have arisen from psychotherapy research on the topic (Horvath, 2011; Horvath & Bedi, 2002; Horvath, Del Re, Flückiger, & Symonds, 2011). One of the reasons for the growing interest in the therapeutic alliance can be attributed to outcome research demonstrating that despite psychotherapy's general effectiveness (Lambert & Bergin, 1994; Miller, Hubble, Chow, & Seidel, 2013), different psychotherapy schools have repeatedly, over many decades, shown equivalence of outcomes (Fiedler, 1950; Lambert, 2013; Luborsky, Singer, & Luborsky, 1975; Luborsky et al., 2002; Smith, Glass, & Miller, 1980). In addition, protocol adherence does not seem to be related to better outcomes either and there is little evidence in support of specific mechanisms moderating or mediating the relationship between treatment and outcomes as theoretically predicted (Wampold & Bhati, 2004).

These findings, in combination with Rogers' (1951, 1957) work on the role of the facilitative conditions that placed the therapeutic relationship to the centre of the healing process and the research agenda, led researchers to embark on a quest for factors, common to all

psychotherapies, that are responsible for the benefits of such treatments (Frank & Frank, 1991; Lambert & Barley, 2001; Lambert & Bergin, 1994). Emphasis was thus given on the therapeutic relationship as an integrating therapy factor (Clarkson, 1990, 1995) and consensus was reached on the alliance as a ‘quintessential integrative variable’ (Wolfe & Goldfried, 1988). Lambert and Barley (2001) in particular indicated that 40% of client outcome could be attributed to extra-therapeutic factors, 30% to common factors, including the client-therapist relationship, 15% to specific interventions and 15% to expectancy or placebo effects. Furthermore, several researchers have identified ‘converging themes’ across therapies, such as the significance of the therapeutic relationship, therapist and client variables, specific therapeutic techniques, as well as common mechanisms of change (Beitman, 2003; Garfield, 2003; Goldfried, & Davila, 2005; Wampold, 2007).

All the aforementioned factors may have significantly accounted for the ever-growing interest in the therapeutic alliance, but what seems as the most striking and potent factor for the popularity of the concept is the consistently modest but robust association between alliance and treatment outcome across a variety of treatments, contexts and client problems (Horvath et al., 2011; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin, Garske, & Davis 2000). The APA’s Division 29 Psychotherapy Task Force on Empirically-Supported Therapy Relationships concluded that the therapeutic alliance is a ‘demonstrably effective’ element of the therapeutic relationship (Norcross, 2002), while a second Task Force on Evidence-Based Therapy Relationships reaffirmed the alliance as a ‘demonstrably effective’ relationship element (Norcross & Wampold, 2011). Although, reservations have been expressed about the conclusions of the APA Task Forces, on both conceptual and empirical grounds, their suggested recommendations are widely endorsed and valued (Kazantzis, Cronin, Norton, Lai, & Hofmann, 2015). Practitioners are therefore encouraged to make use of demonstrably and probably effective relationship elements in their clinical practice in order to achieve better outcomes, and researchers are urged to examine potential mediators and moderators of the association between relationship elements and treatment outcome employing methodologies capable of capturing the complex associations among client characteristics, therapist behaviours and treatment outcome (Norcross & Lambert, 2011; Norcross & Wampold, 2011).

The Alliance: Definitions and Conceptualisations in the Major Schools of Psychotherapy

The Alliance in Psychodynamic Psychotherapy

The concept of the therapeutic alliance firstly appears in Freud’s (1913) early writings. Although Freud did not specifically refer to the term ‘alliance’, he did stress out the importance of an ‘unobjectionable positive transference’ from the analysand to the analyst

that is characterised by cooperation and collaboration, and needs not be analysed. It is precisely this attachment that enables the patient to withstand the painful experience of working through traumatic material and to make purposeful use of the analyst's interpretations (see Crits-Cristoph & Connolly Gibbons, 2003; Horvath, 2000; Saketopoulou, 1999).

Two decades later, Sterba (1934) introduced the term of the 'ego alliance' highlighting the significance of the therapist enabling the patient to flexibly work through the vacillations between an 'experiencing ego' and a 'self-reflective ego', in order to achieve collaboration with the analyst in the task of self-observation. Zetzel (1956) was the first to introduce the concept of the 'therapeutic alliance' stressing the role of the patient's 'ego identification' with the therapist, and the therapist's support in the development of the therapeutic bond and trust. According to Zetzel (1966), the therapeutic alliance is both a prerequisite for the analytic process and therapeutic in and of itself, with the therapist paralleling the good mother who provides an optimal maternal environment that fosters a fundamental sense of trust (Messer & Wolitzky, 2010).

Greenson (1967) further elaborated on the conceptualisation of the alliance and proposed that the therapeutic relationship consists of three distinct yet somehow overlapping configurations. He proposed that the *alliance* is distinct from *transference* that represents the unrealistic aspects of the therapeutic relationship, and the *real relationship* that represents the realistic aspects of the therapeutic relationship. The alliance, like the real relationship, places emphasis on the conscious, rational and non-neurotic rapport between therapist and client, but also seems to be the only element within the therapeutic relationship that is not manifested in extratherapeutic relations (Saketopoulou, 1999). The term 'working alliance' was therefore coined in order to stress the importance of patient's purposeful work in treatment, as opposed to the term 'therapeutic alliance' that places more emphasis on the bond aspect of the relationship (Greenson, 1965). Luborsky (1984) further expanded on the concept of the alliance and identified two alliance categories. In Type I alliances the client perceives the therapist as capable of helping him/ her, whereas in Type II alliances the client perceives the therapeutic process in itself as capable of uniting and mobilising both the therapist's and the client's resources.

The distinction among the alliance and the transference and real aspects of the therapeutic relationship has sparked significant tension and controversy within the gulfs of psychoanalytic psychotherapy bringing to the surface the everlasting debate between the importance of insight versus the value of the therapeutic relationship in itself (Messer & Wolitzky, 2010). Some authors have embraced these distinctions acknowledging their

usefulness yet highlighting their interdependence and intertwining in psychotherapy process (Gelso & Carter, 1994; Meissner, 2006, 2007). On the other hand, several traditional analysts (Adler & Bachant, 1998; Brenner, 1979; Curtis, 1979) have argued that no aspect of the therapeutic relationship is free of transference elements, as this is always determined by past experiences. Consequently, they have cautioned against the possibility that emphasis on the alliance and the real relationship may hinder the full development of transference neurosis, lead to unwarranted gratifications, as well as derail therapists from analysing important aspects of the transference that they experience as realistic.

In contemporary, relational and intersubjective perspectives of psychodynamic psychotherapy (Aron, 1996; Mitchell, 1988), the acquisition of insight is no longer considered as the primary curative agent. Abstinence, neutrality and anonymity (Storolow & Atwood, 1997) give way to interaction, mutuality and authenticity (Mitchell, 1997). The experience of a positive relational experience with the therapist thus becomes crucial and the process of repairing problems in the alliance constitutes the essence of the therapeutic change process (Safran & Muran, 2000).

The Alliance in Humanistic Psychotherapy

The role of the therapeutic relationship in successful psychotherapy outcome has been vastly recognised by humanistic theorists and practitioners. In his influential article 'The Necessary and Sufficient Conditions of Therapeutic Personality Change' (Rogers, 1957), Carl Rogers identified six conditions, necessary and sufficient for psychotherapeutic change to occur. By 'necessary', he meant that all the conditions need to be present for therapeutic process and change to take place, and by 'sufficient', he meant that the six conditions alone could initiate that change. Although Rogers made no explicit reference to the term 'alliance' per se, he was nevertheless the first one to argue that it is the relationship that the therapist provides, rather than the techniques that the therapist implements, that account for therapeutic effectiveness, regardless of the treatment type. Furthermore, it was assumed that it is the therapist who is responsible for the provision of the relationship conditions, namely empathy, unconditional positive regard and congruence, which, if properly communicated, will be perceived by the client mobilising the actualising tendency and initiating personal growth (Horvath, 2000).

The Process-Experiential approach to psychotherapy grew out of Rogers' process research programme, but integrates interventions from person-centred, gestalt, and experiential therapies (Watson & Kalogerakos, 2010). Unlike classical person-centred therapists, who adopt a rather non-directive stance and place emphasis on the therapist offering the core conditions, experiential therapists emphasise the interactive and transactional character of the therapeutic encounter, and combine the core conditions with more active interventions and

tasks (Greenberg, Rice, & Elliott, 1993; Rice & Greenberg, 1984; Watson & Greenberg, 1994, 2000). Consequently, experiential therapists acknowledge the importance of the therapeutic relationship, as postulated by Rogers, but explicitly distinguish between the ‘working conditions’ and the ‘relationship conditions’ of therapy (Watson & Greenberg, 1994; Watson & Kalogerakos, 2010). The working conditions refer to the collaborative aspects of the client-therapist relationship, such as agreement on the aforementioned goals and tasks. The relationship conditions, on the other hand, refer to the emotional bond developed between therapist and client (Watson & Greenberg, 1994). The relationship conditions are thus considered to enable the development of a safe working and relational environment, where clients can engage in self-exploration and process their emotional experience. At the same time, the relationship conditions ‘set the stage’ for the implementation of specific therapeutic tasks under the therapist’s tentative guidance and responsive attunement to the client’s inner phenomenological experience and world-view (Watson & Greenberg, 1994, 2000; Watson & Kalogerakos, 2010).

Decades of research have established the significance of empathy (Bohart, Elliott, Greenberg, & Watson, 2002; Elliott, Bohart, Watson, & Greenberg, 2011), unconditional positive regard (Farber & Doolin, 2011; Farber & Lane, 2002) and congruence (Klein, Kolden, Michels & Chisholm-Stockard, 2002; Kolden, Klein, Wang & Austin, 2011) for the creation of a positive therapeutic relationship and the attainment of successful therapeutic outcome, but have yielded mixed results with regard to the sufficiency of the core conditions. Moreover, meta-analyses on the core conditions are full of methodological limitations, such as small sample sizes, conditions examined in isolation, use of clients not in need to change, therapist variability, reliability and validity of measures, rating perspectives, use of audiotapes, and research bias (Kolden et al., 2011; Patterson, 1984; Parloff, Waskow, & Wolfe, 1978). Interestingly, studies that have used clients’ ratings of the conditions and the therapeutic relationship, as well as studies that have examined the core conditions in combination have consistently yielded positive findings. These findings are more in line with the actualising psychotherapeutic paradigm that privileges clients’ frame of reference and resources (Bozarth & Motomasa, 2008), as well as in accord with Rogers’ hypothesis that the three conditions operate in combination, rather than independently and that it is the client’s perception of the conditions that matters (Kirschenbaum & Jourdan, 2005).

The Alliance in Cognitive-Behavioural Therapy

Cognitive and behavioural therapies’ roots on learning and conditioning, have contributed to a limited emphasis on the role of the therapeutic relationship in successful outcome placing significantly more emphasis on the successful implementation of techniques (Castonguay,

Constantino, McAleavey, & Goldfried, 2010), thus rendering the role of the therapist as relatively unimportant and leaving the role of the alliance fairly under-recognised (Raue & Goldfried, 1994). Wolpe (1958) was one of the first behaviourally oriented therapists who acknowledged the role of the therapist's respect, support and lack of de-moralisation in enabling the client to free himself from unadaptive anxieties. Later on, Goldfried and Davison (1976), and Wilson and Evans (1977) drew on social learning theory and provided a conceptualisation of the therapeutic relationship based on social influence processes. The therapeutic relationship was thus conceived as central for the successful implementation of behavioural methods and facilitation of the change process through the provision of positive reinforcement, modelling and overcoming of client resistance (see Raue & Goldfried, 1994).

Aaron Beck, the founder of cognitive therapy, acknowledged Rogers' (1957) contribution and reaffirmed empathy, warmth and genuineness as important therapist qualities in cognitive therapy. Beck and his associates (Beck, Rush, Shaw, & Emery, 1979) also introduced the term 'collaborative empiricism', in order to emphasise the importance of a collaborative relationship, as opposed to single therapist characteristics, within which therapist and client work together as a team, in order to identify central problems and possible solutions. On the other hand, Albert Ellis (1962), advocated for a more directive therapist stance and argued that the core conditions may be desirable, but are neither necessary nor sufficient for therapeutic change.

Broadly speaking, the therapeutic alliance in the cognitive-behavioural therapies has been historically considered as a 'non-specific' factor, facilitating the use of and adherence to 'specific' therapy techniques. Thus, the alliance has been viewed as a necessary but not sufficient therapeutic agent in and of itself (DeRubeis, Brotman & Gibbons, 2005; Kazdin, 2005). In fact, several cognitive-behavioural practitioners have argued that a good therapeutic alliance may be an artefact of good therapeutic technique (DeRubeis et al., 2005) and/ or prior symptom improvement (DeRubeis & Feeley, 1990; Feeley, DeRubeis, & Gelfand, 1999), as opposed to a productive therapeutic process in itself. Numerous studies (e.g. Burns & Nolen-Hoeksema, 1992; Castonguay et al., 1996; Goldsmith et al., 2015; Klein et al., 2003; Jung, Wiesjahn, Rief, & Lincoln, 2015), however, have established the importance of relationship factors and outcome in the cognitive-behavioural therapies suggesting that alliance and technique are inextricably intertwined in the therapeutic change process (Goldfried & Davila, 2005; Hill, 2005) .

Researchers' and clinicians' interest in the therapeutic alliance constantly gains ground within the gulfs of cognitive-behavioural therapies. In 2007, Gilbert and Leahy published the first book devoted to the therapeutic relationship in CBT stressing out the importance of

therapists' competence in both techniques, as well as in skills around the establishment, development and maintenance of the therapeutic alliance (Hardy, Cahill, & Barkham, 2007). Collaborative empiricism has been regarded by contemporary cognitive-behavioural therapists as a fundamental feature of the therapeutic relationship, as well as a central mechanism of cognitive change (see Kazantzis, Beck, Dattilio, Dobson, & Rapee, 2013; Kazantzis, Freeman, Fruzzetti, Persons, & Smucker, 2013). Furthermore, it is now acknowledged that clients' pre-existing interpersonal schemas, attachment problems, difficulties in emotional processing and regulation, failures in compassion and validation, as well as processes of resistance may be mirrored and re-enacted in the therapeutic relationship providing opportunities for modification and change (Leahy, 2008). Furthermore, schematic mismatch or over-match between the client's and the therapist's 'relational'/ 'interpersonal' schemas may lead to alliance ruptures that can adversely affect therapeutic process and outcome should they remain unexamined (Katzow & Safran, 2007; Leahy, 2007; Wright & Davis, 1994). Consequently, attending to and acquiring awareness of 'cognitive transference and countertransference' dynamics becomes crucial for cognitive-behavioural therapists' successful disengagement from and management of self- and relationship- defeating patterns in the therapeutic process, in order to meet client goals and safeguard successful treatment outcome (Leahy, 2007; Miranda & Andersen, 2007). Within this contemporary perspective of the therapeutic relationship in CBT, strong alliances may not just facilitate implementation of techniques, but also promote active change of cognition, behaviours, and schemas, as well as provide corrective experiences to clients (see Castonguay et al., 2010; Raue & Goldfried, 1994).

Bordin's Pantheoretical Conceptualisation of the Alliance

Given the equivalence of different treatment modalities with regard to psychotherapy outcome (Fiedler, 1950; Luborsky et al., 1975; Smith et al., 1980), Bordin (1979) argued that a good alliance is a prerequisite for therapeutic change in all schools of psychotherapy and offered a transtheoretical re-conceptualisation of the alliance. He used the term *working alliance* utilising a number of Greenson's (1965) ideas, but departing from the psychodynamic premises even more clearly than Luborsky (1984) did (see Horvath & Bedi, 2002; Horvath et al., 2011). According to Bordin (1979, 1994) the working alliance consists of three interdependent elements: the goals, the tasks and the bond. The *goals* refer to the general treatment objectives, which therapist and client mutually endorse and are the target of specific interventions. The *tasks* refer to the specific activities the therapeutic dyad engages in, in order to facilitate change. The therapeutic tasks are expected to differ among the various schools of psychotherapy, but it is crucial that they are mutually perceived as relevant and efficacious. The *bond* between therapist and client is thought to grow out of their experience

from participation in a shared activity and is likely to be experienced and expressed in the sense of mutual liking, trust and respect, as well as a sense of common commitment and shared understanding in the activity.

According to Bordin (1994) the working alliance is dyadic, mutual and constantly negotiated. The therapist is responsible for the implementation of specific tasks, but the client must perceive them as relevant, in order to maintain a collaborative stance and engage in purposeful work. The alliance is therefore re-conceptualised as the conscious aspect of the therapeutic relationship, with emphasis given on collaboration and consensus between therapist and client, as opposed to earlier emphasis on unconscious distortions of the therapeutic relationship and therapists' contributions to the relationship (Horvath & Bedi, 2002; Horvath et al., 2011). Thus, unlike Rogers' suggestion, clients do not automatically respond to the therapist-offered conditions, but rather develop a bond toward the therapist, based on their expectations and evaluation of the offered interventions (Horvath, 2000; Horvath & Luborsky, 1993). In fact, the technical and process aspects of therapy are viewed in constant interaction, each fostering and affecting the development of the other (Bordin, 1979). The alliance is therefore expected to vary in relation to therapist, client and treatment factors that are in constant interaction. In addition, Bordin (1994) postulated that the explicit negotiation of therapy tasks and goals, grounded in a solid bond, is paramount for the building and development of a strong alliance that will be able to withstand potential strains resulting from pathological transference elements. Strains in the working alliance may be manifested with regard to treatment tasks, goals or bonds but, if successfully handled, they can actually make it stronger and lead to client change. The therapeutic alliance is thus conceived as a facilitative context for the implementation of specific therapeutic tasks, but also as a therapeutic agent in and of itself (Horvath, 2000).

Alliance Measures

Bordin's pantheoretical conceptualisation of the alliance, paved the way for the development of a number of alliance measures, which allowed for empirical, rigorous investigation of the relation between alliance and psychotherapy outcome (Horvath & Symonds, 1991). Different alliance measures have arisen from different theoretical approaches (Elvins & Green, 2008) and therefore reflect a somehow distinct theoretical understanding and definition of the construct (Horvath & Symonds, 1991). There are over 30 identified different instruments measuring the alliance (Horvath et al., 2011), but the 'core measures' consist of: The Penn Helping Alliance Scales (HAq; Luborsky, 1976; Luborsky et al., 1996), The Vanderbilt Psychotherapy Process Scales (VPPS; O' Malley, Suh, & Strupp, 1983; Suh, Strupp, & O'

Malley, 1986), The California Psychotherapy Alliance Scales (CALPAS; Marmar, Weiss & Gaston, 1989) and The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989).

The aforementioned measures assess the quality of the alliance from various perspectives (client, therapist, observer), and across varying time spans (portions of therapy sessions, whole therapy sessions, or across several sessions) (Horvath, 1994). In addition, they all demonstrate relatively high reliability (Elvins & Green, 2008; Martin et al., 2000), but the shared variance among them seems to be less than 50% (Horvath et al., 2011), indicating that even though they all measure the same underlying construct, the weight and emphasis given on various alliance components substantially varies among measures (Horvath, 1994). Measures' subscales also demonstrate high inter-reliability, suggesting that they all measure conceptually different but overlapping constructs (Elvins & Green, 2008; Hatcher & Barends, 1996). The WAI is the only measure that has explicitly arisen from Bordin's pantheoretical conceptualisation of the alliance and is therefore considered more appropriate for most research projects (Elvins & Green, 2008; Martin et al., 2000).

A closer examination of the aforementioned alliance scales reveals significant similarities but also substantial differences in both the conceptualisation and measurement of the alliance. Hatcher and Barends (1996) undertook a critical review of three core alliance measures (i.e. HAq, CALPAS, WAI) and although they did identify common factors among them, they concluded that these factors bore little relation to the subscales, as originally proposed by their developers (Hatcher, 1999; Elvins & Green, 2008), suggesting that alliance research could benefit from a return to theory and a reconceptualisation of the term itself (Hatcher & Barends, 1996, 2006). Furthermore, while the VPPS and the CALPAS scales seem to tap into both client and therapist contributions to the alliance, as well as into the interpersonal aspects of the bond, the WAI seems to stress the therapist's contribution to the alliance, missing out the dynamic and mutual nature of the alliance, as originally postulated in Bordin's theory (Hatcher & Barends, 1996).

More importantly, clients' and therapists' perceptions of the therapeutic alliance seem to overlap but also significantly differ (Bachelor, 2013; Hatcher & Barends, 1996; Krause, Altimir, & Horvath, 2011), with clients' ratings of the alliance being more predictive of treatment success (Horvath & Bedi, 2002; Horvath & Symonds, 1991). Taken together, these findings highlight the need for modification of current measures' subscales, as well as the importance of seeking clients' feedback on their expectations and perceptions of the therapeutic relationship (Bachelor, 2013). In addition, when researched from the client's perspective, whilst the cognitive aspects of the alliance (tasks, goals, collaboration, involvement) seem to be highly inter-correlated, they appear as somehow distinct from the

more affective aspects of the alliance (the bonds) (Hatcher & Barends, 1996). These findings suggest that while some items may appear to be directly connected to the work and applicable to all therapeutic modalities, other items concerning specific therapeutic tasks or bonds may not be relevant to all treatment modalities. For example, there may be an optimal level and type of bond that facilitates the tasks and goals across different therapy types (Hatcher & Barends, 2006). According to Hatcher and Barends (2006), the limitations of current alliance measures constitute a vital issue in alliance research. They therefore propose a modification of the scales' items, so they can reflect more accurately the purposive and collaborative nature of the therapeutic alliance.

Alliance and Outcome

The development of research measures opened the way for the exploration of the relationship between therapeutic alliance and outcome. Four large meta-analyses conducted over the past 20 years, have consistently demonstrated a modest but robust link between the quality of the alliance and therapy outcome. Specifically, Horvath and Symonds (1991) found a correlation of $r=.26$ between alliance and outcome, Martin, Garske, and Davis (2000) a correlation of $r=.22$, Horvath and Bedi (2002) a correlation of $r=.21$, and more recently Horvath, Del Re, Flückiger, and Symonds (2011) a correlation of $r=.275$. In fact, the alliance seems to be particularly predictive of outcome when measured early in treatment (between sessions 3 to 5), highlighting the significance of therapists' attending to the alliance from the commencement of therapy (Castonguay, Constantino, & Grosse Holtforth, 2006; Horvath & Bedi, 2002).

Though enlightening and representative of clinical settings, the aforementioned meta-analyses are not without certain limitations. The lack of an explicit consensus on the definition of the alliance, in combination with the variety of measures used in different studies create conceptual ambiguity and render empirical evidence less clinically meaningful (Horvath, 2011; Horvath & Bedi, 2002; Horvath et al., 2011). Moreover, clients' and observers' reports of the alliance appear to be more predictive of outcome than therapists' judgments suggesting that the source of alliance evaluation may be possibly impacting the final correlation between alliance and outcome (Horvath & Symonds, 1991). Furthermore, the correlational design of most designs does not provide support for causal relationships between alliance and outcome nor does it take into account client and therapist variables that may moderate or mediate the relationship between the therapeutic alliance and treatment outcome (Horvath & Bedi, 2002).

Despite these limitations, as well as the relatively modest effect size (ES) of the meta-analyses, accounting for approximately 7% of the outcome variance, the overall relation

between alliance and outcome remains robust regardless of treatment type, treatment length, outcome measures, time of alliance assessment, source of alliance ratings and publication status (Horvath et al., 2011; Horvath & Bedi, 2002; Horvath & Symonds, 1991; Martin et al., 2000), or research design, treatment manual and researcher allegiance (Flückiger, Del Re, Wampold, Symonds, & Horvath, 2012). Furthermore, the magnitude of the correlation has been suggested to be one of the most systematic and robust predictors of treatment outcome, that exceeds the relation of therapist adherence and competence to outcome (Webb, De Rubeis, & Barber, 2010), as well as the outcome variance that can be accounted for by techniques alone (Wampold, 2001).

Despite the unequivocal correlation between alliance and outcome, the causality of the relationship has been the subject of great controversy in psychotherapy research. Several authors have doubted the value of the alliance as an outcome *'predictor'* and have demonstrated that the level of the early alliance may be an artefact of prior symptomatic improvement (DeRubeis & Feeley, 1990; Feeley et al., 1999; Strunk, Brotman, & DeRubeis, 2010). On the other hand, other authors have found support for the predictive value of the alliance in subsequent symptom change, even after partialling out prior symptomatic change (Barber, Connolly, Crits-Cristoph, Gladis, & Siqueland, 2000; Gaston et al., 1991; Klein et al., 2003). They have therefore tentatively concluded that the alliance's relation to outcome may not be amenable to early symptomatic improvement. However, the aforementioned studies are relatively limited and report rather small correlations. Further research, with greater sample sizes, different population and treatment types may further illuminate the causal relation between alliance and outcome (Barber, 2009; Barber et al., 2010). For example, it has been suggested that the alliance may be casually related to treatment outcome in interpersonal/-dynamic but not cognitive-behavioural therapies (DeRubeis & Feeley, 1990).

Even if the alliance is not a significant predictor of treatment outcome, it may be a *'moderator'* of outcome according to the type of clients for whom the treatment works, and the conditions under which the treatment is undertaken (Barber et al., 2010). For example, the alliance has been found to be significantly associated with outcome in specific treatment conditions (clinical management versus CBT) (Carroll, Nich, & Rounsaville, 1997), in clients with medium (as opposed to high or low) levels of perfectionism (Blatt, Zuroff, Quinlan, & Pilkonis, 1996), and in different treatments for cocaine dependence (Barber et al., 2001). Other studies, have failed to find support for the moderating effects of the alliance (Johnson & Ketting, 2006), whereas the study of the alliance as a moderator is a rather complicating task requiring the measurement of the alliance at intake, along with other predictor variables (Barber et al., 2010).

Another possibility is that the alliance is a mechanism of change in itself serving as a ‘*mediator*’ of treatment outcome. Several studies have provided support for the mediating role of the alliance addressing the nature of the alliance’s impact on psychotherapy process and outcome (Castonguay et al., 2006). For example, the alliance has been found to mediate the relationship between clients’ perfectionism (Blatt et al., 1996), pretreatment expectations (Joyce, Ogrodniczuk, Piper, & McCallum, 2003; Meyer et al., 2002), and underinvolved style (Hardy et al., 2001), and outcome.

It has also been vastly acknowledged that *alliance and technique* are inextricably intertwined in the psychotherapy process and outcome (Goldfried & Davila, 2005; Hill, 2005). However, there is limited empirical investigation in this area. Gaston and his associates (1994) found that in long-term psychotherapy both supportive and exploratory interventions interacted with the alliance in outcome prediction. Supportive interventions appeared more helpful for clients with low alliance levels, whereas exploratory interventions appeared more helpful for clients with high alliance levels. Similarly, Barber and his associates (2006) found that in Individual Drug Counselling for cocaine dependency, high counsellor’s adherence to the treatment model was necessary for clients with low levels of alliance, whereas counsellor’s adherence to the treatment model was not as necessary for improvement for clients with high levels of alliance.

Despite the conceptualisation of the alliance as a process variable, the alliance could be arguably considered as an ‘*outcome*’ variable in its own right, especially in the case of clients with specific psychological difficulties (e.g. borderline personality disorder or extreme trauma) who experience severe difficulties with trusting and relating (Barber et al., 2010). A significant amount of research has indeed treated the alliance as an outcome variable with client and therapist factors as the independent variables. Several studies have identified a number of client characteristics (see Sharpless, Muran & Barber, 2010), as well as therapist characteristics and techniques (see Ackerman & Hilsenroth, 2001, 2003) that can affect positively, or negatively the therapeutic alliance yielding compelling and promising findings.

Regardless of the predictive, mediating, or moderating function of the alliance in relation to treatment outcome, the process of how the alliance associates with good outcome still remains unclear (Safran & Muran, 2006). It is thus proposed that an examination of client and therapist factors impacting the alliance and outcome could shed further light onto these complex processes (Barber et al., 2010; Hill & Knox, 2009). Baldwin, Wampold and Imel (2007) employed multilevel models and found that therapist, but not client, variability in the alliance was predictive of outcome, a finding that has also emerged in numerous studies on both outpatient (e.g. Lutz, Leon, Martinovich, Lyons, & Stiles, 2007) and inpatient (e.g. Dinger,

Strack, Sachsse, & Shauenburg, 2009) psychotherapy. On the other hand, Barber and Gallop (2008) found that clients accounted for 24% of the outcome variance, whereas therapists accounted for only 4% of the outcome variance. Despite the contradictory findings, such studies highlight the significant contributions of both therapists and clients to the therapeutic alliance and outcome (Barber, 2009).

Therapist, Client and Interactive Factors Impacting the Development and Maintenance of the Therapeutic Alliance

The psychotherapeutic endeavour consists of the interaction of two subjectivities with unique personalities, life histories, experiences expectations, and worldviews (Hill, 2005; Sharpless et al., 2010). The section below summarises empirical findings on therapist, client, and interactive factors that have been found to affect the process of alliance building and maintenance. Though illuminating, findings should be interpreted with caution, as research on therapist and client interpersonal and intrapersonal variables is at a relatively early stage and therefore evidence may lack in clinical validity and empirical reliability (see Horvath & Bedi, 2002).

Therapist factors that have been found to impede the development of a good alliance, as well as to diminish the quality of an established alliance include unsuccessful management of their countertransference (Benjamin & Critchfield, 2010), unresolved conflicts (Hill et al., 1996; Rosenberg & Hayes, 2002), as well as certain personality attributes (e.g. rigidity, coldness, uncertainty, hostility, defensiveness, unresponsiveness) (Ackerman & Hilsenroth, 2001), in combination with inflexible adherence to techniques, inability to maintain focus on the emotional impact of interpersonal problems (Ackerman & Hilsenroth, 2001), and engagement in client's maladaptive interpersonal styles (Safran & Muran, 2000). On the other hand, certain therapists' personal attributes (e.g. flexibility, honesty, respect, trustworthiness, competence, expertness, confidence, warmth, empathy, openness, honesty) (Ackerman & Hilsenroth, 2003), as well as appropriate use of verbal and nonverbal communication (Bedi, Davis, & Arvay, 2005), and successful implementation of techniques (e.g. reflection, exploration, accurate interpretations, demonstrating empathy and promoting connection, attending to clients' experience and facilitating the expression of affect) (Ackerman & Hilsenroth, 2003) have been found to positively associate with the development and maintenance of the therapeutic alliance.

Client factors that have been found to correlate positively with both the therapeutic alliance and treatment outcome include positive expectations for improvement, good interpersonal functioning, secure attachment styles, as well as a history of positive past and present relationships (see Messer & Wolitsky, 2010; Sharpless et al., 2010; Benjamin & Critchfield,

2010). On the other hand, hostility, defensiveness, poor object relations, and substantial psychopathology or personality disorders are associated with poor alliances and manifestation of ruptures (see Messer & Wolitsky, 2010; Sharpless et al., 2010; Benjamin & Critchfield, 2010). Findings regarding the relation between pre-therapy symptom severity and the quality of the alliance are somehow mixed (Horvath & Bedi, 2002). Some studies suggest that severely disturbed clients tend to form weaker alliances, while others have found no such difference (Messer & Wolitsky, 2010; Sharpless et al., 2010).

Active collaboration and cooperation between therapist and client is positively associated with the therapeutic alliance and outcome (Horvath & Bedi, 2002; Horvath et al., 2011), whereas therapist and client negative complementarity, characterised by negative, hostile, controlling or competing interactions, seems to be negatively associated with the quality of the alliance (see Binder & Henry, 2010). Similarly, transference and countertransference dynamics are also thought to influence the quality of the alliance, whereby clients' strong distortions of the therapeutic process, in combination with therapists' personal reactions to the client may negatively interfere with the alliance, and contribute to the manifestation of therapeutic ruptures (Messer & Wolitsky, 2010; Safran et al., 2011).

Contemporary Reconceptualisations and Advances in Alliance Theory and Research

Decades of psychotherapy research have established the significance of the alliance for positive client change and successful treatment outcome. However, it is also true, that the broad, pantheoretical conceptualisation of the alliance, in combination with the substantial variety of alliance measures, may have impeded the establishment of a clear and cohesive framework for the therapeutic relationship, process and dynamics (Horvath, 2006, 2011). The concept of the alliance in itself and its relation to other relationship elements has not been clearly charted (Horvath, 2011; Kazantzis et al., 2015), whereas it is often equated by many clinicians and researchers with the therapeutic relationship (Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998; Henry & Strupp, 1994), and the terms are often used interchangeably within contemporary textbooks on the therapeutic relationship (e.g. Gilbert & Leahy, 2007; Haugh & Paul, 2008). Bozarth and Motomasa (2008), argue that “the therapeutic alliance is only important as a separate variable within the context of the reactive paradigm of psychotherapy. It is simply part and parcel of the relationship in the context of the actualizing paradigm” (p. 136) that privileges client's frame of reference and resources, as opposed to therapist's contributions and interventions in the therapeutic relationship.

Other authors have explicitly argued against such equations and have postulated that the alliance constitutes a way of looking into the quality of the collaborative relationship and

purposeful work between therapist and client, and it is not the relationship itself (Hatcher, 2010; Hatcher & Barends, 2006). According to Horvath and Bedi (2002) the alliance is inclusive of the affective bonds, as well as the more cognitive, conscious and purposeful aspects of the therapeutic relationship, within which therapist and client partner together and mutually engage in the process of therapy. Similarly, Meissner (2006) has suggested that the therapeutic relationship involves three components: the therapeutic alliance, transference and the real relationship. These three concepts may at times overlap and are in constant interaction and modification. It is the alliance, however, that provides the context for the working through and modification of transference phenomena, which are so central in psychoanalytic work.

On the other hand, Safran and Muran (2000) have pointed out that the construct of the alliance may have been useful at a time when the person-centred tradition and authentic, human components of the therapeutic relationship had been marginalised by the mainstream cognitive-behavioural and classical psychoanalytic therapies, which emphasised the more technical aspects of the therapeutic relationship (Safran & Muran, 2006). However, the concept of the alliance may have outlived its usefulness within the contemporary relational and humanistic paradigms that place emphasis on flexibility, mutuality, spontaneity and authenticity (Safran & Muran, 2006). Within this intersubjective, relational therapeutic framework, there is an ongoing negotiation between two subjectivities and change is co-created within the therapeutic dyad. All interventions thus become relational acts and carry relational meaning (Safran & Muran, 2000). Similarly, within the humanistic tradition, concepts like ‘presence’ (Barrett-Lennard, 2007; Rogers, 1965; Schmid, 2007) and ‘relational depth’ (Mearns & Cooper, 2005) highlight the transformational quality of the therapeutic encounter that transcends the therapist-offered conditions and is seen as co-created and co-experienced by both therapist and client (Wilkins, 2010).

Taking into account these contemporary re-conceptualisations of the therapeutic alliance, several authors suggest that alliance theory and research should move away from further theoretical and empirical investigation of the definition, measures, nature and predictive validity of the concept. Instead, future research can benefit from a micro- rather than a macro-level focus (Horvath, 2006) on the how, in what way, and under which conditions, the therapeutic relationship facilitates and affects the change process (Castonguay et al., 2006; Hill & Knox, 2009; Safran & Muran, 2006).

Therapeutic Implications

The consistent empirical evidence on the importance of a positive therapeutic alliance for successful treatment outcome (Horvath & Bedi, 2002; Horvath et al., 2011) entails significant clinical implications for practitioner psychologists in general and counselling psychologists

in particular, given the prominence of the psychotherapeutic relationship in Counselling Psychology theory, research and practice (BPS, 2005; HCPC, 2015).

Research evidence suggests that the quality of the alliance is indicative of the degree of mutual cooperation, collaboration and commitment between therapist and client towards the tasks and goals of the therapeutic process (Horvath & Bedi, 2002; Horvath et al., 2011). It therefore becomes crucial that practitioners endeavour to develop and foster a collaborative framework, within which clients feel valued, respected and experience themselves as active participants rather than passive recipients (Horvath, 2000).

Most importantly, it is essential that a ‘good enough’ alliance is forged and developed during the early phases of therapy, given the fact that weak initial alliances may lead to clients’ premature termination, whilst the alliance developed by the fifth session is especially predictive of treatment outcome (Horvath, 2000; Horvath & Bedi, 2002; Horvath & Luborsky, 1993; Horvath et al., 2011). It is therefore suggested that, during the initial phase of therapy, counselling psychologists should focus on the phenomenological world of clients and the building of the therapeutic alliance before moving onto the implementation of specific techniques. During the early stages of therapy, techniques appear to contribute less to treatment outcome, whereas a sound alliance characterised by collaborative agreement is thought to set the ground for the successful implementation of therapeutic interventions (Godfried & Davila, 2005; Horvath & Bedi, 2002).

In order to enable the forging of a strong alliance during the early phases of therapy, practitioners should strive to establish consensus on the goals of therapy (Bordin, 1994; Tryon & Winograd, 2011), as well as to modify and adapt therapeutic tasks, in a way that best corresponds to clients’ problems, expectations, preferences, resources and personality styles (Horvath et al., 2011; Norcross & Lambert, 2011; Norcross & Wampold, 2011). Similarly, it is of paramount importance that practitioners attend to the bond element of the therapeutic alliance, meaning the level of trust and attachment between therapist and client required for collaborative, purposeful and effective work to take place. It is thus essential that the alliance is negotiated in the beginning, as well as throughout therapy (Hatcher & Barends, 2006). Different types of treatment entail different types of activities and commitments from the members of the therapeutic dyad, and differ with regards to the emphasis they place on the importance of relational work (Bordin, 1994; Hill & Knox, 2009). Practitioners are therefore invited to make a judgment call in relation to the optimal level and type of bond required for the achievement of therapeutic tasks and goals (Hatcher & Barends, 2006; Hill & Knox, 2009).

Research suggests that therapists' and clients' perceptions of the therapeutic alliance seem to differ, especially in the early stages of therapy (Bachelor, 2013; Krause et al., 2011), with clients' ratings of the alliance being more predictive of treatment success (Horvath & Bedi, 2002; Horvath & Symonds, 1991). Counselling psychologists are therefore recommended to actively monitor clients' felt experience of the alliance (Horvath et al., 2011; Sharpless et al., 2010), as well as to seek clients' feedback on their expectations and perceptions of the therapeutic alliance (Bachelor, 2013; Lambert & Shimokawa, 2011), in order to be able to tailor their therapeutic stance and interventions to best meet clients' needs.

Regardless of the establishment of a positive therapeutic alliance early in therapy, fluctuations in the alliance during the middle stages of treatment are to be expected. Clients' initial high ratings of the alliance may often indicate unrealistic expectations (Horvath & Bedi, 2002), whereas the alliance may often be compromised in the middle phase of therapy due to transference/ countertransference dynamics, negative complementarity, or the therapist challenging clients to work through difficult issues (Horvath & Luborsky, 1993; Horvath et al., 2011). It is important that practitioners remain attuned to such fluctuations in the alliance and attempt to resolve them, as they constitute a normal part of the therapeutic process that, when successfully negotiated and resolved, appears to be related to positive treatment outcomes (Horvath, 2000; Horvath et al., 2011; Safran et al., 2011). In any case, it is indicated that therapists remain responsive to clients' negative reactions, as well as refrain from responding with defensiveness and counterhostility (Henry, Schacht, Strupp, Butler, & Binder, 1993; Horvath et al., 2011; Safran et al., 2011).

The fact that numerous therapist factors have been found to influence the development of the therapeutic alliance highlights the significance of clinical supervision, as well as practitioners' training in skills and/ or treatment manuals that facilitate and enhance alliance building and management (Safran et al., 2011; Sharpless et al., 2010). Although research evidence on the relationship between therapist experience/ training and the quality of the alliance are somehow equivocal, more experienced therapists appear more adept at forging alliances and addressing difficulties with clients suffering from more severe relational problems (Horvath, 2001; Horvath & Bedi, 2002). At the other end of the spectrum, practitioners can also benefit from the knowledge of relevant theory and research on client factors that may enhance or impede the development of the therapeutic alliance, in order to remain attuned to alliance fluctuations and be prepared to manage them, so that problems are successfully resolved and premature termination is avoided (Sharpless et al., 2010).

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**Section C:
Research**

Title:

**“Counselling Psychologists’ Experiences
of Therapeutic Ruptures and Repairs:
An Interpretative Phenomenological
Analysis”**

Abstract

The role and impact of a positive therapeutic alliance on psychotherapy outcome has been vastly documented. However, ruptures in the therapeutic alliance are a common phenomenon posing marked challenges on the work of therapists. Although outcome research indicates that rupture-repair processes contribute to an enhancement of the therapeutic relationship, as well as positive treatment outcome, there is a relative lack of qualitative research on the topic. The aim of the current research project was to address this gap by exploring the ways therapists experience, make sense of and repair therapeutic ruptures. Ten semi-structured interviews with counselling psychologists of various therapeutic orientations were conducted, and subsequently analysed using Interpretative Phenomenological Analysis. Four superordinate themes emerged from the data: *'The Threat'*, *'The Struggle'*, *'The Meaning-Making'*, and *'The Resolution'*. Ruptures were perceived as threatening to the therapeutic endeavour, and experienced in the form of withdrawal, breakage or misattunement. Participants' accounts also revealed experiences of heightened struggles in the form of power and control issues, personal and professional dilemmas, as well as negative emotionality. Participating counselling psychologists appeared to make sense of ruptures in relation to intense intrapsychic and interpersonal dynamics, personal vulnerabilities, as well as pacing of therapeutic interventions. Unique and idiosyncratic ways of processing ruptures were employed, whilst successful resolution was ultimately experienced as transformational for the therapeutic relationship and outcome, and was perceived as a valuable learning experience for both therapists and clients. Overall, therapeutic ruptures and repairs were conceptualised as fundamentally relational, intersubjective acts, co-created and co-experienced by both members of the therapeutic dyad. The emerged findings are examined in relation to existing literature and, the implications for the research, training, and practice of Counselling Psychology are discussed.

Introduction

Research has repeatedly shown that the therapeutic alliance is the most robust predictor of positive psychotherapy outcome across all treatment modalities (Horvath & Bedi, 2002; Horvath, Del Re, Flückiger, & Symonds, 2011; Horvath & Symonds, 1991; Martin, Garske & Davis, 2000), and that poor alliances are associated with poor outcome and unilateral termination (Horvath & Bedi, 2002; Martin et al., 2000; Samstag, Batchelder, Muran, Safran, & Winston, 1998). Moreover, despite psychotherapy's general effectiveness (Lambert, 2013; Miller, Hubble, Chow, & Seidel, 2013) evidence suggests that approximately 5-10% of clients appear to deteriorate as a result of therapy (Cooper, 2008), a finding which could be indicating that some clients have negative experiences (Hill, 2010). However, therapists often tend to respond with counterhostility to clients' negative experiences within the context of weak alliances (Henry, Schacht, & Strupp, 1986; Tasca & McMullen, 1992), while training therapists in avoiding negative relational processes has been proven quite a challenging task (Crits-Cristoph et al., 2006; Henry, Schacht, Strupp, Butler, & Binder, 1993).

Research evidence also suggests that the therapeutic alliance is not a static phenomenon, but rather fluctuates over the course of therapy, even within a particular session (Horvath & Luborsky, 1993; Safran & Muran, 2000), with ruptures in the therapeutic alliance being a common phenomenon in psychotherapy (Eames & Roth, 2000; Safran, Muran, & Eubanks-Carter, 2011; Safran, Muran, Samstag, & Stevens, 2002). If unresolved, ruptures can adversely affect therapy process and outcome, and may lead to premature and unilateral termination (Henry et al., 1986; Muran, Safran, Samstag, & Winston 2005). However, if successfully resolved, ruptures can have positive consequences on the therapeutic relationship and process (Safran & Kraus, 2014; Safran & Muran, 2000). Specifically, a pattern of deterioration in the alliance followed by an improvement over the course of treatment is generally associated with positive outcome (Kivlighan & Shaughnessy, 2000; Stiles et al., 2004; Strauss et al., 2006).

In fact, the APA Division 29 Task on Empirically Supported Therapy Relationships pointed out the repair of alliance ruptures as a 'promising and probably effective' treatment principle (Norcross, 2002), a conclusion that was reaffirmed by the second Task Force on Evidence-Based Therapy Relationships that listed the repair of alliance ruptures among the 'promising but with insufficient research to judge' relationship elements (Norcross & Lambert, 2011; Norcross & Wampold, 2011). It is therefore understood that there is still room for further research in the field of the therapeutic alliance, in general, and the management and repair of ruptures, in particular. In fact, there has been an identified demand for phenomenological studies, in the field of alliance research, in order to identify specific factors and mechanisms

of change within the therapeutic relationship related to psychotherapy outcome (Gumz, Brähler, Geyer, & Erices, 2012; Hill & Knox, 2009).

Alliance Ruptures and Repairs: Theory and Research

Given the significance of the alliance for successful psychotherapy outcome, a ‘second generation’ of research has emerged over the past two decades, in an attempt to illuminate the processes contributing to the development and maintenance of the alliance, as well as to investigate the ways that therapists can best address, manage and repair alliance ruptures (Safran et al., 2011; Safran et al., 2002).

This generation of research has been vastly influenced by Bordin’s (1979, 1994) pantheoretical conceptualisation of the alliance, as consisting of agreement on tasks and goals, as well as an affective bond between therapist and client, characterised by mutual liking, trust and respect. Bordin (1994) postulated that the working alliance is dyadic, mutual and constantly negotiated. Consequently, strains in the alliance are to be expected and can be manifested in the form of disagreements over the tasks and goals of therapy or through strains in the affective bond. According to Bordin (1979), it is precisely this ‘tear and repair’ of the relationship that can actually make it stronger and lead to client change, as it represents opportunities for therapeutic change and for deepening the alliance. In fact this dynamic process between therapist and client has been considered by contemporary alliance theoreticians and researchers as a mechanism of change in and of itself, as long as it is successfully negotiated and resolved (Safran & Kraus, 2014; Safran & Muran, 2000, 2006).

Definitions, Conceptualisations, Measures, and Prevalence of Ruptures

Definitions

Safran and Muran (2006) have defined alliance ruptures as “a breakdown in the collaborative process, periods of poor quality of relatedness between patient and therapist, a deterioration in the communicative situation, or a failure to develop a collaborative process from the outset” (p. 288). According to the authors, a focus on the breakdown in collaboration is closer to Bordin’s conceptualisation of the alliance but fails to fully capture clients’ difficulties in negotiating authentic relatedness. On the other hand, a pure focus on the poor quality of relatedness or on the deterioration of the communicative process encapsulates clients’ relational difficulties, but also deviates from the classical conceptualisation of the alliance as rational collaboration. Other terms that have been used to describe this phenomenon include ‘empathic failures’ (Kohut, 1984), ‘misunderstanding events’ (Rhodes, Hill, Thompson, & Elliott, 1994), ‘therapeutic impasses’ (Hill, Nutt-Williams, Heaton, Thompson, & Rhodes, 1996), and ‘markers of enactments’ (Safran et al., 2002).

The term rupture itself implies a major breakdown in the alliance, however, in reality, ruptures may vary in intensity ranging from minor tension that may go unnoticed, to major breakdowns in collaboration, understanding or communication (Eubanks-Carter, Muran, & Safran, 2010; Safran et al., 2011). Alliance ruptures usually consist of disagreements about the tasks of treatment, disagreements about the goals of treatment, or strains in the bond. Ruptures usually lead to a client marker behaviour that usually takes the form of *withdrawal*, where the client moves away from (e.g. by exhibiting avoidance) or towards (e.g. by exhibiting deference) the therapist, or *confrontation*, where the client moves against the therapist (e.g. by expressing anger or dissatisfaction) (Safran & Muran, 1996). These forms of ruptures are not mutually exclusive, but may pull for different types of therapist interventions (Safran et al., 2002). Lastly, ruptures may be manifested within a single therapy session, over several sessions, or across treatment in the form of a recurrent pattern (Safran & Kraus, 2014).

Conceptualisations

In classical psychoanalytic theory, ruptures were understood as stemming from client's resistance hindering the change process. For some theorists, the analysis of resistance is the therapy, whereas for others resistance is something to be bypassed in order to gain access to the repressed memories and affect (Freud, 1923). In ego psychology resistance was no longer viewed as an obstacle to the therapeutic process, but rather as a part of the psychic surface of the ego that needed to be explored (Fenichel, 1941; Kris, 1951). British object relations theorists and self-psychologists, on the other hand, regarded resistance as a healthy and necessary function of the self (Kohut, 1977) who attempts to protect the individual from retraumatisation (Fairbairn, 1952). Contemporary, relational theorists (Aron, 1996; Mitchell, 1993) view resistance as a function of the relational context, within which the interaction between therapist and client takes place. Client's resistance is therefore understood and explored both intrapsychically and interpersonally taking into account both therapist's and client's contributions to the interaction (Safran & Kraus, 2014; Safran & Muran, 2000). Cognitive theorists have also conceptualised resistance as the client's attempt to protect himself/ herself from further loss, disappointment and criticism, and have stressed out the importance of the therapist 'aligning with the resistance', when indicated (Leahy, 2001, 2007).

Rupture episodes may be also conceptualised as moments of 'intersubjective negotiation' between two different subjectivities (Benjamin, 1990). They can therefore enable the client to negotiate the needs of the self versus the needs of others, leading to the experience of the self as a subject without treating the other as an object. Ruptures thus provide the client with

the opportunity to learn how to constructively assert, negotiate and balance the need for agency/ autonomy with the need for proximity/ relatedness (Muran, Safran, & Eubanks-Carter, 2010). This is of particular relevance for the understanding of withdrawal and confrontation ruptures. For clients who privilege the need for relatedness, withdrawal ruptures may be more common, manifested in the form of submission of their wishes and needs, in order to maintain proximity. On the other hand, confrontation ruptures may be more common for clients who privilege the need for autonomy, reflecting their self-relying style of relating and manifested in their attempts to control and dominate in the relationship (Coutinho, Ribeiro, & Safran, 2009; Safran & Muran, 2000).

Lastly, ruptures can be conceptualised and explained by the principles of ‘interpersonal complementarity’ which postulates that specific, interpersonal behaviours pull for specific, interpersonal responses (Kiesler, 1996). Clients’ maladaptive interpersonal schemas tend to be acted out in the therapeutic relationship inviting the therapist to act and behave in a complementary way that will confirm their schemas. Should the therapist manage to disembed himself/ herself from the enactment, behave in a non-anticipated way and empathically explore the client’s feelings, the maladaptive interpersonal cycle that maintains the client’s dysfunction will gradually subside (Katzow & Safran, 2007; Safran & Muran, 2000). Therapeutic ruptures and repairs are thus significant learning and corrective emotional experiences that enable clients to restructure existing maladaptive schemas and replace them with new, more adaptive relational schemas, within which the self is perceived as capable of eliciting proximity, and the other is perceived as available (Coutinho et al., 2009; Safran & Segal, 1996). Overall, it is evident that therapeutic ruptures constitute windows into clients’ core organising principles and should not be regarded as obstacles that need to be overcome. On the contrary, detailed and empathic exploration of both the client’s and therapist’s experience of and contribution to the interaction has the capacity to transform a difficult impasse into a meaningful understanding of the client’s core relational schemas (Safran & Muran, 2000).

Measures

Ruptures can be measured from the perspective of the client, the therapist or an observer, and can be repaired either within a single session or over a period of sessions (Safran et al., 2011). One method of detecting alliance ruptures consists of having therapists and clients complete Postsession Questionnaires (PSQ; Muran, Safran, Samstag, & Winston, 1992) that include self-report measures of the alliance, as well as occurrence of ruptures, rupture intensity, and extent of resolution within sessions (see Eubanks-Carter et al., 2010; Safran et al., 2011). Self-report questionnaires have certain advantages, such as convenience and data reduction.

Nonetheless, they are also characterised by significant limitations, as participants' responses are subject to their emotional states, as well as their willingness to respond truthfully whilst completing the questionnaires (Coutinho, Ribeiro, Sousa, & Safran, 2014). Furthermore self-report measures are potentially flawed due to client bias and poor self-reflection (Colli & Lingardi, 2009), as well as due to the fact that they rely on retrospective recall, which is limited to what participants are able and willing to disclose at the time (Coutinho, Ribeiro, Hill, & Safran, 2011). Lastly, therapists' and clients' ratings of alliance ruptures do not necessarily converge, with therapists reporting ruptures significantly more often than clients (Safran et al., 2011).

Due to the aforementioned limitations, other researchers have proposed the use of observer-based methods for detecting rupture and repair processes, such as Harper's Coding System (Harper, 1989a, 1989b), the Collaborative Interaction Scale (CIS; Colli & Lingardi, 2009), and the Rupture Resolution Rating System (3RS; Eubanks-Carter, Mitchell, Muran, & Safran, 2009). In Harper's Coding System, judges identify confrontation and withdrawal rupture markers through session transcripts. Similarly Colli and Lingardi's CIS (2009) uses transcripts of sessions for the identification of both ruptures and resolutions. The CIS has demonstrated good inter-rater reliability, and has the unique strength of assessing both therapist and client positive and negative contributions to the therapeutic process. The 3RS (Eubanks-Carter et al., 2009), draws on Harper's manual for coding withdrawal and confrontation ruptures, has also demonstrated adequate inter-reliability, and has the distinct advantage of using video data that do not require transcription of sessions (Coutinho et al., 2014). Studies that have employed observer-based method for the detection of ruptures (e.g. Coutinho et al., 2014; Lansford, 1986; Sommerfeld, Orbach, Zim, & Mikulincer 2008) have consistently demonstrated that ruptures are more frequently reported by observers than therapists or clients suggesting that clients may indeed struggle with the identification and acknowledgment of ruptures (Safran et al., 2011). At the same time, given the fact that clients' ratings of the alliance appear to be more predictive of treatment retention and outcome (Horvath & Bedi, 2002), it has been suggested that self-report and observer-based methods may be used in a complementary fashion (Coutinho et al., 2014).

A third method of identifying rupture and repair sequences are indirect self-reports that consist of tracking alliance fluctuations across therapy sessions. Therapists and clients complete measures of the alliance, such as the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), the Agnew Relationship Measure (ARM; Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998), and the California Psychotherapy Alliance Scales (CALPAS; Marmar, Weiss & Gaston, 1989). Ruptures and resolutions are subsequently measured based on fluctuations in alliance scores across the course of therapy according to the development

of certain criteria (see Eubanks-Carter et al., 2010; Safran et al., 2011). Although indirect self-reports allow the observation of the natural occurrence of rupture and resolution processes and contribute in the clarification of the link between these phenomena and treatment outcome (Eubanks-Carter et al., 2010), recent studies (e.g. Coutinho et al., 2014; Sommerfeld et al., 2008) suggest that they may not be as sensitive as observer-based methods in capturing the occurrence of ruptures. It has thus been argued that these two methods may be actually measuring different phenomena (the construct of the alliance vs. the construct of ruptures per se) or different levels of the same phenomenon (ruptures at session level vs. ruptures at segment level) (see Coutinho et al., 2014).

The development of methods for detecting rupture-repair sequences has undoubtedly paved the way for the conduct of research on the processes underpinning the relationship between therapeutic ruptures and repairs, and treatment outcome. At the same time, the fact that different researchers have used a variety of methods for identifying ruptures potentially renders findings more fragmented and less clinically meaningful (Horvath, 2011). According to Horvath (2011) this is in itself problematic, as each method of assessment appears to be assuming a different definition of ‘ruptures’ bracketing the results of each investigation within the constraints of its proposed definition. Furthermore, the number of detected rupture-repair sequences varies significantly according to the perspective (client, therapist, observer) from which ruptures are identified (Safran et al., 2011), as well as the timing of (Coutinho et al., 2014) and rupture-repair criterion for each measurement (Gumz et al., 2012; Strauss et al., 2006). Consequently, findings from different investigations cannot be linked nor aggregated easily, and insights on ruptures remain limited in their theoretical scope and clinical utility (Horvath, 2011; Strauss et al., 2006), especially if we take into account the substantial intraindividual and interindividual variability characterising participants in each study (Coutinho et al., 2014; Gumz et al., 2012).

Prevalence

Ruptures in the therapeutic alliance appear to be a rather frequent phenomenon. In a recent meta-analysis of eight studies employing client, therapist or observer reports, Safran, Muran and Eubanks-Carter (2011) demonstrated that patients report ruptures in 19% to 42% of sessions, therapists report them in 43% to 56% of sessions and external raters observe them in 41% to 100% of sessions. In general, clients tend to rate the alliance more highly and consistently and clients’ ratings of the alliance seem to be a better predictor of outcome (Horvath & Symonds, 1991). Nevertheless, as therapy progresses, client and therapist reports become more similar (Horvath & Bedi, 2002). This difference in perspective may reflect the impact of therapists’ theoretical orientation through which they view the alliance. On the

other hand, clients seem to think about the alliance based on their prior interpersonal experiences (Krause, Altimir, & Horvath, 2011) and rate the alliance more globally driven by their need for safety and desire to change (Horvath, 2000; Horvath & Bedi, 2002). However, caution should be exercised, as this difference in perspectives could be also attributed to clients' lack of awareness of ruptures or discomfort with acknowledging them (Eubanks-Carter et al., 2010).

Furthermore, therapists across different theoretical orientations tend to differ in their ratings of the therapeutic alliance, with cognitive-behavioural therapists reporting higher alliances and fewer ruptures than therapists in other treatment conditions, such as process experiential therapy (Watson & McMullen, 2005), psychodynamic interpersonal therapy (Raue, Castonguay, & Goldfried, 1993; Raue, Goldfried, & Barkham, 1997), brief relational therapy and short-term dynamic therapy (Muran et al., 2009). One possible explanation for this difference in perspectives may be attributed to the fact that relationship issues may not occur as often or as intensely within the context of brief, manualised treatments, such as CBT (Raue et al., 1997). Another possible explanation could be that cognitive-behavioural therapists may have more difficulty in recognising and acknowledging ruptures, as their theoretical orientation places more emphasis on agreement and collaboration, rather than on the awareness, detection, and explicit addressing of ruptures or strains in the therapeutic relationship (Muran et al., 2009). Consequently, it could also be argued that clients in CBT are more reluctant to share their reactions and feelings with their therapists, as well as that CBT in itself is potentially characterised by less emotionally charged sessions, as a result of a less direct focus on the therapeutic process and relationship (Raue et al., 1997; Watson & McMullen, 2005).

These complementary explanations are in line with research findings on therapists' personality traits and preferred theoretical orientation. Several studies have shown that people drawn to the non-directive approaches tend to privilege intuition, feeling and openness to experience, whereas people interested in the directive approaches gravitate more toward sensing, judging, systematising, asserting and conforming (Arthur, 2001; Scandell, Wlazelek, & Scandell, 1997; Scragg, Bor, & Watts, 2007; Varlami & Bayne, 2007). Humanistic and psychodynamic therapies therefore encourage exploration of clients' feelings, as well as therapists' self-awareness and acceptance of their own feelings. On the other hand, cognitive-behavioural therapy regards emotions as phenomena to be controlled rather than processed and explored. It has thus been postulated that cognitive-behavioural therapists appear less open to feelings, and tend to focus less on emotional processing and expression (Boswell, Castonguay, & Pincus, 2009; Goldfried, Raue, & Castonguay, 1998). They may therefore be less adept at detecting ruptures, as well as more prone towards dealing with the emotional

intensity surrounding ruptures at a more surface rather than an in-depth level, by focusing on areas of agreement rather than moments of tension (Muran et al., 2009; Safran et al., 2011).

Research Findings on Alliance Ruptures and Resolution

The process of repairing alliance ruptures has been nowadays recognised as a “promising but with insufficient research to judge” treatment principle that may be positively associated with treatment outcome (Norcross & Lambert, 2011; Norcross & Wampold, 2011; Safran et al., 2011). Four main methodological paradigms have been therefore employed, in order to further elaborate on the nature and function of this complex phenomenon, as well as to illuminate its relation to psychotherapy process and outcome. These are naturalistic observation studies, task-analytic studies, randomised controlled trials (RCTs) and qualitative studies (Eubanks-Carter et al., 2010).

Naturalistic Studies

Naturalistic studies focus on the natural observation of rupture and repair phenomena, and examine their relation to treatment outcome. Specifically, there are three methods of identification of rupture and resolution processes; therapist and client direct self-reports, observer-based methods, and indirect self-reports (Eubanks-Carter et al., 2010).

Eames and Roth (2000) administered the Postsession Questionnaire (PSQ; Muran et al., 1992) to both therapists and clients and found that therapists reported ruptures in 43% of sessions, while clients reported them in 19% of sessions. They also found that therapist-reported ruptures were positively correlated with a preoccupied attachment style, and negatively correlated with a dismissing attachment style. Similarly, Muran et al. (2009) administered Postsession Questionnaires to both therapists and clients after each session of three different treatments. During the first six treatment sessions, ruptures were reported by 56% of therapists and 37% of clients. Lower rupture intensity and higher rupture resolution were associated with higher ratings of the alliance and session depth. Furthermore, lower rupture intensity was related to better outcome on measures of interpersonal functioning, whilst higher rupture resolution was predictive of better treatment retention.

Given the divergence in therapists’ and clients’ ratings of the alliance and reports of ruptures, observer-based methods seem to be a reasonable way of addressing rupture and repair processes. An early study (Lansford, 1986) that employed observer-based ratings of ‘weakenings’ in the alliance concluded that therapists and clients who actively dealt with ruptures had more successful outcomes. Sommerfeld, Orbach, Zim, and Mikulincer (2008) compared clients’ and observers’ assessments of alliance ruptures in psychodynamic therapy administering the Session Evaluation Questionnaire (SEQ; Stiles, 1980). They found that

observers reported ruptures in 77% of sessions, while clients reported them in 42% of sessions. While there was no association between observers' and clients' perspectives, sessions in which both observers and clients reported a rupture were rated by clients as having greater depth. Furthermore, the researchers also found a significant association between the occurrence of ruptures and the emergence of clients' Core Conflictual Relationship Themes (CCRT; Luborsky & Crits-Cristoph, 1998). Taken together, these findings highlight the importance of therapists' active exploration of ruptures, as they provide windows to clients' core relational schemas and critical opportunities for their modification (Eubanks-Carter et al., 2010).

Indirect self-reports of ruptures and repairs track fluctuations in clients' alliance scores over the course of treatment. Based on Gelso and Carter's (1994) formulation that a curvilinear pattern of alliance development would be characteristic of more effective time-limited therapy, a number of researchers have attempted to investigate patterns of alliance development across time, and to clarify the connection between different alliance patterns and treatment outcome. In a sample of 41 volunteer clients working with novice counsellors, Kivlighan and Shaughnessy (2000) administered the Working Alliance Questionnaire (WAI; Horvath & Greenberg, 1986) and employing cluster analysis, they managed to identify three alliance patterns, namely stable alliance, linear alliance growth and quadratic (U-shape) alliance growth. They found that the latter was associated with greater improvement on different measures of counselling outcome.

Stiles et al. (2004) attempted to replicate Kivlighan and Shaughnessy's (2000) findings in a clinical sample of psychotherapy clients treated for depression. They administered the Agnew Relationship Measure (ARM; Agnew-Davies et al., 1998), and measured alliance fluctuations in different types of treatments for depression, according to specifically developed criteria. Although, they did not find support for U-shaped alliance patterns, they did detect V-shaped rupture-repair sequences, characterised by strong deteriorations and subsequent improvements of the alliance, which were associated with greater treatment gains, as measured by the Beck Depression Inventory and the Brief Symptom Inventory. These findings were supported by Strauss et al.'s (2006) study in a sample of 30 clients with avoidant and obsessive-compulsive disorders who received cognitive-behavioural therapy. By developing specific criteria for rupture-repair episodes and measuring fluctuations in alliance scores on the California Psychotherapy Alliance Scales (CALPAS; Marmar et al., 1989), the researchers demonstrated that stronger early alliances and rupture-repair episodes predicted more improvement in symptoms of personality disorder and depression, as assessed by the pre- and post-treatment scores in the Wisconsin Personality Disorders Inventory and the Beck Depression Inventory. On the other hand, other studies have failed to find an

association between rupture-repair episodes and treatment outcome (Stevens, Muran, Safran, Gorman, & Winston, 2007).

Gumz, Brähler, Geyer, and Erices (2012) developed an alternative and more sophisticated rupture-repair criterion, able to identify rupture sequences not previously considered, and taking into account the length of the crises. They administered the Intrex questionnaire (Benjamin, 1988), a short form of the Structural Analysis of Social Behaviour assessment tool (SASB; Benjamin, 1987), to a sample of patients with depression and personality disorders receiving psychodynamic psychotherapy, and subsequently applied this criterion identifying five patterns of crises and resolutions; “jump in-jump out” (V-shape), “jump in-slide out”, “slide in-jump out”, “slide in-slide out”, “complex patterns”. The most frequent pattern was the V-shape, followed by the “jump in-slide out” pattern. Taken together these findings indicate that temporary deteriorations in the therapeutic relationship constitute a common phenomenon, as well as a distinctive feature of psychotherapy change over the course of treatment. The number, magnitude and length of rupture-repair episodes may substantially vary depending on the specific characteristics of the therapeutic relationship, process, and measures (Gumz, et al., 2012). In any case, the fact that rupture-repair sequences seem to be associated with greater treatment gains confirms the claim that alliance ruptures, manifested in the here and now of the therapeutic relationship, represent opportunities for learning and change (Safran & Muran, 2000; Stiles et al., 2004).

Overall, naturalistic studies are a promising research method for the identification and clarification of processes preceding rupture resolution, and may shed further light onto both clients’ and therapists’ contributions in the process of repairing alliance ruptures. At the same time, they are not without certain limitations, such as the use of small sample sizes that limit generalisability of findings requiring further replication (Kivlighan and Shaughnessy, 2000; Strauss et al., 2006). The clinical utility and generalisability of findings also appears to be compromised by the different criteria used and various timing of measurements conducted to identify rupture-repair episodes, as well as the various clinical problems, treatment approaches, and client populations included in each study (Gumz et al., 2012; Strauss et al., 2006). As a result, the findings of each investigation cannot be easily aggregated nor extrapolated from one to another (Horvath, 2011). Moreover, it has been argued that rupture-repair sequences are not independent from therapist effects and treatment types, and future research can benefit from qualitative studies and multilevel modelling techniques, capable of capturing the responsiveness and complexity of the therapeutic relationship, in order to improve treatment retention and outcome (Stiles et al., 2004; Strauss et al., 2006).

Task Analytic Studies

The task-analytic paradigm integrates a combination of qualitative and quantitative methodologies. Researchers initially develop a theoretical model of processes underpinning ruptures resolution. They subsequently observe successful resolution of rupture events and revise the theoretical model accordingly. Then, they develop specific criteria for assessing each step, select measures, and employ trained judges to code therapist and client behaviours using the selected measures. The theoretical model is further modified based on the results of the coding, yielding a final rational-empirical model of the components of the processes involved in the rupture resolution task (Greenberg, 2007; Safran et al., 2011).

Repairing Alliance Ruptures in Safran and Muran's Model

Through a series of task-analytic studies (Safran, Crocker, McMain & Murray, 1990; Safran, Muran & Samstag, 1994; Safran & Muran, 1996), Safran and colleagues have developed a rupture resolution model that consists of four distinct stages (Muran et al., 2010; Safran et al., 2011):

1. Attending to the rupture marker
2. Exploring the rupture experience
3. Exploring any avoidance away from communicating about the rupture
4. Recognizing patient's expression of an underlying wish or need

(see Muran et al., 2010, p. 324)

The nature and process of clarification in stage 4 depends on the type of rupture. In the withdrawal resolution process, the typical progression consists of moving through increasingly clearer expressions of negative sentiments to self-assertion, in which the client's need for agency and autonomy is met and validated by the therapist. In the confrontation resolution process, the typical progression consists of moving from expressions of anger to the expression of feelings of hurt and disappointment, in order for the client to contact the underlying vulnerability, and deeper wish and need for nurturance (Safran et al., 2002; Safran, Muran, & Eubanks-Carter, 2010).

Based on their research programme, Safran and colleagues have developed a typology of rupture resolution strategies that may be direct or indirect, and may target ruptures at a surface or at a depth level. Such rupture-repair interventions consist of repeating the therapeutic rationale, changing tasks or goals, clarifying misunderstandings at a surface level, exploring patient's relational themes associated with the rupture, linking the alliance rupture to common patterns in a patient's life, providing a new relational experience (Safran et al., 2011).

Repairing Alliance Ruptures in Psychodynamic Psychotherapy

Agnew, Harper, Shapiro and Barkham (1994) selected one case of psychodynamic-interpersonal therapy for depression and tested a psychodynamic-interpersonal model for resolution of confrontation challenges. Their resolution model consisted of six stages:

1. Acknowledgment of the client's feelings around the confrontation challenge
2. Negotiation of the therapist's and client's understandings, in order to reach a shared understanding of their roles and responsibilities
3. Exploration of parallel situations outside therapy
4. Consensus on the understandings of the origins of client's current dissatisfaction and renegotiation of the terms of the working relationship
5. Further exploration of parallel situations outside therapy
6. Discussion of alternative styles of relating in these situations

(see Agnew et al., 1994, p. 165)

In line with Safran and Muran's resolution model, Agnew and colleagues (1994) also highlighted the importance of the therapist acknowledging and collaboratively exploring ruptures with clients. However, they placed greater emphasis on linking ruptures with situations outside therapy, as opposed to clarifying the client's underlying wish or need.

Bennett, Parry, and Ryle (2006) also employed task analysis and proposed a model for the resolution of alliance-threatening transference enactments in cognitive-analytic therapy of clients with borderline personality disorder. Their resolution model consisted of nine stages, although therapists appeared to cycle between and within stages, suggesting that resolution is not necessarily achieved in a fixed, linear way:

1. Acknowledgment of the event and of client's feelings in the here-and-now
2. Exploration of the nature of the feelings
3. Linking and explanation of the feelings with the reformulation
4. Negotiation of patient's acceptance and understanding of the possible link
5. Consensus on the event and its association with the client's other current or past relationships
6. Understanding and assimilation of warded off feelings
7. Further explanation of the procedure and its relation to the reformulation
8. Facilitation of client's engagement in change through exploration of alternatives to identified patterns of relating
9. Closure with the therapist affirming the focus on the therapeutic relationship

(see Bennett et al. 2006, p. 411)

Consistent with Safran and Muran's model, Bennett et al.'s (2006) model also highlighted the significance of therapists' attending to and responding in a non-defensive way to alliance ruptures. However, as in Agnew et al.'s (1994) model, they placed more emphasis on linking ruptures to clients' pre-established formulation and other relationships outside therapy, as opposed to focussing on the immediate process and clarification of clients' underlying wish or need. The findings of these two rupture-resolution models are consistent with research on therapists' theoretical orientation and personality attributes indicating that psychodynamic psychotherapists tend to place more emphasis on past experiences, intrapsychic and interpersonal patterns, unconscious motivation, as well as acceptance and expression of feelings, and acquisition of insight (Arthur, 2001; Goldfried, Castonguay, Hayes, Drozd, & Shapiro, 1997; Tremblay, Herron, & Schultz, 1986).

Repairing Alliance Ruptures in Humanistic/ Experiential Psychotherapy

Ruptures in experiential therapy are viewed as accurate reflections of what is happening in the here-and-now between therapist and client, as opposed to a function of clients' past relationships. In the early stage of therapy, during which the affective bond between participants has not yet fully developed, ruptures may stem from clients' difficulty turning inward, clients' feeling unsafe with therapists or questioning the purpose and value of therapy, as well as a divergence between clients' and therapists' expectations. In the middle stage of therapy ruptures may include task-related difficulties or bond-related difficulties (Watson & Greenberg, 2000).

Elliott and colleagues (2004) (see also Watson & Greenberg, 2000) have proposed a six-step rupture resolution model, even though their suggestions are the by-products of an ongoing research rather than a full task analytic study:

1. Acknowledgment, validation and empathic responsiveness to clients concerns
2. Exploration of the difficulty and inquiry on the contribution of each participant to the interaction
3. Acknowledgment of therapist contribution to the event and examination of the client's contribution, with regard to his/ hers previous emotional patterns, past life events and relational strategies
4. Summarizing the difficulty checking the client's understanding
5. Negotiation of the ways the difficulty can be resolved, including potential changes in the way the therapy is conducted
6. Strengthening of the relationship, deepening of mutual respect, trust, and collaboration

(see Elliott et al., 2004, p. 158)

In line with Safran and Muran's model, Elliott et al. (2004) also emphasise the importance of the therapist directly addressing the rupture, accepting responsibility for his/her contribution to the interaction, and responding to the client's concerns non-defensively. They also both stress out the importance of validation and metacommunication (i.e. communicating about the communication) about the tasks, techniques, and the therapeutic relationship in the here-and-now. At the same time, the process-experiential resolution model seems to pay more attention on the significance of immediacy, as well as on the implementation of task interventions around clients' fears and concerns (see Watson & Greenberg, 2000). The steps involved in the humanistic rupture-resolution model echo Bordin's (1979) claim on the contribution of both therapist and client in the formation of a strong working alliance. They are also consistent with literature on therapist personality and preferred theoretical orientation, according to which, humanistic therapists score higher than their psychoanalytic and cognitive-behavioural counterparts on the domains of openness to experience, feeling and action, self-acceptance, self-actualisation and spontaneity. They therefore consider the therapeutic relationship as the main vehicle to change, privilege empathy and genuineness, demonstrate receptivity to client feedback, and encourage spontaneous expression of feeling and behaviour, whilst they also appear more flexible and willing to employ new and novel activities, in order to best meet clients' needs (Boswell et al., 2009; Scandell et al., 1997; Tremblay et al., 1986).

Repairing Alliance Ruptures in Cognitive-Behavioural Therapy

Ruptures in cognitive-behavioural therapy are thought to arise from unvoiced disagreements on the tasks and goals (clients' avoidance of tasks or unresponsiveness to therapists' interventions) of therapy. Cognitive therapists were traditionally advised to address such negative reactions directly by correcting clients' distorted thoughts (Beck et al., 1979). However, contemporary findings suggest that ruptures can be exacerbated from therapists' persistence with the application of technique, as opposed to focusing on clients' concerns, leading to negative complementary interactions (Aspland et al., 2008; Castonguay et al., 1996).

Aspland and colleagues (2008) employed task-analysis in two good outcome cases treated with CBT for depression. The proposed rupture resolution model consisted of six stages:

1. *Therapist's internal review of pattern/ problem*
2. Change of approach in order to address empathic failure by attending to the client's experience through summarising, exploring and validating
3. Restoration of the collaborative relationship by empowering client's participation, affirming client's contribution, and seeking client's feedback

4. *Linking pattern of interaction with formulation of client's problems*
5. *Revising approach accordingly*
6. Negotiation of new/revised task

(see Aspland et al., 2008, p.707)

In Aspland et al.'s model, resolution occurred when therapists shifted their focus from therapeutic tasks, in order to attend to the client's experience. In line with other rupture-resolution models, emphasis was also given on collaboration and negotiation. What is striking, however, is that the rupture resolution model did not include any overt recognition or exploration of the rupture itself. The processes of rupture recognition, linking interaction pattern to client's formulation, and revising the therapeutic approach to better meet client's feedback and needs appeared to have occurred covertly and silently, as supposed to directly voiced and collaboratively explored. The authors commented that their findings may be attributed to the prevalence of withdrawal, as opposed to confrontation ruptures (Aspland et al., 2008; Safran et al.; 2011). These findings are consistent with existing literature indicating that cognitive-behavioural therapists tend to report fewer ruptures and more positive therapy reports than therapists in other treatment conditions (Raue et al., 1993, 1997; Safran et al., 2009; Watson & McMullen, 2005). They can be also interpreted in light of research on therapists' personality traits, as reflected upon their theoretical orientation and therapeutic focus. Several studies have demonstrated that cognitive-behavioural therapists are inclined towards rationality, empiricism and objectivity. They give precedence to thoughts over feelings, action over insight, and are more practical than intuitive. They therefore appear to exhibit limited flexibility, lower awareness of feeling reactivity, less acceptance for client aggressive feelings and lower capacity for intimate contact (Arthur, 2001; Keinan, Almagor, & Ben-Borath, 1989; Tremblay et al., 1986). It could therefore be argued that in the face of therapeutic ruptures, which are usually emotionally charged, cognitive-behavioural therapists are less aware of and/ or less willing to accept and discuss their own and their clients' feelings via immediacy, and are more interested in adopting a pragmatic solution by revising their approach without necessarily processing the rupture in a relational and collaborative manner (Boswell et al., 2009; Elliott et al., 2004; Goldfried et al., 1997, 1998).

Cash, Hardy, Kellett and Parry (2014) have recently conducted task-analysis of two good outcome cases with borderline personality disorder, in an attempt to replicate Aspland et al.'s (2008) CBT rupture resolution model for depression. They came up with a new model consisting of six stages:

1. Explicit or internal acknowledgment of an interpersonal rupture outside of therapy

2. Acknowledgment of client's feelings, problems or patterns, taking place within or outside therapy that trouble the client and impede progress
3. Change of approach by shifting focus from the implementation of techniques to exploration of client's interpersonal patterns of interaction with regard to the therapeutic alliance, past and present relationships
4. Making links pertinent to client's formulation through clarification and summarizing
5. Restoration of the therapeutic alliance by encouraging client's active participation, affirming client's contribution, emphasizing responsibility of the client's role in therapy and empowering the client
6. Negotiation of the task leading to mutual collaboration in the pursuit of the task or to a revision of the therapeutic approach, paying attention to the client's activated schema

(see Cash et al., 2014, p. 142)

Cash et al.'s (2014) rupture resolution model shares many similarities with Aspland et al.'s model (2008). In line with Aspland et al., the current model did not include an explicit acknowledgment of alliance ruptures, and therefore the hypothesis for the therapist taking responsibility for his/ her contribution to the interaction (Safran et al., 2011) was not validated. These common findings support the claim that cognitive-behavioural therapists appear more likely to directly address relational problems only when they interfere with the therapeutic process (Hill & Knox, 2009) privileging collaboration and agreeableness, rather than openness to feelings and interpersonal intimacy (Arthur, 2001; Boswell et al., 2009; Keinan et al., 1989; Scandell et al., 1997). In contrast to Aspland et al. (2008), the current model involved the therapists acknowledging their own limitations, taking a reflective stance, and engaging in emotional self-disclosure. A focus on the affective experience may be of particular importance in the resolution of ruptures with borderline personality clients who experience significant emotional shifts and affective instability.

Task analytic studies are a promising approach in the investigation of rupture resolution, as they allow researchers to combine theory with discovery-oriented approaches within single studies (Hill & Knox, 2009). Furthermore, they have provided us with great insight with respect to specific steps leading to successful rupture resolution that are of direct relevance to clinical practice and can be also implemented for training purposes. A great disadvantage of task analytic paradigm is that it is very time consuming, whilst there is often a lack of available measures at hand, in order to assess the specific behaviours involved in each step (Hill & Knox, 2009). In addition, it does not provide us with any insight on participants' internal processes during rupture resolution events (Cash et al., 2014). It is also important to keep in mind that particular rupture-resolution models unavoidably reflect the authors'

theoretical orientation. It could therefore be argued that rupture resolution strategies and techniques identified by different models may reflect the researchers' as opposed to clients' preferences (Eubanks-Carter et al., 2010), and cannot be easily generalised from one therapeutic modality to another (Bennett et al., 2006). Lastly, it is difficult to judge whether the findings of each investigation would take the same form with other therapeutic dyads, without further replication (Aspland et al., 2008; Bennett et al., 2006).

Randomised Controlled Trials

Acknowledging the adverse impact of unresolved alliance ruptures on psychotherapy process and impact, several researchers have adopted the RCT research paradigm, in an attempt to investigate whether the integration of rupture resolution techniques may enhance the efficacy and effectiveness of particular treatments (Eubanks-Carter et al., 2010). In fact, a recent meta-analysis of eight studies investigated the impact of rupture resolution training or supervision on client outcome and revealed small but statistically significant improvements for clients of therapists who had undertaken such training or supervision (Safran et al., 2011).

Alarmed by the fact that therapists tended to respond with defensiveness and counterhostility to clients' hostility, Henry and colleagues (1993) tested a manualised time-limited dynamic therapy aiming at the management of therapists' negative relational processes in the therapeutic relationship. Contrary to the researchers' hypothesis, training therapists to resolve alliance ruptures seemed to lead to rigid adherence to manuals interfering with some therapists' normally supportive style. This finding was also supported by subsequent research findings indicating that therapists' attempts to resolve alliance strains through increasing adherence to their preferred model led to poor outcome and premature termination (Castonguay et al., 1996; Piper et al., 1999). Similarly, Crits-Cristoph and colleagues (2006) tested the effectiveness of alliance-fostering therapy (a combination of interpersonal psychodynamic interventions and alliance enhancing techniques) for patients with major depressive disorder. They did find support for moderate to large increases in the alliance from pre- to post-training, albeit these effects did not reach statistical significance. The training also led to small improvements in depressive symptomatology and large improvements in the quality of life. These results were not, however, consistent across therapists suggesting that the relational elements of the therapeutic alliance cannot be easily manualised and that certain alliance skills are not easily mastered by all therapists, whilst clients may have the capacity to see the 'inner person' of the therapist behind the skilful implementation of techniques (see also Binder & Henry, 2010).

In contrast to the previous two studies, Safran and colleagues (2014) preliminary findings from a research programme investigating the impact of alliance-focused training (AFT) on

the management of negative interpersonal processes appear much more promising. Specifically, therapists who undertook AFT supervision, after having received CBT supervision, exhibited less evidence of negative interpersonal processes, and higher capacity for experiential reflection, that seems to be associated with higher rupture resolution (Kazarians, 2012). Furthermore, Bambling and colleagues (Bambling, King, Raue, Schweitzer, & Lambert, 2006) also found that depressed clients treated by therapists who had undergone alliance-focused supervision (skill-focused or process-focused) yielded significantly better outcomes. The equivocal results for the effectiveness of alliance training and supervision on treatment outcome can be attributed to a number of factors, such as therapists', clients', supervisors' and trainers' variability (Crits-Cristoph et al., 2006). It is therefore important for researchers to control for such variables when conducting RCTs (Safran et al., 2011, 2014).

Safran, Muran, Samstag and Winston (2005) conducted an RCT comparing Brief Relational Therapy (BRT), Cognitive-Behavioural Therapy (CBT) and Short-Term Dynamic Therapy (STDT) for patients with Cluster C personality disorders and personality disorders not otherwise specified. Even though the three therapies were equally effective, BRT was more successful with respect to client retention. This finding was replicated in a subsequent study where five clients identified as 'treatment failures' were reassigned to BRT achieving good outcome, with only one dropping out of treatment (Muran et al., 2009).

Two other studies (Castonguay et al., 2004; Constantino et al., 2008) have conducted RCTs investigating the effectiveness of standard Cognitive Therapy (CT) versus Integrative Cognitive Therapy (ICT), an approach that integrates rupture resolution strategies, derived from humanistic and interpersonal therapies into cognitive therapy. In Castonguay et al.'s (2004) study, clients in ICT reported greater symptom improvement than a waiting list condition, and compared favourably to previous findings for CT.

Additionally, in Constantino et al.'s (2008) study, when compared with standard CT, ICT yielded greater client improvement on depressive and global symptoms, greater client-rated alliances and therapist empathy, and a trend toward greater retention. Lastly, a study comparing an integrative CBT package with a standard CBT approach for the treatment of Generalised Anxiety Disorder (GAD) found that the integrative treatment was superior in the decrease of GAD symptoms, accompanied by a significant improvement in interpersonal symptoms (Newman, Castonguay, Borkovec, Fisher, & Nordberg, 2008).

It seems noteworthy to mention that Safran et al.'s (2011) meta-analysis that included the aforementioned studies revealed that the briefer, cognitive-behavioural therapies mainly targeting Axis I disorders yielded more client improvement, when compared with the longer,

dynamic and relational therapies targeting Axis II disorders or interpersonal problems. This finding suggests that client, disorder, and treatment type variability may arguably play a significant role in the effectiveness of alliance-focused training and supervision.

Randomised-Controlled Trials (RCTs) have been traditionally considered as the ‘gold standard’ for clinical research demonstrating causal effects between interventions and outcome, and thus presumably enhancing evidence-based practice (Cooper, 2011). On the other hand, they also have substantial weaknesses. Clients with complicated and multiple diagnosis, and/ or comorbid personality disorders are often screened out of research protocols rendering participant samples not representative of the client population encountered in outpatient setting, and restricting the generalisability of findings (Safran et al, 2009). Therapists are more likely to encounter problems and ruptures in the alliance when working with personality disordered clients. However, if such clients are excluded from RCTs, then the findings of RCT studies are of questionable and eschewed value (Safran et al, 2009). Furthermore, whilst RCTs undoubtedly demonstrate the effectiveness of certain alliance interventions and techniques, they tell us little about the ways and the context within which these are implemented. They therefore do not shed any light onto the processes through which the negotiation of alliance ruptures operates and contributes to successful treatment outcome (Hill & Knox, 2009).

Qualitative Studies

Whilst the majority of quantitative studies attempt to explore rupture and resolution processes at a more global, macroscopic level looking at the development of the alliance over the course of treatment, qualitative studies attempt to explore ruptures and repairs at a more molecular, microscopic level (Coutinho et al., 2011), adopting a bottom-up, rather than a top-down approach (Hill, 2010).

Despite the high prevalence of ruptures, as well as the fact that unresolved ruptures can adversely affect therapy process and outcome leading to premature and unilateral termination (Samstag et al., 1998), findings from qualitative studies suggest that both therapists and clients seem to leave things unsaid, whereas even experienced therapists often appear unable to identify and address ruptures in the therapeutic alliance (Hill et al., 1996; Regan & Hill, 1992). Rennie (1994) conducted grounded theory analysis of 14 psychotherapy client interviews and concluded that while clients often had negative reactions toward their therapists, they presented themselves in a deferential way. Specifically, clients frequently reported concerns about the therapist’s approach, a sense of pressure to meet therapist’s expectations, as well as attempts of metacommunication. Nevertheless, they did not explicitly address their difficulties and exhibited deference resulting from a fear of criticising and

threatening the self-esteem of the therapist, an understanding of the therapist's frame of reference, an acceptance of the therapist's limitations, as well as a sense of indebtedness to the therapist. Similarly, Hill, Thompson, Cogar and Denman (1993) studied both therapists' and clients' own and awareness of each other's covert processes, and found that 65% of clients left something unsaid, mainly due to avoidance while 46% of clients kept secrets, mainly due to feelings of shame or embarrassment. However, only 27% of therapists were able to guess clients' non disclosures, suggesting that clients are pretty good at hiding their negative feelings, thoughts and reactions, and therapists are not that adept at inferring what clients withhold.

More importantly, when therapists are aware of clients' negative feelings, outcomes seem to be even worse (Hill, Thompson & Corbett, 1992, Regan & Hill, 1992), especially with clients who express hostile, as opposed to unasserted, anger (Dalenberg, 2004; Hill et al., 2003). Research suggests that therapists tend to respond defensively and adhere rigidly to their treatment model, when faced with clients' negative reactions resulting to heightened power struggles (Safran et al., 2002). For example it has been suggested that adherence to cognitive theory and techniques (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996) or increased transference interpretations (Piper, Azim, Joyce, & McCallum, 1991), in order to address problems in the therapeutic alliance, appear to further exacerbate alliance strains negatively impacting therapeutic process, change and outcome. By contrast, interpretations that are directly focused on the client's defences, guilt and problematic feelings in relation to the therapist seem to be associated with better alliances and outcome (Foreman & Marmar, 1985).

In an attempt to further illuminate the processes involved in the resolution of misunderstanding events, Rhodes, Hill, Thompson and Elliott (1994) conducted Consensual Qualitative Research (CQR; Hill et al., 1997, 2005) of 19 (11 resolved and 8 unresolved) cases where therapists and therapists in training felt misunderstood by their own therapists. Resolved cases were characterised by a good therapeutic relationship prior to the misunderstanding event, as opposed to unresolved cases that were characterised by a rather poor prior relationship. Immediately prior to the event, clients in both cases reported being engaged in an important therapeutic task, following which the therapist either did something that the client did not like or failed to do something that the client wanted or needed. Following the event, most clients in the resolved cases immediately asserted their dissatisfaction. Following clients' assertion, therapists in the resolved cases accommodated the client's position by accepting responsibility for the interaction, apologising and modifying the problematic behaviour. Both therapist and client subsequently engaged in a mutual repair process that resulted in successful resolution of the event, enhancement of the relationship and client growth. On the contrary, in the unresolved cases, when clients asserted their

dissatisfaction, therapists maintained their original position and did not accommodate the client. The disagreement therefore continued and the event was never resolved. In other cases, a few clients hid their negative reactions and did not express their dissatisfaction. Therapists thus remained unaware of and failed to respond to clients' needs leading to unilateral termination.

Hill, Nutt-Williams, Heaton, Thompson, and Rhodes (1996) conducted a follow-up study on Rhodes et al.'s (1994) study. They interviewed twelve experienced therapists on their retrospective recalls of impasses in long-term therapy that ended in therapy termination and analysed data using Consensual Qualitative Research (CQR). Impasses were characterised as resulting from ongoing disagreements on the tasks and goals of therapy between therapists and clients and were charged with negative emotions. Therapists reported that clients often appeared to experience negative feelings towards them, such as anger, impatience, contempt, horror, confusion, hopelessness, disappointment, abandonment and discouragement. Similarly, therapists themselves experienced frustration, disappointment, anger, hurt, confusion and a sense of incompetence. Therapists also reported several variables associated with the manifestation of impasses, such as severity of client pathology, disagreements over therapeutic strategies, therapist mistakes and personal issues, triangulation and transference issues, and the overall quality of the therapeutic relationship. Most therapists were taken aback, as they were unaware of the extent of the client's dissatisfaction. The majority of therapists attempted to explore with clients the problems in the relationship and enable them to gain insight into the situation. However, the exploration may have come too late, when clients had already decided to terminate therapy. Another strategy employed by therapists was to become more active and directive on advising clients on what to do, but it was unsuccessful resulting to further deterioration of the alliance and subsequent therapy termination. A striking difference between the two aforementioned studies is that in Hill et al.'s (1996) study, clients never asserted their dissatisfaction with their therapist and therapists did not appear aware of their possible mistakes until much later. Furthermore, even though therapists did attempt to explore the difficulties in the therapeutic relationship, they did not accept responsibility, apologise nor modify their problematic behaviours, but rather insisted on the implementation of insight-oriented techniques that further deteriorated the alliance. A possible explanation for these differences is that clients in Rhodes et al.'s study (1994) were therapists and therapists in training themselves, who were arguably more psychologically minded and intellectually adept, as well as less disturbed.

Moltu, Binder and Nielsen (2010) addressed similar issues with Hill et al.'s (1996) study. They interviewed 12 highly experienced therapists this time asking them to recall experiences of difficult therapy impasses that ended well. They, however, employed a different qualitative

methodology focussing on participants' *experiential horizon*, in an attempt to further illuminate therapists' inner experiences during difficult impasses. Analysis revealed three main categories, "helpful subjective presence", "losing hope", and "difficult therapist feelings in the here-and-now". All therapists expressed an a priori commitment to helpful presence characterised by openness, emotional availability and helpfulness balanced with recognition of the client's separateness. Therapeutic impasses were experienced as temporarily threatening therapist's hope and trust in the process, giving rise to strong negative feelings in the here-and-now. These feelings were thought to emerge as a result of the client's aggression or emotional withdrawal. When clients expressed aggression, therapists initially experienced emotional discomfort, which, in the case of extraordinary difficult processes, escalated into intense emotional reactivity leading therapists to experience a sense of being trapped and a restriction of their autonomy. When clients withdrew from the therapeutic encounter, therapists experienced a sense of being left out that progressively gave rise to emotional reactivity characterised by helplessness, irritation and self-doubt. Both types of impasses were successfully resolved when therapists managed to stay helpfully present, tolerating and regulating their difficult feelings, instead of acting them out. These findings highlight the importance of therapists' being aware of and working through their difficult feelings, in order to remain helpfully present, as opposed to allowing their personal vulnerabilities (Bachelor & Horvath, 1999; Binder, Holgersen, & Nielsen, 2008) and countertransference issues (Gelso & Hayes, 2007) to get in the way of therapeutic success.

In an attempt to capture both therapists' and clients' experiences of confrontation and withdrawal alliance rupture events, Coutinho, Ribeiro, Hill and Safran (2011) interviewed therapeutic dyads and conducted Consensual Qualitative Research (CQR). Therapists and clients both agreed that typical precipitants of the rupture event included the therapist doing something the client did not like, such as trying a new intervention and encouraging exploration of a painful topic. They also agreed that therapists were more adept at handling withdrawal, as opposed to confrontation rupture events, as well as on the fact that clients in withdrawal ruptures experienced vulnerability, anguish and despair, whereas clients in confrontation ruptures mainly experienced anger, disappointment, abandonment and rejection. Both therapists and clients also experienced a sense of ambivalence, confusion and being lost during both events. Despite the similarity in therapists' and clients' perspectives on rupture events, therapeutic pairs substantially differed in their internal experiences during the events. Clients reported more feelings related to their role as clients, such as sadness, helplessness, confusion and a sense of being criticised. In contrast, therapists reported more feelings related to their professional role, such as ambivalence, tension and guilt stemming from a sense of incompetence and not knowing what to do. Typical therapist strategies, in

order to deal with the rupture event included attending to the client's immediate experience, providing reassurance, as well as promoting client's contact with what he/ she was avoiding and enhancing understanding on his/ her interpersonal patterns. Clients in confrontation ruptures often reported that nothing that the therapist did or said helped. They appeared, however, more straightforward with regard to their expectation from the therapists, in comparison to clients in withdrawal rupture events.

These findings are consistent with previous studies suggesting that therapists often struggle with clients' anger directed at them experiencing annoyance, frustration, anxiety and incompetence, and responding with avoidance or counter-hostility (Binder & Strupp, 1997; Dalenberg, 2004; Hill et al., 2003). In fact, therapists tend to struggle to respond empathically and therapeutically to clients who express direct hostility, but appear much more comfortable showing concern and encouraging unassertive clients to express their anger. Successful resolution of hostile anger events seems to occur when therapists refrain from challenging the client, attempt to connect with him/her, talk about and provide an explanation for the client's behaviour, and attribute anger events to the therapeutic relationship, as opposed to client's personality problems. In addition, successful resolution seems to take place when therapists turn negative feelings outward, experiencing annoyance and frustration with the client, as opposed to turning negative feelings inward, experiencing anxiety and incompetence. On the other hand, resolution of unasserted anger events seems to take place within the context of a strong therapeutic relationship, whereby the therapist recognises and directly raises the topic of anger, enabling the client to gain insight (Hill et al., 2003).

Haskayne, Larkin and Hirschfeld (2014) are the only investigators who have explored therapeutic ruptures and repairs employing Interpretative Phenomenological Analysis (IPA). They specifically explored therapeutic ruptures through parallel accounts of four client-therapist dyads in long-term psychodynamic therapy. Their analysis resulted in four overarching themes; "negative emotions as dangerous", "the therapeutic discovery", "the struggle" and "positive connection". Clients' accounts entailed many descriptions of emotions as dangerous, uncontained and frightening leading to an employment of protective strategies and defences that had been proven unfulfilling and unsuccessful. The journey of the therapeutic endeavour towards discovery was described by both therapists and clients as "*hard work and a gradual process*", which was at times experienced as painful, exhausting and frustrating. The therapeutic discovery additionally entailed a "*to and fro*" quality, characterised by a cyclical, evolving process that oscillated between clients' sharing and hiding difficult feelings. Both therapists and clients narrated struggles in the therapeutic relationship characterised by a lack of emotional and physical contact leading to feelings of frustration and despair. Clients experienced uneasiness and a sense of "*not knowing*" resulting

from therapists' use of silence and lack of feedback, whereas therapists' sense of "*not knowing*" was related to the sense of having unfinished and unaddressed business in therapy. Struggles were also characterised by "*control and power*" issues evident in power imbalances over the role and responsibilities of the dyad's members. Following the survival of the struggle, both therapists and clients appeared to experience a positive connection manifested in the form of "*emotional sensitivity*". Specifically, participants described being emotionally attuned, working within an optimal pace in therapy, and experiencing intimacy, with the therapist being perceived as providing containment, care and understanding. Following the struggle, participants also described moments of the therapist "*shining a light*" on clients' helpful and unhelpful patterns of relating as re-enacted within the therapeutic relationship. These moments were perceived as emotionally demanding, but also as extremely helpful in enhancing clients' acknowledgment and understanding of difficult feelings. These findings provide support for the process of repairing alliance ruptures as a mechanism for therapeutic change leading into tolerance and expression of emotional experiences, as well as to modification of maladaptive ways of relating.

Qualitative studies of therapeutic ruptures and repairs have the distinct advantage of tapping into participants' inner experiences during relationship processing events that are usually not assessed in other research methodologies (Hill & Knox, 2009). They are not however without certain limitations. The low return rates and small sample sizes, in combination with the purposive, and at times homogenous, selection of participants restrict studies' representativeness and decrease the generalisability of findings (Hill et al., 1996; Rhodes et al., 1994). Another limitation is that most, but not all, studies only examine either the therapist's or the client's perspective, not thus telling the whole story (Coutinho et al., 2011; Haskayne et al., 2014). Furthermore, the use of retrospective recall of events restricts findings to what participants are, consciously or unconsciously, willing and able to disclose (Coutinho et al., 2011; Hill et al., 1996). Lastly, findings are always subject to researchers' bias, a phenomenon that is eliminated in studies where assessments of independent judges/ observers are used (Coutinho et al., 2011; Hill & Knox, 2009).

Factors Impacting Ruptures and Resolution

Combining together the conclusions from the aforementioned theory and research findings, it becomes evident that alliance ruptures constitute a common psychotherapy phenomenon across treatment types that may facilitate or endanger the therapeutic alliance and outcome, depending on whether they are successfully or unsuccessfully resolved. In fact, the process of repairing alliance ruptures is considered by many researchers as a mechanism of change in itself that can directly affect treatment process and outcome (Coutinho et al., 2009). Whilst

the processing of ruptures is addressed across all schools of psychotherapy, approaches do vary in the extent to which they acknowledge the centrality of relational work for therapeutic change, as well as therapists' contribution to relationship dynamics (Hill & Knox, 2009). Research confirms that client, therapist, and interactive factors, all contribute significantly to the therapeutic alliance and outcome (Barber, 2009; Barber & Gallop, 2008; Baldwin, Wampold & Imel, 2007), in general, and the manifestation and resolution of ruptures (Hill & Knox, 2009; Safran et al., 2011), in particular. However, knowledge about which particular therapist and client characteristics are related to alliance building and development is currently limited (Barber, 2009; Nissen-Lie, Havik, Høglend, Rønnestad, & Monsen, 2015). The section below therefore summarizes empirical evidence therapist, client, interactive and in treatment factors that have been found to affect the process of repairing alliance ruptures.

Therapist Factors

Therapists' failure to successfully manage their countertransference (Benjamin & Critchfield, 2010; Hill et al., 1996; Moltu et al., 2010), as well as therapists' unresolved conflicts (Hill et al., 1996; Rosenberg & Hayes, 2002) and self-directed hostility (Henry et al., 1993; Nissen-Lie et al., 2015) have been all found to negatively impact the alliance leading to counter-therapeutic interactions. It has also been proposed that therapists' theoretical orientation may influence the type of alliance ruptures, as well as the kind of resolution processes that are most effective (Aspland et al., 2006; Eubanks-Carter et al., 2010). Therapists' personality attributes, such as rigidity, inflexibility, uncertainty, hostility, defensiveness, in combination with the exhibiting of tension, tiredness, boredom, distraction and lack of support have been also found to impede the development of a good alliance, as well as to diminish the quality of an established alliance (Ackerman & Hilsenroth, 2001; Messer & Wolitzky, 2010). On the other hand, therapists' personal attributes, such as flexibility, honesty, respect, trustworthiness, competence, expertness, confidence, warmth, empathy, openness, honesty (Ackerman & Hilsenroth, 2003), as well as appropriate body language, appropriate use of verbal and nonverbal prompts, and self-disclosure (Bedi, Davis, & Arvay, 2005) have been found to positively associate with the development and maintenance of the therapeutic alliance. Therapists' techniques that may negatively impact the alliance producing ruptures include inflexible adherence to cognitive techniques (Castonguay et al., 1996) or transference interpretations (Piper et al., 1999), inability to maintain focus on the emotional impact of interpersonal problems (Ackerman & Hilsenroth, 2001), engagement in client's maladaptive interpersonal styles (Safran & Muran, 2000), blaming and manifesting hostility toward the client (Dalenberg, 2004; Hill et al, 2003), unresponsiveness (Sharpless, Muran, & Barber, 2010), as well as a lack of attentiveness to the therapeutic relationship (Hill et al., 1996; Rhodes et al., 1994). On the other hand, therapist positive techniques that may lead to an

enhanced alliance and contribute to rupture resolution include acknowledging relationship problems, awareness of own reactions to clients, encouraging clients to explore feelings, demonstrating empathy and promoting connection, disembedding from maladaptive interpersonal interactions, apologizing and taking responsibility for own contribution to problematic interactions, changing offensive behaviours, using transference and relational interpretations appropriately, using immediacy, meta-communication, mindfulness, and maintaining a reflective stance (Ackerman & Hilsenroth, 2003; Hill & Knox, 2009; Safran & Muran, 2000).

Client Factors

Clients' positive expectations for improvement, as well as good interpersonal functioning, in terms of positive past and present relationships, have been found to positively associate with both the therapeutic alliance and outcome (Messer & Wolitzky, 2010; Sharpless et al., 2010). On the other hand, hostility (Benjamin & Critchfield, 2010; Hill et al., 2003; Safran & Muran, 2002), defensiveness (Kasper, Hill, & Kivlighan, 2008), higher levels of interpersonal problems (Hersoug, Høglend, Havik, von der Lippe, & Monsen, 2009), and substantial psychopathology or personality disorders (Hill et al., 1996, 2003; Safran et al., 2009) are associated with poor alliances and manifestation of ruptures. Findings regarding the relation between pre-therapy symptom severity and the quality of the alliance have provided are somehow mixed (Horvath & Bedi, 2002; Kuutmann & Hilsenroth, 2012). Some studies suggest that severely disturbed clients tend to form weaker alliances, while others have found no such difference (Messer & Wolitzky, 2010; Sharpless et al., 2010). Furthermore, there seems to be an interaction among therapist's level of experience and relational stance, client's level of impairment and the quality of the therapeutic alliance (Horvath & Bedi, 2002; Kuutmann & Hilsenroth, 2012). Similarly, clients with secure attachment styles appear more likely to form positive alliances, as opposed to clients with insecure attachment styles (Eames & Roth, 2000; Mallinckrodt, Gantt, & Cobble, 1995; Watson & Kalogerakos, 2010). At the level of personality traits, factors such as openness, agreeableness and extraversion, as opposed to control, avoidance and self-directed hostility, are positively associated with the alliance (Benjamin & Critchfield, 2010; Diener, Hilsenroth, & Weinberger, 2009). Lastly, clients' positive contributions to the alliance in the face of ruptures consist of asserting negative reactions, exploring feelings about the relationship, accepting therapist apology and attempting to understand his perspective, as well as understanding underlying wishes and needs as reflected in the therapeutic relationship (Hill & Knox, 2009).

Interactive Factors

Therapist and client positive or negative complementarity seems to be associated with the quality of the alliance, as friendly and autonomy-enhancing interactions, as opposed to negative, hostile, controlling or competing interactions, appear to yield more positive alliances (Binder & Henry, 2010; Safran & Muran, 2000). Along these lines, therapists' personality and epistemic traits, as reflected in their chosen therapeutic orientation and preferred ways of practice, are also thought to interact with clients' characteristics suggesting that a degree of fit between therapists' and clients' personality characteristics, values, beliefs and worldviews may potentially enhance the therapeutic process and client outcome satisfaction (Arthur, 2001; Boswell et al. 2009; Tremblay et al., 1986). In addition, active collaboration and cooperation between therapist and client is positively associated with the therapeutic alliance and outcome (Horvath & Bedi, 2002), while a breakdown in collaboration may lead to the manifestation of ruptures (Safran & Muran, 2006). Transference and countertransference dynamics are also thought to influence the quality of the alliance. Clients' strong distortions of the therapeutic process, in combination with therapists' personal reactions to the client may interfere with the alliance (Messer & Wolitsky, 2010; Sharpless et al., 2010), and contribute to the manifestation of therapeutic ruptures (Ellman, 2007). In contrast, a strong therapeutic relationship seems to limit the manifestation of ruptures, as well as to facilitate rupture resolution (Coutinho et al, 2011; Hill et al., 1996, 2003; Rhodes et al., 1994).

Research Aims

Taking into account the distinct role of the therapeutic relationship in the discipline of Counselling Psychology the present research project aims to shed light onto counselling psychologists' subjective experiences, meaning making processes and interpretations of ruptures, the unique ways therapists employ in order to manage and overcome them, as well as therapists' experiences of the successful or unsuccessful rupture resolution processes, as reflected upon the therapeutic alliance, process and outcome. Particularly within the 'reflective practitioner' paradigm (Schön, 1983), notions of therapist reflexivity and relationship dynamics gain paramount importance. It is therefore maintained that the ability to reflect upon and successfully manage ruptures in the therapeutic alliance may enhance counselling psychologists' skills and efficacy, optimise treatment outcome and safeguard clients' well-being.

Research Questions

Taking into account the context of the reviewed literature, as well as the proposed research aims, the research questions are therefore formulated as follows:

- 1) How do counselling psychologists experience and make sense (cognitively, emotionally, interpersonally) of ruptures in the therapeutic alliance?
- 2) In what ways do counselling psychologists and clients contribute to rupture manifestation and resolution?
- 3) What ways do counselling psychologists employ in order to process and manage ruptures within the therapeutic alliance?
- 4) How do counselling psychologists experience the impact (positive or negative) of ruptures upon psychotherapy relationship, process and outcome?

Rationale for Adopting a Qualitative Research Approach

Although qualitative methodologies have historically shaped counselling and psychotherapy theory and practice, they have gradually fallen out of favour in the field of psychology in general, and counselling and psychotherapy in particular, leaving their place to positivist and post-positivist research paradigms that favour measurable data and objectivity, as opposed to process, self-reflection, and subjectivity (Ponterotto et al., 2010). However, there have been recent attempts toward integration and pluralism, reflected in the emergence of a constructivist/ interpretivist epistemological paradigm in the field of counselling psychology and evident in the increasing implementation of qualitative and mixed methodologies (Hanson, Creswell, Plano Clark, Petska, & Creswell, 2005; Ponterotto, 2005).

Within the context of the paradigmatic and methodological shift in the field of counselling psychology, the present research project chooses to embrace a qualitative method of inquiry in order to investigate a complex and dynamic therapeutic phenomenon with tremendous clinical significance and implications. Qualitative methodologies are particularly compatible with the humanistic ethos and values of counselling psychology, as they place emphasis on participants' cognitive and emotive aspects of experience, whilst taking into account the social context within which the process of meaning-making is co-constructed and expressed (HCPC, 2015; McLeod, 2003; Ponterotto et al., 2010).

Up to date, there is an abundance of quantitative studies that have established an unequivocal relationship between a positive therapeutic alliance and successful treatment outcome (Horvath & Bedi, 2002; Horvath et al., 2011; Horvath & Symonds, 1991; Martin et al., 2000). There is also a substantial amount of research that has demonstrated that ruptures in the therapeutic alliance constitute a common phenomenon (Safran et al., 2011) which, if managed successfully, is associated with greater treatment gains (Gumz, et al., 2012; Kivlighan & Shaughnessy, 2000; Stiles et al., 2004; Strauss et al., 2006). Task-analytic studies have substantially enhanced our understanding on the steps involved in successful rupture resolution (Agnew et al., 1994; Aspland et al., 2008; Cash et al., 2014; Safran et al., 2011),

and randomised controlled trials have demonstrated the superiority of integrative psychological therapies that focus on alliance building and development, over standard treatments (Castonguay et al., 2004; Constantino et al., 2008; Safran et al., 2014).

What seems, however, to be lacking substantially from current research on therapeutic ruptures and repairs are qualitative studies, capable of illuminating therapists' and clients' inner experiences, and meaning-making processes of therapeutic ruptures and repairs, as well as processes underpinning rupture resolution. The answers to the aforementioned issues hold particular clinical implications, as they can enhance clinical practice and advance psychological knowledge on counselling and psychotherapy processes and outcomes by generating rich descriptions of both individual subjective experiences and local, socio-cultural contexts (Nelson & Quintana, 2005). We do know that a good alliance and successful rupture resolution are indeed associated with successful treatment outcome, but we have yet to discover how, in what ways, and under which circumstances the negotiation of ruptures operates as a mechanism of change, and is linked to psychotherapy process and outcome (Castonguay et al., 2006; Coutinho et al., 2009; Gumz, et al., 2012; Hill & Knox, 2009). Qualitative methodologies can therefore effectively supplement and add 'depth' to existing quantitative findings by exploring and illuminating therapists' subjective experiences, whilst taking into account the dynamic interplay between contextual and individual processes.

In employing a qualitative methodology, the present research therefore aims to respond to the identified demand for phenomenological studies that can shed light onto specific factors and mechanisms of change within the therapeutic relationship, and the ways that these are linked with treatment outcome (see Castonguay et al., 2006; Gumz, et al., 2012; Hill & Knox, 2009; Horvath, 2006). Qualitative analysis of recalled events is particularly recommended in the context of research on ruptures and resolutions, as it allows for phenomenological exploration of participants' inner experiences, during relationship processing events, which cannot be captured by quantitative methodologies or through observation of session tapes (see Hill & Knox, 2009). It can thus contribute to the clarification of the ways the therapeutic alliance play a central role in the change process (Safran & Muran, 2006). An exploration of types of ruptures and ways of reparation within the therapeutic relationship can also hold significant clinical implications for counselling psychologists. It could clarify ways of identifying, working through and overcoming ruptures, in order to strengthen the therapeutic relationship, increase therapeutic effectiveness and achieve positive outcome.

Furthermore, as the proposed research study focuses on therapists' internal and meaning-making processes during ruptures and repairs, it may provide useful insight into specific client and therapist characteristics that may influence the development of the therapeutic alliance.

Given the significant contribution of client and therapist variability in treatment outcome (Baldwin et al., 2007; Barber & Gallop, 2008), such insights may hold significant implications for clinical and ‘reflexive’ practice. The proposed research study can therefore hold implications for counselling psychology training including the importance of personal therapy. Considering the centrality of the therapeutic relationship in the discipline of Counselling Psychology, in combination with the identified difficulty of training therapists in learning relational skills (see Henry et al., 1993; Crits-Cristoph et al., 2006), it becomes crucial for future counselling psychologists to be trained in ways of fostering, maintaining and repairing the therapeutic alliance (see Hill et al., 1996; Hill & Knox, 2009).

Rationale for Adopting Interpretative Phenomenological Analysis

According to Willig (2013), research questions, choice of methodology and data collection techniques are inextricably intertwined and cannot be thought of in isolation. In the present study a range of alternative qualitative methods of analysis was given thorough consideration, in order to arrive at the choice of the most suitable one that could best answer the postulated research questions and capture the type of knowledge the research study wished to produce.

A methodology that was initially given serious consideration was Consensual Qualitative Research (CQR; Hill et al., 1997, 2005). CQR is a very popular method of inquiry in Counselling Psychology, especially in the United States (Morrow, Castañeda-Sound, & Abrams, 2012; Ponterotto et al., 2010). In fact, it has arisen directly from the gulfs of Counselling Psychology, in order to thoroughly study the processes underpinning rupture resolution. Most qualitative studies on therapeutic ruptures and repairs have indeed employed a CQR method of investigation (Hill et al., 2005). CQR was given thorough consideration, as it is especially sensitive to capturing participants’ inner experiences, and recommended for studying covert processes and understudied events. It is also methodologically rigorous, as it pays attention on consensus among judges in the interpretation of findings, thus reducing researchers’ biases (Hill et al., 2005). Although appealing, CQR was not selected as a preferred method of analysis mainly due to practical, as well as epistemological reasons. Specifically, CQR is very time-consuming and demanding, as it requires a number of researchers to work as a team in order to achieve consensus, and also somewhat lacks in methodological clarity (Hill et al., 2005), rendering it less suitable for a PhD thesis conducted by a sole researcher. Furthermore, it was assumed that its postpositivist epistemology, in terms of emphasis on consensus in the analysis of data, would somehow fail to fully capture participants’ individual, subjective experiences, as well as to fully embrace the researcher’s interpretative role in data gathering and analysis.

Grounded theory (Charmaz, 2008) was also considered as an alternative to IPA due to their inductivist approach to inquiry, as well as their shared conceptual, methodological and analytic similarities. However, whilst grounded theory has its roots in the study of social processes and seeks to make general, theoretical claims based on large samples, IPA has directly arisen from psychology and seeks to illuminate subjective experiences of a small number of people paying attention to both convergences and divergences among participants (Smith et al., 2009; Willig, 2013). IPA was deemed as a more appropriate methodology for the present research project, as the purpose of the study was to illuminate the quality and texture of therapists' subjective experiences of ruptures and resolution, as opposed to explicate and make general claims about processes underlying rupture and repair episodes (see Willig, 2013).

Discursive methodological approaches, such as Discursive Psychology and Foucauldian Discourse Analysis were also considered alongside IPA given their shared emphasis on the ways discursive constructions serve as a means to understand the ways individuals experience and make sense of their lives (Eatough & Smith, 2008). It would have therefore been interesting to employ Discourse Analysis (Potter & Wetherell, 1987), in order to examine the way therapists use language and organise their talk rhetorically, when they describe their experiences of a rather delicate and challenging clinical phenomenon (i.e. ruptures) that may give rise to personal and professional vulnerabilities. However, such a method of analysis with a strong commitment to social constructionism could have potentially missed the idiographic, subjective experiences and idiosyncratic meaning-making processes (Smith et al., 2009) of counselling psychologists trying to make sense of and manage therapeutic impasses, and would thus fail to illuminate significant therapeutic processes, relevant to clinical practice.

Following thorough examination of a number of alternative research methodologies, the method of IPA was primarily chosen as the most consistent with the epistemological position of the research questions. Specifically, IPA is particularly suitable for research questions that focus on people's experiences and understandings, and are oriented towards exploration, process and meaning (Smith et. al., 2009). It provides the researcher with an 'insider's perspective' (Conrad, 1987) into participants' personal world, whilst acknowledging the dynamic, interpretative interplay between the researcher's and participant's subjective world, in the process of meaning making (Smith & Eatough, 2006; Smith & Osborn, 2008). IPA has been extensively applied in the field of health, applied, clinical and counselling psychology, and is concerned with participants' 'lived experiences', understandings, and meaning-making processes (Reid, Flowers, & Larkin, 2005; Smith, 2011). The researcher therefore felt that IPA was the method that could best capture therapists' cognitive, affective and embodied

experiences, as well as meaning-making and sense-making processes of therapeutic ruptures repairs within the therapeutic alliance. IPA is commonly used for the study of ‘unexplored territory’ (Reid et al., 2005), as well as experiences that carry personal significance for participants (Smith, 2011). There is currently an identified lack of qualitative, phenomenological studies of therapeutic ruptures and repairs (Gumz et al., 2012; Hill & Knox, 2009) despite the fact that rupture resolution holds particular importance and clinical relevance for practitioners, who often appear ill-prepared and unable to successfully resolve therapeutic impasses (Hill et al., 1996; Hill et al., 2003; Safran et al., 2002). IPA was also deemed as the most appropriate method for the present study due to its unique focus on phenomenology and experience rendering it ideal for tapping into participants’ inner experiences during relationship processing events. Furthermore, the researcher was drawn to IPA due to its clear, comprehensive and accessible procedural and analytic guidelines (e.g. Smith & Osborn, 2008; Smith et al., 2009), which nevertheless allow space for personal interpretative work and creativity (Smith, 2004). Lastly, it was postulated that the present IPA study could successfully complement and illuminate existing quantitative research on ruptures and repairs, as well as present new findings to be discussed alongside qualitative studies in this area (see Smith, 2011).

Methodology and Procedures

Methodology

Design

This was a qualitative study, which aimed to explore counselling psychologists’ experiences and meaning-making processes around ruptures and resolutions within the therapeutic relationship. Specifically, therapists participating in the study were asked to recall ruptures in the therapeutic work with specific clients, and to discuss the way that they managed them, as well as their impact upon the therapeutic relationship and outcome. Data were collected through ten semi-structured interviews and were analysed using Interpretative Phenomenological Analysis (IPA).

Paradigmatic Underpinnings and Philosophical Assumptions of the Research Project

A research paradigm may be viewed as an umbrella framing the context of research (Morrow et al., 2012). As such, it entails a set of beliefs and assumptions around ontology (i.e. the nature of reality and being), epistemology (i.e. the acquisition of knowledge, and the relationship between the participant and the researcher), axiology (i.e. the role of the researcher’s beliefs and values in the research process), rhetorical (i.e. the language used in the research presentation) and methodology (i.e. the process and procedures of research)

(Ponterotto, 2005). Four main research paradigms have been identified by Guba and Lincoln (1994) and have been further elaborated by Ponterotto (2005) for counselling psychologists. These include positivism, postpositivism, constructivism-interpretivism and critical-ideology.

The present research clearly embraces the constructivist-interpretivist paradigm, which also seems to anchor the majority of qualitative studies, followed by a combination of postpositivist and constructivist-interpretivist paradigms (Ponterotto, Kyriakose, & Granovskaya, 2010).

In terms of ontology, the research adopts a constructivist-interpretivist stance, according to which there is no single and objective truth. There are multiple, equally valid and socially constructed versions of reality (Hansen, 2004; Ponterotto, 2005). Consequently, the present study is concerned with therapists' subjective experiences, meaning-making processes, and interpretations of therapeutic ruptures and resolutions. The researcher does not seek to uncover a 'single truth', but does aim to explore participants' lived experiences looking at both convergences and divergences within and between participants' accounts.

With regard to epistemology, the research project also espouses a phenomenological and constructivist-interpretivist stance. It is concerned with capturing participants' descriptions of subjective experiences, but at the same time postulates that meaning is hidden and comes to the foreground through reflexive interpretation (Ponterotto & Grieger, 2007; Willig, 2013). Researcher and participant thus mutually influence each other and collaboratively co-create findings through interactive dialogue and interpretation (Morrow et al., 2012; Ponterotto, 2005). Accordingly, the present research seeks to understand participants' subjective experiences of ruptures in the therapeutic alliance and accompany them in the journey of sense-making and resolution processes, awaiting to influence and be influenced by the mutuality of the interaction during the interview process and data analysis.

In terms of axiology, the research also adopts a constructivist-interpretivist framework. In contrast to positivists and postpositivists who advocate for the researcher's true objectivity and emotional detachment from the research process, constructivists-interpretivists recognise that personal values, beliefs, assumptions and biases unavoidably influence the understanding, interpretation and analysis of data and therefore attempt to 'bracket' them, though not eliminating them, as they are constantly present within the researcher-participant interaction (Ponterotto, 2005; Willig, 2013). The researcher's values and biases are of particular importance in the present study, due to her shared identity (i.e. counselling psychologist) with the participants, as well as the research topic in itself that addresses a common and challenging phenomenon in clinical practice (i.e. ruptures).

With respect to rhetorical structure, the research lies somewhere between postpositivism and constructivism-interpretivism. It is postpositivist in the sense that the majority of the research report is written in a scientific manner and data are reported in the third person. At the same time the subjective and interactive role of the researcher is vastly acknowledged and certain sections of the report (i.e. personal and epistemological reflexivity) are written in the first person and personalised manner. Much space is devoted in the description of the researcher's own experiences, biases, preconceptions, values and beliefs with relation to the research topic (Ponterotto, 2005). Similarly, chosen participants' extracts contain vivid, emotional, and rich descriptions of participants' experiences, and extracts' interpretation is accomplished through a use of language that attempts to balance academic writing that satisfies academic requirements with vivid lay language that does justice to participants' accounts.

Finally, in terms of methodology, the research clearly identifies with the constructivist-interpretivist paradigm. Data were gathered in naturalistic settings (i.e. participants' homes or workplaces), through in-depth, face-to-face, semi-structured interviews, and were analysed using IPA. The centrality of the researcher-participant interaction is acknowledged throughout the interviews' procedure, as well as data analysis. Embedded meaning is uncovered through the extensive immersion in and interpretation of words and texts. 'Hermeneutics' are of paramount importance in the uncovering of meanings, which are co-constructed through the researcher's interaction with the participants and the transcripts (Ponterotto, 2005; Ponterotto & Grieger, 2007).

Philosophical Underpinnings and Key Characteristics of IPA

IPA was developed by Jonathan Smith in the mid-1990s. In his seminal paper introducing IPA, Smith (1996) made a compelling argument in favour of a more pluralistic psychology that would be both experimental and experiential (see also Smith, Flowers & Larkin, 2009). And, indeed, IPA undoubtedly follows an experiential approach to psychological inquiry, which is theoretically grounded in three key areas of the philosophy of knowledge; phenomenology, hermeneutics and idiography (Smith, 2011; Smith et al., 2009). These three theoretical approaches underpin IPA's distinctive epistemological standpoint and research methodology (Shinebourne, 2011).

IPA is phenomenological in that it deals with the detailed examination of participants' 'lived experiences' and aims to explore the processes through which participants make sense of their personal and social world (Smith & Eatough, 2006; Smith & Osborn, 2003, 2008). Drawing from phenomenological philosophers, such as Husserl, Heidegger, Sartre and Merleau-Ponty, IPA focuses on subjective experience in its own right and attempts to examine it by adopting a phenomenological attitude, characterised by openness, genuine curiosity and reflexivity

(Finlay, 2014; Smith et al., 2009). At the same time, IPA acknowledges the embodied, embedded and contextual nature of our relationship to the world. Experience and selfhood are conceived as contingent upon the existence of others, and the nature of our engagement with the world is essentially intersubjective, meaning shared, overlapping and relational (Smith et al., 2009). Experiences are therefore historically, socially and culturally bounded, and can be only understood by examining how objects, states or events are experienced and given meaning by individuals (Eatough & Smith, 2008).

Consequently, IPA is also interpretative in that it acknowledges the role of the researcher in the attempt to interpret and make sense of participants' lived experiences (see Eatough & Smith, 2008; Smith et al., 2009). Hermeneutic phenomenologists, such as Heidegger, Schleiermacher and Gadamer, have postulated that meaning is often hidden and can only be brought to the surface through a process of intense engagement and interpretation. At the same time, our understanding of objects and events is mediated by our prior experiences, pre-existing knowledge and fore-conceptions, as well as constrained and contextually-bounded by the socio-cultural contexts within which we live and act (Eatough & Smith, 2008; Smith et al., 2009). Interpretation therefore takes the form of a 'hermeneutic circle', and becomes a dynamic dialogue between what we bring to the text and what the text brings to us, between the past and the present, between the researcher and the participant (Smith et al., 2009). IPA thus entails a 'double hermeneutic', an intense interpretative activity whereby "the participants are trying to make sense of the world; the researcher is trying to make sense of the participant trying to make sense of their world" (Smith & Osborn, 2003, p. 51). The concept of 'double hermeneutic' also refers to the researcher's own involvement with the research project, in the form of his/her biases and preconceptions that, unless they are partially 'bracketed' or acknowledged, they can hinder the process of interpretation (Smith, 2007). Finally, IPA operates 'double hermeneutic' by combing 'hermeneutics of empathy' with 'hermeneutics of suspicion' (Ricoeur, 1970). Whereas empathic interpretation focuses on what is there and strives to understand from within participants' experiences, suspicious interpretation attempts to uncover what is hidden and asks critical questions in order to uncover latent meaning (Smith & Osborn, 2008; Willig, 2013). IPA adopts a 'centre-ground position' between these two interpretative approaches (Smith, 2004), as combining both types of interpretation is likely to lead to a deeper and richer analysis, and arguably do fuller justice to the totality of the person (Smith & Eatough, 2006; Smith & Osborn, 2008).

IPA is also idiographic, as it deals with the detailed and nuanced analysis of particular instances of participants' lived experiences, either in a single case study or in a small group of cases (Shinebourne, 2011; Smith et al., 2009). In contrast to nomothetic research that focuses on the uncovering of general patterns of human behaviour, and aims to predict and

explain phenomena, idiographic research focuses on the in-depth understanding of the individual as a unique entity, and is concerned with the detailed description and presentation of subjective experience (Ponterotto, 2005). At the same time, IPA is committed to the particular in that it strives to understand the ways that particular phenomena are experienced by particular individuals in particular contexts. Consequently, IPA makes use of small, homogenous, purposefully selected and contextually situated samples (Smith et al., 2009). In that sense, IPA adopts an attitude of ‘analytic induction’ that allows space for reflection and modification of one’s thinking in the light of unanticipated evidence. IPA does, however, adopt an interrogative stance and wishes to make a contribution to psychology by connecting its findings to existing literature, and interrogating or illuminating existing psychological research. Delving into the particular is thus thought as bringing us closer to the universal, and the detailed examination of the individual experience is thought as bringing us closer to a shared humanity (Smith, 2004; Smith et al., 2009).

At this point, it is worth acknowledging that IPA positions itself within the gulfs of psychology. IPA and mainstream psychology share a common interest in the examination of the ways people think about what is happening to them, but diverge in the ways they conceptualise cognition, and in their suggested methodologies for addressing such questions (Smith & Eatough, 2006; Smith & Osborn, 2008). In fact, IPA has received substantial criticism with regard to the meaning and the use of the term ‘cognition’ (Langdrige, 2007; Willig, 2001). Cognition, as conceptualised in cognitive psychology, is viewed as incompatible with the phenomenological tradition, as it implies a separation between the ‘knower’ and the ‘known’, and refers to a propositional type of knowledge (Willig, 2013). Smith and colleagues (Smith & Eatough, 2006; Smith & Osborn, 2008; Smith et al., 2009) reply to these critiques by offering an alternative conceptualisation of cognition, closer to the original vision of cognitive psychology, before the rise of behaviourism, as a ‘science of meaning’ as opposed to a ‘science of information processing’ (Smith, 2004). From the perspective of mainstream psychology, cognitions are operationalised as compartmentalised, separate processes and functions that can be studied through quantitative and experimental methodologies. On the other hand, from the perspective of IPA, cognitions are conceptualised as complex, nuanced processes of meaning-making, which are dynamic, embodied and affective, and can only be indirectly accessed through in-depth qualitative analysis of participants’ accounts (Smith et al., 2009).

Lastly, IPA also endorses social constructionism and acknowledges a significant debt to symbolic interactionism in particular. Social constructionism postulates that historical and socio-cultural processes affect the ways individuals experience, make sense and talk about of their lives (Eatough & Smith, 2008). Symbolic interactionists, such as Mead and Blumer,

conceive individuals as creative agents who actively conceive and construct their lifeworlds and purposefully attribute meaning to their experiences through interpretative action that is informed by intersubjectivity and reflexivity. Mind and self are viewed as products of relationships and social interactions, and linguistic symbols are, in turn, viewed as systems of socially shared meanings. Individual contexts and mental processes arise within specific socio-cultural contexts, and therefore self and thoughts can only be understood in the light of meanings available within the culture the individual is immersed. At the same time, individuals that have gradually developed a capacity for mind and self through social interactions, become autonomous agents characterised by selfhood and unique tendencies of thought. People are therefore conceived as both constructed but also constructors (Ashworth, 2008). IPA posits itself at the light end of social constructionism, in the sense that it acknowledges the importance of language in the construct of our lifeworlds and the action-oriented nature of talk, but at the same time posits that subjective meaning-making transcends socio-linguistic restrictions and culturally available stock of meanings (Eatough & Smith, 2008).

Personal and Epistemological Reflexivity

Willig (2013) distinguishes between two types of reflexivity. ‘Personal reflexivity’ refers to the ways the researcher’s experiences, values, beliefs and assumptions shape research. ‘Epistemological reflexivity’ requires from the researcher to reflect upon his/ her epistemological and ontological assumptions, as well as upon the implications of these assumptions for the research process and findings. The person and theoretical background of the researcher unavoidably influence the research process and ought to be thoroughly monitored when conducting qualitative research, as the nature of qualitative research is essentially subjective (Morrow, 2005; Willig, 2013).

Personal Reflexivity

On reflecting upon the issue of personal reflexivity with regard to the current research project, the first thing that comes to mind is the reason behind the choice of the research topic. As a counselling psychologist I have been trained in a variety of therapeutic approaches and I would describe myself as an integrative practitioner. Nevertheless, I view the therapeutic relationship as the cornerstone of successful therapy and as an essentially integrating variable across all schools of psychotherapy. I therefore deeply wanted to conduct my research thesis on a topic around the therapeutic relationship. The topic of therapeutic ruptures and repairs, in particular, was genuinely inspired by my clients. Throughout the years, I have learnt a lot from them and I would like to think that they have enabled me to develop and grow as a person, and as a practitioner. Interestingly, at the time I decided on the research title, I was

rather unaware of the existing literature on ruptures in the therapeutic alliance. I was therefore surprised and excited to discover the research conducted around the subject. I was also left wondering why we were not taught of those issues in our counselling psychology training, despite the integrative and relational orientation of the counselling psychology programme I have attended.

At this point, it is worth acknowledging that I believe that the literature review that I have conducted, in combination with my emotional interest in the research topic and my deeply seated commitment to humanistic and relational approaches to psychotherapy may have undoubtedly affected the collection and interpretation of data (see Morrow, 2005). I have nevertheless attempted to address these issues by keeping reflective notes throughout the research project and by attempting to 'bracket' them, in order to maintain a spirit of empathic openness and genuine curiosity toward participants' experiences during data collection and analysis (Finlay, 2014). Furthermore, I have consulted both my supervisor and a colleague of mine during data analysis, in order to give space to alternative data interpretations, as well as to better monitor my responses to the research process (Hill et al., 2005; Morrow, 2005).

I also acknowledge that my demographic characteristics may have in turn influenced the research process. I am a chartered counselling psychologist in my mid-thirties, trained in the UK but currently living and practicing in Greece. Initially, I had considered recruiting a purposive, homogenous sample of chartered counselling psychologists practicing in the UK, who would be more representative of the British therapeutic community. However, the geographical limitations meant that the interviews would have had to be conducted via telephone or skype. Despite some research evidence highlighting the advantages of email or telephone interviews (see Brocki & Wearden, 2006), I personally felt more drawn to the profound immediacy and natural communication of face-to-face interviews, and therefore decided to recruit participants from the Greek therapeutic community. Language was not a problem, as my sample consisted of counselling psychologists who had conducted their training in the UK and were therefore fluent in the English language.

.In retrospect, I would like to think that my shared cultural and professional identity with participants enabled them to feel more at ease and to experience a sense of connection, but I remember myself at the time wondering whether our shared professional capacity would perhaps render participants hesitant, in terms of openly disclosing possible 'failures' and 'weaknesses' in their clinical work. Furthermore, my theoretical orientation was known to some participants who were referred to me through other colleagues. I was therefore mindful of the possibility that they may have felt pressured to satisfy my presumed expectations, as opposed to providing me with accounts of their true experiences. For that reason, I genuinely

strived to maintain an empathic and compassionate stance during the interview, attempting to enter participants' world and allow participants' stories to unfold without leading them or constraining them in any way. In retrospect, I dare to say that there were many times during the interviews that I stood in awe of and I was deeply moved by what participants had to say. And yet, at other times, I felt tempted to adopt a more 'supervisory' role, which I tried to restrain in order to give precedence and pay ultimate respect to participants' experiences.

In the beginning of the research project, I also held certain assumptions and biases with regard to the ways counselling psychologists of different theoretical orientations dealt with ruptures in the therapeutic alliance. I had assumed, for example, that psychodynamic or humanistic therapists would address ruptures more explicitly, reflectively and in greater depth than their counterpart cognitive-behavioural therapists. Again, I tried to 'bracket' those assumptions of mine and keep an open mind during data collection, in order to closely follow participants' accounts. And, indeed, most participants genuinely surprised me and provided me with alternative and compelling perspectives on the topic. The fact that unexpected findings were allowed to emerge may arguably signify that I was able to see and feel beyond my biases.

Lastly, it is worth pinpointing that my personal assumptions, values and biases may have influenced the analysis and interpretation of the data. Indeed, it is acknowledged that different researchers may have provided us with alternative interpretations and may have given rise to a different pattern in the data. After all, IPA is an entirely subjective enterprise and the researcher is considered as a co-constructor of meaning (Morrow, 2005). In any case, I did find myself immersed in the data during the stage of analysis, and I have attempted to ground my interpretations within participants' extracts, rather than import my interpretations from outside (see Smith, 2004; Smith et al., 2009).

Epistemological Reflexivity

One of the main things that has attracted me to IPA is its epistemological diversity and methodological uniqueness. My bachelor degree was in Philosophy and Social Studies, and involved the studying of philosophy, sociology, literature and psychology. I believe that the acquisition of such a diverse knowledge base enabled me to consider the dialectical interplay within, as well as between different disciplines, and enhanced my understanding of human nature and relationships. In turn, my postgraduate training in Counselling Psychology offered me the opportunity to train and practice in three diverse psychotherapeutic models with an emphasis upon the therapeutic relationship and integration, as well as to familiarise myself with both quantitative and qualitative methods of psychological inquiry. In that sense, I can undoubtedly state that my academic studies have shaped me both as a researcher and clinician. IPA does not claim a distinctive epistemological or methodological position. It rather draws

from and integrates a number of closely related approaches, which share a mutual commitment to the exploration of lived experience, but nevertheless have different emphases and adopt diverse techniques, in order to best engage with the task of exploration (Smith, 2004). I therefore consider it as highly compatible with my sense of open-mindedness and freedom, as well as the value I place on pluralism and integration.

I also consider IPA as highly compatible with my humanistic worldview and way of practice, in terms of its commitment to phenomenology and idiography. Although, phenomenology and person-centred therapy have emerged relatively independent from each other, they share significant similarities, in terms of their emphasis on lived experiences, as well as their fundamental belief that the 'truth' resides within individuals, as opposed to being an external, objective and fixed entity (Cooper, 2007). IPA strives to examine and illuminate individuals' subjective experiences, as opposed to making universal, nomothetic claims. It therefore adopts a realist approach to knowledge production (Willig, 2013), and I deeply value its commitment to the individual as a unique entity.

At the same time, IPA espouses a relativist and symbolic interactionist perspective to knowledge, as it acknowledges the process of meaning-making as an essentially interpretative and relational activity that is informed by intersubjectivity and reflexivity (Eatough & Smith, 2008; Willig, 2013). In my mind, this epistemological position shares many parallels with relational models of clinical practice that stress the importance of intersubjectivity and view both therapist and client as active participants engaging in a mutual exchange of affects, thoughts and actions, creating and providing meaningful experiences to one another. Therapeutic change is therefore viewed as taking place within a co-constructed and co-created intersubjective environment that provides the space for new experiences and meanings to take place (Rizq, 2008). IPA's unique and dynamic approach to meaning is thus also highly consistent with and particularly meaningful to my worldview as a person, researcher and therapist.

Another thing that has attracted me to IPA is its preoccupation with language. Due to my background in literature, I am fascinated by the ways we use language in order to perform actions and functions, and I have been therefore always drawn to qualitative methodologies that actively deal with linguistic elements, such as Discourse Analysis and IPA. I do believe that people's understandings of their lifeworlds are partly defined and constrained by the socio-cultural contexts that they inhabit, but I tend to agree with Eatough and Smith's (2008) claim that individuals' meaning-making processes extend beyond socio-linguistic restrictions and culturally available stock of meanings.

Lastly, I was drawn to IPA's approach to data gathering and interpretation. I do find semi-structured interviews as a meaningful and deep method of data collection, which is close to my clinical training and practice (Ponterotto et al., 2010), and where I find myself at a relative comfort and ease. Furthermore, IPA offers flexibility in terms of data analysis allowing for multiple but equally valid levels of interpretation (Smith, 2004). This approach is consistent with my personal ontological view of reality as consisting of a multiplicity of subjective social constructions, as well as my research and clinical attempts to grasp individuals' meaning-making processes through balancing empathic with suspicious interpretations.

Despite the fact that I have selected IPA as the most appropriate methodology to best answer my research questions, I do acknowledge that it is not without certain limitations. Although IPA does seek to illuminate subjective lived experiences and meaning-making processes, it does not provide a causal explanation for the occurrence of such experiences, nor does it clarify the reasons behind individual differences in the phenomenological representations of experience. In that sense, IPA offers us a rather limited understanding of phenomena that fails to move beyond experience itself by encompassing wider historical and socio-cultural contexts and structures within which we live our lives (Willig, 2013). Consequently, this research project aims to illuminate counselling psychologists' experiences and sense-making of ruptures, but is restricted in its ability and ambition to make causal inferences or generalisations on the phenomenon under investigation.

A mixed-method project on the other hand could have provided us with a more holistic and rigorous view of the topic under investigation combining 'breadth' with 'depth'. For example, combining quantitative methods and IPA in order to address the research questions could have potentially been highly illuminating. Postsession Questionnaires (PSQ; Muran, Safran, Samstag, & Winston, 1992) could have been administered to a number of Counselling Psychologists, in order to detect the occurrence of ruptures, and the extent of rupture resolution within sessions across participating therapists, depending on their demographic characteristics, theoretical orientation, therapy duration, clinical setting or other variables. In that way, significant differences could have been detected. Through the conduct of semi-structured interviews with a selection of participants and the method of IPA, we could have subsequently acquired a deeper and fuller understanding of the ways participants experience, make-sense of and manage such phenomena (see Willig, 2013). Alternatively, it would have been interesting to combine IPA with Foucauldian Discourse Analysis (FDA). While IPA focuses on individuals' experiences within particular contexts, FDA provides a critical analysis of the socio-cultural context itself, within which individuals are positioned. Albeit their

epistemological differences, the two approaches could therefore function in a complementary fashion providing us with a richer and deeper analysis (Eatough & Smith, 2008; Shinebourne, 2011). Mixed-method research projects tend to maximise the strengths and overcome the weaknesses of each type of method separately (Creswell, Klassen, Plano Clark, & Smith, 2011) and can thus strengthen the validity of the findings through triangulation (see Hammersley, 2008; Patton, 1999). Despite my deep-seated commitment to pluralism and integration, the employment of a mixed-methods project was dropped mainly due to practical reasons, as it is rather time-consuming and demanding, and requires a substantial amount of relevant training and experience, which as a researcher I did not feel confident that I adequately possessed.

Trustworthiness and Validity

The recent proliferation of qualitative methodologies in psychology has given rise to the issue of the best ways to assess the validity of qualitative research. Traditionally, psychological research has been predominated by quantitative studies, rooted in a positivist philosophical paradigm, and validated against well-established and vastly acknowledged criteria (e.g. validity, reliability, generalisability, objectivity) (Yardley, 2000). In contrast, the evaluation of qualitative research has been less straightforward giving rise to a polemic debate among quantitative and qualitative researchers (Meyrick, 2006). The question of validity therefore entails taking into account the paradigmatic assumptions underpinning, as well as the ontological and epistemological positions framing the research project (Sousa, 2014; Willig, 2013).

A number of authors have attempted to formulate appropriate criteria for evaluating the quality of qualitative research. Despite the fact that most guidelines appear to tap into similar issues, the suggested evaluative criteria seem to reflect the authors' preferred qualitative methodology that in its turn may be linked to different ontological and epistemological positions, thus raising issues of applicability to different types of qualitative research (Meyrick, 2006; Willig, 2013). The validation and quality of the present research has been primarily assessed, according to Elliott, Fischer and Rennie's (1999), and Yardley's (2000, 2008) evaluation criteria, as they seem to adopt a more refined and pluralistic stance, as well as Smith's (2011) seven recently proposed criteria that were specifically developed for the evaluation of IPA studies.

The first validity criterion proposed by Yardley (2000, 2008) is sensitivity to context. *Theoretical sensitivity to context* in the present study has been arguably achieved through the conduct of a thorough literature review framing the research project, a clearly articulated rationale for the study's conduct, as well as a clear presentation of my epistemological stance

(Meyrick, 2006; Yardley, 2000). Furthermore, I have attempted to provide a clear and coherent description of the paradigmatic underpinnings of the research project, as well as a thorough and concise account of the rationale behind the choice of methodology, and the philosophical underpinnings and key features of IPA (Smith et al., 2009). With regard to *sensitivity to data*, I have strived to honour IPA's phenomenological, interpretative, and idiographic stance (Smith, 2011), by closely attending to participants' subjective experiences, and attempting to engage in an interpretative activity grounded in participants' accounts, but at the same time allowing the illumination of their meaning-making processes, whilst reflectively acknowledging my own role in the interpretative process. Each case was examined in detail before moving on to the next case, allowing for fresh, unexpected findings to come to the foreground, as opposed to attempting to verify pre-determined hypotheses deriving from existing literature, and pre-existing findings deriving from previous case analysis (Finlay, 2014; Smith, 2004). Furthermore, special attention to the sensitivity to data (Yardley, 2000) and 'grounding in examples' (Elliott et al., 1999) was given at the presentation of data analysis, with the inclusion of a significant amount of extracts, in order to illustrate variation, as well as pinpoint both convergences and divergences within and across participants' accounts (Smith & Osborn, 2008). I have tried to achieve *sensitivity to participants' socio-cultural setting* across a number of levels. Firstly, the sample choice and demographic characteristics have been critically discussed and thoroughly presented, in order to allow for adequate contextualisation and representative illustration of the subjective experiences of this particular group of people (i.e. chartered counselling psychologists, trained in the UK and practicing in Greece offering time-limited or open-ended therapy) (Elliott et al., 1999; Meyrick, 2006; Yardley, 2000). Secondly, the issue of the researcher's identity and relationship to the participants has been approached with reflexivity, as illustrated in the reflexivity, participants, and ethical considerations parts of the report. Furthermore, I have attempted to remain respectful to participants' context by interviewing them at a convenient for them time and place, as well as by adopting an empathic, warm and collaborative stance during the interview process. My main goal was to create an open and non-judgmental climate that would allow time and space for reflection. I have also tried to address power dynamics by providing participants with the opportunity to discuss our shared professional and/ or cultural identity, as well as to address possible concerns arisen by their participation in the study. Particular attention was paid to *sensitivity to ethical issues*, as presented in the ethical considerations section of the report.

Commitment and rigour is the second criterion proposed by Yardley (2000, 2008). *Commitment* refers to the degree of care and attentiveness paid to participants, as well as to the case analysis, while *rigour* refers to the general thoroughness of the study, in terms of

sampling, interviewing and analysis. The sample was purposive and homogenous, consistent with the research questions, as well as the theoretical principles and practical guidelines of IPA (Meyrick, 2006; Smith et al., 2009). Throughout the interview process, I have attempted to put participants at ease by remaining empathic, using gentle probing, and carefully asking for clarifications when needed. Interestingly, most participants paralleled the interview process with supervision, in the sense that it provided them a safe space for self-reflection and evaluation. Throughout the analysis, I have also tried to maintain a reflective stance and to honour the idiographic character of IPA. I believe that I have managed to deeply immerse myself into the data by going over each case several times, by trying to see things from the participants' point of view, by continuously moving back and forth within and across cases, as well as parts and wholes (Finlay, 2014; Smith et al., 2009). The emergent superordinate themes and subthemes, as well as the prevalence of subthemes were all presented in summary tables, and extracts from at least three participants were selected and illustrated in the presentation of each subtheme, according to the recent recommendations of Smith (2011). Of course the degree of the demonstrated commitment and rigour is ultimately open to the reader's evaluation.

Yardley's (2000, 2008) third criterion for evaluating research validity is transparency and coherence in terms of the clarity and cogency of the presentation. In terms of *transparency*, I have endeavoured to provide readers with a detailed, 'thick description' of each stage of the research process in a clear and elaborated way (Morrow, 2005; Ponterotto & Grieger, 2007). I believe that the data collection process, the creation of the interview schedule, the research procedure, and the employed analytic strategy have been discussed at great depth and length, while an extensive amount of extracts has been presented, in order to allow readers to resonate with the subject matter and arrive at their own conclusions with regard to the quality of analysis and interpretation (Elliott et al., 1999; Meyrick, 2006; Smith, 2011; Yardley, 2000). At the same time, I have attempted to 'own my perspective' (Elliott et al., 1999), and remain reflexive and transparent with regard to my own experiences, biases and assumptions that may have impacted the product of the research investigation, as stated in the reflexivity section of my report (Meyrick, 2006; Morrow, 2005; Yardley, 2000). *Coherence* refers to the total quality of the narrative in a way that the readers can 'resonate' with the research's constructed reality in a meaningful way (Elliott et al., 1999; Smith, 2011; Yardley, 2000). I have attempted, to the best of my ability, to integrate the research's 'parts' in a meaningful 'whole', in terms of presenting my arguments in a logical and coherent way, as well as producing the final set of superordinate themes and subthemes, whilst engaging in deviant case analysis and addressing contradictions and nuances between and within cases (Elliott et al., 1999; Meyrick, 2006; Yardley, 2000). In addition, enough verbatim evidence has been

presented, in order to allow readers to evaluate the analysis and to establish internal coherence by determining whether the presented interpretations were coherent with the data (Smith, 2011). Coherence also refers to the ‘degree of fit’ among the posed research question and the adopted philosophical perspective (Yardley, 2000). The rationale for choosing IPA, as opposed to another qualitative methodology, has been thoroughly outlined and explained. Furthermore, I have strived to remain faithful to the theoretical principles of IPA by providing rich phenomenological descriptions of participants’ experiences, whilst engaging in a ‘double hermeneutic’ interpretative activity (Smith et al., 2009).

Yardley’s (2000, 2008) fourth criterion is impact and importance, alternatively termed as ‘social validity’ (Morrow, 2005). In terms of *theoretical impact*, I strongly believe that phenomenological, qualitative studies of this kind can substantially complement existing qualitative studies and illuminate existing quantitative research on therapeutic ruptures and repairs, as they can shed further light onto the micro-processes involved in rupture resolution. In terms of *practical impact* and within the current demand for evidence-based practice (Meyrick, 2006), the study deals with a topic of clinical significance for counselling psychologists (Smith, 2011) that arguably carries significant practical implications, given the fact that repairing alliance rupture seems to be strongly linked to successful clinical practice and treatment outcome. Lastly, in terms of *socio-cultural impact* the study does not make any general claims, given the idiographic nature of IPA. However, it is hoped that it provides a window into the subjective experiences and the unique ways of meaning-making of a small, particular subgroup of counselling psychologists who are trained in the UK, but are practicing in Greece. Assessing the study’s impact and importance ultimately lies at the readers’ discretion. In any case, caution should be exercised against making ‘general claims’ and attempting to generalise the findings of the present study to other populations and/ or contexts (Elliott et al., 1999).

In concluding this section, it is worth highlighting that the validity of the present study can be also checked through the ‘paper trail’ produced which may serve as an alternative ‘credibility check’ (Elliott et al., 1999). The produced paper trail consists of my initial notes on the research proposal, reflective notes kept throughout the research process, the original research proposal and the ethical submission to the University. It also includes earlier versions, as well as the final version of the interview schedule, interview audio-tapes and transcripts, notes and figures on each case, initial and revised drafts of the research project, as well as the final report (see Smith et al., 2009). Furthermore, my external supervisor has conducted mini-audits of my work throughout the research project, while a colleague of mine has also been involved in the cross-reference of the emergent produced themes, in order to achieve ‘triangulation’ of findings and enhance the project’s validity (see Patton, 1999).

Procedures

Participants

Consistent with the theoretical principles and analytic processes of Interpretative Phenomenological Analysis, sampling was purposive rather than probabilistic (Smith et al., 2009), as the research study aimed to investigate and illuminate chartered counselling psychologists' idiographic experiences and understandings of ruptures in the therapeutic alliance. A small, particular subgroup of counselling psychologists who were trained in the UK, but were practicing in Greece were therefore contacted via snowballing, in order to offer their shared experiences and unique perspectives on the phenomenon under investigation, as posed by the research questions, which were oriented towards meaning, process and exploration (see Smith et al., 2009; Willig, 2013). Snowballing is a sampling strategy where identified respondents are then used to refer researchers on to other respondents (Robinson, 2014), and it is commonly employed in IPA studies (Smith et al., 2009). It is particularly advantageous for descriptive, exploratory, qualitative studies that are primarily conducted through interviews (Hendricks, Blanken & Adriaans, 1992). Snowball sampling is a method for obtaining research participants who are hard to reach or where a substantial amount of trust is required to initiate contact (see Atkinson & Flint, 2001). Given my decision to recruit participants from the Greek therapeutic community, within which the number of chartered counselling psychologists is indeed very limited, snowball sampling was deemed a useful strategy, in order to locate a homogenous group of participants who shared the characteristics that would make them eligible for inclusion in the study (see Morgan, 2008). Moreover, due to the delicate nature of the research topic (where participants were invited to discuss difficult times with clients that might have been resolved successfully or unsuccessfully) and taking into account the relative low response rates that similar studies have yielded, snowballing seemed like an appropriate sampling strategy, as it provided access to an eligible sample of participants who felt fairly comfortable and trusting towards the researcher, as referrals had been made by peers or acquaintances.

Inclusion criteria specified that participants should possess a minimum of two years of clinical experience post-chartership, in order to ensure that they had gained sufficient experience in working relationally with clients. Participants were also required to be engaged in ongoing supervision due to the delicate nature of the proposed project and the possible emotional disturbance that could have potentially arisen by their participation in the study. Furthermore, participants were recruited from settings where they provided time-limited (i.e. minimum 15 sessions) or open-ended therapy. It has been postulated that although alliance ruptures may manifest relatively early in therapy often leading to premature dropout within

the first few sessions of treatment (see Muran et al., 2009), they often require a substantial period of time to be managed and resolved. Consequently, participants working in an NHS setting were excluded from participation in the study, as the type of treatment offered is mainly short-term.

The sample consisted of ten qualified chartered counselling psychologists of various therapeutic orientations. Small sample sizes are consistent with IPA's idiographic commitment that strives to say something about the subjective experiences and understandings of a particular group, rather than make general claims about the wider population (Smith & Osborn, 2008). According to Smith et al. (2009) a range between four and ten participant interviews seems appropriate when conducting IPA for professional doctorate programmes. This sample size provides researchers with the opportunity to examine both similarities and differences between participants' accounts, without compromising the idiographic focus of IPA, and without getting lost in a great amount of generated data (Smith & Osborn, 2008).

Participants had completed BPS-accredited training programmes in the UK and were at the time residing and practicing in Greece. Their first language was Greek, but they were all fluent in English, as they had completed postgraduate studies in the UK. In accordance with the principles of IPA, the sample was purposive and homogeneous in terms of professional training and academic qualifications, as the research questions must hold personal significance and relevance for participants (Smith & Eatough, 2006; Smith et al, 2009). However, the sample was fairly heterogeneous in terms of participants' therapeutic orientation and professional post mirroring the diversity of counselling psychologists, and thus potentially increasing sample's representativeness (Carradice, Shankland, & Beail, 2002; Robinson, 2014). It is worth mentioning that I had originally thought of dividing the sample into therapists and clients, in order to acquire multiple and multifaceted perspectives on the topic under investigation (Smith et al., 2009). This thought was, however dropped, due to the complex ethical issues that would have been involved in the recruitment of clients.

Eight participants were female and two were male. Their age ranged from 29 to 44 years ($M = 35.5$) and their years of professional experience (post-chartership) ranged from 2 to 15 years ($M = 7.0$). Participants were employed in the fields of private practice, public mental health, non-profit organisations and academia. With regard to their theoretical orientation, three participants described it as integrative, three as mainly existential, two as psychodynamic, one as mainly cognitive-behavioural, and one as schema therapy (for the full demographics of participants, see Table 1).

Therapist Name	Therapist Number	Sex	Age	Years of Experience	Therapeutic Orientation	Nationality	Professional Post
Elaine	1	F	36	7	Integrative	Greek/ English	Daycentre/ Private Practice
Mia	2	F	29	2	Existential	Greek	Private Practice/ Academia
Christina	3	F	35	5	Psychodynamic	Greek	Mental Health Service/ Private Practice
George	4	M	34	5	Cognitive-Behavioural/ Integrative	Greek	Private Practice
Sara	5	F	41	14	Integrative/ Mindfulness Inspired	Greek	Private Practice/ Academia
John	6	M	34	6	Integrative	Greek	Private Practice/ Academia
Stella	7	F	30	3	Existential/ Integrative	Greek	Private Practice/ Academia
Maria	8	F	36	6	Existential	Greek	Private Practice/ Education
Rose	9	F	36	7	Psychodynamic	Greek	Private Practice
Angela	10	F	44	15	Schema Therapy	Greek	Private Practice/ Academia

Table 1: Demographics of Participants.

Interview Schedule

Data were collected through individual, semi-structured interviews, consisting of twelve open-ended questions, in order to present subject areas for discussion, without constraining or influencing participants' responses. A schedule consisting of around ten questions is likely to elicit conversation lasting from 45 to 60 minutes, depending on the topic under investigation (Shinebourne, 2011). One-to-one, semi-structured interviews are considered as the exemplary method of collecting data for IPA and have been adopted in the majority of IPA studies (Brocki & Wearden, 2006; Smith, 2011), as they allow the researcher and participant to engage in an interactive dialogue, whereby questions are transformed in the light of unexpected answers and the researcher is able to delve deeper into significant and interesting areas (Smith & Osborn, 2008). In-depth interviews are consistent with IPA's aspiration of eliciting detailed and rich descriptions of participants' experiences, thoughts and

feelings (Smith et al., 2009). Participants are considered as experts of their own experiences, and are encouraged to tell their stories, in their own words, and in as much detail as possible (Reid et al., 2005). Priority is given to establishing rapport with and demonstrating empathy to the interviewees, in order to enter their psychological and social world, and allow for the emergence of novel areas, capable of eliciting richer data (Smith & Osborn, 2008). Consequently, the interview schedule attempts to address the research questions, but merely guides rather than dictates the course of the interview (Smith & Eatough, 2006).

The interview schedule (presented in Appendix 1) was constructed in order to present the issues that the interview would cover. The literature review, as well as personal reflections, guided the selection of topics that I wished to cover. At the same time, I thoroughly attempted to phrase the interview questions in an open-ended, neutral and clear way, in order to avoid influencing participants' responses, and enable them to feel comfortable and open up on their thoughts and feelings. Possible, gentle prompts were thought in advance, in order to frame the initial interview questions more explicitly (Smith & Osborn, 2008).

Pilot Study

At this point, it is worth highlighting that the interview schedule puzzled me quite a lot, and I devoted a substantial amount of time and energy to its construction. Following the initial draft of my interview schedule, I decided to conduct an unofficial, mini pilot study with four colleagues of mine, in order to receive some feedback on the quality and tone of the interview questions (see Smith & Osborn, 2008), following which a number of readjustments have been made. A salient issue that arose was a sense of confusion around the terms 'therapeutic relationship' and 'therapeutic alliance'. Two colleagues did not appear to differentiate between the two terms, whilst the other two did. This confusion seemed to reflect current tensions in the field, whereby many clinicians and researchers equate the concept of the alliance with the therapeutic relationship (Agnew et al., 1998; Henry & Strupp, 1994), and argue that the term alliance in itself may have outlived its usefulness within contemporary relational and humanistic paradigms (Bozarth & Motomasa, 2008; Safran & Muran, 2006). Upon consultation with both my external and internal supervisor, the opening question was rephrased to include the broader term of 'therapeutic relationship', and the more specific term 'alliance' as a prompt, so it would not lead or influence respondents in any particular way.

The pilot study also revealed some difficulty around the definition of ruptures. The second interview question was therefore included and phrased in an open way, in order to explore what constitutes a rupture for each participant, as opposed to me making assumptions or generalisations about what a rupture is. Nevertheless I decided to extend the literature's definition of ruptures on the Participant Information Sheet, so that respondents would not

experience uneasiness or discomfort, should they have not been familiar with the relevant literature on the topic. Following the pilot study, I also decided to incorporate extra prompts in questions four and five, so that participants would be given the opportunity to give detailed descriptions of their experiences and meaning-making processes around ruptures. Lastly, following the pilot study, I also decided to include three extra questions in the interview schedule, influenced by my delving deeper into the literature review. I therefore decided to include the question on both therapists' and clients' contributions to ruptures, as well as the questions on what they have learnt from the experience and what they would have done differently. By adding these three questions, I endeavoured to encourage participants to engage in meaningful and deep self-reflection that could potentially lead to a richer and fuller data analysis. It goes without saying that the final interview schedule was reviewed by my two supervisors, in order to ensure its quality and appropriateness.

Interviewing

Interview topics were placed in the most logical sequence, so that the interview would have coherence and flow. In line with IPA recommendations, interviews opened with more general questions and gently moved on to the more specific and sensitive subjects under investigation, in order to make respondents feel more at ease and to begin establishing trust and rapport (Smith & Eatough, 2006; Smith & Osborn, 2008). In general lines, there was an oscillation between more narrative or descriptive questions, and more evaluative or analytic questions (Smith et al., 2009). Interjections by the interviewer to clarify points or facilitate conversation were also encouraged (Hunt & Smith, 2004), although I attempted to use as little prompts as possible. I had learnt the schedule in advance, so that I could monitor the coverage of the scheduled topics, but I also tried to grant participants maximum freedom, in terms of the interview's pace and process (Smith & Osborn, 2008; Smith et al., 2009). In fact, I often found myself going back and forth the interview schedule, changing the questions' sequence, or not asking every question included in the schedule. In other words, I allowed myself to be led by the respondents' stories and to enter new and unexpected areas of investigation (Smith & Eatough, 2006). Above all, I attempted to stay focused and monitor the interview's impact on the respondents by closely attending to their verbal and non-verbal behaviour (Smith & Osborn, 2008; Smith et al., 2009). I often found myself employing a repertoire of my counselling skills, such as empathic reflections, paraphrasing and summarising, whilst refraining from adopting a supervisory or therapeutic role. In retrospect, I do believe that I have managed to put participants at maximum ease, despite the delicacy and challenging nature of the research topic. Almost all respondents paralleled the interview to supervision, in terms of being provided with a safe and open safe space for self-reflection. I do, however, acknowledge that my personal biases, values, and beliefs have unavoidably shaped and

influenced the interview process, despite my conscious attempts to 'bracket' personal thoughts, feelings and preconceptions. I did at times catch myself feeling over-excited over certain arisen issues or experiencing the urge to share my therapeutic perspective and interpretations. I do hope that I was not accidentally leading participants, and that I have managed to a significant degree to enter their lifeworlds.

Interview Procedure

As mentioned above, participants were recruited via the method of snowballing. The researcher originally identified and approached two respondents, who were then used to refer the researcher on to other respondents. Participants, were originally informed on the nature of the study via a Recruitment Letter (for a copy of the Recruitment Information, see Appendix 2). Those who expressed an initial interest and willingness to participate, were subsequently approached individually by the researcher and were informed with regard to the nature and aims of the study, both verbally and in writing through a Participant Information Sheet (for a copy of the Participant Information Sheet, see Appendix 3). They were also encouraged to ask questions regarding the purposes and implications of the project. Caution was taken, in order for participants not to feel obliged to take part in the study, due to the relationship with the respondent who initially referred them to the researcher (see section on ethical considerations).

Respondents, who had read the Participant Information Sheet and still expressed a wish to take part in the proposed research study, were subsequently provided by the researcher with two copies of an Informed Consent Form (for a copy of the Informed Consent Form, see Appendix 4), explaining to them confidentiality issues, right for withdrawal, handling of the material, as well as ethical implications arising from the conduct of the study. They were subsequently asked to read carefully, sign and return one copy of the Informed Consent Form within a week. Participants who signed and returned their forms were then invited to take part in a semi-structured interview lasting approximately 90 minutes (including the introductory and debriefing phase). The interviews took place in a quiet room at participants' home, private practice or workplace at a convenient for them date and time. There were no significant health and safety issues identified, as it was assumed that the chosen location sufficiently met relevant health and safety policies.

Upon interviews' completion, all participants were given a Debriefing Sheet (for a copy of the Debriefing Sheet, see Appendix 5) providing them with the researcher's and supervisor's contact details, as well as a list of professional organisations they could turn to should they have wished to address questions, anxieties or concerns arisen from the study. They were also strongly encouraged to share them with their own supervisors and/ or therapists. Furthermore,

they were asked to fill in a short monitoring form consisting of their demographic details (for a copy of the Monitoring Form, see Appendix 6). During the briefing session, participants were also given the opportunity to explore the working relationship between themselves and the researcher, as well as the implications arising from their participation in this study. In addition, they were encouraged to ask questions around the nature and outcome of the research project.

Ethical Considerations

Ethical permission for the project was sought and granted from City University's Research Ethics Committee (for a copy of the Ethics Application Form and Ethics Approval Letter, see Appendix 7 and 8 respectively). The proposed research project was not particularly time-consuming for participants, as they were only required to take part in one semi-structured interview lasting approximately 90 minutes (including introductory and debriefing phases). Nevertheless, participants were specifically asked on whether they were at the time engaged in another research project, as well as on their emotional and practical availability. Participants with a heavy workload and/ or other research obligations were strongly encouraged to take into account their various commitments before deciding to give their final consent for participation in the study. Emphasis was given on participants' right to decline participation in the research project and sufficient time was dedicated in explaining to them (both verbally and in writing) the nature of the research project, as well as the level of commitment required by them. The duration of the interview process, including the introductory and debriefing phase, were clearly explained and punctually kept.

An issue that was given thorough ethical consideration was the shared professional identity between the researcher and participants (i.e. chartered counselling psychologists), which might have made it difficult for participants to refuse to take part in the study. For that reason, the invitation for participation in the study was not addressed to them personally, but rather through the method of snowballing. They were therefore given the right to decline participation whilst maintaining their anonymity. Another source of pressure that was taken into account was participants' relationship with the respondent who initially referred them to the researcher, as they might not have found it socially desirable to refuse to take part. In both cases, participants who had decided to take part in the study were given the opportunity to explore their shared professional identity with the researcher, and were reassured that refusal to participate would not affect the working relationship in any way. Lastly, participants were informed of their right to decline answering any of the questions and to withdraw from the study at any time, up to the point that the analysis had been finalised, without any further explanation, and without being disadvantaged or penalised in any way.

Every effort was made to ensure that participants understood that all personal information mentioned in the study would remain strictly confidential and anonymous and were instructed to avoid using details, which could lead to their identification. They were, however, also notified that, in accordance with the BPS Code of Ethics and Conduct (2009), confidentiality would have to be breached should they disclose material, which raised concerns about potential risk, safety of clients, as well as health and safety of children or vulnerable adults. In such a case, the researcher had informed participants that she would raise the issue to the supervisor, and might have to take further action and report it elsewhere, such as the University's or the BPS's Ethics Committee.

Participants were all experienced counselling psychologists who had completed or were still engaged in personal therapy, and received ongoing supervision. It was therefore assumed that they were physically and mentally suitable to participate in the study. In addition, at the conclusion of their participation, they were fully debriefed and were encouraged to ask questions around the nature and outcome of the research. In the case where participants disclosed a particular emotional, psychological or practical need, they were offered the opportunity to explore their issues with the researcher in an open and supportive way. Furthermore, all participants were given a debriefing sheet providing them with the researcher's and supervisor's contact details, as well as a list of professional organisations they could turn to should they wish to address questions, anxieties or concerns arisen from the study. They were also strongly encouraged to share them with their own supervisors and/or therapists.

Lastly, every attempt was made to safeguard confidentiality, through sensitive and sound treatment of the material, as well as safe and responsible storage of audio recordings, transcripts, and monitoring forms consisting participants' demographic information. As previously mentioned, interviews took place in a quiet room of participants' workplace, private practice or home, while all research data were handled in accordance with the BPS Code of Human Research Ethics (BPS, 2010) and the Data Protection Act (1998). Audio-recordings and transcripts produced were kept in a locked filing cabinet at a secure place, to which only the researcher had access. Participants' personal information data (i.e. those included in the monitoring form) were kept separately from the raw data, in order to further safeguard anonymity. In addition, electronically stored data (e.g. transcripts and researcher's personal notes) were password protected. According to the University's policy on data retention, audio-recordings and transcripts produced will be kept for 5 years after the successful completion and submission of the research study.

Participants' identity was only known to the researcher conducting the study and the audio-recordings produced were only listened by the researcher herself. Participants were made fully aware that the interviews would be audio-recorded and subsequently transcribed. They were also made aware that the audio-recordings, as well as the transcripts, with identifying details removed, might be heard or seen by supervisors and examiners, while extracts from the interviews could potentially appear in subsequent publications or a display of the dissertation's copy at the University's library for educational purposes. In any case, the anonymity of the participants was protected through using a pseudonym when labelling the recording, as well as when producing the transcripts. Furthermore, transcript sections, which could lead to the identification of participants (e.g. work setting, agency location), as well as participants' clients mentioned in the interview were excluded from presentation.

Audio-Recording and Transcription

The duration of the interviews ranged from 49 to 75 minutes, with an average interview lasting 61 minutes. They were audio-recorded on a Sony Digital Voice Editor (version 2.4), and were subsequently transferred to a CD-R that was stored in a locked filing cabinet at the researcher's home. All interviews were transcribed verbatim according to relevant IPA recommendations (Smith & Osborn, 2008; Smith et al., 2009). As IPA is concerned with interpreting the content of participants' accounts, transcription was generally at a semantic level and did not include prosodic or non-verbal elements of the recordings. It did however include all words spoken by both the researcher and participants, as well as false starts, notable pauses and meaningful non-verbal utterances. Wide enough margins were left at both sides of each transcript, in order to provide enough space for subsequent analytic comments. Upon transcription, all identifying details of participants and their clients were changed and each participant was assigned a fictitious name in order to maintain anonymity.

Analytic Strategy

The interviews were subjected to Interpretative Phenomenological Analysis, following the recommendations by Smith & Osborn (2008) and Smith et al. (2009). An idiographic approach to the analysis was taken beginning with the detailed examination of each interview transcript before slowly moving on to the examination of next cases and working up to more general categorisations (Smith & Osborn, 2008). The analysis consisted of the following steps:

- 1) Several close and detailed readings of the first (and subsequently for each) transcript were made, in order to familiarise myself with, as well as obtain an in depth and holistic perspective of each participant's account. The first reading of each interview transcript

was conducted in parallel with the listening of the interview's audio-recording, in order to immerse myself deeper into each participant's mental, emotional and social world.

- 2) At this stage, I attempted to immerse myself in the participant's lifeworld. Initial thoughts and comments were noted using the left margin of the transcript. Exploratory commenting was conducted via descriptive (focusing on the content and meaning of participant's words), linguistic (concerned with participant's use of language) and conceptual (focusing on the context of participant's experience, and adopting a more interpretative and interrogative stance) notes. Initial impressions, associations and interpretations, as well as similarities within individual accounts were also noted, although care was taken to stay close to the original text and its meaning.
- 3) In this part of the analysis, the emergent data and exploratory comments were clustered into identifying and representative themes of participants' experiences, which were checked against participants' accounts and were noted down the right margin of each transcript. Caution was exercised, in order to capture the essential quality of the account and achieve data reduction, whilst maintaining complexity and staying grounded in the text itself. At this stage, the analysis took an iterative form involving a close interaction with the text and I found myself immersed in the data constantly moving back and forth between parts and wholes and trying to see things from the participant's frame of reference (Finlay, 2014; Smith et al., 2009). I also found myself struggling to balance empathic interpretation with suspicious interpretation, entering participant's world, whilst posing critical questions. I was therefore operating within the 'hermeneutic circle', whereby I had to re-organise the whole transcript into meaningful parts grounded in the text, only to subsequently integrate the parts into a meaningful whole, representative of participant's account (Smith et al., 2009) (This process is demonstrated in an extract from a transcript that can be found in Appendix 9).
- 4) The emergent themes were then listed on a sheet of paper in chronological order of appearance within the text. These were closely examined and, interconnections and patterns between themes were identified adopting a more analytical and theoretical ordering. Meaningful connections between emergent themes were sought via 'abstraction', 'subsumption', 'polarisation', 'contextualisation', 'numeration' and 'function' (see Smith et al., 2009). The themes were then condensed and clustered together to produce a main list of 'subthemes'. From the main 'subthemes' identified, some of them were clustered together, and a smaller number of 'superordinate' themes was then produced. At this stage, a summary table of the emergent themes was produced including the provisionally identified and labelled 'superordinate' themes and cluster of

‘subthemes’, accompanied by brief extracts from participant accounts plus references on the page number and line of the transcript of selected extracts. During this stage, ‘subthemes’ that were not representative of participant’s experiences, were not characterised by sufficient richness and depth, or exhibited a weak evidential base were dropped from the analysis. This final clustering of ‘subthemes’ was carefully checked against the transcript, in order to ensure that it was grounded in and representative of participant’s actual words (for an example of a table of superordinate themes and subthemes from one participant, see Appendix 10).

- 5) This stage involved moving on to the next case and repeating the same process for each interview. Keeping in line with IPA’s idiographic nature as to honour each participant’s individuality, every possible attempt was made to ‘bracket’ assumptions and findings deriving from previous cases.
- 6) The final stage of the analysis consisted of searching for patterns across cases, whilst staying respectful to both convergences and divergences, within and between participants’ accounts. Again this stage involved me moving back and forth between parts and wholes, as well as between various analytic stages. At this point, the individual summary table of each participant’s account was cut and paste into Word files on the computer and was printed on individual pieces of papers. The prints were then constantly moved around in an attempt to compare, organise and condense the produced themes. By comparing the themes across cases, a whole new set of reconfigured and relabelled ‘subthemes’ and ‘superordinate’ themes was produced, representative of participants’ subjective experiences and accounts. At this stage, a fellow counselling psychologist, as well as my external supervisor, were both involved, in order to cross-reference and achieve ‘triangulation’ of findings, thus enhancing the project’s validity. A final table of ‘superordinate’ themes and ‘subthemes’ was then produced including illustrative participant extracts, as well as the page and line references for each quote (the final table of superordinate themes and subthemes for the group can be found in Appendix 11). In line the recommendations of Smith (2011) for IPA studies with over eight participants, a second table was also produced indicating the prevalence of identified themes across participant interviews, and thus enhancing validity of findings (the table of recurrent themes can be found in Appendix 12).

In the last stage of the analysis, a narrative account of participants’ subjective experiences, in their own words, and the researcher’s interpretative activity was produced. In some cases, false starts and extraneous words that were not considered particularly meaningful were edited out, in order to enhance text legibility and flow. In the verbatim extracts from

interviews, ellipsis points ... indicate pauses in participants' flow of speech, whilst ellipsis points within square brackets [...] indicate omitted text. Lastly, text that appears within parenthesis (text) has been added for clarificatory purposes. Key notation at the end of each extract indicates the participant's pseudonym, followed by the transcript's page number(s) and the page's line number(s).

Findings

Overview

The present section outlines and discusses the four superordinate themes, as emerged from the analysis of participants' accounts. The presentation of the emergent superordinate themes attempts to tell the story of participants' narratives, as it was naturally and contextually unfolded in their accounts. It is therefore organised in terms of the temporal moments and developmental context within which participants' experiences, meaning-making processes and actions took place (see Smith et al., 2009).

The first superordinate theme entitled '*The Threat*' refers to the '*what*' participants experienced as a rupture in the therapeutic relationship. The second superordinate theme entitled '*The Struggle*' describes the '*how*', meaning the ways and dynamics, through which ruptures were manifested. The third superordinate theme entitled '*The Meaning-Making*' attempts to highlight participants' attempts to retrospectively make sense of and find an answer as to the '*why*' ruptures occurred. Lastly, the last superordinate theme entitled '*The Resolution*' focuses on the '*when*' therapeutic ruptures were repaired shedding light onto the ways therapists employed to overcome them, as well as onto the impact of rupture resolution upon the therapeutic process and relationship.

Each superordinate theme contained a set of interrelated and often overlapping subthemes representing participants' experiences, as portrayed in their accounts. Both convergences and divergences were observed between, as well as within participants' accounts, highlighting the complexity and richness of their experiences, as well as the dynamic and often contradictory process of meaning making. Each subtheme will be discussed in turn, demonstrated by supporting quotations from participants' accounts and accompanied by the researcher's interpretative analysis (for a summary table of the emergent superordinate themes and subthemes, see Table 2).

Superordinate Themes	Subthemes
Superordinate Theme 1: The Threat	<ol style="list-style-type: none"> 1. Withdrawal 2. Breakage 3. Misattunement
Superordinate Theme 2: The Struggle	<ol style="list-style-type: none"> 1. Power Issues 2. The Dilemma 3. Negative Emotionality
Superordinate Theme 3: The Meaning-Making	<ol style="list-style-type: none"> 1. Interpersonal Dynamics 2. Intrapsychic Dynamics 3. Individual Vulnerabilities 4. Timing/ Pacing of Interventions
Superordinate Theme 4: The Resolution	<ol style="list-style-type: none"> 1. The Way Out 2. The Therapeutic Transformation 3. The Learning Experience

Table 2: Summary Table of Superordinate Themes and Subthemes

Superordinate Theme One: The Threat

The first superordinate theme portrays participants' perceptions and experiences of ruptures manifested within the therapeutic dyad. Regardless of the form and shape of ruptures, they were experienced as threatening, albeit at times unavoidable, to the therapeutic endeavour. Three subthemes emerged, which represented three interconnected and complementary views and definitions of ruptures. Interestingly, therapeutic ruptures were conceptualised as essentially intersubjective, relational acts, co-created and co-experienced by both therapists and clients, as opposed to distinct client behaviours.

Subtheme One: Withdrawal

Participants' accounts revealed that ruptures were often perceived and experienced by therapists in the form of silence, avoidance and detachment.

Rose explains that ruptures may be often characterised by subtle, almost unnoticeable changes in the therapeutic interaction following a therapist's comment or intervention that the client does not identify with, and therefore silently opposes to it by becoming unresponsive or covertly disregarding it:

“At times this might be just a small rupture and it might not even be noticed. It might just be noticed in the very brief silences that follow a comment I make, that it didn't make any sense to the client and he just disregarded it.” (Rose, 3, 20-22)

For George this silence and withdrawal is experienced as threatening and hindering to the therapeutic process, as things left unsaid seem to create distance giving rise to negative feelings and sensations:

“It’s the unspoken, which creates confusion, avoidance, anger, walls, distance. I think, actually, in therapy that’s the worst thing, the worst I don’t like to, you know, it’s not about good or bad but it’s, um, this is what makes things more difficult.” (George, 3, 17-19)

George’s description evokes the image of an impenetrable fortress. The raised walls, accompanied by the words ‘avoidance’ and ‘distance’ vividly portray a sense of detachment and separation between therapist and client, whereby they cannot reach each other experiencing confusion, as well as anger. The repetition of the phrase “the worst thing” highlights the magnitude of George’s discomfort when it comes to dealing with such types of ruptures in the therapeutic relationship. In spite of acknowledging that withdrawal may be a natural phenomenon in the therapeutic process, he genuinely admits to his difficulty in dealing with it.

Stella echoes George’s words, in terms of the withdrawal and detachment experienced when working with a particularly withdrawn and challenging client:

“And let’s say, as a metaphor, I would feel that I was very far from this client. Um, and for him, I would feel that he was in the bubble that we, we were talking before, um, and not expressing his true self. So not being able to actually, he would, I think, that’s very common with clients being on their heads and not their senses and not into their bodies and not into their emotions.” (Stella, 7, 13-17)

The metaphor of the “bubble” surrounding the client also vividly highlights the level of separation and distance between therapist and client. According to Stella, the client’s disconnection from his emotions, senses and body is mirrored in the disconnection between them which seems to be going both ways. She feels withdrawn from the client, unable to reach him, whilst the client appears trapped in his bubble and mind, cut off from and unable to express his true self.

At times the magnitude of the client’s withdrawal and detachment appears to frustrate and exhaust the therapist who appears to experience a sense of purposelessness, as Sara eloquently describes:

“I remember that for a long time in therapy, my, I had an image of a huge mountain that would never be moved; it would always be there and, um, I think rupture came at

a point where I really was tired of trying to, um, I don't, with my little shovel try to slowly scrape the mountain, you know.” (Sara, 6, 10-13)

Sara parallels the client's suffering to a huge mountain that cannot be moved. The contrast between the client's stuckness and immobility, and the therapist's desperate attempts to achieve the unachievable with limited means resembles the image of the battle between David and Goliath. With the odds being against her, Sara gradually and unavoidably experiences exhaustion by the client's withdrawal manifested as a rupture in their therapeutic relationship.

Elaine also portrays the embodied and physical manifestation of withdrawal between therapist and client, signalling the occurrence of a therapeutic rupture:

“[...] But, but it was then and I knew when there was a rupture because he was, he would go, he would disappear [...] He would move away like I did, so we were both go, physically as well, I mean we wouldn't leave our chairs but, you know, you could see him going backwards.” (Elaine, 10, 8-12).

Therapist and client both appear to be moving away from each other, both physically and symbolically. Their body language mirrors the magnitude of their mutual withdrawal and seems to speak in itself of what remains unspoken between them.

Subtheme Two: Breakage

In contrast to ruptures which are experienced in the form of withdrawal and are characterised by subtlety, silences, detachment, participants also described more intense and overt forms of ruptures characterised by tension, aggression and a 'breakage' of the therapeutic boundaries, frame and relationship.

Quoting the Greek philosopher Heraclitus who views war in general and fire in particular as the beginning of the universe and creation, Maria parallels therapeutic ruptures with war:

“[Clears throat] Um, how would I define ruptures? Um I think it is, I'm thinking of Heraclitus [laughs] who said that the beginning of all is war. And war meaning, um, a rupture, where there is this flash, where the flame is created. And so, um, even if they are difficult for me, um, I, I feel that they are very useful when they come. So rupture can be [...] Um, rupture can be, um [pause] disagreeing on the logistics of therapy; time, money, um, sequence, all this, boundaries, in general or can be a person who can become angry for, for, for, um, for my reaction or a question or, um, that I do.” (Maria, 2, 10-19)

Just like fire has both the capacity for destruction, as well as creation, ruptures may take violent forms with destructive consequences, but can also allow for rebirth from the ashes.

Every war is characterised by painful losses, as well as opportunities for new beginnings. In that sense, ruptures are perceived as both destructive and useful. According to Maria, such ruptures may take the form of disagreements over the therapeutic contract, violations of therapeutic boundaries or aggressiveness towards a therapist's intervention.

Likewise, Angela perceives ruptures as hostile and aggressive client behaviours manifested against the therapist or against the therapeutic endeavour in general:

"I don't know anything could go wrong. They can hit you, they can leave, storm out of the door, they can shout at you, um, what else?" (Angela, 3, 1-2)

George vividly describes the constant tension experienced in the therapeutic relationship with one of his clients:

"[...] There is tension in the relationship and if I don't manage that, it can be a rupture, very easily with her... I mean sometimes I have found myself being on the border with her. One wrong, um, one wrong manipulation of mine, therapeutic manipulation and we can have problems...or I can, she can even terminate or get distant or whatever." (George, 14, 26-31)

Just like an active volcano which is ready to erupt at any time, George appears to be walking on eggshells with this particular client. He feels that he must constantly monitor and contain his therapeutic interventions, otherwise the therapeutic encounter may escalate into a full blown rupture leading to the client's withdrawal or premature termination. George's hesitant speech, as well as the repetition of the words "one wrong manipulation" possibly mirror his tentativeness and restraint with this client triggered by his fear and anxiety that the tension in the relationship may easily lead to a violent and irreparable rupture.

In contrast to Maria's account that seems to view ruptures as possibly destructive yet immensely useful, both Mia's and John's accounts appear to fall at the opposite side of the spectrum perceiving ruptures as fundamentally irreparable and unfixable:

"I think rupture is a very strong word. Um... and it's, it feels like... so even irreparable, so I don't know; it's like breaking a glass and trying to put the pieces back together. You will never make it." (Mia, 3, 12-14)

"[...] But sounds as if rupture is something, you know, unfixable. Something breaks, something ruptures you know, and it's; the way I, I hear it, um, so my, for example, I don't know, my mind would go somewhere, um, like, um, I'm just trying to think of an example. You know, a client not, for whatever reasons, I would say not, not coming back. So something as, what's the word, severe?" (John, 4, 27-31)

Mia and George both appear to perceive ruptures, or what they personally conceive as rupture, as severe, intense, unfixable and irreparable. By paralleling ruptures with a broken glass, they highlight the irreversibility of the event and the implausibility of reparation, as in the case of a client's premature termination.

Subtheme Three: Misattunement

In addition to ruptures experienced in the form of withdrawal or breakage, most participants also provided experiences of ruptures characterised by a mutual misattunement between the members of the therapeutic dyad. This misattunement was evident in moments of miscommunication and misunderstanding, as portrayed in John's account:

“And since we are talking about ruptures, I don't know, perhaps bringing communication into the equation and since I'm saying, you know, “I got that message from her” but obviously as things followed and happened, I suppose my message was incorrect; my, the perception of the message was incorrect, whether she didn't make it clear or I misunderstood it, well I couldn't tell.” (John, 12, 13-17)

John explains the way a “message” sent by the client was incorrectly interpreted and decoded by himself leading to miscommunication. He then wonders and self-reflects on whether he perceived the message incorrectly or whether the client was not explicit with regards to her intentions. In any case, it seems hard to separate each participant's contribution in the interaction and John seems to be placing equal responsibility to both himself and the client for the miscommunication occurring between them.

Similarly, George describes moments of tension and miscommunication between himself and his clients, whereby a client misinterprets an intervention or action or he himself fails to adopt an empathic stance and remain appropriately attuned to the client's world:

“I think ruptures can be [...] the tension but when I say tension I mean, you know, kind of misunderstandings, difficult to communicate, when I say something and the client, um, kind of misinterprets, misinterprets, what I'm saying; um, he or she thinks that I might want to put him down or that I'm, I'm doing an attack or maybe I recognise in myself, sometimes I kind of might be, my spot might not be appropriate, you know, it might be more angry or more distant or more, yeah; or maybe not so empathic, let's say. Um, but I think yeah, I think it's in the communication.” (George, 2, 21-29)

Rose echoes George's words taking full responsibility for the occurrence of therapeutic ruptures due to her inability to remain attuned to the client's internal world:

“Um, it seems to me that a rupture takes place whenever, um... [long pause] I fail to be attuned to the client’s internal world. Um... [pause] um... [pause] so there are moments that this deeper connection with his world, um, fails and something, and, and in those moments, I lose my deeper understanding of what he’s saying, of what he feels and either, um, and I respond in a way that it is not attuned to his needs.” (Rose, 3, 14-18)

According to Rose, ruptures can thus take the form of misattunement that can compromise the deeper connection between therapist and client. In these moments of misattunement, she feels that she loses her ability to follow clients’ spoken communication, synchronise with their emotional states and respond to their needs.

Sara also elegantly describes the experience of the lack of connection between the members of therapeutic dyad:

“(When there is connection) I feel like I am doing my work. I am allowed to do my work, because, and I think, um, before I mentioned something about trying to kind of like find a connection as if in a phone line, you know, like being there struggling on the telephone [laughter]. Um, so, if there is no connection, um, yes, I often feel that I can’t work. Um, and of course I am trying to use that in therapy and to work with it, but I think the feeling is that, that, um, I am less touched, so there is no space for me [...] Yes, I feel, um, it feels strange sometimes. Um, it makes me wonder “Ok, so what, if there is no connection, what, what am I doing here”? or “What am I being asked to do here? [...] Am I asked to be a witness?”” (Sara, 2 & 3, 37 & 1-11)

In her account, Sara parallels the telephone connection with the therapeutic connection. When the telephone connection is good, communication runs smoothly. Likewise, when there is connection with the client Sara feels that her therapeutic work is enabled and facilitated. On the contrary, when the telephone connection is bad communication is significantly compromised. Similarly, when Sara is faced with miscommunication and disconnection in the therapeutic relationship, she struggles significantly. She finds herself less present in the therapeutic encounter and less touched by the client, experiencing a sense of purposelessness and meaninglessness, and feeling like an outsider, a bystander rather than an active participant in the therapeutic relationship.

Superordinate Theme Two: The Struggle

The second superordinate theme highlights the intense struggle participants engaged in, as a result of ruptures in the therapeutic relationship. Specifically, ruptures were followed by

struggles in the form of heightened power and control issues, significant ethical and professional dilemmas, as well as an electrifying negative emotionality.

Subtheme One: Power Issues

All participants appeared to experience intense power issues in relation to ruptures, whereby both therapists and clients attempted to control each other, as well as the therapeutic relationship. Power imbalances took different forms and shapes, which appeared to significantly compromise the therapeutic endeavour. In the following extract, Sara vividly describes the uneasiness and discomfort she experienced with a male client since the beginning of therapy due to the client's attempts to control the therapeutic relationship, as he tends to do in his intimate relationships with others in his life:

“I think a part of me from the beginning felt a little bit, a little bit at the edge of my seat. It was, I wasn't completely relaxed within that relationship [...] Because I think that, um, that I sensed that he needed to have control in my relationship, as well [...] I felt a bit like walking on eggshells and, um, and I felt a bit that he was trying to put me in a position where I had to prove in each session my worth as a therapist. So, um, but in a kind of way where he was “Ok, do your, let me see your magic here”, but at the same time, “Don't do too much of magic because, you know, like I can't take it”.”
(Sara, 15, 2-15)

Sara appears rather pressured to perform and prove her worth as a therapist to the client who attempts to recreate his familiar pattern of relating to women with Sara, in order to provoke her and gain control. The expression “walking on eggshells” illustrates the magnitude of Sara's tentativeness and discomfort with the situation, in an effort to perform to the standards set by the client. At the same time this seems as a rather implausible task, as the attempts to strike a ‘happy middle’ between the challenge set by the client and her professional role seems to hit a dead end due to the client's inability to withstand and make use of her therapeutic interventions.

Similarly, Rose recounts her experience of a therapeutic rupture with a male client who attempted to control the therapeutic encounter through overtly trashing the therapy, whilst idealising spiritual activities:

“[...] After a year and a half in therapy, we had entered into a period where, um, he was very openly attacking therapy. Therapy was useless, I was useless, um, psychotherapy does not capture the essence of human beings. And he was bringing in, um, ideas from, um, other spiritual activities he engaged in and he compared therapy and our work to these spiritual activities and he was trashing our work and he was

idealising the spiritual things [...] Um, so my countertransference was so intense with this, um, patient, that I hadn't realised that, um, I had entered into a kind of competition with him. Because I found myself lecturing about the importance of psychotherapy. Trying to convince him about the benefits of our work [laughter].” (Rose, 10, 4-17)

The client appears to be masterfully attempting to devalue the therapist and their psychotherapeutic work, in order to remain in control and gain power. Both therapist and client engage into a fierce competition of who is going to dominate. Unable to contain her strong countertransference reactions, Rose seems to be falling into the client's 'trap' by desperately trying to convince him about the benefits of their work together. As also indicated by her nervous laugh, Rose retrospectively appears mindful of her unsuccessful efforts that yet at the time probably appeared as the sole means of regaining control of the situation.

Angela talks about the power imbalance manifested in the therapeutic relationship between herself and a male client due to their gender difference:

“There was no way I could handle my fear, as a young woman [...] and vulnerability, I was very vulnerable, as a young woman. He was a man, he was probably a strong man, that was my fantasy, you know, and [...] and I felt like a vulnerable young child, actually. So my healthy adult was not present at all in that session, I don't think.” (Angela, 3 & 4, 35-36 & 1-7)

Previously, Angela has explained her decision to terminate therapy with this particular client due to his anger management issues that left her feeling frightened and uncontained. This extract portrays the immense fear and vulnerability triggered in Angela by her client. The power imbalance between the members of the therapeutic dyad is vividly highlighted by the graphic language employed in the contradictory descriptions of herself and the client. In Angela's eyes, the client appears as a powerful, strong man, whereas her self is experienced as a vulnerable, young woman. Later on she actually describes herself as a vulnerable, young child stressing even more her weakness, defencelessness and powerlessness. Importing clinical terminology from Schema Therapy, Angela stresses the way the “vulnerable child” almost entirely eliminates her “healthy adult” rendering her completely disarmed in the therapeutic interaction.

Christina highlights another interesting power imbalance between herself and the client, namely that of their difference in their financial status that significantly seems to be influencing the therapeutic interaction. Prior to this extract Christina spoke about her difficulty to address with her client the issue of frequent cancellations, as well as her difficulty to charge her for the missed sessions, even though the issue had been explicitly discussed in

their original therapeutic contract. In the extract below, Christina attributes the reasons behind her reluctance to the financial inequality existing between them:

“Generally, she is a powerful woman, um, financially or she appears to be anyway. Or, you know, she has a sort of an air about her that’s very, sort of powerful financially. Um, unlike me at the time that I was struggling quite [laughs] a lot financially and so, you know, an income and a stable income was really important for me and I guess I was very, I was scared. I was scared to discuss it with her because I felt that money... money was a, um, a theme that kept re-emerging in, in our sessions. And I felt that, I don’t know, I felt, um, I didn’t feel real confident addressing that with her.” (Christina, 5, 24-30)

Christina seems to portray an image of her client as financially powerful and of herself as financially powerless. The repetition of the word “powerful” in the description of the client, as opposed to the repetition of the word “scared” in the description of herself seems to highlight even more the contradiction between them, as well as the sense of powerlessness and inferiority experienced by the therapist in relation to the client. Christina admits to being financially dependent on her client, and yet struggles to bring up the issue of missed appointments, perhaps as a result of her fear of appearing needy or angering the client. Interestingly, in her narration Christina alternates between present and past tense suggesting that she possibly still re-experiences the past struggle in the therapeutic relationship.

In the case of Stella the power imbalance between herself and the client seems to be triggered by their health status and physical appearance:

“She had Turner disease, it’s a disease with chromosomes, and so on..., um..., I think that it could have been, as well, that I was young, healthy, let’s say, how someone looks; ok, you have someone with Turner’s disease, they have a spider neck, they have, you know, the physical appearance. Um, I remember her telling me that I’m young, for example.” (Stella, 14, 6-9)

In her account, Stella illustrates the power dynamics, as they unfolded between herself and an older, female client with a chronic illness. She specifically gives a graphic description of the client’s physical appearance and highlights the contradiction between them in terms of looks and age. The client is therefore depicted as older and physically deformed, as opposed to the therapist who is depicted as young and healthy. It is possible that the obvious power differential between them gave rise to negative comparisons and feelings within the client, which she possibly attempted to counteract by attempting to control and criticise the therapist for her young age and thereby limited experience.

Subtheme Two: The Dilemma

During the manifestation of therapeutic ruptures, most participants experienced powerful personal, ethical and professional dilemmas, as to the best course of action they should follow, in order to manage and resolve them. For example, in the extract below, Stella speaks about her indecisiveness with regards to openly addressing ruptures with clients:

“And that's a call, as well. How honest you want to be in the relationship, it's a harsh call for the therapist because you're not sure when the person is ready. Ok, you can, let's say, feel it but you never know how they're going to react and how they're going to take it.” (Stella, 10, 26-28)

Stella seems to be faced with a significant dilemma between her wish to openly explore ruptures with clients and her uncertainty on clients' level of readiness to confront it. She is thus forced to rely on her intuition, in order to make an informed judgment call, which nevertheless entails a certain level of risk with regards to the client's possible reactions.

Maria also gives a representative description of a dilemma surrounding a rupture with a client who was constantly demanding a rescheduling of sessions, albeit for fairly valid reasons:

“Um, but, um, I, I was always, always, most of the times, I was finding myself with, in a great dilemma; what to answer to him; “Would it be a yes or would it be a no? Would it be a, um, with, um, under conditions? ‘Yes’ under conditions?” But or, it was like, you know, negotiating all the time with myself and with him, as well [...] There was, yes, there was a battle, yes, yeah. And I think that the inner battle was getting, um, bigger when, um, until we finally tried to discuss it and stay more on it, in therapy; when it was opened up and he stayed on, on this subject [...]” (Maria, 5, 19-27)

Maria describes a state of constant negotiation and rumination in relation to the situation. She appears torn between the decision to give in to or refuse the client's demands. The repetition of the word “battle” highlights the intensity of her struggle with both her inner self, as well as with the client. An ideal solution to the matter does not seem to appear and the battle only seems to tone down when bringing it out and openly discussing it with the client.

Mia was also forced to make a judgment call with regards to the preferred course of action, in order to manage an emerged rupture manifested in the form of her client's intense withdrawal:

“[...] It was so obvious that, that incident had shaped all of his future years, that it was a pity not to explore it further. But at the same time exploring it for him, was going to open up the can of worms that he wasn't even considering addressing. So, you know, I

said “What’s the point of putting him in a position if it is going to make more harm than good?” Um [...] He was afraid of what he was going to, he was afraid of what was going to come out and also he was afraid of, um, how he would see himself afterwards and also, possibly, how I was going to see him. So he didn’t want us to develop an image of him that he didn’t like.” (Mia, 13, 6-16)

The client has briefly spoken about a significant life event, but has subsequently and categorically refused to further explore it. Mia’s dilemma seems to be centred on her clinical judgment as a therapist and her humane respect for the client’s explicit wish. On the one hand, Mia considers the particular event as critical for the client’s development and difficulties. She therefore regrets the missed opportunity to further explore and work on it. On the other hand, the client appears to be dreading the consequences of such an exploration that could possibly shatter his self-image and identity. Mia carefully balances the two options and makes an informed choice to give priority to the client’s wish, as opposed to her professional curiosity. Given the time limitations of brief therapy that she has previously mentioned, in combination with the ethical danger of “doing more harm than good”, she therefore decides not to “open the can of worms”, which she and the client would have possibly not been able to contain.

In the extract below, Sara eloquently portrays the magnitude of her dilemma framing a rupture, whereby she feels positioned in a “double bind” with regards to the appropriate therapeutic action she should take with a particular client, doubting her clinical judgment and professional role:

“She was suffering, but she was definitely not going anywhere [laughs], you know, and, and that, that also made a lot of sense for her, the fact that I realised retrospectively not to move [...] So, so I think that, um, so I think that, that she was also placing me in a sort of a double bind; you know; if I didn’t do anything I was just validating the fact that she is useless and that her life is a complete mess, that is, you know; if I did do something, you know, to help her, then that meant that she had to keep up [...] It was quite threatening and then she didn’t want to do that either, so, so... And I think that, um, I was so determined to try [laughs] that at some point, I suppose I, she has to face me and say “look, I just don’t want to do it” [laughter]” (Sara, 11 & 12, 26-33 & 1-3)

The client appears to be suffering, but refuses to move further and make progress in therapy. At the time, Sara feels compelled to do something, in order to alleviate the client’s distress but finds herself trapped in a ‘no win’ situation. On the one hand, she fears that a potential inactivity from her part, will be perceived as lack of support, reinforcing her client’s sense of uselessness and inadequacy. On the other hand, she imagines that a potential activity and willingness to help on her behalf may be perceived as threatening by the client who does not

appear ready to move. Either way, Sara feels like hitting a wall and the resolution to her dilemma appears to come from the client herself who finally explicitly expresses her wish to stay a bit longer in her suffering before moving on.

Subtheme Three: Negative Emotionality

All therapists faced with ruptures in the therapeutic relationship appeared to substantially struggle with negative emotionality ranging from milder, subtle emotions to more intense, overwhelming emotions.

Both Mia's and George's accounts illustrate the emotions aroused in them by the encounter with two rather withdrawn and disengaged clients:

"I felt disengaged. I think I was bored... um... I think that, that's the first thing that I recall; I was, I felt very bored during the sessions and I felt that the sessions were very, very, very long [laughter][...] Sometimes... yawning at sometimes." (Mia, 16, 2-4)

"He did not want to talk about feelings, he didn't want. He told me straight that I don't want to talk more about this. So actually I felt, as well, very detached and defensive and angry and disappointed and I found no meaning of working with him [...] I lost my interest and slowly, gradually I struggled with, between being there and not being here." (George, 5, 22-27)

In the first extract, Mia describes her experience with a rather detached and unresponsive client. The client appears to be triggering her own detachment, giving rise to immense boredom, reflected in her experience of the sessions as endless and physically embodied in her occasional yawning. Interestingly, Mia's pace of speech in this extract is characterised by frequent and prolonged pauses, as if mirroring her sessions with the client at the time.

Similarly, George recollects his emotional experience with a client who was rather reluctant to express and work with his feelings. The client's withdrawal elicits in George a mixture of negative and uncomfortable feelings ranging from detachment and disappointment to defensiveness and anger. These feelings gradually seem to become overwhelming leading George to experience a sense of meaninglessness and purposelessness. His therapeutic presence appears to be substantially compromised, as he struggles to remain attuned in the here-and-now of the therapeutic relationship.

Sara echoes George's experience by describing her sense of invalidation and frustration with a client who would refuse to make use of her therapeutic interventions:

"And I, I felt like, you know this game snakes and ladders? I felt that I had been swallowed by, I had just climbed a ladder and then in the next block there was a snake

which took me back to square one. And I felt, um...um, I don't remember this word in English; I think a part of me felt... invalidated. And, um, and also very, very troubled and upset by thinking that "Ok, so we're not going to use the key. So what? We're stuck here?"" (Sara, 7, 17-23)

The evoked metaphor of the game 'snakes and ladders' gives us a powerful image of Sara's experience at the time, whereby she momentarily felt that she was moving forwards with the client only to be thrown back to square one experiencing a sense of invalidation, purposelessness and stuckness.

Elaine and Christina also provide vivid descriptions of their anxiety once faced with therapeutic ruptures:

"I was very aware, I was very anxious, I was, I don't think it was obvious but I was shaking, um, inside I'm going to lose him." (Elaine, 5, 24-25)

"I was very anxious, um, that was a physical. That was, I remember the, I was sat...we were sat, you know, opposite each other and when she started sort of shouting and being sort of being angry, I felt like my heart was like sort of, um, like somebody put pressure around my heart and as though my heart jumped in my mouth a bit. I was like "Oh shit now, she's going to think that or she's going to misunderstand". And, you know, I was scared momentarily that she wasn't going to understand the underlying meaning that I was trying to bring; about this thing, about what was going on." (Christina, 12, 20-26)

Both extracts illustrate the magnitude of therapists' anxiety, which is embodied in the form of intense physical sensations, such as shaking, heart pressure and palpitations. Anxiety also appears to be going hand in hand with fear. Elaine's fear seems to be triggered by the prospect of losing the client, while in the case of Christina, fear seems to be elicited by the client's extreme anger, as well as the possibility of the client misunderstanding the motive behind and the meaning of her therapeutic interventions.

Rose, also describes her intense emotional and physical experience with a client, following a rather challenging interpretation from her part:

"Um... she, I think she didn't speak for like five, seven minutes? And, and I could feel the tension building up in the room and actually I started shaking. As, you know, I was realising that "Oh, my god, I said something, um, horrible to her and, and it was too much and something is boiling now here and an explosion is about to take place". And I was very much, um, scared, um, um, so in that moment I started feeling that,

obviously, her, her anger, that she's, she's afraid of her anger and I was very much afraid of her anger.” (Rose, 6, 4-10)

Rose's intervention is followed by the client's prolonged silence and it feels like there is tension in the air, thick enough to be cut through with a knife. Rose appears kind of regretful, as well as mindful of the possibility that her intervention has angered the client. She feels like beneath the silence between them, there is accumulated tension, as if an explosion is about to take place. It sounds like she can almost feel the client's anger inside her rendering her scared of what may follow.

In the case of Angela, the client's anger is so intense that leaves her entirely immobilised, unable to think clearly and act therapeutically:

“And in the session he was so, so angry and I was in such a panic and I just, I, I, I could not deal with my anger, with my panic, actually, with my feelings [...] He was verbally aggressive and I remember I was sitting near the door and all I was thinking, I wasn't mindful at all, I wasn't present, all I was thinking was “Ok, if he tries to hit me, I'm going to rush out of the room” [...] I was scared. And anyway, at some point the session ended, I can't remember if we did the whole session or if I decided to end it earlier, but after that...and I was so scared that I decided I wasn't going to see him again.” (Angela, 3, 22-31)

The client's aggression elicits Angela's panic leaving her completely uncontained. She comes across as threatened and intimidated by the client's behaviour, genuinely scared for her own safety and wishing to escape in order to protect herself from a possible attack. This state of panic naturally places her in a state of defence cutting her off from the therapeutic interaction. The event appears to have traumatised her, as indicated by her compromised memory of that particular session, as well as her decision to terminate therapy with that particular client.

Superordinate Theme Three: The Meaning-Making

Following the manifestation of ruptures in the therapeutic relationship, all participants appeared to engage in an intense effort to make sense of and attribute meaning to the reasons that gave rise to them. For most participants, this process of meaning-making and self-reflection was only achieved after gaining some distance from the interaction, as opposed to whilst being engaged in the maladaptive way of relating. Supervision, personal therapy and individual self-reflection were all mentioned as immensely helpful in the process of meaning-making highlighting the powerful and emotionally charged dynamics surrounding therapeutic ruptures.

Subtheme One: Intrapsychic Dynamics

All participants appeared to make sense of ruptures in terms of turbulent and entrapping transference and countertransference dynamics that often compromised their ability to think clearly and act therapeutically.

Angela offers a representative account of the function and impact of these dynamics, from her experience as a qualified schema therapist:

“I think the rupture is usually triggered when the client’s schemas may trigger some of the therapist’s schemas or something in the therapist. This is when the problems arise and, actually this could happen quite frequently but if the therapist is not aware of their own schemas and the impact of whatever is going on...on their own schemas, at the time when it’s happening, um, they cannot, this is when the problem, this is when the rupture happens.” (Angela, 2, 15-19)

Angela stresses the ways clients’ schemas interact with therapists’ schemas giving rise to problems in the therapeutic relationship. She, however, emphasises the importance of the therapist’s self-awareness in the here-and-now in relation to his/her schemas, in order to contain or prevent ruptures from escalating. Therefore, whilst Angela refers to the mutual and intersubjective contribution of both members of the therapeutic dyad to the manifestation of ruptures, she appears to be placing much more responsibility to the therapist, in terms of self-awareness and self-containment.

Elaine’s and Christina’s extracts also illustrate their understandings and meaning-making processes of ruptures in terms of transference and countertransference dynamics threatening the interaction between therapist and client:

“We had a working alliance, sort of, a very brief one, but I think it went into the transference relationship extremely quickly and I think in his life he sort of like he’s in a transference fog, so, you know, he’s kind of that’s why he sees people all the time as and they very clearly always react as in if the father and mother was there.” (Elaine, 3, 38- 42)

“I think that in some sort of structural aspects, perhaps of the personality I was a bit similar. I mean, I always feel, I always believe as a principle that, um, when we hate a client, when we find them difficult is because they are mirroring aspects of ourselves.” (Christina, 16 & 17, 36 & 1-2)

In the case of Elaine, the transference relationship appears to be unfolding rather quickly threatening the working alliance. The client comes across as often ‘blinded’ by the strong

transference reactions behaving in his interpersonal interactions, as well as in the therapeutic relationship as if his parents were present. This seems to be compromising his ability to see and connect to the therapist as a real person leading to alliance ruptures.

Similarly, Christina complements Elaine's account by bringing to the table her understanding of the significance of the therapist's countertransference in the manifestation of ruptures. Referring to the case of a female client that was characterised by constant ruptures and ended unsuccessfully, she speaks about her strong countertransference reaction, as underscored by the use of the verb "hate". According to Christina, her countertransference was stemming from her strong similarity with the client, in terms of some core personality traits. It seems like the client was mirroring her own unacknowledged vulnerabilities leaving her overwhelmed and uncontained.

Sara also provides her personal experience of the ways strong transference-countertransference dynamics may coerce the therapist into a dysfunctional way of acting and reacting:

"I think that what happened between the two of us was that, um, I had...also because she was, as I said, a very lovely girl, so part of me responded to her and really wanted to help her. And also, because she was coming from a very abusive family, so, um, I think that I went too quickly into this protective role of this corrective parent; that "I will be the right parent for you, the parent that your parents could never be". Um, and she very wisely showed me, retrospectively looking at it now, that -there was of course "I am valuing that"- she was not there, she, she we needed to understand something first; we needed to do something else first before she could, um, move on and do what I thought that she should do." (Sara, 7 & 8, 36-37 & 1-6)

Prior to the selected extract, Sara has spoken about her attempt to offer practical support to her client by informing her on a job vacancy. To her surprise, the client refused, and the event led to a rupture in their previously solid therapeutic relationship. In this extract, Sara attempts to make sense of her therapeutic stance and behaviour at the time, which was quite uncharacteristic of her normally non-directive style of work. It seems like her client's personality, as well as abusive family background triggered in Sara strong parental feelings rendering her eager to provide the client with a facilitative environment and a corrective emotional experience, in order to compensate for previous parental failures. Unfortunately, Sara's eagerness to help pushes her into offering practical solutions as opposed to being emotionally attuned to her client's needs at the time. The client explicitly expresses her dissatisfaction by turning down her offer, a sign that Sara retrospectively interprets as the client's wish to explore and understand some things emotionally before moving into an action

stage. It appears that Sara's deep-seated wish to become the 'good enough' parent unintentionally coerced her into behaving like a rather oppressive and demanding parent herself, therefore re-enacting the client's traumatic experience with her parents and causing a rupture in the therapeutic relationship.

Rose perceives strong, negative countertransference reactions towards her client as leading her to make a rather inappropriate intervention that severely compromises the therapeutic relationship and injures the client:

“Um, and, um, and, that she felt that my comment was very intrusive and very frightening and, um, and quite violent. Um, so for her in that moment I became the abusive father who could not connect with any part of her; could not really sense how it feels for her to experience all this abuse and he was just doing whatever he wanted. And, um, fearing the anger, I became the abuser. Exactly what she was scared of. She was afraid that if she unleashed this anger, she would become abusive. I was afraid of the anger, I became abusive with my interpretation and she got scared of me. She felt very much threatened.” (Rose, 6, 20-27)

This extract is highly illustrative of the way relational patterns with significant others are replayed and re-enacted in the therapeutic relationship in the form of transference and countertransference dynamics. Rose's intense anxiety and fear of her client's aggressive part appear to overwhelm her leading her into making a rather abusive interpretation that at the time serves her own rather than her client's needs. Unable to contain her overwhelming feelings, she attempts to protect herself and regain control of the interaction through her intervention. She therefore unwillingly reincarnates in her face all those qualities of the abusive father who disregards, intrudes and violates the client, leaving her even more threatened, scared and traumatised.

Subtheme Two: Interpersonal Dynamics

Apart from intrapsychic dynamics, participants' accounts also revealed their intense attempts to reflect on and attribute meaning to therapeutic ruptures in relation to maladaptive interactional patterns between the members of the therapeutic dyad, whereby they found themselves interlocked in dysfunctional relational dynamics, from which they found it extremely hard to disengage.

George explains the ways in which two different clients elicit different responses from him, according to their particular way of relating and interacting:

“There is flow, there is flow and actually, exactly what exists with this client that did not exist with the other one, is that there is a relationship and she's taking part in the

relationship, she's not detached. So, that helps me not being me, not being detached, as well. Because if the other client is like this, then he triggers also my own detachment." (George, 20, 23-26)

In the case of the first client, ruptures are often manifested in the form of disagreements, but are subsequently resolved due to the client's active participation and engagement in the therapeutic relationship that counteracts George's tendency to withdraw when problems arise. On the contrary, in the case of the second client ruptures usually take the form of withdrawal. The client's walling off appears to be also triggering George's emotional detachment causing stagnation and avoidance, as opposed to flow and connection in the therapeutic relationship. Maria, also provides a vivid account of the way a client's controlling behaviour coerces her into adopting a submissive behaviour, which entraps both of them in a rather unfulfilling and problematic interactional pattern:

"I realised it when there was this, there was a continuous, um, expectation, a request. I mean it was ok to transfer a session because, we, um, he couldn't make it. Not, not because of the panic attacks, because there were many other, um, reasons. But when, when he was asking for a second time to transfer the same session or to do it Skype, or whatever, um, this was making me feel disrupted. It, I felt, you know, that it was bothering me to do all this, um [...] It was like he was asking more than I could give. So this was the starting point, I think [...] [laughter] I was thinking, you know, that he's using me, that he's using my kindness. Um, that I may be more lenient than, um..., you know, than expected. Um, it was like he was shaking up my professional identity. Because I was doing things that I wouldn't do for other clients [...] Like he was, yes, um, he was getting special treatment. And he was asking for more and more and more. If I was saying yes, he would ask for more." (Maria, 4, 4-22)

It appears that the client's constant requests for transferring and re-scheduling of sessions has gradually become a solidified pattern in the therapeutic encounter that puzzles and torments Maria. Although initially willing to accommodate the client's requests in the case of valid reasons, she is gradually starting to experience disruption and annoyance by the repetitive and pressurising demands that seem to be placing her in a state of inconvenience. Maria feels that her client keeps asking her for more than she can give leaving her drained and resentful. Progressively, she feels used and exploited by the client whom she perceives as taking advantage of her kindness and lenient behaviour. Despite her feelings towards the client, Maria also appears rather resentful of herself for being over-accommodating and giving this client special treatment. This realisation seems to be shattering her professional identity and self-image as a therapist who is able to manage such behaviours and treat clients equally.

Maria seems to be caught in a disabling relational pattern, whereby every time she submits to the client's demand, he comes back for more, becoming even more controlling of their interaction. The repetition of the word "more" when referring to the client's requests, highlights the magnitude of the client's greediness, as well as Maria's sense of helplessness and frustration.

In contrast to Maria who appears to be submitting to her client's attempts to control her, Rose appears to be adopting a more domineering style, in response to her client's attacks:

"So, in this period he comes for a session, um, and, and the rupture is there, obviously, and he comes fifteen minutes earlier. Um, so I open the door and that was a client that, he was pushing the barriers, uh, the boundaries, a lot, so, I was very much aware that I had to be very firm and keep the boundaries. But, anyway, I opened the door and I tell him in a very abrupt and domineering way that he is very early and that he needs to come back in fifteen minutes. And I closed the door [...] Um, so he comes in, fifteen minutes later, shouting, um, "How rude I am, how horrible I am, um, I am the worst therapist he has ever worked with". Um [long pause] and that he's never coming back. Um, and no matter how much I tried to, um, to sort of give a meaning to what was this about... I did try, but it was too late." (Rose, 11, 2-16)

Rose describes a rather turbulent relationship with her client, whereby ruptures are perceived to be manifested in the client's attempts to violate the therapeutic boundaries. She therefore decides to adopt a rather firm stance and responds to the client's attacks through counter-attacking, as opposed to recoiling. Unfortunately, her domineering and controlling reactions appear to be triggering the client's rage and resentment leading him to the decision to terminate therapy. It seems like both members of the dyad are interlocked in an attacking and defensive relational pattern that deprives them from the opportunity to further explore the underlying meaning and emotions of the client.

Later on, Rose reflects on their relational pattern acknowledging her responsibility and attempting to retrospectively make sense of what has actually occurred:

"I was very much aware that it was a countertransference reaction and I did know that I should, um, I should not react on it. But I could not [laughs]. Well, as I said he's a, he, he, he was perverse, he was sadistic and I was sadistic, um, and in this client group that's the most intense and difficult part of the work. So it's very difficult to disentangle yourself from the perverse way of interacting. And the perverse individual knows that what he's doing is not right, but he chooses to go on with it. And I chose to go, um, I chose, in quotes, but I could not reframe from enacting this very sadistic part." (Rose, 11, 26-34)

Rose appears extremely aware of her strong countertransference towards her client, yet unable to contain it and restrain herself from acting it out. It almost sounds as if a higher force was pulling her, compelling her to re-enact a dysfunctional and destructive pattern of interaction. According to Rose, the client's sadism and perversion elicited strong, sadistic feelings within her that, despite her high self-awareness, were impossible to be controlled in practice. Rose's use of strong language, as well as hesitant and repetitive speech and nervous laughter appear to highlight the intensity and uneasiness of the interaction, whilst her generalisation and placement of the client into "this client group" possibly underscore the magnitude of the therapist's challenge, as well as inability to disentangle herself from this maladaptive relational pattern.

Subtheme Three: Individual Vulnerabilities

In their attempts to make sense of and give meaning to therapeutic ruptures, all participants referred to therapists' and clients' personal vulnerabilities that often led to ambivalent feelings and reactions, and resulted in maladaptive intrapsychic and interpersonal dynamics.

Christina's financial vulnerability for example appears to have triggered anxious feelings, and to have compromised her ability to address her client's inconsistency in terms of attendance maintaining the pre-existing rupture in the therapeutic relationship:

"Absolutely I was contributing (to the rupture), absolutely. Because I think, maybe, if I was in less financial need at the time, maybe I would have found it easier to address it. Obviously my anxiety was partly fuelled about...by, by losing the client. By clashing with her and then her, um, either her thinking that I see her... Because, I mean, she was, she is, she is a source of income for me, but this is not the only thing that I see with this person." (Christina, 7, 28-33)

Christina honestly and explicitly acknowledges her contribution to the rupture highlighting the mutuality characterising the therapeutic relationship. She appears to make sense of her reluctance to explicitly address the rupture between herself and the client in relation to her actual financial dependence upon the client, as well as her fear of being misunderstood by the client. Christina fears that openly addressing her client's inconsistent attendance in relation to her patterns of relatedness may escalate into an overt confrontation, which may lead the client to feel that the therapist sees her as a source of income and result in therapy termination. Christina does admit that losing the client does equate with a loss of income, but at the same time asserts that the client means much more to her implying that her loss would also have an emotional cost for her.

Stella on the other hand, describes her experience of the way her physical vulnerability while she was still in training interfered with her acting therapeutically with one of her clients at her counselling placement:

“I wasn't ready to and not as developed, let's say, as a therapist to deal with my inner self. So what we are actually talking about now is how I am as a person, yes, um, saying that yeah, well yeah, saying that when that happened, um, when I was working at this I was working with chronic illnesses, at this setting [...] one of the group of people that I was seeing, was Turner's. At that year, I was diagnosed with an auto-immune condition. Um, I was recommended by a few people to change my setting, to do something... And now that I'm thinking about it, what we were discussing about feeling weak, feeling, you know, um, to be honest it was something I was actually experiencing at that time. Like, I started facing my own, weakness, at that point. Randomly, it happened, um, and to be honest it's not fair, but the fact that the setting and what happened to me personally were combined, helped me a lot to develop as a therapist.”
(Stella, 16, 4-18)

Stella initially understands the difficulties experienced with that client in relation to her inexperience, immaturity and limited personal development at the time, whilst working at a rather challenging setting for chronic illnesses. She subsequently refers to her own diagnosis with a chronic illness, whilst working with people suffering from Turner's disease. It seems like at that point, she came in touch with her own weakness and vulnerability, as if she was in a parallel process with her client. Stella chose to disregard the recommendations to change the setting of her placement, as it was 'too close to home', perhaps overestimating her therapeutic power and ability. She retrospectively acknowledges that the combination of the setting, her diagnosis, and her trainee status at the time enabled her professional development, but perhaps at the expense of the client, as indicated by the use of the phrase "it's not fair", which perhaps implies a sense of regret and guilt.

Rose's account complements Stella's experience by highlighting the way her fragile therapeutic identity during a transitional period of her life rendered her particularly vulnerable as a therapist:

“Probably the part of me that facilitated the whole incident, um, was the part of me that did not feel secure in my own role. Um, um, I began seeing this client soon after I returned to Greece and I, and it was a period that I felt extremely vulnerable, as a therapist. I could not speak in Greek, I was looking for the words, um, only English words were coming to my mind, so my own therapeutic identity was very shaky, um, and it was very easy for him and easy for me to feel humiliated. And, um, so, um, I was

caught up in this. I did feel humiliated and useless [laughs] [...] Um, and exactly because my therapeutic identity was not, um, very strong at that time, I think I didn't have the capacity to reflect on this, um, um, in a way I think I took it personally, although it wasn't personal. So I somehow, I had to defend myself, although I knew that I wasn't attacked personally." (Rose, 12, 14-28)

Rose recollects the period, during which she returned from the UK to live and work in Greece. At the time she felt extremely anxious, vulnerable and insecure as a therapist, which was also mirrored in her struggle to think and speak therapeutically in the Greek language. Rose appears to make sense of her proneness to her client's constant attempts to diminish and humiliate her in relation to her unstable and shaky identity at the time. It seems like the client's sadistic tendencies were tapping into her own fragility making her feel useless and invalidated. Her vulnerability appears to be clouding her ability to reflect on the interaction and coerces her into interpreting the client's reactions as personal attacks, against which she must defend herself.

Apart from their own vulnerabilities as therapists, participants also appeared to make sense of ruptures in relation to clients' vulnerabilities, mainly in relation to certain personality traits, relational difficulties, ambivalent feelings and conflicting needs.

In the extract below, Maria replies to her client's hostility with transparency and immediacy. The disclosure of her personal feelings appears to be taking the client aback:

"“Are you saying that you have feelings for me”? And I said “Yes, I am saying that I have feelings for you”. And she was, she was surprised [laughs] and it was the first time that she actually heard it. Even if I was, you know, um...putting it into the therapy six months ago. Um, and she, you know, she was surprised, she said, um, “You can't do that; you can't have feelings for me”. Um, and actually this was the exact same thing that we were discussing all these six months, about her difficulty of intimacy, of going close to people, of, um, accepting other peoples' feelings; good or bad. Um, about feeling trapped in loneliness and obliged to-to-to, um, to handle everything on her own.” (Maria, 12, 22-31)

The client comes across as generally struggling with intimacy and closeness. She is therefore surprised with and dubious about Maria's self-disclosure. It seems like there has been a re-enactment of her relational pattern in the therapeutic relationship, whereby she demonstrates limited capacity for closeness, relatedness and emotional contact. This pattern of relating entraps her into a vicious cycle of loneliness and self-reliance, which sabotages her intimate relationships outside therapy, as well as the therapeutic relationship in itself.

Sara offers a similar account of a male client who decided to end therapy prematurely:

“[...] A part of him was craving intimacy because he didn't have it and because he was tired of not having it and you know, um; because you see in his relationships, you know, being the saviour of women in distress, as I used to say in supervision, you know, he was, he was feeling, maintaining a distance; you know, he was feeling not really being intimate, so I think that in therapy he brought both his need for real intimacy and I think that a part of him responded and engaged in therapy because, it was, it was...um...new and, and, um, maybe a positive experience for him to not be the one who has complete control and resists responsibility and you know, but to be taken care of, instead. At the same time, this was the exact thing that, that was a big challenge.”
(Sara, 16 & 17, 29-36 & 1-2)

Sara portrays her client as struggling between his craving and his dread for intimacy, between his need to be the saviour and his need to be saved. These two parts seem to be severely clashing with one another triggering in the client ambivalent and conflicting emotions. The part of the client that wishes for intimacy engages in the therapeutic relationship, is able to let go of the need for control and allows to be taken care of. On the other hand, the part of the client that fears intimacy maintains distance, resists closeness and attempts to control the therapeutic relationship, as Sara has previously mentioned. These conflicting parts of the client constitute a great therapeutic struggle, as they often sabotage the therapeutic process.

Rose echoes Sara's experience:

“He needed to humiliate me; he needed to, um, um, put me down because I was very threatening for him. Um, he needed to destroy every possibility of therapy. Um, in a like Oedipus, in the Greek tragedy; he didn't know his mother, yet, come on, on some level you must know she's your mother. So you both know, but you don't know. So he wanted to be in therapy to get to know himself, but at the same time he didn't want to know about himself. So he, he had to destroy therapy somehow and we both did [laughter] and we destroyed it together because I couldn't escape from this dynamic. He was re-enacting.” (Rose, 12, 1-8)

Like Oedipus in the Greek tragedy, Rose's client is portrayed as struggling between his wish and his fear of 'knowing'. The part of him that desires to reach self-awareness and catharsis brings him to therapy. On the other hand, the part of him that dreads that self-knowledge may have tragic consequences resists and sabotages the therapeutic process in order to protect the self from knowing. The urge to destroy the therapy, is manifested in the client's attempts to humiliate the therapist who possibly impersonates the tool to awareness, which is experienced as extremely threatening by the client. In the end, the part that resists knowledge gets to

dominate, as it manages to entangle the therapist into a maladaptive relational pattern that eliminates any possibility for resolution and catharsis.

Subtheme Four: Timing/ Pacing of Interventions

In their accounts, participants also appeared to understand and make sense of the manifestation of ruptures in relation to the pacing of their interventions. The correct timing, and not so much the content, of their interventions was deemed as crucial, as Rose's account reveals:

“Um, you know, it might have been a correct interpretation, but it was at the wrong time... So it was the wrong intervention, at the end of the day.” (Rose, 8, 11-14)

According to Stella, rushing into a therapeutic intervention or leaving it for too late was perceived as associated with a therapeutic rupture that was hard to deal with:

“Okay, yes, I left a few sessions to go by and then addressed it. I think if that space is, it's quite big, then it's quite hard.” (Stella, 15, 17-18)

Similarly, John recollects his experience with a client, whereby the incorrect timing of his intervention is understood as leading the client to shut down:

“I picked up the message, you know, “I'm ready”... “Let's go there” and perhaps maybe then, as you said, I just perhaps, I don't know, it's debatable, but I moved faster or deeper than she, I mean maybe she was willing to but at her pace or with her terms [...] I played the music louder than she wanted or yes, I, I, I came along with some few more people who were not invited (to the party), for example.” (John, 11, 18-28)

John grasps the opportunity given by his client in order to explore a core, deep-seated issue with her. He parallels the client's willingness to talk about this issue to an invitation to a party. Unfortunately, he retrospectively acknowledges that as a 'guest', he got slightly carried away by his excitement and somehow along the way he lost attunement with the 'hostess's' wishes and needs. It sounds like he overestimated her level of readiness and underestimated her ambivalence on the matter. He therefore moved faster and deeper into the client's world and that was perceived as leading to her withdrawal, as she may have been ready for exploration but at her time and with her terms.

Similarly, Rose explains how her decision to rush into an interpretation, was driven by pure anxiety and fear:

“So it was that fear that pushed me to make, um, an interpretation. Um, and if, if I wasn't afraid of her anger the way she was afraid of her anger, I would be able to be more attuned to her and realise that, you know, it's not the right moment, um, she's

doing all the work herself, I don't need to intrude and say something. She's working very well. She talks about things, she reflects on things, I don't need to rush and make the connections for her. And obviously the only reason I rushed was that I was anxious." (Rose, 6, 10-16)

Scared of her client's anger and unable to contain the anxiety elicited in her, Rose loses attunement with her client and 'violates' her personal world by making a valid, yet hasty, interpretation that disrupts the client's process leading to a perceived rupture in the therapeutic relationship. Her interpretation at the time appears to be serving her own rather than her client's needs, as it momentarily protects Rose from her fear and anxiety at the expense of the client's process and feelings.

In her account, Christina comments on the other side of the coin, whereby her fear and anxiety of clashing with her client led her to postpone addressing some relational dynamics in the here-and-now at the expense of the therapeutic relationship:

"Because it was an open-ended therapy and I was still building the, the alliance, I was still constructing the, the relationship, um, I'm not, you know, I was also aware of, you know, how immediate and how fast should I be very immediate. You know, within the first five sessions to talk about us. I don't know, maybe that would have freaked her out [...] But I think it was also to do with the...it was a difference in technique, obviously, but I think I wouldn't be entirely honest if I said that it had nothing to do, you know, with my personal discomfort, as well. Which, you know, it was accommodated very nicely in the open-ended frame of the therapy because then that meant that I did not have to do it immediately...I could have given it some time [laughter]" (Christina, 10, 20-38)

Christina originally makes sense of her reluctance and uncertainty to explicitly make reference to the problematic relational pattern between herself and her client to the nature and techniques framing open-ended, as opposed to time-limited therapy, as well as to her wish to protect her client. She later goes on to admit that it is possible that she chose to 'hide' behind her theoretical orientation and therapeutic frame in an attempt to save herself from the anxiety and discomfort that she was experiencing at the time. In essence, it sounds like she was buying herself some time, until she could feel ready and secure enough to confront her client.

Superordinate Theme Four: The Resolution

This last superordinate theme examines the area of rupture reparation and is comprised of three intertwined and supplementary subthemes. The first subtheme explores the unique ways participants employed in order to manage and repair ruptures. The second theme looks into

the impact of rupture resolution on relational and process dynamics, with subtheme three illuminating the learning experience that was acquired for both therapist and client through rupture and repair episodes within the therapeutic encounter.

Subtheme One: The Way Out

Participants gave interesting descriptions of the best ways to address and repair therapeutic ruptures that were often influenced by their theoretical stance, as well as clinical experience. Taken together, all these accounts appear to compose a fascinating tapestry of emotions, actions and interventions that may pave the way out of ruptures threatening the therapeutic endeavour.

Angela comments on what she considers crucial in the management of ruptures, informed by her theoretical orientation as schema-therapist:

“To be able to bring your healthy adult in the room. Because the, you know, the healthy adult can actually manage ruptures, not the angry child, not the vulnerable child, you know, whoever else... The healthy adult can manage all the different parts within you and you make different choices, in terms of how you manage or how you deal with the ruptures. You can choose to behave in a way that is healthy, respectful, um, repairing for the client because, like I was saying earlier, it is very important that we try to repair the unmet needs. So there is no point in, for the therapist, you know, to create a situation or something in the room that the client relives earlier experiences. The point is when you try to repair ruptures, it's also to do it in a way that is repairing in terms of the needs, as well. And this is what the healthy adult can do.” (Angela, 9, 28-38)

Angela presents two antithetical parts that exist within her; the healthy adult versus the vulnerable/ angry child. When in charge, the healthy adult is able to contain intrapsychic dynamics and provide access to a repertoire of interpersonal behaviours. As a result, she feels capable of dealing with ruptures in a mature, healthy and facilitative way offering a reparative relationship that can compensate for clients' unmet needs. On the contrary, the vulnerable/ angry child is portrayed as less mature and strong to deal with ruptures, and thus in danger of re-enacting painful as opposed to offering reparative experiences to clients.

Rose also highlights the significance of the therapist's ability to gain some distance from maladaptive interactional patterns, reflect upon relational dynamics and take responsibility for therapeutic failures:

“Not reacting, being aware all the time that what is happening, um, in the room, um, has a therapeutic meaning, um, it, um, it relates to the client's history and be aware of that all the time and try to reflect on it. Um, being open, um, about it, um, taking

responsibility. Taking responsibility, it's not the same with being, with feeling guilty or being apologetic. Um, for example, the fact that, um, my intervention was abusive to her, um, does not mean that in reality I was abusive to her [...] If you are aware about the therapeutic significance of the rupture, um, and what, um, and what, and what it tells us about the client, then you don't feel guilty because you know that one way or another, it would have happened.” (Rose, 15, 17-35)

Rose stresses the importance of the therapist's self-awareness in relation to the therapeutic significance of ruptures. Self-awareness is portrayed as essential, in order to contain as opposed to acting out her internal reactions, as well as in order to contextualise and assign meaning to the rupture in relation to the client's unique history, as opposed to viewing it as a loose, isolated event. This intense engagement in self-reflection allows Rose to contain her internal reactions, refrain from taking the client's reactions personally, whilst at the same time assuming responsibility for the symbolic rather than the actual meaning of her interventions. In that way, she escapes from internalising guilt over emerging ruptures, which she views as unavoidable, uniquely tied to each client's history, always holding therapeutic significance and constituting opportunities for exploration.

George echoes Rose's point of view on the importance of self-reflection when it comes to dealing with ruptures:

“Being reflective by speaking the truth, by speaking the unspoken, um, I think that's the most important thing, not to, which is a challenge and, um, I think actually, it's a kind of, um, a very important, very important attitude of the therapist to be able to reflect and to be open and honest about what happens. I think that's the most important thing, this will offer, maybe, offer a repair... If you are not reflective with yourself then you can't explore this with the clients. So the first step is to be aware of what happens and second, to bringing it out; ok, you know, bring this in the therapy and reflect on the pattern.” (George, 22, 17-27)

According to George, the therapist who engages in self-reflective practice can face and speak the truth. He seems to view reflection as a challenging but necessary therapist quality comprised of two complementary levels; internal reflection, in the form of internal self-awareness, is portrayed as the first step towards rupture resolution, whereas external reflection, in the form of honesty and openness, is portrayed as the second step towards rupture resolution, which consists of bringing ruptures out in the open and exploring their therapeutic meaning with the client.

John views this process of bringing ruptures out in the open as an essentially relational act, which involves two subjectivities engaging in a fruitful dialogue, each taking responsibility

for his/ her actions and collaboratively reflecting upon their mutual contribution to the interaction:

“So, what you would do with that is actually bring it up, and by bringing it up you’re actually involving yourself into this and your interventions, in accordance of course with what’s happening with the client. So in a sense...[pause]...you’re coining it as acting out, so in a sense you’re not taking responsibility, in, again, that it’s part of what you would expect; in dealing with it, yes you are involving the relationship and engaging in that sort of dialogue with the client, in seeing, you know, what has been happening, why has this been happening, how have I contributed to this or, you know, what has happened in the interaction to bring about this acting out...” (John, 6, 29-36)

What is implicit in John’s account is the intersubjective nature of ruptures. If ruptures are conceptualised as “acting out”, the whole responsibility seems to be falling onto the client, whereas if ruptures are conceptualised as fundamentally relational acts, then both members of the therapeutic dyad hold mutual responsibility. According to John, by openly and congruently exploring ruptures in the here-and now, the therapist essentially acknowledges the mutuality of the therapeutic relationship.

In their accounts, Elaine and Stella provide two illustrative examples of the value and function of immediacy and meta-communication in relation to rupture resolution:

“It was very obvious I was anxious and I wanted to, to acknowledge it in order to be able to, you know, reconnect, um, and I felt feelings of extremely strongly when I was with him; um, I felt it was important to mention it, together with “I understand that, you know, you probably you’re not interested, you’re quite right”; but it’s important for me to tell you that I’m a human being, as well, and I do have feelings as you do and I used it consciously in order to, kind of, you know, in a sense as a modelling; “Ok, I’m therapist but I haven’t got everything strict or I don’t have everything fixed, so it’s important that you know that”.” (Elaine, 6, 7-23)

“So I brought all of this into the room; like, “I feel that you are quite stressed and, you know, I know it’s a new experience for you”, because he hadn’t been to a therapist before, “but I feel that you try to keep your distance, as well, and you also try to put me on the spot light; that you expect something from me and you try to behave in a certain way and you want me to behave in a certain way and I wonder if you can see that”. And then we started discussing about how he’s in the room and outside the room.” (Stella, 9, 31-36)

Elaine decides to openly self-disclose her anxiety to the client, as she feels that it is preventing her from truly connecting with him. By admitting her weakness and exposing her vulnerability, she is also consciously hoping to model to the client an alternative, more authentic and healthy pattern of relating, as well as to legitimise her client's disowned and suppressed feelings. Stella also uses immediacy, in order to address a therapeutic rupture. She initially validates the client's feelings and experience, and subsequently reflects on the relational pattern that has developed between them, inviting the client for a joint exploration of his feelings and motives behind his actions. This approach seems to pave the way for the acquisition of insight into the client's patterns of relating in and outside the therapy room.

In this final extract, Rose also comments on the significance of immediacy and responsibility taking, in order to manage and repair ruptures:

“Um, so I acknowledged that it was a mistake from my part and at, at that moment, I didn't realise how much painful that was for her, um, and, um, and that I rushed into something that she wasn't prepared to talk about, and that yes, indeed, at that moment I was, in a way, abusive as her father was. Um, in the beginning she said “So what now, just because you acknowledge your mistake, am I supposed to forgive you”? Um, and she was right. So we talked about the importance of, um, of being able to stay with her anger but at the same time preserve in her mind the idea, um, that it is possible for mistakes to take place. So we can both be angry and know, um, something about the other person's intentions. Um, um she didn't say anything about it but gradually she allowed herself to fall back into the session and, and she relaxed a little bit. So I think there was, we did something about this rupture.” (Rose, 8, 14-24)

Rose openly acknowledges her mistake, takes full responsibility for the inappropriateness of her intervention, and validates her client's pain and anger. Despite her client's initial reluctance to forgive her, Rose's genuine and non-defensive stance enables further exploration and fosters a process of mentalisation around the rupture event. In that sense, the rupture is used as an opportunity to provide a new relational and learning experience to the client that subsequently allows for reconnection and relaxation to take place.

Subtheme Two: The Therapeutic Transformation

Following the reparation of ruptures, all participants described a transformation in the therapeutic relationship, process and dynamics that had a radical impact upon both members of the therapeutic dyad. For John, the rupture event and its exploration provided a window into the client's core issues, as well as underlying wishes and needs. It also enhanced the client's sense of trust and safety within the therapeutic relationship, and reminded John of the significance of 'being with', as opposed to 'doing things to' the client. It seems like the client

actually knew where she wanted to go, but needed to feel protected and secure before going further and deeper:

“Well, I guess in retrospect, what we just said. Like that it opened this window...um...for us to discuss perhaps, you know, that, um, of course she, she wants to or she kind of; see it goes back to what we were saying back at the beginning. Perhaps she knows what, what she has to do but it's a matter of feeling trust and, um, comfortable going down that line and I suppose that's, it can only take place, not through doing things but, you know, through the relationship and feeling protected in doing certain things.” (John, 15, 21-26)

For Maria, resolving a severe and prolonged rupture with a client had a beneficial effect on two important levels. Firstly, it brought greater equality in the therapeutic relationship. Both she and the client took responsibility for their contribution in the rupture, and in that way the weight was lifted off her shoulders and shared with the client who became more responsible and accountable in their interaction:

“So, um, so, you know, by discussing it, more than one sessions of course, um, it was like I was taking all the weight off me deciding for that and putting it between us and he, he took the responsibility of this. So it was like he was taking charge of his part.” (Maria, 7, 22-31)

Secondly, the rupture resolution brought greater depth to the therapeutic relationship, which was characterised by a sense of transparency, mutuality and attunement, and was accompanied by warm, honest feelings:

“I think that it deepened the relationship. I mean it was a very, it was, um, like warm feelings after that in the session, um, and it was like, you know, the, the...there was no hidden agenda let's say. It was like it was very clear what we were discussing... We were on the same page.” (Maria, 8, 18-22)

Christina provides a vivid and moving description of the impact of repairing an intense rupture with a client:

“And that (i.e. the rupture resolution) felt to instantly soothe her. That is the arousal, once the link, the link had been made, immediately dropped the levels of arousal. And it was sort of, I could feel the, the reparation in that the distance between us became, um, shorter. We came closer instantly, whereas we started the session feeling as though we were apart, by the end of it we were closer [...] Um...I don't know, I can't explain it. I'm not sure whether it, it can be explained verbally. It was some sort of, it was more, we were on an equal...It was as though there was a synchronicity emotionally. I mean

at the beginning it felt as though we were...we were not meeting, um, somehow. I don't know how I can explain that in words really. It's just a sense, it is a physical sense, but it's not like a sensation. It's like a warmth in the air, it's like the temperature in the room. I'm not sure, I'm not sure how to put it into words. It's just a feeling.” (Christina, 13, 16-28)

Following an interpretation, whereby Christina addresses the client's relational patterns in and outside therapy, as well as validates the client's feelings, it sounds like something mystical takes place. The client's physical arousal drops and she becomes emotionally soothed. The distance between them is minimised and closeness is fostered both literally and symbolically. Warm feelings roam the room, and it seems like an almost divine union takes place; a special moment of meeting, an almost perfect emotional synchronicity that resembles the mother- infant interaction. The atmosphere is oozing warmth and tenderness, which is not communicated verbally, but is embodied and felt physically. The sense of emotional attunement and connection is so deep and penetrating that Christina seems to struggle to find the right words to describe it. She talks about feelings, senses and sensations, but it appears that this experience is so special that transcends linguistic limitations and can only be experienced physically. It appears that Christina has actually experienced the transpersonal dimension of the therapeutic relationship, which is characterised by an alteration of consciousness, a powerful sense of betweenness and a special kind of intimacy.

Ruptures that were successfully resolved were indeed followed by positive and invigorating emotions, such as happiness and pride, as well as a sense of reconnection, meaningfulness and belief in human potential for growth and development. Such positive descriptions were evident in all participants' accounts, as illustrated in the selected extracts below:

“Oh, I felt happy... Uh! I was relieved I think more than happy. I was quite proud of myself.” (Elaine, 11, 34)

“I'm really happy because I found meaning in my work again [laughter]. Um, 'cause yeah, because that was another thing in that time of feeling disengaged, like “Should I continue working with him?” Or questioning “Am I of any help if I'm feeling so distant?”” (Mia, 15, 33-35)

I felt very happy. I mean I do feel happy... Um, I felt and I felt deeply moved because what I maintain from the very beginning of our therapy was that I could sense that this girl had a lot of strength in her and she couldn't see it. And she couldn't get in touch with it. (Sara, 10, 24-27)

At the other end of the spectrum, ruptures that remained unresolved and led to premature termination were accompanied by a range of negative and often painful emotions that appear to have left a sour taste in participants' mouth.

Mia appears to be tormented by guilt with regards to the way she handled a fatal rupture with her client. She still ruminates about what she could have done differently and is regretful for not being able to provide the client with a corrective therapeutic and relational experience:

"I guess I was feeling very guilty that I couldn't...I didn't handle it better, but I can't really think of what I could have done differently; um...I think, I definitely felt guilty for letting him go with that feeling or with that being the last experience of therapy and our relationship." (Mia, 6, 33-35)

In her account, Elaine comes across as having mixed feelings with regards to the therapy's unilateral termination initiated by the client:

"[...] I was quite relieved when we finished [...] I was sad, but I was also quite relieved. I found it quite... [sighs]... I found very emotional thing, very, very difficult...yeah, but, you know, I enjoyed that [...] In fact I was relieved, I was relieved. And he had asked me when we finished, you know, "If I can call you"? I said "Um"! I hope he didn't hear the "um"!" (Elaine, 15, 38-44)

On the one hand, it sounds like Elaine enjoyed working with her client in spite of her struggle at the time. She was therefore sad to see him go. On the other hand, she claims that she found their work so emotionally demanding that she was extremely relieved by their closure, as highlighted by the repetition of the word "relief". It is as if her emotional drainage were so intense that she desperately needed distance from him, in terms of time and space.

Christina uses stronger language, in order to describe the magnitude of her relief when one very challenging client of hers dropped out of therapy:

"I didn't care at all... No, it was a relief that she left. That was a massive, I mean this was like, this client is a sore point in my life [laughter]. I just, I don't feel that she got anything from me and I don't care and I think that, um, um, I was relieved that she left. We were all happy in the end, except her probably [laughs]." (Christina, 15, 21-27)

Although she claims that she did not care about the client's unsuccessful treatment and premature termination, the jump into present tense when referring to the client as "a sore point in her life" possibly reveals that she still holds intense emotions around their therapeutic encounter. Furthermore her nervous and sarcastic laughter could be interpreted as masking

her discomfort and perhaps shame and regret around her inability to provide the client with a more meaningful therapeutic experience.

Subtheme Three: The Learning Experience

Despite the challenging and threatening nature of ruptures, most participants considered them as valuable learning and relational experiences for their clients as well as themselves.

Rose's account eloquently illustrates the therapeutic meaning and value that ruptures hold for clients:

“Um, again I am going to quote Winnicott. He talked about the optimal frustrations. Um, it would be very, very damaging for the client if we never failed them. Um, we would construct the image of us being omnipotent, idealised beings, um, and we would cultivate fantasies that have nothing to do with reality and with the external world. So, ruptures, um, if, um, are not huge [laughs] to blow up the relationship, could act as these optimal frustrations. Um, and, and if managed, in a way that they can acquire meaning, um, for what the client brings from the past, how the client repeats things in the future, how people are set up, um, to react in, um, in predetermined roles in their scenario, if, if they acquire this meaning, then they can actually, um, um, repair something that is very much damaged and, and offer a therapeutic opportunity.” (Rose, 9, 16-25)

Quoting Winnicott, Rose parallels therapeutic ruptures with optimal frustrations. Just like the ‘good enough mother’ at times inevitably fails her infant, therapists also unavoidably fail their clients. According to Rose, these optimal frustrations bring clients to the reality of the external world, as opposed to maintaining idealised fantasies of omnipotence in their internal world. In the same way that the infant needs to experience an optimal frustration, in order to gradually achieve a sense of separateness and autonomy, clients need to experience therapeutic ruptures, in order gain insight into their repetitive and often maladaptive and restricted relational patterns. When successfully managed, ruptures therefore acquire therapeutic meaning and become vital relational experiences that can be used as therapeutic opportunities for breaking and repairing clients’ maladaptive ways of acting and relating.

Similarly, Elaine comments:

“I believe that there needs to be, not necessarily needs to be a rupture for the relationship to be better; not a big rupture but I think that, you know, that it isn’t just the reparative relationship and I, you know, that sort of thing, which I have a tendency especially with those clients that had a very strong reaction to, extremely strong and, um, you know, to mother them and take care of them and what have you and the

tendency to communicate my tentative part, so very strong reaction but it isn't just not that. You know, there's a reality, the reality of what's happening and, um, there's the life outside the therapy session and the life carries on and it is the real life, um, and the relationship is real, I'm not saying it isn't, but that's where he would carry on his life." (Elaine, 8, 14-22)

Elaine makes reference to and differentiates between the “real”, as well as the “reparative” nature of the therapeutic relationship. Whilst she acknowledges the value and necessity of the reparative relationship, she also views ruptures as acts that bring the therapeutic dyad closer to a real relationship. Despite her strong urge to take care of and mother certain vulnerable clients offering them the developmentally needed relationship, Elaine, like Rose, postulates that ruptures in a way prepare clients for the life in the real world, away from the protected environment of the therapeutic encounter. And in real relationships, people do get disappointed and hurt. It is therefore the therapist's duty to function as a secure base, but at the same time prepare clients for the raw reality of the external world. Ruptures thus become significant learning experiences for clients, which they can use as relational guides in their relationships outside therapy.

Ruptures have also taught Christina a valuable lesson:

"I have learned that anything that happens, um, between client and therapist affectively, behaviourally, cognitively is relevant and is vital information, and particularly ruptures, and it should be addressed. I think if a rupture is not addressed, the therapist is in danger of recreating some sort of pattern that exists, you know, in the client's life and just sort of repeating an experience, rather than, um, repairing an experience. I think it's absolutely vital, ruptures. They don't feel great, when you have to deal with them, but they are absolutely necessary. It's the...they are more important, in my opinion, um, ruptures are more important than sort of non-ruptures if you know what I mean; like harmony or whatever, peace." (Christina, 14, 27-35)

Christina has gradually come to learn to pay attention and address ruptures, manifested in different shapes and forms in the therapeutic relationship. In fact, she has ended up viewing them as important therapeutic tools that carry therapeutic meaning. Despite their challenging nature, ruptures are portrayed as vital for therapeutic progress and, in fact, much more beneficial than a stable and harmonic therapeutic relationship. According to Christina addressing ruptures is what enables the therapist to provide reparative experiences, as opposed to repeating traumatic experiences. The vivid and exaggerated language she uses in her account, evident in the repetition of “more” and “absolutely” is probably indicative of how strongly and passionately she feels about the therapeutic value of ruptures.

For Stella, the manifestation and unsuccessful management of ruptures has gradually forced her to come to terms with her limitations as a therapist, as well as a human being:

“You need to be able to let go. You, like for me, it was interesting because it happened throughout my training that I was diagnosed with a chronic health condition and dealt, dealing actually with my weaknesses, and that we're humans. And maybe that I accepted this, working at the setting, was a great experience for me to develop as, as a counselling psychologist but it wasn't that responsible for my clients, if you think about it from a different point of view. So, I think it's very, very important, yes, to have courage, yes, to be firm, yes, to be honest but also be honest to yourself whether you can handle the case or not [...] Yeah, because otherwise you do take an expert position. You think that you can do everything and you're the expert that can solve everyone's problems. No, you're not that. You're human, you're going to be, um, you're going to have certain times in your life that maybe you're fragile and you first need to deal with your fragileness, let's say, before dealing with the other's.” (Stella, 17 & 18, 30-35 & 1-12

Reflecting once again on her therapeutic experience with a client with Turner's disease at a time when she was diagnosed with a chronic health condition, Stella highlights the importance of the therapist's responsibility towards himself/ herself, as well as towards his/ her clients. Her inability at the time to face her frailness and accept her limitations appear to have cost her the client. Unable to let go of her placement setting, as well as of her self-image as a strong person and powerful therapist, Stella compromised the relationship with the client, and whilst in the long-term that functioned in favour of her professional development, at the time functioned at the expense of her also fragile client. Stella retrospectively realised that the ability to be honest with and helpful to clients presupposes the ability to be honest about her own limitations and fragility, as well as responsible towards her self-care. Otherwise, the therapist is in danger of adopting an omnipotent, infallible therapeutic stance that may potentially harm clients.

This final extract appears to be accurately encapsulating the core lesson learned by the majority of participants:

“They could be very frightening because they could damage the therapy, but ok, they could be helpful. If we survive that, there is a beauty inside.” (Rose, 16, 31-32)

Ruptures are experienced as challenging and potentially threatening for the therapeutic process but, when carefully contained and successfully resolved, they are seen to constitute helpful and moving therapeutic events.

Discussion

This was a qualitative study that aimed to investigate counselling psychologists' experiences of therapeutic ruptures and repairs employing Interpretative Phenomenological Analysis. In this section, findings will be discussed in relation to existent literature and research. Limitations of the study will be also thoroughly discussed, and implications for Counselling Psychology research, training and practice will be highlighted.

Theoretical Insights

The Threat: Withdrawal, Breakage and Misattunement

Despite their diverse theoretical orientations, all participating therapists appeared to experience ruptures as threatening to the therapeutic endeavour, albeit recognising their unavoidability and potentially beneficial nature. Their descriptions revealed that they often defined and experienced ruptures in the forms of withdrawal, breakage and misattunement. Their perceptions and definitions of ruptures, as captured in the 'withdrawal' and 'breakage' subthemes seem to parallel Safran and Muran's (1996, 2000, 2006) distinction between withdrawal and confrontation ruptures. However, whilst Safran and Muran (2000) define ruptures in terms of client withdrawal or confrontation marker behaviours, participants in this study referred to such behaviours as mutually stemming from and as being experienced by both therapist and client.

In general terms, withdrawal was described and experienced as a sense of separation, distance and detachment between therapist and client. A state where both members of the therapeutic dyad appeared to be moving away from each other, both emotionally as well as physically. Withdrawal was usually manifested in quite subtle, covert and non-verbal ways. Nonetheless, it was physically embodied and sensed giving rise to negative and uncomfortable emotions. In contrast, breakage was manifested in quite intense and aggressive ways that usually involved the client breaking the therapeutic frame or boundaries or directly attacking the therapist. Breakage was experienced as quite threatening by most therapists giving rise to negative feelings, as well as a sense of irreversibility and irreparability.

At this point, it is worth highlighting that the findings of the present study are somehow inconsistent with previous studies indicating that therapists tend to struggle more with 'confrontation', as opposed to 'withdrawal' ruptures (Coutinho et al., 2011; Hill et al., 2003). What emerged from participants' accounts was that therapists tend to experience clients' hostility and/ or withdrawal in quite idiosyncratic ways depending on their individual personalities and relational patterns. For example, in his account, George describes clients' withdrawal as the "worst thing" and he explicitly links that to his own tendency to withdraw

from relationships. On the contrary, Angela appears fearful of clients' anger and hostility, and in her interview relates that to the way she experiences and positions herself both as a woman and as a female therapist in a male dominated society. The findings of the study are in accordance with existing research demonstrating that the therapist's personality, philosophy, background and status interacts with those of the client's, as manifested in their between interaction (Arthur, 2001; Baldwin et al., 2007). They therefore once more draw our attention to the uniqueness and intersubjectivity of the therapeutic relationship, whereby unique client and therapist characteristics are in constant interaction, co-creating unique patterns of relatedness (Kahn, 1997; Rizq, 2008).

Furthermore, participants' idiosyncratic conceptualisations of ruptures appeared to significantly influence the ways they experienced them, reinforcing the claim that human experiences are contextually embedded and bound (Eatough & Smith, 2008; Smith et al., 2009). For example, Maria's conceptualisation of hostile ruptures as both destructive and creative led her to experience them as uncomfortable, but also therapeutic. On the other hand, Mia's and John's conceptualisations of confrontation ruptures as violent, severe and intense relational events led them to experience them as fundamentally irreparable and unfixable. It is possible that participants' diverse definitions of ruptures were influenced by their theoretical orientation and/ or their familiarity with the relevant literature. Prior experiences and pre-existing knowledge do indeed appear to shape subjective experience highlighting the essentially embodied, embedded and contextual nature of our relationship to the world (Eatough & Smith, 2008; Smith et al., 2009).

The fundamentally intersubjective character of therapeutic ruptures was especially highlighted in the subtheme 'misattunement', whereby most participants made references to moments of misunderstanding and miscommunication between themselves and their clients. Most of the times, those difficult moments were attributed to both members of the therapeutic dyad, in the sense that it was either the therapist who lost emotional attunement with his/ her client's emotional world, or it was the client who misperceived or misinterpreted the therapist's intervention or intention. Therapists' reference to moments of misattunement seems to mirror Kohut's (1984) conceptualisation of ruptures as 'empathic failures', during which the therapist loses the capacity to remain empathically attuned to the client's needs. In addition, the experienced misattunement is in line with Safran and Muran's (2006) definitions of ruptures as "periods of poor quality of relatedness or a deterioration in the communicative situation between therapist and client" (p. 288).

Taken together, these three subthemes highlight the relational and intersubjective experience of ruptures, a finding that is consistent with existing theoretical literature (e.g. Coutinho et

al., 2009; Safran & Kraus, 2014) and qualitative studies (e.g. Haskayne et al., 2014) on the topic. It also brings us up against the problematic definition of the concept of ruptures per se. Safran and Muran (2006) have defined alliance ruptures as “a breakdown in the collaborative process, periods of poor quality of relatedness between patient and therapist, a deterioration in the communicative situation, or a failure to develop a collaborative process from the outset” (p. 288). According to the authors, defining ruptures as a breakdown to the existing collaborative process or a failure to establish a collaborative process from the beginning is more consistent with Bordin’s (1979) conceptualisation of the alliance that emphasises collaboration, but fails to address the emotional and relational nature of ruptures. On the other hand, defining ruptures as deteriorations in the communicative process or periods of poor relatedness captures their relational meaning but deviates from Bordin’s emphasis on rational collaboration. They have therefore proposed the use of definitions that capture both the collaboration, as well as the relatedness aspect of alliance ruptures (Safran & Muran, 2006).

Indeed, participants in this study conceptualised and experienced ruptures as problems in the form of disagreements over the practical aspects of therapy, as well as misunderstandings and miscommunications that compromised mutual collaboration. At the same time, they made explicit references to moments of emotional disengagement, tension and misattunement. Whilst, the proposed definitions of ruptures do cover a wide spectrum of therapists’ and clients’ experiences, it seems that they fail to capture the full range and depth of the emotional experience that surrounds them, as also highlighted in the study of Haskayne and colleagues (2014). Existing conceptualisations also appear problematic, as they tend to define ruptures in relation to specific client behaviours (Muran et al., 2010), rather than co-created and co-experienced by both members of the therapeutic dyad. When referring to their experiences of ruptures, participating therapists described both client and therapist behaviours that appeared to threaten the alliance and compromise relatedness. In fact, all therapists explicitly stressed the mutual contribution and responsibility of therapist and client, once more emphasising mutuality and intersubjectivity.

Another problematic area in the definition of ruptures regards their intensity, meaning the extent of how intense a “poor quality of relatedness” or “breakdown in collaboration” must be, in order to be considered a rupture (see Safran & Muran, 2006). Whilst the term rupture in itself indicates a major breakdown in the alliance, in reality ruptures can be characterised by small, subtle fluctuations in the quality of collaboration, communication or relatedness (Safran & Muran, 2006; Safran et al., 2011). A certain confusion around this matter was also reflected in some participants’ accounts who were not familiar with relevant literature. For example, John preferred the use of terms, such as ‘resistance’ and ‘acting out’ when referring to subtler problems in the therapeutic alliance, as these terms indicated that the problem could

be worked through and resolved. In contrast, when alliance problems were conceptualised as ‘ruptures’, there was a sense of definiteness and irreversibility, as portrayed in both John’s, George’s and Mia’s accounts. This finding is highly illustrative of the importance of language in the construction of our lifeworld and shaping of our subjective experiences (Eatough & Smith, 2008). It is also consistent with research findings suggesting that lower rupture intensity is associated with higher ratings of the alliance and session quality, as well as better treatment outcome with regard to interpersonal functioning (Muran et al., 2009).

The Struggle: Power Issues, Dilemmas and Negative Emotionality

All participants experienced an intense struggle in relation to therapeutic impasses. This struggle was manifested in the form of power issues, pertinent dilemmas and difficult emotions. Power struggles, in particular, were centred on a range of issues, such as financial status, gender roles and health status, and they were experienced as client and therapist attempts to negotiate their roles, gain control and reinstate the balance in the therapeutic relationship. This finding is consistent with current research that seems to view power struggles as an inherent and unavoidable element of the therapeutic process (Aspland et al., 2008; Haskayne et al., 2014; Safran et al., 2011).

In the cases of Sara and Rose, it appears that their clients attempted to control the therapeutic interaction by undermining their professional competency, negating any therapeutic benefit and doubting therapy in itself. Sara was placed in a situation whereby she constantly felt the need to perform and live up to her client’s standards, whereas Rose found herself lecturing the client on the benefits of psychotherapy, in an attempt to justify her therapeutic interventions and re-claim expert knowledge. On the other hand, both Angela and Christina felt immensely intimidated by their clients’ gender and financial status, respectively. The power balance appeared to shift in favour of the client, giving rise to uncomfortable feelings, and severely compromising their therapeutic capacity. Interestingly, in the case of Stella, her expert status as a therapist appeared to have been challenged by her female client who came across as attempting to shift the power imbalance, stemming from her poor health status, in her favour through implicitly undermining Stella’s therapeutic experience due to her young age and trainee status.

The power issues described in all participants’ accounts could be interpreted in light of Benjamin’s (1990) notion of ‘capacity for intersubjectivity’, that is the capacity to experience both the self and the other as subjects. Individuals acquire a sense of self in the presence of others, but others are often experienced as threatening our need for autonomy. Both therapist and client attempts to control the other could thus be viewed as attempts to assert their independence and autonomy. At the same time, when the attempts to control the other grow

out of proportion, they run the risk of destroying the other's subjectivity, leaving the individual with nobody to confirm his/ her existence, and thus compromising his/ her fundamental need for relatedness (Coutinho et al., 2009; Safran & Muran, 2000). Similarly, participants' accounts revealed that ruptures, which were manifested in the form of extreme power struggles were often unsuccessfully resolved leading the client to premature and unilateral termination, as in the case of Sara, Rose, Angela and Stella.

Furthermore, participants' accounts challenge traditional assumptions about the inherent 'power differential' in psychology and psychotherapy, which is always in the favour of the therapist over the client (Gutheil & Brodsky, 2008; Pope & Vasquez, 2007) What transpired from most accounts was that power in the therapeutic relationship is indeed not exclusively possessed nor exercised by therapists (Zur, 2014). On the contrary, whilst participating therapists undoubtedly possessed significantly more 'expert knowledge' and 'professional role' power, clients in this study were often portrayed as quite powerful and forceful themselves rendering therapists vulnerable and intimidated. For example, Angela's and Rose's clients were depicted as possessing significant 'coercive and manipulative power' over them, in terms of physical strength and intimidating behaviour. Christina's financially powerful client was portrayed as possessing substantial 'reward power', as she was in the position to terminate therapy or withhold payments that were necessary for the therapist's livelihood. Similarly, both Sara's and Rose's clients appeared to use their 'reward power' through not acknowledging the therapeutic progress and value, whilst Stella's client was overtly undermining her 'expert knowledge' and 'professional role' power through frequent references to her young age, and thus limited knowledge and experience (see also Zur, 2009a; 2014).

According to Totton (2009), psychological wounds around rank and power are inevitably re-enacted in the therapeutic encounter, and can shed substantial light onto the client's process. They should therefore be acknowledged, understood and worked through, as opposed to being ignored and defused, in order to have transformative effects and constitute corrective experiences for clients. Similarly, Safran and colleagues (2011) suggest that the exploration of similarities between control struggles in the therapeutic relationship and client's relational patterns outside therapy may lead to successful rupture resolution.

Participants' struggle with therapeutic ruptures was also manifested in the form of powerful and pertinent dilemmas with regards to the best ways of managing them. Specifically, dilemmas appeared to revolve around therapists' ethical, professional and clinical judgment, in relation to their clients' level of readiness, emotions, wishes and needs. Several qualitative studies (e.g. Coutinho et al., 2011; Hill et al., 1996; Moltu et al., 2010) have also reported that

when confronted with ruptures, therapists tend to experience confusion, ambivalence, self-doubt, as well as a sense of being lost, incompetence linked to ‘not knowing’ what to do, having ‘unfinished business’ in therapy (Haskayne et al., 2014) or having their therapeutic ‘hope threatened’ (Moltu et al., 2010). Participants in this study indeed provided vivid descriptions of inner struggles with regards to the most appropriate course of action they should follow as professional therapists, as well as human beings. These inner struggles often took the form of a ‘double-bind’, as eloquently presented in Sara’s account, whereby therapists felt like being trapped in dead-end, insurmountable situations.

According to Coutinho and colleagues (2011), internal contradictions during rupture events, could be attributed to moments of negotiation between the needs of the therapist and the client, as the therapeutic impasse instantly brings the negotiation of the therapeutic alliance into the foreground. For example, Mia appeared to struggle between her need to explore a specific event versus the client’s need to conceal it. Maria seemed to struggle between her need to keep the therapeutic boundaries and the client’s need to tamper them, whilst Sara appeared to struggle between her need to do something for the client and the client’s need to just be with her.

In line with Benjamin’s (2004) theory, therapeutic ruptures indeed appeared to compromise the therapeutic dyads’ ‘intersubjective process of thirdness’, which is characterised by mutuality. Instead interaction seemed to break down into a ‘complimentary twoness’, which is characterised by conflicting wishes and needs and compromises the therapist’s ability to receptively meet and be with the client. In some cases, as portrayed in Mia’s and Sara’s accounts, the dilemmas were resolved by the client asserting his/ her need and the therapist accommodating it. In Stella’s case, the therapist had to rely on her intuition, take a risk, and make an informed judgment call, whilst in Maria’s case the dilemma was resolved when it was explicitly brought up and collaboratively explored with the client. Once more the unique nature and idiosyncratic reactions of each therapeutic dyad were reaffirmed highlighting the mutual and intersubjective nature of the therapeutic encounter.

The intense power struggles and therapeutic dilemmas were accompanied by heightened negative emotionality. Ruptures in the therapeutic alliance appeared to trigger in participating therapists a range of difficult emotions differing in quality and intensity. This finding is consistent with existing qualitative studies linking ruptures to strong negative feelings, such as anxiety, anger, hurt, frustration, disappointment, hopelessness and guilt in both therapists and clients (Coutinho et al., 2011; Dalenberg, 2004; Hill et al., 1996, 2003; Moltu et al., 2010). In line with Moltu and colleagues’ (2010) study, participating therapists provided compelling accounts regarding the experience of ‘difficult feelings in the here-and-now’,

stemming from clients' withdrawal or aggression. At time these feelings were experienced as overwhelming, frightening and uncontained (Haskayne et al., 2014) compromising their therapeutic presence and capacity.

Interestingly, clients' withdrawal or aggression appeared to give rise to different emotions, in terms of quality and intensity. Client withdrawal appeared to elicit in participating therapists a mixture of feelings ranging from boredom, detachment and disappointment to frustration, irritation and anger, leading them to experience a sense of purposelessness and meaninglessness in their therapeutic work. This was particularly portrayed in Mia's, George's and Sara's accounts. On the other hand, client aggression appeared to trigger in participating therapists feelings of intense anxiety, panic and fear accompanied by intense physical sensations, as evidenced in Christina's, Elaine's, Rose's and Angela's accounts. This finding highlights the embodied and embedded nature of our relationship to the world, as pinpointed by the phenomenological philosopher Merleau-Ponty (see Smith et al., 2009). It is also consistent with Moltu and colleagues' (2010) finding claiming that both withdrawal and confrontation ruptures may give rise to intense emotional reactivity, whereby therapists confronted with client withdrawal tend to experience a sense of being left out, despair, irritation and self-doubt, whereas therapists confronted with client aggression tend to experience discomfort, vulnerability, as well as a sense of being threatened and trapped.

Existing research suggests that therapists tend to be more adept at responding empathically and being supportive to clients who exhibit withdrawal, as opposed to clients who exhibit aggression, to whom they tend to respond with defensiveness and counter-hostility (Binder & Strupp, 1997; Dalenberg, 2004; Hill et al., 2003). Participants' accounts provide partial support to these findings, as client hostility indeed appeared to trigger more intense and overwhelming emotions that were more difficult to be contained. At the same time, it seems like therapists' emotional responses to withdrawal or confrontation ruptures were also related to their idiosyncratic relational patterns and emotional difficulties. For example both George and Mia admitted that they generally struggle with client withdrawal, as they also tend to become emotionally withdrawn when confronted with emotional struggles in their relationships. In contrast, Elaine and Angela explained that, due to personal experiences, they tend to become anxious when confronted with others' aggression. Given the fact that affective experience provides individuals with vital information about the meaning of their interpersonal interactions, as well as their own action dispositions (see Safran & Muran, 2000), findings underscore and reinforce the importance of therapists being aware of, regulating and tolerating difficult feelings, as opposed to acting them out in the therapeutic relationship (Binder et al., 2008; Moltu et al., 2010; Nissen-Lie et al., 2015).

The Meaning-Making: Intrapsychic and Interpersonal Dynamics, Individual Vulnerabilities, and Pacing of Interventions

In an attempt to make sense of and attribute meaning to the intense struggle elicited by therapeutic ruptures, all participants engaged in a process of self-reflection. Unfortunately, in some cases insight on the matter was only achieved retrospectively, when unresolved ruptures had already resulted in clients' premature termination. It seems like in some instances and with some clients, the struggle was so intense that rendered participants unable to make sense of ruptures and utilise them in any therapeutic way.

In line with existing literature suggesting that clients' strong distortions of the therapeutic process, in combination with therapists' personal reactions to the client may negatively interfere with the alliance (Benjamin & Critchfield, 2010; Hill et al., 1996; Messer & Wolitsky, 2010; Moltu et al., 2010), all participants linked therapeutic ruptures to intense and entrapping transference and countertransference dynamics, which presumably gave rise to the strong negative emotionality described above. According to Ellman and Carsky (2002), each phase of psychoanalytic treatment is conceptualised as consisting of a series of transference cycles. During each cycle, there are a number of unavoidable ruptures and repairs that can either jeopardise or facilitate the transition to the next transference cycle. A similar description was provided in Elaine's account, whereby she experienced the client's strong transference reactions towards her as threatening to both the alliance and the real relationship.

It is argued that when the analytic pair manages to survive ruptures, love develops, ruptures are more easily endured, and transitions between transference cycles smoothen. In other words, client's resistance gradually subsides giving its place to relatedness, authenticity and mutuality (Ellman, 2007). In contrast, therapists' failure to successfully manage their countertransference (Benjamin & Critchfield, 2010; Hill et al., 1996; Moltu et al., 2010), as well as therapists' unresolved conflicts (Hill et al., 1996; Rosenberg & Hayes, 2002) have been found to negatively impact the alliance leading to counter-therapeutic interactions. Such interactions were also vividly portrayed in most participants' accounts, whereby they gave descriptions of intense transference-countertransference enactments in the therapeutic relationship. For example, Sara found herself drawn into a 'rescuer-fixer' role who would take care of her injured and unnurtured client, in order to compensate for the client's past parental failures. Rose, on the other hand, unwillingly impersonated the role of the client's abusive father, out of fear of the client's anger.

Interestingly, most participants appeared to conceptualise the transference-countertransference matrix in more relational, as opposed to classical psychoanalytic terms,

in that they seemed to acknowledge their contribution to the interaction and closely attended to their countertransference feelings, in order to gain better understanding of the client's inner world and characteristic relational patterns. Moreover, countertransference was not solely conceptualised as therapists' reactions to clients' projections, but as something activated when clients' transference reactions interacted with something already existing within them (see also Safran & Muran, 2000), as portrayed in both Angela's and Christina's accounts. This finding reaffirms the importance of therapists' awareness, management and containment of their countertransference reactions, in order to prevent ruptures from escalating, compromising therapists' helpful presence and impeding therapeutic progress (Gelso & Hayes, 2002, 2007; Moltu et al., 2010). For example, Newirth (2000) has emphasised the importance of the therapists using their countertransference and disclosing their subjective experience and emotional reactions, as opposed to adhering to traditional transference interpretations, in case of impasses in the alliance. In this way, they can provide the client with a corrective emotional experience and facilitate the integration of disowned emotions and parts of self. Furthermore, the process of the therapist surviving and containing clients' unbearable feelings can in itself be therapeutic, as it communicates to clients that they are also capable of regulating and tolerating their affective experiences (Safran & Muran, 2000).

Intrapsychic dynamics were inextricably linked to interpersonal dynamics, whereby participants experienced themselves as being coerced into problematic patterns of relating, in response to clients' specific behaviours. In fact, all participants made sense of alliance ruptures in relation to dysfunctional relational interactions, which gave rise to strong negative feelings and restricted sets of behaviours.

Therapeutic ruptures stemming from such interactions may be understood in light of the principles of 'interpersonal complementarity' (Kiesler, 1996), which postulates that specific interpersonal behaviours have the tendency to provoke specific interpersonal responses, which are typically assessed along the two dimensions of control (dominance-submission) and affiliation (friendly-hostile). An individual's behaviour on the control dimension tends to elicit opposite behaviours from others, whereas an individual's behaviour on the affiliation dimension tends to elicit similar behaviours from others. Indeed, Maria exhibited submission in response to her client's demanding behaviours, whereas Rose responded with counter-hostility to her client's hostile interactional style.

Participants' accounts therefore complement existing studies demonstrating that successful therapeutic dyads are characterised by greater positive and less negative interactions (Henry et al. 1986, 1990; Tasca & McMullen, 1992), whereas therapeutic dyads that engage in hostile and controlling interactions tend to form weaker alliances and are more susceptible to

ruptures (Benjamin & Critchfield, 2000; Binder & Henry, 2010). Moreover, they presumably shed more light onto the mechanisms through which therapists who are confronted with clients' anger, tend to experience anxiety, frustration, incompetence, and tend to respond with defensiveness or counter-hostility (Binder & Strupp, 1997; Dalenberg, 2004; Hill et al., 2003).

Clients' relational patterns are often re-enacted in the therapeutic relationship encouraging specific therapist responses that confirm their maladaptive interpersonal schemas. If the therapist responds in the anticipated way, he/ she runs the risk of confirming clients' maladaptive schemas and perpetuating their problematic relational styles. But if the therapist manages to disembed himself/ herself from the enactment and empathically explore clients' feelings and needs, he/ she can break their maladaptive way of relating and enable them to gradually develop new, more adaptive relational schemas. In that way, therapeutic ruptures may constitute windows into clients' core organising principles, as well as meaningful learning experiences that can provide clients with a new model of how to resolve relational difficulties in their life outside therapy (Coutinho et al., 2011; Safran & Muran, 2000; Safran & Segal, 1996).

All participants indeed provided vivid descriptions of being trapped into problematic interactional patterns with their clients, from which they found it extremely hard to disentangle themselves, as vividly portrayed in Rose's account. In some cases, they therefore unwillingly appeared to reinforce their clients' relational patterns instead of exploring the underlying meaning of the interaction and consequently providing them with corrective emotional experiences leading clients dropping out of therapy. The fact that, despite being aware of their countertransference, they were unable to unhook themselves from the dysfunctional interactions highlights the overwhelming force of the enactment, and once more reaffirms the importance of therapists' ability to contain difficult feelings (Binder et al., 2008; Hayes, Gelso, & Hummel, 2011) modify their interactional styles in response to clients' needs (Norcross & Lambert, 2011) and collaboratively explore with clients their mutual contribution to the rupture (Safran et al., 2011).

In trying to make sense of therapeutic ruptures, participants also speculated that both therapist and client personal vulnerabilities may have interfered with therapy rendering them more susceptible to intense transference-countertransference dynamics, as well as to entrapping interactional patterns. Therapists' individual vulnerabilities appeared to compromise their professional role and therapeutic competency, whereas clients' individual vulnerabilities appeared to sabotage the therapeutic relationship and endeavour.

In accordance with existing research findings (Hill et al., 1996; Moltu et al., 2010), most participants in the current study linked ruptures to their own vulnerabilities stemming from a range of issues such as financial and health problems, unresolved conflicts, idiosyncratic relational styles, and transitional life periods. Furthermore, the majority of participants attributed ruptures to their limited clinical experience and personal development during their training, as well as at the beginning of their professional practice (see also Coutinho et al., 2011). All the aforementioned issues appeared to undermine therapists' confidence, giving rise to anxiety and uncertainty, and leading them to doubt their professional competence. This finding is in line with existing research suggesting that therapist's qualities such as confidence, expertness, training and experience positively contribute to the formation and maintenance of a good therapeutic alliance (see Ackerman & Hilsenroth, 2001, 2003; Horvath, 2001; Horvath & Bedi, 2002). It also highlights the importance of personal therapy, supervision and professional development, in order for therapists to accept their vulnerabilities and limitations (Safran & Muran, 2000), as well as cultivate and enhance their personal attributes and professional skills (Ackerman & Hilsenroth, 2001), given the crucial impact of therapist factors in successful alliance building and treatment outcome (Baldwin et al., 2007).

Apart from personal vulnerabilities, most participants also made references to individual client vulnerabilities, which were brought to the therapeutic encounter and often led to the manifestation of ruptures. In accordance with previous research, participating therapists in the current study referred to clients' high personality pathology (Kuutmann & Hilsenroth, 2011; Safran et al., 2005), poor interpersonal functioning (Diener et al., 2009; Sharpless et al., 2010), greater interpersonal problems (Hersoug et al., 2009; Messer & Wolitzky, 2010) and low readiness for change (Norcross, Krebs & Prochaska, 2011) as factors that often hindered the therapeutic process leading to alliance ruptures. Participants' accounts revealed that such ruptures were often manifested in the form of clients' ambivalence, conflict and resistance towards the therapeutic endeavour. For example, it appeared that both Maria's and Sara's clients were struggling to balance their need for closeness and intimacy with their need for self-reliance and control. Whereas, Rose's client was torn between his need and his fear of reaching self-awareness in therapy. Participants' accounts revealed that such struggles were emotionally tormenting for both members of the therapeutic dyad, giving rise to maladaptive interactional patterns that often resulted in therapeutic impasses.

Therapist and client vulnerabilities related to therapeutic ruptures may be understood as moments of 'intersubjective negotiation' between two different subjectivities (Benjamin, 1990), whereby both members of the therapeutic dyad attempt to negotiate the needs of the self versus the needs of the other, hopefully leading to the experience of the self as a subject

without treating the other as an object. Moreover, each member of the dyad is called to negotiate his/her need for agency and autonomy, with his/her need for proximity and relatedness (Coutinho et al., 2009; Safran & Muran, 2000). Participants' accounts demonstrated that this process was particularly evident in clients' cases, who appeared to genuinely struggle between their need for and fear of relatedness, as they experienced it as threatening to their need for autonomy and self-definition. They therefore oscillated between moments of engagement and intimacy in the therapeutic relationship, and moments of sabotaging and undermining the therapeutic endeavour.

Clients' ambivalence and resistance was often interpreted by participating therapists as clients' attempts to protect themselves from painful discoveries and emotions, as well as relational injuries and disappointments (see also Leahy, 2007; Safran & Muran, 2000). At the same time such attempts were experienced as dangerous and difficult to tolerate for both therapists and clients, a finding that also emerged in Haskayne et al.'s study (2014). It is hard to tell whether participating therapists viewed clients' resistance as a solely intrapsychic process or as a function of the interpersonal context within which it was taking place. In their study on ruptures in adolescent psychotherapy, Binder et al. (2008) came to the conclusion that therapists struggled as to whether to explore adolescents' ambivalence in relation to intrapsychic factors or in relation to relational factors. In the present investigation, as well, there were divergences with regards to the extent that therapists attributed clients' resistance to intrapsychic or interpersonal factors. There was however great convergence with regards to the acknowledgment of both therapist and client contribution to the manifestation of alliance ruptures, as highlighted in the emerged subthemes of intrapsychic and interpersonal dynamics, and individual vulnerabilities.

Examined in combination, these findings appear to be more in line with contemporary relational theories (e.g. Aron, 1996; Mitchell, 1988) of conceptualising the therapeutic encounter in general, and therapeutic ruptures in particular. The two-person perspective regards the therapeutic relationship as a constant interplay between two subjectivities, whereby each contributes to the interaction and influences the other. From that perspective, ruptures ought to be explored and understood both intrapsychically, as well as interpersonally (Safran & Kraus, 2014; Safran & Muran, 2000). This conclusion is also supported by numerous research findings suggesting that therapist and client characteristics interact and affect the therapeutic alliance and outcome in general (Barber, 2009; Barber & Gallop, 2008; Wampold & Imel, 2007), as well as the manifestation and resolution of ruptures, in particular (Hill & Knox, 2009; Safran et al., 2011).

Existing research has illustrated that ruptures often come as a result of therapists' inflexible adherence to techniques, such as increased transference interpretations (Piper et al., 1999), or extensive emphasis on cognitive distortions (Castonguay et al., 1996). Other studies have linked ruptures to client-therapist disagreements over therapeutic strategies or therapists' attempts to employ new interventions (Aspland et al., 2008; Coutinho et al., 2011; Hill et al., 1996). Therapists' inflexibility and misapplication of techniques has been thus proven to have a negative relational impact on the development and maintenance of the alliance (Ackerman & Hilsenroth, 2001), as opposed to therapists' accurate interpretations, as well as encouragement of exploration, reflection and expression of affect (Ackerman & Hilsenroth, 2003).

Surprisingly, only one participant in the present study proposed a link between the type of his interventions, informed by his therapeutic approach, and the manifestation of an alliance rupture. This finding may be attributed to participating counselling psychologists' integrative and relational training, which could have arguably made them to adhere less rigidly to their preferred theoretical model, and demonstrate more flexibility in their clinical practice (Ackerman & Hilsenroth, 2001, 2003; Boswell et al., 2009). In contrast, all but one participant attributed ruptures to the unfortunate pacing of their interventions. It seems like for the participating therapists ruptures were not so much the result of incorrect *type*, but rather of incorrect *timing* of interpretations, as eloquently portrayed by Rose who stated that "it might have been a correct interpretation, but it was at the wrong time, so it was the wrong intervention, at the end of the day". Some participants appeared to move faster than their clients' preferred pace, jumping into an intervention that the client was not able to receive nor handle. In his account, George attributed his rather hasty intervention to his excitement and impatience in relation to working on a client's important issue. Rose conversely, attributed her rather intrusive intervention to the anxiety and fear evoked in her by the client's anger. In both cases the premature timing of their interventions resulted in the client's withdrawal and shutting down. On the other hand, Stella and Christina provided accounts of the ways they prolonged proceeding into more challenging but necessary relational interventions, out of fear of and uneasiness around their clients' reactions. In these cases, the therapist's lingering seemed to perpetuate and aggravate the rupture in the already fragile therapeutic relationship. Consequently, this appears as a rather interesting finding, which has been overlooked in current research on alliance ruptures, but nevertheless has theoretical explanations and carries significant clinical implications.

Leiman and Stiles (2001) have suggested that interventions that are more challenging than the client can tolerate may lead to ruptures, as they are beyond the client's 'zone of proximal development' (Vygotsky, 1978), meaning the space between the client's actual and potential

development. They can thus be disregarded by clients, as they are experienced as entailing substantial and intolerable risk (Coutinho et al., 2011). Emmerling and Whelton (2009) have also found that ruptures may stem from therapists' misunderstandings of clients' stages of change. In combination, these findings underscore the significance of therapists' attunement with clients' stages of change, adjusting the pacing of their interventions to clients' motivational stages and individual needs (Prochaska & DiClemente, 2005). Furthermore, they echo the Rogerian view on the importance of staying with the client's actual process and experience (Rogers, 1961), and once more highlight the importance of the therapist's ability to contain and regulate instead of acting out difficult feelings (Moltu et al., 2010).

The Resolution: The Way Out, the Therapeutic Transformation and the New Learning Experience

The final superordinate theme that emerged from the present analysis is concerned with the process and impact of resolving therapeutic ruptures. Nevertheless, it should be acknowledged that the concept of 'resolution', as captured in the three emerged subthemes is twofold, as it addresses both successful and unsuccessful rupture resolutions, which nevertheless constituted significant learning experiences for both therapists and clients.

Participants' narratives shed ample light onto the unique ways that therapists employ in order to manage and overcome ruptures, in other words their idiosyncratic ways of finding a 'way out' of therapeutic impasses. Whilst participants' accounts diverged with regards to the therapeutic interventions they employed with specific clients, under specific conditions, there was nevertheless great convergence in relation to the key elements that they considered as crucial in rupture resolution, irrespective of their therapeutic orientations and preferred ways of practice. This finding is consistent with the view that the alliance, in general, and the process of addressing alliance ruptures, in particular, is a 'common factor' across a range of therapeutic orientations and contexts, and yet a 'specific factor' to the helping process that operates as a mechanism of change in and of itself (Coutinho et al., 2009; Horvath, 2000).

All participants emphasised the importance of self-awareness and self-reflection in the process of rupture resolution. Unfortunately, in some cases this was only achieved retrospectively, when ruptures had substantially escalated or when clients had already decided to terminate therapy. This is not surprising, as the extreme negative emotionality, in combination with the intense intrapsychic and interpersonal dynamics surrounding ruptures may have compromised therapists' reflective functioning and capacity for mentalisation in the here-and-now (Fonagy & Target, 1997, 1998; Safran, Muran & Shaker, 2014). It also highlights the importance of therapists' ability to 'reflect-in-action' (Schön, 1983), that is to be able to step back, identify negative processes and monitor their responses during the

unfolding of problematic therapeutic interactions (Binder & Henry, 2010). Indeed, most participating therapists stressed the significance of being able to disembed themselves from maladaptive enactments, in order to contain strong negative feelings and countertransference reactions, and respond in a non-defensive and empathic way to the clients' wishes and needs, as portrayed in Angela's, Rose's and George's accounts. Participants' emphasis on self-awareness and self-reflection is in line with numerous qualitative and task analytic studies that highlight the importance of therapists attending to rupture markers, being aware of and accepting towards their feelings, disembedding from problematic relational matrices and acknowledging their contribution to the interaction (see Hill & Knox, 2009; Safran et al., 2011; Safran et al., 2000). Given the unique capacity of IPA to tap into participants' inner experiences, participating therapists' emphasis on intense self-reflection for successful rupture resolution may also provide an explanation, as to why some task analytic studies (e.g. Aspland et al., 2008; Cash et al., 2014) do not include any overt recognition or exploration of the rupture itself, but rather include a therapist's internal review of the problem or pattern. It could be assumed that in certain cases therapists' ability to engage in self-reflective practice and modify the therapeutic approach accordingly, without having to explicitly address and explore ruptures with clients, may in itself be sufficient for rupture resolution, depending on the type of therapy, type of rupture and client's needs (Aspland et al., 2008; Safran et al., 2011).

Whilst self-awareness was portrayed as the necessary first step towards rupture resolution, participants' accounts also pointed out the value of metacommunication and immediacy in the process of reparation, a finding that has also been evidenced in a number of qualitative (Coutinho et al., 2011; Hill et al., 2008; Moltu et al., 2010) and task analytic studies (Agnew et al., 1994; Bennett et al., 2006; Elliott et al., 2004; Safran et al., 2011). According to Safran and Muran (2000) metacommunication or otherwise 'mindfulness in action' consists of the therapist stepping out of therapeutic enactments, characteristic of ruptures, and attempting to communicate about the interaction through collaborative exploration with the client. In that way, the therapist can move towards a third perspective that values the subjectivity of both client and therapist through empathising with the client's experience, without letting go of his own subjectivity (Safran et al., 2014b; Safran & Kraus, 2014). In the case of John, the very act of communicating about the therapeutic relationship in the here-and-now constitutes a relational act that carries a relational meaning, as it equally divides the responsibility for the rupture between therapist and client, highlighting the therapist's contribution in the interaction, as opposed to locating the problem solely within the client's personality or behaviour.

Similarly, immediacy refers to the process of working with the therapeutic relationship in the here-and-now through exploring client's reactions to the therapeutic relationship, drawing parallels between the therapeutic relationship and client's relationships outside therapy, processing therapeutic ruptures, and disclosing personal feelings towards the client (Hill & Knox, 2009). Stella's account beautifully illustrates the use of immediacy that ultimately facilitates acquisition of insight into the client's patterns of relating in and outside the therapy room, whereas in Elaine's account the use of immediacy entails a substantial amount of therapist self-disclosure which aims to foster re-connection and model to the client an alternative experience of a more authentic way of relating. At this point, it is worth pinpointing that there was substantial divergence between participants' accounts as to the usefulness of making explicit links between ruptures in the therapeutic relationship and clients' relational patterns outside therapy. This is in line with existing research findings suggesting that transference interpretations, as opposed to open exploration of the here-and-now of the therapeutic relationship, may be experienced by clients as blaming and criticising suggesting that the problem lies primarily within the individual, as opposed to stemming from the mutuality of the therapeutic relationship (Piper et al., 1991; Safran et al., 2005, 2011).

In accordance with clinical research (Dalenberg, 2004; Elliott et al., 2004; Rhodes et al., 1994; Safran et al., 2011), all participants also stressed the importance of exploring and taking responsibility for their own contribution to the interaction, highlighting once again the essentially relational and intersubjective nature of the therapeutic encounter, whereby therapist and client are viewed as active co-participants, who mutually affect and are affected by each other (Aron, 1996; Mitchell, 1988). From an intersubjective framework, ruptures thus carry relational meaning, shedding light onto clients' unique relational patterns, and are inherently embedded in the unique relational context of the therapeutic interaction (Safran & Kraus, 2014; Safran & Muran, 2000). By accepting responsibility and apologising, therapists can therefore model to clients that mistakes and anger are possible but can be overcome within the context of a good therapeutic relationship, and thus provide them with corrective emotional experiences (Dalenberg, 2004; Safran & Muran, 2000), as eloquently described in Rose's account. At the same time, accepting negative feelings and taking responsibility appears to protect therapists from turning negative feelings inwards and internalising unnecessary guilt, which is associated with unsuccessful rupture resolution (Hill et al., 2003).

Participants' narratives revealed that successful rupture resolution had positive consequences on a number of levels for both members of the therapeutic dyad. In line with existing literature, the process of repairing therapeutic ruptures in itself was perceived by many participants as a window into clients' core organising principles (Safran & Muran, 2000), as well as a means towards clarifying and understanding clients' underlying wishes and needs

(Safran et al., 2011). This was graphically illustrated in John's account in which he comments on the way his client showed him that she firstly needed him to provide her with nurturance and security, in order to use him as a 'secure base' from which she could proceed into exploring painful issues and engaging into action. Furthermore, the process of rupture resolution appeared to have provided both therapists and clients with the opportunity to negotiate their needs with the needs of the other, both taking responsibility for their contribution to the interaction, and thus both treating and relating to each other as a subject, as opposed to an object (Coutinho et al., 2009; Safran & Muran, 2000), as highlighted in Maria's account. Successful rupture resolution was thus experienced by all participants as enhancing to the alliance, deepening the therapeutic work and fostering intimacy and closeness, as portrayed in both Maria's and Christina's accounts. Participants' experiences are consistent with existing research findings suggesting that therapeutic ruptures and repairs have a positive impact on the therapeutic alliance, enable clients to express their feelings, and constitute corrective relational and learning experiences for clients (Coutinho et al., 2011; Hill et al., 2003, 2008; Hill & Knox, 2009; Kasper et al., 2008; Rhodes et al., 1994; Safran et al., 2011).

In their accounts, all participants provided moving descriptions of positive and warm feelings following successful rupture resolution, such as happiness, joy and pride. It seems like the negative emotionality framing ruptures was somehow replaced by a sense of emotional synchronicity, closeness and reconnection, after reparation had taken place, as poignantly described in Christina's account. And this sense of emotional attunement also appeared to have been physically embodied and felt, as opposed to verbally articulated and communicated, as if represented in the form of an 'implicit relational knowing' (Stern, 1985) taking place within the 'interpersonal unconscious' of both therapist and client (Scharff & Scharff, 2011). Participants' descriptions of their positive emotional experiences following therapeutic repairs echo Haskayne et al.'s findings (2014), as captured in the emerged subtheme 'emotional sensitivity', whereby therapist and client dyads narrated experiences of emotional attunement, containment and intimacy following rupture resolution. At the other end of the spectrum, unsuccessful rupture resolution was accompanied by a series of uncomfortable and negative feelings that often appeared to have lingering effects on therapists even after years of therapy termination, a finding also evidenced in Hill et al.'s study (1996). Some participating therapists experienced a sense of guilt, regret and self-doubt with regards to the way they handled therapeutic impasses, as depicted in Mia's accounts. On the contrary, other therapists came across as having experienced immense relief following clients' premature termination due to unresolved impasses, as if they had been saved from great suffering and pain.

Taken together, these findings highlight the importance of affect regulation in rupture resolution, meaning therapists' ability to manage and tolerate their own, as well as their clients' difficult and unbearable feelings (Muran et al., 2010; Safran & Kraus, 2014). In the healthy mother-infant dyads, moments of affective miscoordination are usually followed by moments of affective coordination that enable the infant to bear difficult feelings, as well as to build a relational schema of the other as essentially available and a schema of the self as capable of eliciting closeness (Tronick, 1989). In that way, the infant gradually learns to regulate, attribute meaning to and communicate his/ her emotions (Gergely & Watson, 1996). Similarly, in the therapeutic dyad, when ruptures are followed by repairs characterised by emotional attunement, the client can arguably develop an adaptive relational schema of others as potentially available and a schema of the self as capable of negotiating relatedness, even in the face of interactional ruptures (Safran & Muran, 2000; Safran & Segal, 1996). It has therefore been argued that the reparation of therapeutic ruptures may directly contribute to the resolution of clients' relational difficulties (Horvath, 2000).

A final finding, common to all participants' narratives, was therapists' experiences and views of therapeutic ruptures and repairs as fundamentally relational and learning experiences for both members of the therapeutic dyad. Most therapists appeared to perceive ruptures and repairs as opportunities to offer clients' corrective emotional experiences enabling them to replace their existing relational schemas with more adaptive ones (see Coutinho et al., 2011; Safran et al, 2011; Safran & Muran, 2000). This was especially pertinent in both Rose's and Elaine's accounts, whereby they provided a conceptualisation of ruptures as 'optimal frustrations'. They both stressed the importance of the therapist occasionally failing clients, in order to enable them to let go of their sense of omnipotence and prepare them for the disillusionment of the real world, just like the 'good enough mother' does for her infant (Winnicott, 1956). In that way clients can gradually come to acknowledge the therapist's limitations, as well as their separateness, as individuals with their own wishes and needs, which can never be fully met, but can nevertheless be acknowledged and validated. It is through this process that clients come to realise that relatedness is possible in separateness, nurturance is possible in the presence of negative feelings and togetherness is not contingent upon disowning parts of oneself (Safran & Kraus, 2014; Safran & Muran, 2000).

At the other end of the spectrum, participants' accounts revealed that therapeutic ruptures constituted valuable learning lessons for therapists, as well. Different therapists appeared to have learnt different things, but there was great convergence with regards to the therapeutic value and constructive nature of ruptures, despite participants' struggles to manage and overcome them. For example, Christina describes how she has gradually become more aware of and attuned with subtle indications of ruptures in the therapeutic relationship, and has come

to view them as opportunities for exploration. In fact, she appears to consider them as more beneficial than a stable and harmonic alliance, a view that was also supported by other participants and is in line with naturalistic studies linking rupture and repair sequences to greater treatment gains (Gumz et al., 2012; Kivlighan & Shaughnessy, 2000; Stiles et al., 2004; Strauss et al., 2006). Furthermore, ruptures were portrayed in the majority of participants' accounts as therapeutic events that have enabled them to come to terms with their weaknesses and limitations, as therapists as well as human beings, leading them to abandon their delusions of omnipotence and come to accept the reality of being 'good enough'. This is a rather important finding, as according to Safran and Muran (2000) therapists' acceptance of their own pains, failures and limitations is crucial for their ability to accept and show compassion towards clients' feelings, as opposed to becoming hooked on clients' dysfunctional relational matrices.

Methodological Limitations and Reflections

Limitations

IPA sampling tends to be purposive and broadly homogenous, as a small sample size can provide a sufficient perspective given adequate contextualisation (Smith & Osborn, 2003; Smith et al., 2009). The sample of the present study was homogenous in that it consisted of ten chartered counselling psychologists, but heterogeneous in that it was comprised by therapists of different theoretical orientations and professional posts. On the one hand, it could be argued that the heterogeneous sample was representative of the therapeutic community of counselling psychologists allowing for some generalisability of findings. On the other hand, as mentioned by other authors (e.g. Carradice et al., 2002; Flowers, Duncan, & Frankis, 2000), it should be pointed out that not all participants articulated the themes identified, suggesting that individuals might have held a more limiting understanding of the phenomenon investigated, than that portrayed by the group model, especially if we take into account the fact that participants demonstrated different levels of familiarity with the literature on the topic under investigation. It could therefore be argued that therapists from the same theoretical background, with similar knowledge of the topic of alliance ruptures might have given rise to a different pattern in the data and thus caution should be exerted when generalisations are drawn from the current study. However, it should be noted that other authors have argued for the use of heterogeneous samples when using IPA, as it allows transferability of findings and captures diversity of perspectives (Carradice et al., 2002).

Furthermore, the sample consisted of counselling psychologists trained in the UK but practicing in Greece, and therefore caution should be also exercised against making 'general claims' and attempting to transfer the findings of the present study to other populations and/

or contexts (Elliott et al., 1999), as counselling psychologists from different socio-cultural backgrounds might have given rise to a different data pattern. For example, the majority of participating therapists in the current study were employed in private practice or organisations providing time-limited or open-ended psychotherapy. Counselling psychologists employed within NHS settings, mainly offer their services in IAPT programmes implementing short-term, cost-effective treatments with CBT being the dominant force. Within such a context, the rationalisation, manualisation and bureaucratisation of treatments often leave little space for relational ‘anxiety-work’, meaningful emotional involvement with clients (Rizq, 2011, 2012) and engagement in self-reflective practice (Donati, 2016). Consequently, therapists may potentially lack the time, energy and training to develop strong therapeutic alliances, address relational issues and successfully negotiate ruptures. Such a sample of counselling psychologists could have thus provided a completely different account on the way they experience, make sense of and manage therapeutic ruptures and repairs.

Furthermore, it is important to take into account that, as counselling psychologists, participants were trained in a variety of therapeutic models with an emphasis on humanistic and relational values of practice. This could have arguably made them more sensitive towards process and relational issues, as well as more adept at tracking and managing ruptures in the therapeutic relationship. It could thus be argued that a sample consisting of therapists of different theoretical backgrounds and models of practice might have given a different pattern in the data, as according to research the theoretical background and epistemological values of therapists significantly affect their relational styles and ways of practice (see Arthur, 2001).

Additionally, it is worth to briefly consider the particularity of the historical and socio-political context framing participants’ experiences and meaning-making processes (Eatough & Smith, 2008). As previously mentioned, participating therapists were chartered counselling psychologists trained in the UK but practicing in Greece during an undoubtedly turbulent period of political instability, economic upheaval and rising unemployment. Within this context of uncertainty, anxiety and despair, both therapists and clients are often faced with financial issues threatening their identity, security and self-esteem. Clients may be significantly distressed by money issues, whereas therapists themselves may be confronted with a significant reduction in their caseload and income struggling to preserve the viability of their practice (Apostolopoulou, 2013; Zur, 2009b). On the one hand, it could be argued that such anxieties manifesting themselves within the therapeutic relationship and dynamics could have presumably given rise to intense ruptures posing marked challenges on the work of participating therapists. On the other hand, it could also be assumed that therapists struggling to sustain the viability of their practice could have devoted substantial effort and commitment to repairing ruptures, in order to prevent clients from dropping out. In any case

it would be interesting to investigate whether therapists practicing in a socio-political climate of prosperity, stability and security would have articulated the same worries, fears and anxieties or they would have experienced and managed therapeutic ruptures in similar ways.

A final but important point regarding the sample characteristics is that participating therapists' native tongue was Greek. All participants had completed accredited programmes and had practiced in the UK. They were therefore fluent in the English language. However, research shows that culture is internalised and communicated through language, and that bilingual speakers often think about and represent things, (Ji, Zhang, & Nisbett, 2004), process and understand information (Lemhöfer, Dijkstra, Schriefers, Baayen, Grainger, & Zwitserlood, 2008), recollect and interpret events (Marian & Neisser, 2000), categorise and express emotions (Kitayama & Markus, 1994; Wierzbicka, 2004) differently in a second language rather than their mother tongue. Given the importance of language in the construction of our lifeworld and shaping of our subjective experiences (Eatough & Smith, 2008), it could thus be argued that the fact that the interviews were not conducted in participants' mother tongue may have constituted a socio-linguistic restriction constraining participants' cognitive processing and emotional expression, and thus failing to fully capture the richness and depth of their experiences and sense-making processes. Moreover, it could be also hypothesised that participating therapists' subjective experiences, understandings and recollections of therapeutic ruptures and repairs may have been coloured by their unique socio-cultural background, rendering transferability of findings to other populations and contexts a rather cautious task.

Despite the aforementioned considerations, it is worth highlighting that participants' accounts appeared to be to a large extent consistent with existing research allowing for a certain amount of theoretical generalisability and practical applicability, and ultimately permitting readers to evaluate them alongside their own theoretical knowledge and professional experience (Smith & Osborn, 2007). In any case, it would be interesting to replicate the present findings with different therapist groups, in terms of theoretical orientation, clinical experience and socio-cultural background.

Another possible limitation is that the sample was self-selected, and therefore possibly consisting of counselling psychologists who were more accessible or more comfortable with and adept at managing therapeutic ruptures, thus compromising the representativeness of the research findings (see Miles & Huberman, 1994). However, the fact that all participants spoke about mistakes and failures in the management of ruptures, and described extreme struggles and negative emotionality surrounding therapeutic impasses does not seem to support this claim. In addition to this consideration, it should be also acknowledged that the present study

only examined therapists' perspectives on therapeutic ruptures and repairs, thus not telling the whole story. It would have been interesting to have both therapists' and clients' accounts, in order to acquire multiple and multifaceted perspectives on the topic under investigation (see Coutinho et al., 2011; Haskayne et al., 2014) as rupture resolution is an essentially interpersonal process (Rhodes et al., 1994).

A further limitation lies in the retrospective nature of the acquired data. Unfortunately in retrospective recollections of actual events, the description of subjective, internal experiences may be skewed by memory (see Dickson, Knussen & Flowers, 2007), meaning that findings are limited to information that participants are aware of and willing to disclose (Coutinho et al., 2011; Hill et al., 1996). Furthermore, it is possible that therapists' memories, experiences and meaning-making processes of therapeutic ruptures may have evolved and reconstructed over time influencing the final 'product' presented in their narratives. The interviewer did not ask participants to recall ruptures that had occurred within a particular context, and it is true that whilst some participating psychologists chose to talk about fairly recent or ongoing ruptures, others recalled ruptures that had occurred during their training or the beginning of their professional practice. It may have therefore been more useful to have requested from participants to recall fairly recent ruptures or alternatively to have combined qualitative analysis of recalled events with qualitative analysis of actual events, as advocated by certain researchers (Hill & Knox, 2009). In that way, observing actual tapes of therapy sessions and interviewing participants about events after the session could have enabled us to acquire different and complementary perspectives on the overt and covert processes involved in rupture events. However, it is worth highlighting that all participants were able to recall rupture-repair events with a substantial amount of detail and self-reflection, as captured in their rich and elaborate accounts.

An inherent limitation of the study is related to the employed qualitative methodology, namely IPA. Although IPA has the unique advantage of capturing subjective lived experiences and meaning-making processes it is not without certain limitations, as it does not provide causal explanations for them and does not take into account the historical and socio-cultural contexts framing such experiences and processes (Willig, 2013). Employing a mixed-method design or combining IPA with Foucauldian Discourse Analysis could have arguably provided us with a richer and more complete understanding of the topic of therapeutic ruptures and repairs (Eatough & Smith, 2008), therefore enhancing the validity and credibility of the findings through triangulation (see Hammersley, 2008; Patton, 1999).

Qualitative research acknowledges that there are biases that the researcher brings to the research process. In IPA, the researcher's perspective will have an effect on the interpretative process (Smith, 1996), which can raise questions of reliability and validity (Golsworthy & Coyle, 2001). Despite attempts to acknowledge and 'bracket' existing knowledge, preconceptions, and biases when conducting the interviews and analysis, it should be acknowledged that the researcher's influences from previous literature findings, as well as her deep-seated interest in integrative and relational models of psychotherapy might have constituted a bias in the process of data gathering and interpretation. However, there were attempts to address and overcome such issues through a thorough grounding of the interpretations in participants' extracts, as well as through the process of 'triangulation' of findings by involving my supervisor and a colleague in the cross-referencing of the emergent produced themes (see Patton, 1999). Furthermore, enough verbatim evidence was presented, in order to allow readers to evaluate the analysis and to establish internal coherence by determining whether the presented interpretations were coherent with the data, as advocated by Osborn and Smith (1998).

Lastly, it could be argued that the fact that both the interviewer and participants were counselling psychologists, as well as practicing therapists might have given rise to a social desirability bias (McLeod, 2003). Some participants were aware of the researcher's interest in relational and intersubjective models of psychotherapy, and it is possible that this knowledge may have exercised some pressure on them to meet presumed expectations or hide personal weaknesses and vulnerabilities, in order to be viewed favourably by the researcher. However, the content, as well as the openness and intimacy of the interviews do not seem to support this claim. In fact, the majority of participants paralleled the interview with supervision and appeared very appreciative of the opportunity to reflect on therapeutic ruptures with clients.

Reflections

The researcher's epistemological and personal reflexivity, as well as issues around validity and trustworthiness, before and during the research project, have been extensively discussed in previous sections. In this section, I will therefore attempt to explain the ways in which I have been influenced and shaped as a researcher, supervisor and clinician following the completion of the current investigation.

Conducting this research was undoubtedly a strenuous but deeply rewarding process. Whilst I had been engaged in the conduct of qualitative research, and IPA in particular, during my training, as well as post-training years, my deep involvement in the current research project and immersion into relevant literature has made me realise the extent of my ignorance and

limitations with regards to the knowledge I naïvely thought I already possessed around the philosophical underpinnings and methodological features of IPA. Through my extensive engagement with the research project, I have gradually become much more confident in my ability to conduct qualitative analysis and IPA in particular. I have also had the opportunity to reflect on and re-evaluate my epistemological standpoint as a qualitative researcher who struggles between her faith in the validity of subjective experience and her belief that the socio-cultural contexts, which we inhabit, unavoidably shape, reform and redefine our subjective worlds and meaning-making processes. I have therefore also come to evaluate my existing values, biases and preconceptions that I firstly needed to understand and accept, before being able to 'bracket' them. That was not an easy task, as I tend to feel quite passionately about the things I believe in. Involving myself in the research project has also 'forced' me to become more disciplined and organised in the way I work and live my life, as it required a high level of time-management and organisational skills, if I were to balance my professional with my personal life. Another gift that arose from this process was that I now feel much more confident and complete in my counselling psychologist identity as a 'scientist-practitioner', as well as a 'reflective practitioner'. Lastly, the process of conducting the study, in combination with the emerged findings has strengthened my faith in the value of qualitative methods of inquiry that can shed light onto process issues that are highly relevant for clinical practice.

In my professional life, I have the immense luck of being a lecturer on an MSc programme in Integrative Counselling and Psychotherapy, as well as of being a supervisor for trainee counsellors and psychotherapists. During the research process, I became so fascinated by my research topic and practical implications that I decided to introduce two new lectures into the course; one on the therapeutic relationship in the different schools of psychotherapy and another one on therapeutic ruptures and repairs. To my great satisfaction, both lectures were enthusiastically received by students, who appeared much taken with the applicability of these topics to their counselling practice. I have also gradually started to introduce relevant theory on therapeutic ruptures and repairs into my supervision sessions, in order to enable supervisees to capture and manage relational difficulties with clients in light of relevant theoretical perspectives and research findings. At the same time, I have gradually become much more aware of and attuned to subtle markers indicating ruptures in the supervisory relationship, which I attempt to manage through regularly asking feedback from my supervisees, as well as through inviting them for an open exploration of what is taking place between us.

My involvement with the research project has also unavoidably influenced me as a practitioner counselling psychologist in a quite radical and productive way. Becoming

familiar with relevant literature on alliance ruptures and repairs, as well as listening to participants' stories has retrospectively enabled me to make sense of both past and present therapeutic ruptures with clients. At the time I was lacking the 'vocabulary' to define them as such, and therefore my theoretical understanding and clinical capacity was limited in its scope and utility. But, through my engagement with my research investigation, it feels like I have discovered a whole new world of meanings and possibilities, a world that I was unconsciously and scarcely aware of, but I never quite had the 'evidence' to prove its existence. Listening to and analysing participants' experiences has somehow made me feel less alone and less inadequate experiencing a sense of universality and togetherness. Delving deeper and deeper into the literature and analysis significantly enhanced my knowledge on the topic and increased both my confidence and competence in dealing effectively with therapeutic ruptures. I have always worked relationally with clients, but it is through this research process that I have found even more courage and strength to actively address therapeutic ruptures in the here-and-now, and refrain from taking clients' aggression or withdrawal personally, and thus acting defensively or driven by guilt. I have also started to request more feedback from clients on what they like and what they do not like in the therapeutic process. Overall, my involvement with the research project has enabled me to grow and mature as a practitioner, and has also strengthened my belief in the humanistic and relational models of psychotherapy that emphasise mutuality, intersubjectivity, spontaneity and authenticity.

Implications for Counselling Psychology Research, Training and Practice

The current research project aimed to investigate counselling psychologists' experiences and meaning-making processes of therapeutic ruptures and repairs. Counselling psychology has been defined as the application of psychological knowledge to the practice of counselling (Strawbridge & Woolfe, 2003), whilst BPS guidelines encourage the development of phenomenological models of research and practice "...which marry the scientific demand for rigorous empirical inquiry with a firm value base grounded in the primacy of the counselling/psychotherapeutic relationship" (BPS, 2005, p.1). In accordance with the aforementioned guidelines, the current study employed a qualitative, phenomenological method of inquiry, in order to address a complex phenomenon, which holds significant practical and clinical implications for counselling psychologists.

Current research on alliance ruptures and repairs is dominated by quantitative studies, such as naturalistic and task analytic studies, which have provided us with compelling evidence with regards to the importance of rupture resolution for positive treatment outcome, and have enhanced our understanding in relation to the necessary steps required for successful rupture

resolution (see Hill & Knox; 2009; Safran et al., 2011). However, such studies fail to capture participants' inner experiences and meaning-making processes during rupture events, as well as to illuminate the ways in which rupture resolution operates as a mechanism of change affecting the therapeutic relationship, process and outcome (see Coutinho et al., 2009; Gumz et al., 2012; Hill & Knox, 2009). Furthermore, the majority of qualitative studies conducted in the field have employed Consensual Qualitative Research (CQR; Hill et al., 2005), a qualitative research methodology capable of tapping into participants' inner experiences and covert processes during rupture events, but which nevertheless espouses a postpositivist epistemology, in terms of emphasis on judges' consensus to construct the interpretation of the data (Hill et al., 2005) rather than on the provision of rich descriptions of participants' subjective experiences (Hill et al., 2003). Consequently, by employing Interpretative Phenomenological Analysis, the current study aspired to complement existing quantitative and qualitative studies by exploring and illuminating counselling psychologists' subjective experiences, whilst taking into account the socio-cultural context which frames such individual processes (Smith, 2011). IPA was chosen as the methodology that could best answer the research questions. At the same time IPA is highly compatible with the humanistic ethos of Counselling Psychology that privileges equally subjectivity and intersubjectivity, and encourages practice-led research (BPS, 2005).

Implications for Research

The findings that emerged from the present study suggest that current research may benefit from a re-definition of alliance ruptures, as existing definitions as proposed by Safran and Muran (2006) do not seem to fully capture the intersubjective nature and the emotional struggle framing ruptures (see also Haskayne et al., 2014). In addition, existing rupture conceptualisations do not appear to offer conclusive evidence with regards to the impact of rupture intensity on the therapeutic alliance. The present study also revealed that ruptures often manifest themselves in the form of power and control struggles, a finding that has been witnessed in a couple of studies (Aspland et al., 2008; Haskayne et al., 2014), but has not been given adequate consideration in current research, and arguably deserves further investigation. The intense negative emotionality and pertinent dilemmas experienced by participants during ruptures may also constitute fertile areas for further research that could focus on the relationship between therapists' capacity for affect regulation and successful rupture resolution. The powerful intrapsychic and interpersonal dynamics, in combination with the individual vulnerabilities that were thought to give rise to ruptures and impede resolution illuminate the ways in which client and therapist characteristics interact and may operate as moderating variables in the processing and resolution of therapeutic ruptures (see Hill & Knox, 2009). This conclusion has been highlighted in numerous research findings

(Barber, 2009; Safran et al., 2011), but needs further investigation and replication, as the ways client and therapist characteristics interact and affect each other during rupture events, and under which conditions, remain rather vague and unclear. A very interesting finding of the present research project, that has been absent from existing research is that participants often attributed ruptures to the pacing/ timing of interventions. It may therefore be useful to conduct further research on ruptures and their relationship to clients' stages of change. Participants also pinpointed the importance of immediacy and metacommunication, as a central mechanism of change in the process of rupture resolution. However, further research is needed, in order to assess with what client groups, at which stage of therapy, and under which conditions relational work is indicated. Lastly it would be worth to further investigate the exact impact of rupture resolution within and outside therapy (see also Hill & Knox, 2009). Overall, research on therapeutic ruptures and repairs constitutes a rather fertile and intriguing area for counselling psychologists, as it entails significant practical implications that can be directly implemented in clinical practice.

Implications for Training

Findings from the current study also hold important implications for the training of counselling psychologists. Despite the fact that the research sample consisted of experienced counselling psychologists, all participants appeared to struggle with alliance ruptures emotionally, behaviourally and interpersonally. Their accounts revealed that they often felt entrapped in intense transference and countertransference dynamics, and dysfunctional interpersonal dynamics that were often triggered by their personal vulnerabilities, and led them to react in counter-therapeutic ways. These findings highlight the importance of training counselling psychologists in the building and repairing of the therapeutic alliance, in order to enhance their theoretical knowledge and practical skills on the matter (see Crits-Christoph et al., 2006; Safran et al., 2014). At this point, it is worth mentioning that, despite the primacy of the therapeutic relationship in Counselling Psychology, the majority of participating psychologists were unfamiliar with relevant theory and research on alliance ruptures. It is thus proposed that Counselling Psychology programmes in the UK could certainly benefit from introducing the topic in their curriculum. For example, trainee students could substantially increase their confidence in addressing and dealing with alliance ruptures through watching educational videos, participating in role plays or practicing their counselling skills in simulated environments (see Binder & Henry, 2010; Hill & Knox, 2009). At the same time, it is worth pointing out that studies investigating the impact of alliance-focused training on rupture resolution have yielded mixed results (Binder, 1993; Crits-Christoph et al., 2006) suggesting that the relational skills involved in rupture resolution are not easily manualised nor mastered by all therapists. This conclusion could be explained in

light of the present finding that therapists' personal vulnerabilities interfere with their ability to successfully negotiate therapeutic ruptures. Another venue for such training could therefore be supervision, where counselling psychologists may engage in self-reflection on their affective reactions and thought processes behind their actions, examine their own intrapsychic and interpersonal processes, contain difficult feelings, and practice new skills involved in rupture resolution within the safety of the supervisory relationship (see also Binder & Henry, 2010; Hill & Knox, 2009). The fact that most participants recalled ruptures that had occurred during their training or early in their professional practice suggests that the ability to work relationally matures and develops with time and experience. The current findings therefore also highlight the necessity of continuing professional development, as well as personal therapy, in order to enable counselling psychologists to acquire self-awareness, and mature both personally and professionally.

Implications for Practice

Lastly, participants' experiences of therapeutic ruptures and repairs carry significant implications for the practice of Counselling Psychology. An emerged finding was that participating therapists appeared to experience ruptures as mutually co-constructed and co-experienced by both members of the therapeutic dyad. Furthermore, they tended to respond to ruptures with quite idiosyncratic ways depending on their unique personality and relational style. It becomes therefore crucial for counselling psychologists to constantly attend to subtle rupture markers in their clients or within themselves, as well as to regularly request clients' feedback on the quality of the therapeutic alliance (see also Hill & Knox, 2009; Safran et al., 2011). Furthermore, counselling psychologists need to attend to and work through ruptures manifested in the form of power struggles in the therapeutic relationship, as they often represent re-enactments of injuries around rank and power (Totton, 2009). As ruptures tend to elicit extreme negative emotionality in both therapists and clients, practitioners also need to demonstrate the ability to contain and regulate difficult feelings, otherwise they run the risk of acting them out in the therapeutic relationship (Moltu et al. 2010). Along those lines, practitioners should also constantly monitor their countertransference, use it to better understand clients, but also contain it, in order to be able to disembed themselves from transference-countertransference enactments that compromise relatedness and threaten the therapeutic alliance. Similarly, it becomes paramount that counselling psychologists refrain themselves from responding to clients' withdrawal or hostility with defensiveness or counter-hostility (see Binder & Henry, 2010; Safran et al., 2011), as well as work through their personal issues in therapy or supervision, as they tend to get in the way of rupture resolution. It is also important that therapists pace and time their therapeutic interventions in ways that are attuned with and respectful of clients' process and stage of change. When faced with

ruptures, it is essential that therapists attempt to employ metacommunication and immediacy, empathising with clients' feelings, collaborative exploring what is taking place between them, and taking responsibility for their contribution in the interaction (see Hill & Knox, 2009; Safran et al., 2011). It is also necessary that counselling psychologists engage in self-reflective practice, as well as accept their limitations and weaknesses, in order to become more accepting and compassionate towards clients (Safran & Muran, 2000). Last but not least counselling psychologists need not be intimidated by ruptures as, when successfully resolved, they can constitute great learning and relational experiences for both therapists and clients (Safran & Muran, 2000).

Conclusion

A fundamental contribution of the present study to the discipline of Counselling Psychology is its commitment to the subjectivity of participants' experiences that resulted in a living testimony to the intersubjectivity of our existence. A pertinent finding that appeared to run like a thread throughout the analysis was that participants conceptualised and experienced therapeutic ruptures and repairs as essentially relational acts, carrying relational meaning, and bearing relational consequences. This is a conclusion that has been vastly lost in existing quantitative and, to some extent, qualitative research. And yet, through IPA's commitment to phenomenology, idiography and hermeneutics, it was somehow enabled to come to the surface, validating the claim that experience is contingent upon the existence of others and that the nature of our engagement with the world is essentially intersubjective, meaning shared, overlapping and relational (Smith et al., 2009). These findings could not have been more compatible with the values and ethos of Counselling Psychology that emphasises subjectivity and intersubjectivity, proclaims empathy and respect for subjective experience, and privileges practice-led research that can in turn inform professional practice (BPS, 2005).

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Appendices

Appendix 1 - Interview Schedule



1. What is the role of the therapeutic relationship in your work with clients?
Prompt: What about the alliance?
2. How would you define a rupture in the therapeutic alliance?
3. Could you recall and describe a rupture with a client (or more) that might have ended successfully or unsuccessfully?
Prompts: At which phase of therapy was it manifested?
What were you working on at the time?
In what way/ form was the rupture manifested?
4. How did you experience the rupture?
Prompts: cognitively, emotionally, bodily, interpersonally?
5. How did you make sense of the rupture?
Prompts: cognitively, emotionally, interpersonally?
6. In what way(s) do you think that you and the client may have contributed to the rupture?
7. How did you process and manage the rupture within the therapeutic relationship?
8. In what ways did the rupture impact (positively or negatively) upon psychotherapy relationship, process and outcome?
9. How did you experience the rupture resolution or non-resolution?
10. What have you learnt from the experience?
Prompts: self, client, process?
11. What would you have done differently?
12. Is there anything else you would wish to add?

Appendix 2 - Recruitment Information



I am a Chartered Counselling Psychologist currently conducting a DPsych (top-up) in Counselling Psychology at City University London, Department of Psychology, and I would like to invite you to take part in my postgraduate research project entitled “Rupture and Repair in the Therapeutic Relationship”.

The research project aims to investigate counselling psychologists’ experiences of managing and repairing ruptures within the therapeutic alliance, as well as to examine ruptures’ implications upon the therapeutic relationship, process and outcome.

I am looking for chartered counselling psychologists with a minimum of two years of clinical experience (post-chartership) who offer open-ended or time-limited therapy (minimum 15 sessions) within their private practice or workplace. Potential participants may be from various theoretical orientations but must be receiving ongoing clinical supervision for their practice.

Should you decide to take part, you will be asked to describe your experiences of processing and managing ruptures within the therapeutic relationship in an individual, semi-structured, audio-recorded interview, which will last approximately 60 minutes.

If you are interested in taking part or if you have any queries regarding the research project, you can contact me or my supervisor via the e-mail addresses or on the telephone numbers provided below.

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This study has been reviewed by, and received ethics clearance through the Ethics Committee of City University, London. If you would like to complain about any aspect of the study, please contact the Secretary to the University’s Senate Research Ethics Committee on 020 7040 3040 or via email: Anna.Ramberg.1@city.ac.uk

I would like to thank you in advance for your time and help.

Appendix 3 - Participant Information Sheet



Title of study: “Rupture and Repair in the Therapeutic Relationship”

I am a chartered counselling psychologist and would like to invite you to participate in my research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

Purpose of study: The research project is part of a DPsych (top-up) in Counselling Psychology and is expected to be completed within a year and a half. The role and impact of a positive therapeutic relationship on psychotherapy outcome has been vastly documented. However, ruptures in the therapeutic alliance are a common phenomenon and pose marked challenges on the work of psychotherapists. Ruptures have been defined as deteriorations in the collaborative relationship between therapist and client (Safran & Muran, 1996). When successfully resolved, they can contribute to positive treatment outcome and change. When unresolved, they can adversely affect process and outcome often leading to negative feelings and unilateral termination. Therefore, the aim of the proposed research project is to address this question by exploring therapists’ experiences of processing, managing and repairing alliance ruptures.

You have been invited to take part in the present study because you are a chartered counselling psychology with a minimum of two years of clinical experience post-qualification who offers open-ended or time-limited therapy and receives ongoing clinical supervision. The study will include a total of 10 chartered psychologists like yourself.

Participation in the research project is entirely voluntary and it is entirely up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form, however you will still be free to withdraw at any time and without giving a reason.

Should you decide to take part, you will be invited to participate in an individual, semi-structured interview with the researcher. The interview will take place in a quiet room at your workplace or home, at a convenient for you time and date, and will last approximately 90 minutes (including the introductory and debriefing phase). The interview will be audio-recorded and subsequently transcribed verbatim. The data collected will be then analysed using Interpretative Phenomenological Analysis

In the beginning of your meeting with the researcher, you will be informed verbally on the nature and aims of the research project and you will be encouraged to ask questions

and clarifications. During the interview, you will be asked to answer a series of open-ended questions posed by the researcher as clearly and openly as possible. Upon the interview's completion, you will be asked to fill in a short Monitoring Form with some demographic details. Subsequently, the researcher will debrief you (both verbally and in writing) on the research project and will encourage you to address possible issues, anxieties or concerns arisen by your participation in the study.

Due to the delicate nature of the research topic, the present study contains a minimum risk of causing you slight psychological and emotional discomfort, as you will be expected to describe difficult times with your clients. In such case, you retain the right to decline answering questions which are experienced as too personal or intrusive, as well as to withdraw from the interview process at any time without having to provide any explanation. Should you experience any sort of anxiety or discomfort, you will be given the opportunity to discuss this with the researcher and will be also strongly encouraged to address them with your supervisor and/ or therapist.

If you decide to take part in the research project, you will be hopefully provided with the opportunity to think reflectively and meaningfully on the therapeutic relationship with your clients. Your participation will also contribute to shedding further light into the ways counselling psychologists experience, manage and repair ruptures in the therapeutic relationship. An exploration of types of ruptures and ways of reparation within the therapeutic relationship holds significant clinical implications for psychologists, psychotherapists and counsellors, as it could clarify ways of identifying, working through and overcoming ruptures, in order to strengthen the therapeutic relationship, increase therapeutic effectiveness and achieve positive treatment outcome. Furthermore, the proposed research study can also hold significant training implications, as it may further illuminate the ways future counselling psychologists, and practitioners in general, can be trained in ways of establishing, maintaining and repairing the therapeutic alliance. Finally, as the proposed research study focuses on therapists' experiences of ruptures and repairs, it may provide useful insight into specific client and therapist characteristics that may influence the development of the therapeutic relationship, and thus highlight the importance of 'reflexive' practice.

All research data will be handled in accordance with the Data Protection Act 1998. Your identity will only be known to the researcher conducting the study and the audio-recordings produced will only be listened by the researcher herself and possibly by supervisors/ examiners. Interviews will be audio-recorded and subsequently transcribed verbatim, while part of them, with identifying details removed, may be heard or seen by supervisors and examiners. Every effort will be made to ensure confidentiality and safeguard anonymity. However, in accordance with the BPS Conduct of Ethics and Conduct, confidentiality (March 2006) might have to be breached should you disclose material, which raises concerns about potential risk, safety of clients, as well as health and safety of children or vulnerable adults. In such a case, the researcher will raise the issue to her supervisor and may take further action and report it elsewhere. Audio-recordings and transcripts produced will be kept in a locked filing cabinet at a secure place, to which only the researcher will have access. Your personal information data (i.e. those included in the monitoring form) will be kept separately from the raw data, while electronically stored data will be password protected, in order to further safeguard anonymity. In line with the University's policy, all data will be destroyed five years after completion of the study. Transcripts, monitoring forms and personal data will be shredded, electronic data will be deleted, and audio-recordings will be erased.

Results of the research study will be seen by supervisors and examiners for the purposes of the project's evaluation. In addition, they may potentially appear in subsequent publications or a display of the dissertation's copy at the University's library for educational purposes. However, your anonymity will be protected through using a pseudonym when producing the transcripts. Furthermore, sections which could lead either to your (e.g. work setting, agency location), or your clients mentioned in the interview identification will be excluded from presentation. In order to ensure your anonymity, you are specifically instructed to avoid using details, which could possibly lead to your personal or clients' identification by others. Should you wish to receive a copy of the completed research project and/ or a copy of a potential future publication, you may state it to the debriefing phase.

Your participation is entirely voluntary and you can choose not to participate in part or all of the project, as well as to withdraw at any stage of the project, up to the point that the analysis has been finalised, without having to give any reason and without being penalised or disadvantaged in any way.

If you have any problems, concerns or questions about this study, you should ask to speak to the researcher or her supervisor at the contact details provided below:

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Crete
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If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: "Rupture and Repair in the Therapeutic Relationship". You could also write to the Secretary at:

Anna Ramberg
Secretary to Senate Research Ethics Committee
Research Office, E214
City University London
Northampton Square

Appendix 4 - Participant Consent Form



Research Title: “Rupture and Repair in the Therapeutic Relationship”

I have been asked and I have agreed to take part in the above City University London research project. I have had the project explained to me, and I have read the Participant Information Sheet, which I know I may keep for my records.

I understand that consenting to participate in the research project means that I am willing to take part in a 60 minute, individual, semi-structured interview, which will be audio-recorded and subsequently transcribed. I agree to the interview being conducted in a quiet and safe room at my home or workplace, in order to safeguard confidentiality and allow sound conduct of the process.

I appreciate that the audio-recordings and transcripts produced will be kept in a secure place, to which only the researcher will have access. The recordings produced will only be listened to by the researcher herself and possibly by supervisors/ examiners within the institution and will be destroyed upon successful submission of the research project to the Examination Board. Similarly, extracts of the transcripts, with identifying details removed, may also be seen by supervisor/examiners and potentially appear in subsequent publications arising from the study. However, transcript sections, which could lead to my personal identification, as well as clients’ identification mentioned in the interview will be excluded from presentation and will not be disclosed in any reports on the project, or to any other party. I have been also informed that I will be given a transcript of data concerning me for my approval before it is included in the write-up of the research.

I understand that any information I provide is confidential, however, in accordance with the BPS Conduct of Ethics and Conduct (March 2006) confidentiality might have to be breached upon disclosure of material, which raises concerns about potential risk, clients’ safety, as well as health and safety of children or vulnerable adults. I confirm that I have been advised against disclosing such information, which could require from the researcher to take further action.

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project, up to the point that the analysis has been finalised, without having to give any reason and without being penalised or disadvantaged in any way.

I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purposes set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998. Acknowledging this I am willing to take part in the above study.

Participant's Name:

Participant's Signature:

Researcher's Name:

Researcher's Signature:

Date:

Researcher: Angelika Apostolopoulou
School of Arts and Social Sciences
Department of Psychology
City University
Northampton Square
London
EC1 0HB
E-mail: Angeliki.Apostolopoulou.1@city.ac.uk

Supervisor: Dr Akis Giovazolias
School of Social Sciences
Department of Psychology
University of Crete
Gallos Campus
Rethymnon 74100
Crete
E-mail: giovazot@uoc.gr

Appendix 5 - Participant Debriefing Information



Thank you for taking part in this research project, which aims to investigate chartered counselling psychologists' experiences of processing, managing and repairing ruptures within the therapeutic relationship.

Previous research has shown that ruptures in the therapeutic alliance are a common phenomenon and pose marked challenges on the work of psychotherapists. When ruptures are resolved successfully, they can contribute to positive treatment outcome and change. When unresolved, they can adversely affect process and outcome often leading to negative feelings and unilateral termination. Taking into account the distinct role of the therapeutic relationship in the discipline of Counselling Psychology the present research project aims to shed light upon counselling psychologists' subjective experiences of ruptures, and the unique ways practitioners employ in order to manage and overcome them. Particularly within the 'reflective practitioner' paradigm, notions of therapist reflexivity and relationship dynamics gain paramount importance. It is therefore maintained that the ability to reflect upon and successfully manage alliance ruptures may enhance counselling psychologists' skills and efficacy, optimise treatment outcome and safeguard clients' well-being.

I hope you have enjoyed taking part in this study. Please feel free to ask questions that might have arisen by your participation in the study. Should you wish to know more about the outcome of this study or wish to obtain a copy of a potential publication arising from it, please do not hesitate to contact the researcher at the contact details mentioned below.

Researcher: Angelika Apostolopoulou
School of Arts and Social Sciences
Department of Psychology
City University
Northampton Square
London
EC1 0HB
E-mail: Angeliki.Apostolopoulou.1@city.ac.uk

Supervisor: Dr Akis Giovazolias
School of Social Sciences
Department of Psychology
University of Crete
Gallos Campus
Rethymnon 74100
Crete
E-mail: giovazot@uoc.gr

In addition, should you feel you have been affected by any issues raised during your participation in the study, you might wish to address it with your personal supervisor and/ or therapist, or contact one of the organisations listed below:

British Association for Counselling and Psychotherapy

Tel: 01455 883300. Website: www.itsgoodtotalk.org.uk

British Community Advice and Listening Line (C.A.L.L.) - Helpline

Tel: 0800 132 737. Website: www.callhelpline.org.uk

Samaritans - Helpline

Tel: 08457 909090. Website: www.samaritans.org

Aeginiteio SOS Line - Helpline

Tel: 210 7222333 (3:00 p.m.-11:00 p.m.). Website: www.eginitio.gr

Appendix 6 - Participant Monitoring Form



Please, fill in the information below for monitoring purposes.

Name:

Age:

Gender:

Therapeutic Orientation:

Nationality:

Ethnicity:

Professional Post:

Years of Professional Experience (post-chartership):

Appendix 7 - Ethics Application Form



Senate Research Ethics Committee Application for Approval of Research Involving Human Participants

Please tick the box for which Committee you are submitting your application to

<input type="checkbox"/>	Senate Research Ethics Committee
<input checked="" type="checkbox"/>	School of Arts & School of Social Sciences Research Ethics Committee
<input type="checkbox"/>	School of Community and Health Sciences Research Ethics Committee
<input type="checkbox"/>	Learning Development Centre
<input type="checkbox"/>	Optometry Research Committee

For **Senate** applications: return one original and 17 additional copies of the completed form and any accompanying documents to Anna Ramberg, Secretary to the Senate Research Ethics Committee, City Research Development and International Relations Office, Northampton Square, London, EC1V 0HB.

For **School of Arts & School of Social Sciences** Research Ethics Committee submit a single copy of the application form and all supporting documentation to [Andrea Tinson](#) (Social Sciences) and [Gail Marsom](#) (Arts) by email.

For **School of Community and Health Sciences** applications: submit all forms (including the Research Registration form) electronically (in Word format in a single document) to A.Welton@city.ac.uk, followed up by a single hard copy with signatures.

For **Optometry** applications: submit A SINGLE COPY OF THE APPLICATION FORM AND ALL SUPPORTING DOCUMENTATION to [Ron Douglas](#) by email.

Refer to the separate [guidelines](#) while completing this form.

PLEASE NOTE

- Please determine whether an application is required by going through the [checklist](#) before filling out this form.
- Ethical approval **MUST** be obtained before any research involving human participants is undertaken. Failure to do so may result in disciplinary procedures being instigated, and you will not be covered by the University's indemnity if you do not have approval in place.
- You should have completed every section of the form
- The Signature Sections must be completed by the Principal Investigator (the supervisor and the student if it is a student project)

Project Title:
"Rupture and Repair in the Therapeutic Relationship: An Interpretative Phenomenological Analysis"
Short Project Title (no more than 80 characters):
"Rupture and Repair in the Therapeutic Relationship"
Name of Principal Investigator(s) (all students are required to apply jointly with their supervisor and all correspondence will be with the supervisor):
Angeliki Apostolopoulou

Post Held (including staff/student number):
Research Student, Student Number: 050029610
Department(s)/School(s) involved at City University:
Department of Psychology, School of Arts and Social Sciences.
If this is part of a degree please specify type of degree and year
DPsych (Top-Up) in Counselling Psychology.
Date of Submission of Application:
20/03/2014

1. Information for Non-Experts

Lay Title (no more than 80 characters)

"Rupture and Repair in the Therapeutic Relationship"
--

Lay Summary / Plain Language Statement (no more than 400 words)

<p>The role and impact of a positive therapeutic relationship on psychotherapy outcome has been vastly documented. However, ruptures in the therapeutic alliance are a common phenomenon and pose marked challenges on the work of psychotherapists. When ruptures are resolved successfully, they can contribute to positive treatment outcome and change. When unresolved, they can adversely affect process and outcome often leading to negative feelings and unilateral termination. The aim of the proposed research project is to address this question by exploring therapists' experiences of processing, managing and repairing alliance ruptures. Ten semi-structured interviews with chartered counselling psychologists of various therapeutic orientations will be conducted, and subsequently analysed using Interpretative Phenomenological Analysis. The proposed research project will be examined in relation to existing literature and the implications for the practice, training, and research of Counselling Psychology will be discussed.</p>
--

2. Applicant Details

This project involves:

(tick as many as apply)

<input type="checkbox"/>	Staff Research	<input checked="" type="checkbox"/>	Research Student
<input type="checkbox"/>	Undergraduate	<input type="checkbox"/>	M-level Project
<input type="checkbox"/>	Externally funded	<input type="checkbox"/>	External investigators
<input type="checkbox"/>	Collaboration	<input type="checkbox"/>	Other
Provide details of collaboration and/or other			

Address for correspondence (including email address and telephone number)

(Principal Investigator)

<p>10 Amazonon Str., P.Faliro 175 63, Athens, Greece Tel No: (0030) 210 9835581/ (0030) 6937690260 E-mail: Angeliki.Apostolopoulou.1@city.ac.uk / angelika_apostolopoulou@hotmail.com</p>
--

Other staff members involved

<i>Title, Name & Staff Number</i>	<i>Post</i>	<i>Dept & School</i>	<i>Phone</i>	<i>Email</i>
Professor Carla Willig	Professor in Psychology	School of Arts & Social Sciences Department of Psychology City University	(0044) 02070408522	C.Willig@city.ac.uk
Professor Akis Giovazolias	Assistant Professor in Counselling Psychology	Department of Psychology University of Crete	(0030) 2831077520	giovazot@uoc.gr

All students involved in carrying out the investigation

<i>Name & Student Number</i>	<i>Course / Year</i>	<i>Dept & School</i>	<i>Email</i>
Angelika Apostolopoulou/ 050029610	DPsych (Top-Up) in Counselling Psychology	School of Arts & Social Sciences Department of Psychology	Angeliki.Apostolopoulou.1@city.ac.uk/ angelika_apostolopoulou@hotmail.com

External co-investigators

<i>Title & Name</i>	<i>Post</i>	<i>Institution</i>	<i>Phone</i>	<i>Email</i>

Please describe the role(s) of all the investigators including all student(s)/external co-investigator(s) in the project, especially with regards to interaction with study participants.

Not Applicable.

If external investigators are involved, please provide details of their indemnity cover.

Not Applicable.

Application Details

2.1 Is this application being submitted to another ethics committee, or has it been previously submitted to an ethics committee? *This includes an NHS local Research Ethics Committee or a City University London School Research Ethics Committee or any other institutional committee or collaborating partners or research site. (See the guidelines for more information on research involving NHS staff/patients/ premises.)*

YES NO

If yes, please provide details for the Secretary for the relevant authority/committee, as well as copies of any correspondence setting out conditions of approval.

Not Applicable.

2.2 If any part of the investigation will be carried out under the auspices of an outside organisation, e.g. a teaching hospital, please give details and address of organisation.

Not Applicable.

2.3 Other approvals required – has permission to conduct research in, at or through another institution or organisation been obtained?

YES NO

If yes, please provide details and include correspondence

Not Applicable.

2.4 Is any part of this research project being considered by another research ethics committee? YES NO

If yes, please give details and justification for going to separate committees, and attach correspondence and outcome

Not Applicable.

2.5 Duration of Project

Start date: 20/05/14

Estimated end date: 03/08/15

Funding Details

2.6 Please provide details of the source of financial support (if any) for the proposed investigation.

The proposed investigation will be self-funded.

2.6a Total amount of funding being sought:

Not Applicable

2.6b Has funding been approved?

YES NO

If no, please provide details of when the outcome can be expected

Not Applicable.

2.6c Does the funding body have any requirements regarding retention, access and storage of the data? YES NO

If yes, please provide details

Not Applicable.

3. Project Details

3.1 Provide the background, aim and justification for the proposed research.

Research has repeatedly shown that the therapeutic alliance is the most robust predictor of positive psychotherapy outcome across all treatment modalities (see Horvath & Symonds, 1991; Norcross 2002; Orlinsky, Grawe & Parks, 1994), and that poor alliances are associated with unilateral termination and poor treatment outcome (Horvath & Luborsky, 1993; Samstag, Batchelder, Muran, Safran, & Winston, 1998). Research evidence also suggests that the therapeutic alliance is not a static phenomenon, but rather fluctuates over the course of therapy, even within a particular session (Horvath & Luborsky, 1993; Safran & Muran, 2000). Ruptures in the therapeutic alliance are a common phenomenon and have been defined as deteriorations in the collaborative relationship between therapist and client (Safran & Muran, 1996). If unresolved, ruptures can adversely affect therapy process and outcome, and may lead to premature and unilateral termination. However, if successfully resolved, ruptures can have positive consequences on the therapeutic relationship and process (see Aspland, Llewelyn, Hardy, Barkham & Stiles, 2008; Muran et al., 2005). Specifically, a pattern of deterioration in the alliance followed by an improvement over the course of treatment is generally associated with positive outcome (Kivlighan & Shaughnessy, 2000; Stiles et al., 2004; Strauss et al., 2006).

According to Safran and Muran (2000) ruptures emerge as a result of a misunderstanding event leading to a client marker behaviour that usually takes the form of withdrawal or confrontation. They have therefore proposed a four-stage process model of ruptures resolution which entails attendance to the rupture marker, exploration of the rupture experience, examination of client's avoidance, and exploration of the interpersonal schema (Safran & Muran, 1996). A number of studies have highlighted the significance of clients asserting themselves and expressing negative feelings about the therapy and the therapeutic relationship, and have stressed the importance of therapists' role in exploring ruptures openly and non-defensively, while accepting responsibility for their contribution to the interaction (see Safran, Muran & Eubanks-Carter, 2011; Richards, 2011). Whilst the processing of ruptures is

addressed across all schools of psychotherapy, approaches do vary in the extent to which they acknowledge the centrality of relational work for therapeutic change, as well as therapists' contribution to relationship dynamics (Hill & Knox, 2009).

Taking into account the distinct role of the therapeutic relationship in the discipline of Counselling Psychology the present research project aims to shed light upon counselling psychologists' subjective experiences of ruptures, and the unique ways therapists employ in order to process, manage and overcome them. Particularly within the 'reflective practitioner' paradigm, notions of therapist reflexivity and relationship dynamics gain paramount importance. It is therefore maintained that the ability to reflect upon and successfully manage ruptures in the therapeutic alliance may enhance counselling psychologists' skills and efficacy, optimise treatment outcome and safeguard clients' well-being. Employing a qualitative methodology the present research aims to respond to the identified demand for phenomenological studies that can shed light upon specific factors and mechanisms of change within the therapeutic relationship influencing therapy process and outcome (see Gumz, Brahler, Geyer, Erices, 2012; Hill & Knox, 2009).

Within the context of the reviewed literature, the *research questions* are therefore formulated as follows:

1. How do counselling psychologists conceptualise and define a rupture in the therapeutic relationship?
2. How do therapists experience (cognitively, emotionally, interpersonally), manage and repair ruptures in the therapeutic relationship?
3. In what ways do ruptures impact (positively or negatively) upon psychotherapy relationship process and outcome?

3.2 Provide a summary and brief justification of the design, methodology and plan for analysis that you propose to use.

Design: To address the above questions, the proposed study will employ a qualitative methodology in order to explore counselling psychologists' experiences with ruptures and resolutions within the therapeutic relationship. Specifically, therapists participating in the study will be asked to recall and discuss ruptures in the therapeutic work with specific clients, as well as to discuss the way they impeded upon the therapeutic relationship and outcome. Qualitative analyses of recalled events are generally recommended in the context of research on ruptures and resolutions, as they allow for phenomenological exploration of participants' inner experiences, during relationship processing events, which cannot be captured by quantitative methodologies or through observation of session tapes (see Hill & Knox, 2009).

Participants: The participant sample will consist of ten qualified chartered counselling psychologists of various therapeutic orientations, who have completed BPS-accredited training programmes in the UK.

Procedure: Participants will be recruited through the strategy of *snowballing* and will be subsequently informed by the researcher with regard to the nature and aims of the study, both verbally and in writing. Participants who express a willingness to participate will be then invited to take part in a semi-structured interview lasting approximately an hour. Individual interviews will be conducted at the convenience of the participating counselling psychologists' home or workplace and will be transcribed verbatim. Transcripts will be anonymised and every attempt will be made to safeguard confidentiality, through sensitive and sound treatment of research materials.

Analytic Strategy: Data will be collected through ten semi-structured interviews. Interview questions will be used in an open, semi-structured way, merely as markers aiding the exploration of counselling psychologists' experiences of alliance ruptures and resolutions, and in order to present subject areas for discussion, without constraining or influencing participants' responses (see Hunt & Smith, 2004). As the study aims to explore the subjective perceptions and meanings attached to the therapeutic relationship, ruptures and reparation, participant interviews will be analysed using Interpretative Phenomenological Analysis (IPA) (Smith & Osborn, 2008). IPA is deemed as an appropriate methodology as it provides the researcher with an 'insider's perspective' (Conrad, 1987) into participants' inner experience and acknowledges the dynamic, interpretative interplay between researcher and participant in the meaning-making process (Smith & Osborn, 2003; Smith & Eatough, 2006). It is proposed that a quantitative study or a qualitative study of a different methodology would not fully capture the richness and breadth of participants' inner experiences during an 'alliance rupture' event,

as well as to adequately illuminate specific factors and meaning-making processes that take place within the therapeutic relationship influencing psychotherapy process and outcome. Finally, IPA is deemed as an ideal methodology for the proposed study as it seems consistent with the ethos and humanistic values of counselling psychology whilst requiring rigour and analytical skills of a high standard. Given the reflexive emphasis of IPA it is worth briefly acknowledging that the researcher is a Greek BPS-chartered and HPC-registered counselling psychologist, working in private practice. The implications of her personal experiences and relationship with the topic will be addressed extensively within the research project itself.

3.3 Please explain your plans for dissemination, including whether participants will be provided with any information on the findings or outcomes of the project.

Due to its emphasis on the therapeutic relationship and its sample consisting of chartered counselling psychologists, the present research could seek publication in both a UK journal such as the *Counselling Psychology Review* and/ or a European/ international counselling psychology journal, such as the *European Journal of Psychotherapy and Counselling*, in order to raise awareness and promote further research on the ways counselling psychologists experience, manage and overcome ruptures in the therapeutic relationship. In addition, it could be presented in conferences as well as academic settings, in order to provide food for thought, promote dialogue and encourage collaboration among counselling psychologists and other mental health practitioners (trainees, researchers and clinicians alike). Hopefully the present research, along with similar studies in the field, could constitute a useful tool in the development of future professional and training guidelines regarding the successful management of ruptures within the therapeutic relationship, in order to enhance therapeutic outcome and positive client change. Information on the findings and outcomes of the project will be also made available to participants, should they require so. Specifically, during the debriefing phase, participants will be encouraged, both verbally and in writing, to contact the researcher should they wish to know more about the outcomes of the study.

3.4 What do you consider are the ethical issues associated with conducting this research and how do you propose to address them?

It is worth acknowledging and highlighting the rather delicate nature of the research topic. Participants will be asked to expose themselves and discuss possible difficulties and 'failures' in their work with clients, and that calls for sensitive and thoughtful handling. Not surprisingly, both quantitative and qualitative studies investigating similar topics have yielded rather low response rates. This can be further exacerbated by the fact that participants will share the same professional capacity with the researcher (i.e. chartered counselling psychologists). Participants will therefore be given the opportunity to discuss this issue with the researcher, and will be informed of their right to decline answering any of the questions and to withdraw from the study at any time, up to the point that the analysis had been finalised, without any further explanation. Every effort will be made to ensure that participants understand that all personal information mentioned in the study will remain strictly confidential and anonymous and will be instructed to avoid using details, which can lead to their identification. Lastly, every attempt will be made to safeguard confidentiality, through sensitive and sound treatment of the material, as well as safe and responsible storage of audio recordings transcripts, and monitoring forms consisting participants' demographic information.

3.5 How is the research intended to benefit the participants, third parties and/or local community?

The proposed study aims to explore counselling psychologists' experiences of managing and repairing ruptures within the therapeutic relationship. It can thus contribute to the growing amount of existing research that demonstrates the unequivocal association of the therapeutic alliance and positive psychotherapy outcome. An exploration of types of ruptures and ways of reparation within the therapeutic relationship can also hold significant clinical implications for psychologists, psychotherapists and counsellors. It could clarify ways of identifying, working through and overcoming ruptures, in order to strengthen the therapeutic relationship, increase therapeutic effectiveness and achieve positive treatment outcome. Furthermore, as the proposed research study focuses on therapists' experiences of ruptures and repairs, it may

provide useful insight into specific client and therapist characteristics that may influence the development of the therapeutic relationship, and thus highlight the importance of 'reflexive' practice. The proposed research study can also hold significant training implications. Given the paramount role of the therapeutic relationship in the discipline of Counselling Psychology, in combination with the identified difficulty of training therapists in learning relational skills (see Crits-Cristoph et al., 2006; Henry et al., 1996), it becomes crucial for future counselling psychologists and practitioners in general to be trained in ways of establishing, maintaining and repairing the therapeutic alliance (see Hill & Knox, 2009).

3.6a Will invasive procedures (for example medical or surgical) be used?

YES NO

3.6b If yes, what precautions will you take to minimise any potential harm?

Not applicable.

3.7a Will intrusive procedures (for example psychological or social) be used?

YES NO

3.7b If yes, what precautions will you take to minimise any potential harm?

Not applicable. The proposed research project does not involve any source of participant manipulation, coercion or deception.

3.8a In the course of the investigation might pain, discomfort (including psychological discomfort), inconvenience or danger be caused?

YES NO

3.8b If yes, what precautions will you take to minimise any potential harm?

Participants will be informed from the beginning, both verbally and in writing, that they have the right to decline to answer any questions put to them during the interview and that they can withdraw from the study at any time, up to the point that the analysis has been finalised, without having to give any reason and without being penalised or disadvantaged in any way. In addition, in the briefing session, participants will be given the opportunity to explore with the researcher the implications arising from their participation in this study. Lastly, participants will be experienced therapists, who have undergone personal therapy and attend regular supervision. They will be strongly encouraged to address possible concerns or discomfort arisen by their participation in the research project with their therapists, supervisors, as well as with the researcher herself and/ or her external supervisor.

3.9 Please describe the nature, duration and frequency of the procedures?

Participants will be required to participate in a one-to-one, semi-structured interview lasting approximately 60 minutes. The whole procedure, including the introductory and debriefing phase, as well as the filling of the relevant monitoring form with participants' demographic details (please see relevant form in Section 11), is expected to last approximately 90 minutes.

4. Information on participants

4.1a How many participants will be involved?

The participant sample will consist of ten qualified chartered counselling psychologists.

4.1b What is the age group and gender of the participants?

There will be no particular age range or gender specification.

4.1c Explain how you will determine your sample size and the selection criteria you will be using. Specify inclusion and exclusion criteria. If exclusion of participants is made on

the basis of age, gender, ethnicity, race, disability, sexuality, religion or any other factor, please explain and justify why.

The sample will consist of ten qualified chartered counselling psychologists of various therapeutic orientations. According to Smith, Flowers and Larkin (2009) a range between four and ten participant interviews seems appropriate when conducting Interpretative Phenomenological Analysis for professional doctorate programmes. Participants will have completed BPS-accredited training programmes in the UK and have been practicing in different settings, such as the registered charities, private organisations and private practice. In accordance with the principles of IPA, the sample will be purposive and homogeneous in terms of professional training and academic qualifications, as the research questions must hold personal significance and relevance for participants (Smith & Eatough, 2006). However, the sample will be fairly heterogeneous in terms of participants' therapeutic orientation and professional post mirroring the diversity of counselling psychologists, and thus increasing sample's representativeness. A minimum of two years of clinical experience post-chartership will be required for participation in the present study, in order to ensure that participants have gained sufficient experience in working relationally with clients. Participants will be also required to be engaged in ongoing supervision due to the delicate nature of the proposed project and the possible emotional disturbance that may arise by their participation in the study. Furthermore, participants will be recruited from settings where they provide time-limited (e.g. minimum 15 sessions) or open-ended therapy. It is postulated that although alliance ruptures may manifest relatively early in therapy often leading to premature dropout within the first few sessions of treatment (see Muran et al., 2009), they require a substantial period of time to be managed and resolved. Consequently, participants working in an NHS setting will be excluded from participation in the proposed study, as the type of treatment offered is mainly short-term.

4.2 How are the participants to be identified, approached and recruited, and by whom?

Consistently with the principles of Interpretative Phenomenological Analysis, sampling will be purposive rather than probabilistic (see Smith, Flowers & Larkin, 2003), as the proposed study aims to investigate and illuminate participants' experiences of the phenomenon under investigation. Participants will therefore be contacted via *snowballing*; Snowballing is a sampling strategy where identified respondents are then used to refer researchers on to other respondents. It is particularly advantageous for descriptive, exploratory, qualitative studies that are primarily conducted through interviews (Hendricks, Blanken & Adriaans, 1992). Snowball sampling is a method for obtaining research participants who are hard to reach or where a substantial amount of trust is required to initiate contact (see Atkinson & Flint, 2001). Due to the delicate nature of the research topic (where participants are going to be invited to discuss difficult times with clients that may have been successfully or unsuccessfully) and taking into account the relative low response that similar studies have yielded, snowballing seems like an appropriate sampling strategy; it will provide access to an eligible sample of participants who may feel more comfortable and trusting towards the researcher, as referrals will have been made by peers or acquaintances. Participants, who express an initial interest and willingness to participate, will subsequently be approached individually by the researcher and will be informed with regard to the nature and aims of the study, both verbally and in writing through a Participant Information Sheet. They will also be encouraged to ask questions regarding the purposes and implications of the project. Caution will be taken, in order for participants not to feel obliged to take part in the study, due to the relationship with the respondent who initially referred them to the researcher. In particular, participants will be informed that they have the right to decline to participate in the research project or that in case they agree to participate, they can withdraw their consent at any time up to the point that the analysis has been finalised without being penalised or disadvantaged in any way.

4.3 Describe the procedure that will be used when seeking and obtaining consent, including when consent will be obtained. Include details of who will obtain the consent, how are you intending to arrange for a copy of the signed consent form for the participants, when will they receive it and how long the participants have between receiving information about the study and giving consent.

Respondents, who have read the Participant Information Sheet and express a willingness to take part in the proposed research study, will subsequently be provided by the researcher with

two copies of an Informed Consent Form, explaining to them confidentiality issues, right for withdrawal, handling of the material, as well as ethical implications arising from the conduct of the study. They will be subsequently asked to read carefully, sign and return one copy of the Informed Consent Form within a week. Participants who sign and return their forms will be then invited to take part in a semi-structured interview lasting approximately 60 minutes.

4.4 How will the participant's physical and mental suitability for participation be assessed?

Participants will be experienced counselling psychologists who have completed or are still engaged in personal therapy, and receive ongoing supervision. It is therefore assumed that they will be physically and mentally suitable to participate in the study. Should concerns be raised during their involvement in the interview process, they will be offered the opportunity to explore possible concerns with the researcher and they will be also encouraged to address them with their supervisor and/ or therapist. Consequently, they will be exempted from the proposed research study.

4.5 Are there any special pressures that might make it difficult to refuse to take part in the study? Are any of the potential participants in a dependent relationship with any of the investigators (for instance student, colleague or employee) particularly those involved in recruiting for or conducting the project?

One possible pressure that might make it difficult for participants to refuse to take part in the study could be the shared professional identity with the researcher (i.e. chartered counselling psychologists). However, the invitation for participation in the study will not be addressed to them personally, but rather through the method of snowballing. They will therefore be given the right to decline participation whilst maintaining their anonymity. Another source of pressure could be the participants' relationship with the respondent who initially referred them to the researcher, as they may not find it socially desirable to refuse to take part. In both cases, should participants decide to take part in the study, they will be given the opportunity to explore the working relationship with the researcher, they will be reassured that refusal to participate will not affect the work relationship in any way, and they will be explicitly informed of their right to decline to answer any questions put to them and to withdraw from the study at any time (up to the point that the analysis has been finalised) without being disadvantaged or penalised in any way.

4.6 Are there any issues related to the ability of participants to give informed consent themselves or are you relying on gatekeepers on their behalf?

There are no issues of participants' ability to give informed consent themselves.

4.7 Will the participant's doctor be notified?

YES NO

(If so, provide a sample letter to the subject's GP.)

4.8 What procedures are in place for the appropriate referral of a study participant who discloses an emotional, psychological, health, education or other issue during the course of the research or is identified by the researcher to have such a need?

During the briefing session, participants will be given the opportunity to explore the working relationship between themselves and the researcher, as well as the implications arising from for their participation in this study. In addition, at the conclusion of their participation, they will be fully debriefed and will be encouraged to ask questions around the nature and outcome of the research. Should participants disclose or should the researcher identify a particular emotional, psychological or practical need, participants will be offered the opportunity to explore their issue with the researcher in an open and supportive way. Furthermore, all participants will be given a debriefing sheet providing them with the researcher's and supervisor's contact details, as well as a list of professional organisations they can turn to

should they wish to address questions, anxieties or concerns arisen from the study. They will also be strongly encouraged to share them with their own supervisors and/ or therapists.

4.9 What steps will be taken to safeguard the participants from over-research? (I.e. to ensure that the participants are not being used in multiple research project.)

The proposed research project will not be particularly time-consuming for participants, as they will only be required to take part in one semi-structured interview lasting approximately 90 minutes (including introductory and debriefing phases). Nevertheless, participants will be asked on whether they are engaged in another research project, as well as on their emotional and practical availability. Participants with a heavy workload and/ or other research obligations will be strongly encouraged to take into account their various commitments before deciding to give their final consent for participation in the study. Emphasis will be given on participants' right to decline participation in the research project and sufficient time will be dedicated in explaining to them (both verbally and in writing) the nature of the research project, as well as the level of commitment required by them. The duration of the interview process, including the introductory and debriefing phase, will be clearly explained and punctually kept.

4.10 Where will the research take place?

The research will take place in a quiet room at participants' workplace, private practice or home at a convenient for them date and time.

4.11 What health and safety issues, if any, are there to consider?

There are no significant health and safety issues. Interviews will be conducted at participants' home, private practice or workplace, where it is assumed that health and safety policies are sufficiently met. In order to safeguard the researcher's safety, in the case where interviews take place at participants' home or private office, the researcher will have provided her supervisor with a sealed envelope containing participant's address. The supervisor will be specifically instructed to only open the envelope, if the researcher has not contacted him at an agreed time following interview completion, so he can check her whereabouts and well-being.

4.12 How have you addressed the health and safety concerns of the participants, researchers and any other people impacted by this study? Have you conducted a risk assessment?

Not applicable.

4.13 Are you offering any incentives or rewards for participating? YES NO

If yes please give details

Not applicable.

5. Vulnerable groups

5.1 Will persons from any of the following groups be participating in the study? (if not go to section 6)

Adults without capacity to consent	<input type="checkbox"/>
Children under the age of 18	<input type="checkbox"/>
Those with learning disabilities	<input type="checkbox"/>
Prisoners	<input type="checkbox"/>
Vulnerable adults	<input type="checkbox"/>
Young offenders (16-21 years)	<input type="checkbox"/>
Those who would be considered to have a particular dependent relationship with the investigator (e.g. those in care homes, students, employees, colleagues)	<input type="checkbox"/>

5.2 Please provide your ISA number

5.3 Will you be recruiting or have direct contact with any children under the age of 18?
 YES NO

5.3a If yes, please give details of the child protection procedures you propose to adopt should there be any evidence of or suspicion of harm (physical, emotional or sexual) to a young person. Include a referral protocol identifying what to do and who should be contacted.

5.3b Please give details of how you propose to ensure the well-being of the young person, particularly with respect to ensuring that they do not feel pressured to take part in the research and that they are free to withdraw from the study without any prejudice to themselves at anytime.

5.3c Please give details of any City staff or students who will have contact with young people (under the age of 18) and details of current (within the last 3 years) enhanced City University CRB clearance.

<i>Name</i>	<i>Dept & School</i>	<i>Student/Staff Number</i>	<i>Date of CRB disclosure</i>	<i>Type of disclosure</i>

5.3d Please give details of any non-City staff or students who will have contact with young people (under the age of 18) and details of current (within the last 1 year) enhanced CRB clearance.

<i>Name</i>	<i>Institution</i>	<i>Address of organisation that requested the disclosure</i>	<i>Date of CRB disclosure</i>	<i>Type of disclosure</i>

5.4 Will you be recruiting or have direct contact with vulnerable adults? YES NO

5.4a If yes, please give details of the protection procedures you propose to adopt should there be any evidence of or suspicion of harm (physical, emotional or sexual) to a vulnerable adult. Include a referral protocol identifying what to do and who should be contacted.

5.4b Please give details of how you propose to ensure the well-being of the vulnerable adult, particularly with respect to ensuring that they do not feel pressured to take part in the research and that they are free to withdraw from the study without any prejudice to themselves at anytime. You should indicate how you intend to ascertain that person's views and wishes.

5.4c Please give details of any City staff or students who will have contact with vulnerable adults and details of current (within the last 3 years) enhanced City University CRB clearance.

Name	Dept & School	Student/Staff Number	Date of CRB disclosure	Type of disclosure

5.4d Please give details of any non-City staff or students who will have contact with vulnerable adults and details of current (within the last 1 year) enhanced CRB clearance.

Name	Institution	Address of organisation that requested the disclosure	Date of CRB disclosure	Type of disclosure

5.5 Will you be recruiting any participants who fall under the Mental Capacity Act 2005?
YES NO

If so you MUST get approval from an NHS COREC approved committee (see separate guidelines for more information).

6. Data Collection

6.1a Please indicate which of the following you will be using to collect your data

Please tick all that apply

Questionnaire	<input type="checkbox"/>
Interviews	<input checked="" type="checkbox"/>
Participant observation	<input type="checkbox"/>
Focus groups	<input type="checkbox"/>
Audio/digital-recording interviewees or events	<input checked="" type="checkbox"/>
Video recording	<input type="checkbox"/>
Physiological measurements	<input type="checkbox"/>
Quantitative research (please provide details)	<input type="checkbox"/>
Other	<input type="checkbox"/>
Please give details	

6.1b What steps, if any, will be taken to safeguard the confidentiality of the participants (including companies)?

Interviews will take place in a quiet room of participants' workplace, private practice or home, while all research data will be handled in accordance with the Data Protection Act (1998). Participants' identity will only be known to the researcher conducting the study and the audio-recordings produced will only be listened by the researcher herself and possibly by supervisors/examiners. Participants will be made fully aware that the interviews will be audio-recorded and subsequently transcribed. They will also be made aware that the audio-recordings, as well as the transcripts, with identifying details removed, may be heard or seen by supervisors and examiners, while extracts from the interviews may potentially appear in subsequent publications or a display of the dissertation's copy at the University's library for educational purposes. In any case, the anonymity of the participants will be protected through using a pseudonym when labelling the recording, as well as when producing the transcripts. Furthermore, transcript sections, which could lead to the identification of participants (e.g. work setting, agency location), as well as participants' clients mentioned in the interview will be excluded from presentation. In order to ensure clients' anonymity, participants will be specifically instructed to avoid using details, which could possibly lead to clients' identification by others. However, participants will also be notified that, in accordance with the BPS Conduct of Ethics and Conduct (2006), confidentiality might have to be breached should participants disclose material, which raises concerns about potential risk, safety of clients, as well as health and safety of children or vulnerable adults. In such a case, the researcher will raise the issue to the supervisor, and may have to take further action and report it elsewhere, such as the University's or the BPS's Ethics Committee. Audio-recordings and transcripts produced will be

kept in a locked filing cabinet at secure place, to which only the researcher will have access. Participants' personal information data (i.e. those included in the monitoring form) will be kept separately from the raw data, in order to further safeguard anonymity. In addition, electronically stored data (e.g. transcripts and researcher's personal notes) will be password protected. All data will be destroyed upon completion of the study.

6.1c If you are using interviews or focus groups, please provide a topic guide

Data will be collected through individual, semi-structured interviews, consisting of four open-ended questions created by the researcher. Consistent with IPA recommendations, interviews will open with more general questions and gently move on to the more specific subjects under investigation, in order to make respondents feel more at ease and to begin establishing trust and rapport (Smith & Eatough, 2006). Interjections by the interviewer to clarify points or facilitate conversation will also be encouraged. The *interview questions* are formulated as follows:

1. What is the role of the therapeutic relationship in your work with clients?
2. How would you define a rupture in the therapeutic relationship?
3. Could you recall and describe a relationship rupture with a client (or more) that might have ended successfully or unsuccessfully?
4. How did you experience (cognitively, emotionally, interpersonally) the rupture?
5. How did you process and manage the rupture in the therapeutic relationship?
6. In what ways did the rupture impact (positively or negatively) upon psychotherapy relationship, process and outcome?

7. Confidentiality and Data Handling

7.1a Will the research involve:

• complete anonymity of participants (i.e. researchers will not meet, or know the identity of participants, as participants are a part of a random sample and are required to return responses with no form of personal identification)?	<input type="checkbox"/>
• anonymised sample or data (i.e. an <i>irreversible</i> process whereby identifiers are removed from data and replaced by a code, with no record retained of how the code relates to the identifiers. It is then impossible to identify the individual to whom the sample of information relates)?	<input type="checkbox"/>
• de-identified samples or data (i.e. a <i>reversible</i> process whereby identifiers are replaced by a code, to which the researcher retains the key, in a secure location)?	<input checked="" type="checkbox"/>
• subjects being referred to by pseudonym in any publication arising from the research?	<input checked="" type="checkbox"/>
• any other method of protecting the privacy of participants? (e.g. use of direct quotes with specific permission only; use of real name with specific, written permission only)	<input checked="" type="checkbox"/>
Please give details of 'any other method of protecting the privacy of participants' is used	
Use of direct quotes with permission only, omission of transcript sections that may lead to participants' or clients' identification	

7.1b Which of the following methods of assuring confidentiality of data will be implemented?

Please tick all that apply

• data to be kept in a locked filing cabinet	<input checked="" type="checkbox"/>
• data and identifiers to be kept in separate, locked filing cabinets	<input checked="" type="checkbox"/>
• access to computer files to be available by password only	<input checked="" type="checkbox"/>
• storage at City University London	<input type="checkbox"/>
• stored at other site	<input checked="" type="checkbox"/>
If stored at another site, please give details	Data will be safely kept at the researcher's private office.

7.1c Who will have access to the data?

Access by named researcher(s) only

YES NO

Access by people other than named researcher(s) YES NO

If people other than the named researcher(s), please explain by whom and for what purpose

Part of the data (e.g. interview extracts) will be also accessed by the researcher's internal and external examiners and supervisors for the purposes of examination.

7.2a Is the data intended for reuse or to be shared as part of longitudinal research?

YES NO

7.2b Is the data intended for reuse or to be shared as part of a different/wider research project now, or in the future?

YES NO

7.2c Does the funding body (e.g. ESRC) require that the data be stored and made available for reuse/sharing?

YES NO

7.2d If you have responded yes to any of the questions above, explain how you are intending to obtain explicit consent for the reuse and/or sharing of the data.

Not applicable.

7.3 Retention and Destruction of Data

7.3a Does the funding body or your professional organisation/affiliation place obligations or recommendations on the retention and destruction of research data?

YES NO

If yes, what are your affiliations/funding and what are the requirements? (If no, please refer to University guidelines on retention.)

7.3b How long are you intending to keep the data?

According to the University's policy on data retention, audio-recordings and transcripts produced will be kept for 5 years after the successful completion and submission of the research study.

7.3c How are you intending to destroy the data after this period?

Transcripts, monitoring forms, researcher's notes will be shredded, audio-recordings will be erased and electronic files will be deleted.

8. Curriculum Vitae

CV OF APPLICANTS (Please duplicate this page for each applicant, including external persons and students involved.)

[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]


[REDACTED]

8.1 Supervisor's statement on the student's skills and ability to carry out the proposed research, as well as the merits of the research topic (up to 500 words)

The researcher has completed postgraduate studies (at MSc level) in the Counselling Psychology field. She is also a Greek BPS-chartered and HPC-registered counselling

psychologist, working in private practice and lecturing at postgraduate level. Her extensive professional experience combined with her previous involvement with qualitative research (having already published piece of her work), verify her competence in conducting this research project.

The topic itself has great merit as it focuses on core issues of the counselling psychology practice (i.e. therapeutic relationship), aiming to provide further understanding to an under-researched element (i.e. a 'difficult' occurrence in the process). Using a sound methodological / analytical approach (IPA) the researcher also abides to the scientist-practitioner model, offering a scientific framework in the study of therapeutic relationship.

Supervisor's Signature	
Print Name	Theodoros Giovazolias

9. Participant Information Sheet



CITY UNIVERSITY
LONDON

Participant Information Sheet

Title of study: "Rupture and Repair in the Therapeutic Relationship"

I am a chartered counselling psychologist and would like to invite you to participate in my research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

Purpose of study: The research project is part of a DPsych (top-up) in Counselling Psychology and is expected to be completed within a year and a half. The role and impact of a positive therapeutic relationship on psychotherapy outcome has been vastly documented. However, ruptures in the therapeutic alliance are a common phenomenon and pose marked challenges on the work of psychotherapists. Ruptures have been defined as deteriorations in the collaborative relationship between therapist and client (Safran & Muran, 1996). When successfully resolved, they can contribute to positive treatment outcome and change. When unresolved, they can adversely affect process and outcome often leading to negative feelings and unilateral termination. Therefore, the aim of the proposed research project is to address this question by exploring therapists' experiences of processing, managing and repairing alliance ruptures.

You have been invited to take part in the present study because you are a chartered counselling psychology with a minimum of two years of clinical experience post-qualification who offers open-ended or time-limited therapy and receives ongoing

clinical supervision. The study will include a total of 10 chartered psychologists like yourself.

Participation in the research project is entirely voluntary and it is entirely up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form, however you will still be free to withdraw at any time and without giving a reason.

Should you decide to take part, you will be invited to participate in an individual, semi-structured interview with the researcher. The interview will take place in a quiet room at your workplace or home, at a convenient for you time and date, and will last approximately 90 minutes (including the introductory and debriefing phase). The interview will be audio-recorded and subsequently transcribed verbatim. The data collected will be then analysed using Interpretative Phenomenological Analysis

In the beginning of your meeting with the researcher, you will be informed verbally on the nature and aims of the research project and you will be encouraged to ask questions and clarifications. During the interview, you will be asked to answer a series of open-ended questions posed by the researcher as clearly and openly as possible. Upon the interview's completion, you will be asked to fill in a short Monitoring Form with some demographic details. Subsequently, the researcher will debrief you (both verbally and in writing) on the research project and will encourage you to address possible issues, anxieties or concerns arisen by your participation in the study.

Due to the delicate nature of the research topic, the present study contains a minimum risk of causing you slight psychological and emotional discomfort, as you will be expected to describe difficult times with your clients. In such case, you retain the right to decline answering questions which are experienced as too personal or intrusive, as well as to withdraw from the interview process at any time without having to provide any explanation. Should you experience any sort of anxiety or discomfort, you will be given the opportunity to discuss this with the researcher and will be also strongly encouraged to address them with your supervisor and/ or therapist.

If you decide to take part in the research project, you will be hopefully provided with the opportunity to think reflectively and meaningfully on the therapeutic relationship with your clients. Your participation will also contribute to shedding further light into the ways counselling psychologists experience, manage and repair ruptures in the therapeutic relationship. An exploration of types of ruptures and ways of reparation within the therapeutic relationship holds significant clinical implications for psychologists, psychotherapists and counsellors, as it could clarify ways of identifying, working through and overcoming ruptures, in order to strengthen the therapeutic relationship, increase therapeutic effectiveness and achieve positive treatment outcome. Furthermore, the proposed research study can also hold significant training implications, as it may further illuminate the ways future counselling psychologists, and practitioners in general, can be trained in ways of establishing, maintaining and repairing the therapeutic alliance. Finally, as the proposed research study focuses on therapists' experiences of ruptures and repairs, it may provide useful insight into specific client and therapist characteristics that may influence the development of the therapeutic relationship, and thus highlight the importance of 'reflexive' practice.

All research data will be handled in accordance with the Data Protection Act 1998. Your identity will only be known to the researcher conducting the study and the audio-recordings produced will only be listened by the researcher herself and possibly by

supervisors/ examiners. Interviews will be audio-recorded and subsequently transcribed verbatim, while part of them, with identifying details removed, may be heard or seen by supervisors and examiners. Every effort will be made to ensure confidentiality and safeguard anonymity. However, in accordance with the BPS Conduct of Ethics and Conduct, confidentiality (March 2006) might have to be breached should you disclose material, which raises concerns about potential risk, safety of clients, as well as health and safety of children or vulnerable adults. In such a case, the researcher will raise the issue to her supervisor and may take further action and report it elsewhere. Audio-recordings and transcripts produced will be kept in a locked filing cabinet at a secure place, to which only the researcher will have access. Your personal information data (i.e. those included in the monitoring form) will be kept separately from the raw data, while electronically stored data will be password protected, in order to further safeguard anonymity. In line with the University's policy, all data will be destroyed five years after completion of the study. Transcripts, monitoring forms and personal data will be shredded, electronic data will be deleted, and audio-recordings will be erased.

Results of the research study will be seen by supervisors and examiners for the purposes of the project's evaluation. In addition, they may potentially appear in subsequent publications or a display of the dissertation's copy at the University's library for educational purposes. However, your anonymity will be protected through using a pseudonym when producing the transcripts. Furthermore, sections which could lead either to your (e.g. work setting, agency location), or your clients mentioned in the interview identification will be excluded from presentation. In order to ensure your anonymity, you are specifically instructed to avoid using details, which could possibly lead to your personal or clients' identification by others. Should you wish to receive a copy of the completed research project and/ or a copy of a potential future publication, you may state it to the debriefing phase.

Your participation is entirely voluntary and you can choose not to participate in part or all of the project, as well as to withdraw at any stage of the project, up to the point that the analysis has been finalised, without having to give any reason and without being penalised or disadvantaged in any way.

If you have any problems, concerns or questions about this study, you should ask to speak to the researcher or her supervisor at the contact details provided below:

██	██
██	██
██	██
██	██
██	██
██	██
██	██
██	██

If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: "Rupture and Repair in the Therapeutic Relationship". You could also write to the Secretary at:

[Redacted]

10. Participant Consent Form



CITY UNIVERSITY
LONDON

Participant Consent Form

Research Title: “Rupture and Repair in the Therapeutic Relationship”

I have been asked and I have agreed to take part in the above City University London research project. I have had the project explained to me, and I have read the Participant Information Sheet, which I know I may keep for my records.

I understand that consenting to participate in the research project means that I am willing to take part in a 60 minute, individual, semi-structured interview, which will be audio-recorded and subsequently transcribed. I agree to the interview being conducted in a quiet and safe room at my home or workplace, in order to safeguard confidentiality and allow sound conduct of the process.

I appreciate that the audio-recordings and transcripts produced will be kept in a secure place, to which only the researcher will have access. The recordings produced will only be listened by the researcher herself and possibly by supervisors/ examiners within the institution and will be destroyed upon successful submission of the research project to the Examination Board. Similarly, extracts of the transcripts, with identifying details removed, may also be seen by supervisor/examiners and potentially appear in subsequent publications arising from the study. However, transcript sections, which could lead to my personal identification, as well as clients’ identification mentioned in the interview will be excluded from presentation and will not be disclosed in any reports on the project, or to any other party. I have been also informed that I will be given a transcript of data concerning me for my approval before it is included in the write-up of the research.

I understand that any information I provide is confidential, however, in accordance with the BPS Conduct of Ethics and Conduct (March 2006) confidentiality might have to be breached upon disclosure of material, which raises concerns about potential risk, clients’ safety, as well as health and safety of children or vulnerable adults. I confirm that I have been advised against disclosing such information, which could require from the researcher to take further action.

I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project, up to the point that the analysis has been finalised, without having to give any reason and without being penalised or disadvantaged in any way.

I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purposes set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998. Acknowledging this I am willing to take part in the above study.

Participant's Name:

Participant's Signature:

Researcher's Name:

Researcher's Signature:

Date:

[Redacted signature area]

[Redacted signature area]

11. Additional Information



CITY UNIVERSITY
LONDON

Recruitment Information

I am a Chartered Counselling Psychologist currently conducting a DPsych (top-up) in Counselling Psychology at City University London, Department of Psychology, and I would like to invite you to take part in my postgraduate research project entitled "Rupture and Repair in the Therapeutic Relationship".

The research project aims to investigate counselling psychologists' experiences of managing and repairing ruptures within the therapeutic alliance, as well as to examine ruptures' implications upon the therapeutic relationship, process and outcome.

I am looking for chartered counselling psychologists with a minimum of two years of clinical experience (post-chartership) who offer open-ended or time-limited therapy (minimum 15 sessions) within their private practice or workplace. Potential participants may be from various theoretical orientations but must be receiving ongoing clinical supervision for their practice.

Should you decide to take part, you will be asked to describe your experiences of processing and managing ruptures within the therapeutic relationship in an individual, semi-structured, audio-recorded interview, which will last approximately 60 minutes.

If you are interested in taking part or if you have any queries regarding the research project, you can contact me or my supervisor via the e-mail addresses or on the telephone numbers provided below.

[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]
[REDACTED]	[REDACTED]

This study has been reviewed by, and received ethics clearance through the Ethics Committee of City University, London. If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on 020 7040 3040 or via email: [REDACTED]

I would like to thank you in advance for your time and help.



Participant Debriefing Information

Thank you for taking part in this research project, which aims to investigate chartered counselling psychologists' experiences of processing, managing and repairing ruptures within the therapeutic relationship.

Previous research has shown that ruptures in the therapeutic alliance are a common phenomenon and pose marked challenges on the work of psychotherapists. When ruptures are resolved successfully, they can contribute to positive treatment outcome and change. When unresolved, they can adversely affect process and outcome often leading to negative feelings and unilateral termination. Taking into account the distinct role of the therapeutic relationship in the discipline of Counselling Psychology the present research project aims to shed light upon counselling psychologists' subjective experiences of ruptures, and the unique ways practitioners employ in order to manage and overcome them. Particularly within the 'reflective practitioner' paradigm, notions of therapist reflexivity and relationship dynamics gain paramount importance. It is therefore maintained that the ability to reflect upon and successfully manage alliance ruptures may enhance counselling psychologists' skills and efficacy, optimise treatment outcome and safeguard clients' well-being.

I hope you have enjoyed taking part in this study. Please feel free to ask questions that might have arisen by your participation in the study. Should you wish to know more about the outcome of this study or wish to obtain a copy of a potential publication arising from it, please do not hesitate to contact the researcher at the contact details mentioned below.

[REDACTED]

In addition, should you feel you have been affected by any issues raised during your participation in the study, you might wish to address it with your personal supervisor and/ or therapist, or contact one of the organisations listed below.

British Association for Counselling and Psychotherapy

Tel: 01455 883300. Website: www.itsgoodtotalk.org.uk

British Community Advice and Listening Line (C.A.L.L.) - Helpline

Tel: 0800 132 737. Website: www.callhelpline.org.uk

Samaritans - Helpline

Tel: 08457 909090. Website: www.samaritans.org



Participant Monitoring Form

Please, fill in the information below for monitoring purposes.

Name:

Age:

Gender:

Therapeutic Orientation:

Nationality:



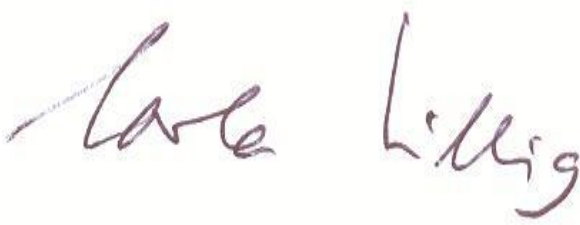
Ethnicity:

Professional Post:

Years of Professional Experience (post-chartership):

12. Declarations by Investigator(s)

- I certify that to the best of my knowledge the information given above, together with any accompanying information, is complete and correct.
- I have read the University's guidelines on human research ethics, and accept the responsibility for the conduct of the procedures set out in the attached application.
- I have attempted to identify all risks related to the research that may arise in conducting the project.
- I understand that **no** research work involving human participants or data can commence until **full** ethical approval has been given

Print Name		Signature
Principal Investigator(s) (student and supervisor if student project)	Angeliki Apostolopoulou (Research Student)	
	Theodoros Giovazolias (External Supervisor)	
	Carla Willig (Internal Supervisor)	
Associate Dean for Research (or equivalent) or authorised signatory		
Date	20/03/14	

Researcher's checklist for compliance with the Data Protection Act, 1998

This checklist is for use alongside the *Guidance notes on Research and the Data Protection Act 1998*. Please refer to the notes for a full explanation of the requirements.

You may choose to keep this form with your research project documentation so that you can prove that you have taken into account the requirements of the Data Protection Act.

	REQUIREMENT	✓	
A	<i>Meeting the conditions for the research exemptions:</i>		
1	The information is being used exclusively for research purposes.	✓	Mandatory
2	You are not using the information to support measures or decisions relating to any identifiable living individual.	✓	Mandatory
3	You are not using the data in a way that will cause, or is likely to cause, substantial damage or substantial distress to any data subject.	✓	Mandatory
4	You will not make the result of your research, or any resulting statistics, available in a form that identifies the data subject.	✓	Mandatory
B	<i>Meeting the conditions of the First Data Protection Principle:</i>		
1	<p>You have fulfilled one of the conditions for using personal data, e.g. you have obtained consent from the data subject. Indicate which condition you have fulfilled here:</p> <ul style="list-style-type: none"> - Data obtained will only be used for the purposes outlined in the Informed Consent Statement and will not be shared with any other organization. - Informed consent will be obtained. - Participants' and their clients' possible identifying details will be anonymised. - No identifiable personal data will be published. 	✓	Mandatory
2	<p>If you will be using sensitive personal data you have fulfilled one of the conditions for using sensitive personal data, e.g. you have obtained explicit consent from the data subject. Indicate which condition you have fulfilled here:</p> <p>_____</p> <p>_____</p> <p>_____</p>		Mandatory if using sensitive data
3	<p>You have informed data subjects of:</p> <p>What you are doing with the data;</p> <p>Who will hold the data, usually City University London;</p> <p>Who will have access to or receive copies of the data.</p>	✓	Mandatory unless B4 applies
4	<p>You are excused from fulfilling B3 only if all of the following conditions apply:</p> <p>The data has been obtained from a third party;</p> <p>Provision of the information would involve disproportionate effort;</p> <p>You record the reasons for believing that disproportionate effort applies, please also give brief details here:</p> <p>_____</p> <p>_____</p> <p>_____</p>		Required only when claiming disproportionate effort

	N.B. Please see the guidelines above when assessing disproportionate effort.		
C	<i>Meeting the conditions of the Third Data Protection Principle:</i>		
1	You have designed the project to collect as much information as you need for your research but not more information than you need.	✓	Mandatory
D	<i>Meeting the conditions of the Fourth Data Protection Principle:</i>		
1	You will take reasonable measures to ensure that the information you collect is accurate.	✓	Mandatory
2	Where necessary you have put processes in place to keep the information up to date.	✓	Mandatory
E	<i>Meeting the conditions of the Sixth Data Protection Principle:</i>		
1	<p>You have made arrangements to comply with the rights of the data subject. In particular you have made arrangements to:</p> <p>Inform the data subject that you are going to use their personal data.</p> <p>Stop using an individual's data if it is likely to cause unwarranted substantial damage or substantial distress to the data subject or another.</p> <p>Ensure that no decision, which significantly affects a data subject, is based solely on the automatic processing of their data.</p> <p>Stop, rectify, erase or destroy the personal data of an individual, if necessary.</p> <p>Please give brief details of the measures you intend to take here:</p> <p>I intend to take all the aforementioned measures.</p> <ul style="list-style-type: none"> - Participants are going to be notified that only the researcher will have access to their personal data and that personal or identifying will be anonymised and/ or excluded from presentation. - Participants will be explicitly made aware of their right not to participate in part or all of the project, and to withdraw at any stage of the project, up to the point that the analysis has been finalised, without having to give any reason and without being penalised or disadvantaged in any way. - Data will be collected, processed and presented in a way that will not cause substantial damage or distress to participants. - All personal data will be destroyed 5 years after successful completion of the proposed research project, or should a participant decide to withdraw at any stage of the study. Specifically, transcripts will be shredded, audio-recordings will be erased and electronic files will be deleted. 	✓	Mandatory

Appendix 8 - Ethics Approval Letter



Psychology Research Ethics Committee
School of Social Sciences
City University London
London EC1R 0JD

28th March 2014

Dear Angelika Apostolopoulou,

Reference: PSYETH(UPTD) 13/14 43

Project title: Rupture and Repair in the Therapeutic Relationship: An Interpretative Phenomenological Analysis.

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval

Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments

You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

- (a) Recruit a new category of participants
- (b) Change, or add to, the research method employed
- (c) Collect additional types of data
- (d) Change the researchers involved in the project

Adverse events

You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee (), in the event of any of the following:

- (a) Adverse events
- (b) Breaches of confidentiality
- (c) Safeguarding issues relating to children and vulnerable adults
- (d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards,

Alice Kingsnorth
Secretary
Email:

Katy Tapper
Chair
Email:

Appendix 9 - Extract from Rose's Transcript

Interpretation
 Client Angry at Therapist but Turning Anger Inwards In Order to Protect Therapist from Anger / Rage (Wishing to Hurt but Hurting Self Instead)

protects me from her anger and she turns this anger towards herself by eating so much that she feels pain / afterwards.

Q: /uh, uh-huh.

R: Um...she, I think she didn't speak for like five, seven minutes? And, and I could feel the tension building up in the room (R: Um) and actually I started shaking (Q: Uh). As, you know, I was realising that "Oh, my god, I said something, um, horrible (R: Um) to her and, and it was too much and something is boiling now here and an explosion is about to take place". And I was very much, um, scared, um...um...so in that moment I started feeling that, obviously, her, her anger, that she's, she's afraid of her anger and I was very much afraid of her anger. So it was that fear that pushed me to make, um, an interpretation.

Q: Uh.

R: Um, and if, if I wasn't afraid of her anger the way she was afraid of her anger, I would be able to be more attuned to her and realise that, you know, it's not the right moment, um, she's doing all the work herself, I don't need to intrude and say something. She's working very well. She talks about things, she reflects on things, I don't need to rush and make the connections for her. And obviously the only reason I rushed was that I was anxious. And I was anxious of, of the anger she was feeling and, so, um, after I think five or seven minutes in silence, um, she said that, obviously, I was becoming like her father.

Q: Uh.

R: Um...and...um and that she felt that my comment was very intrusive and very frightening and, um, and quite violent (Q: Uh). Um, so for her in that moment I became the abusive father who could not connect with any part of her; could not really sense how it feels for her to experience all this abuse and he was just doing whatever he wanted (Q: Uh). And...um... fearing the anger, I became the abuser. Exactly what she was scared of (Q: Uh). She was afraid that if she unleashed this anger, she would become abusive. I was afraid of the anger, became abusive with my interpretation and she got scared of me. She felt very much threatened.

Q: So there was a re-enactment?

R: There was a re-enactment, yes. Very helpful for the therapeutic process, indeed, ok; there are many things you can do around this but, it was a definite rupture (Q: Uh). And, um, and I could tell that for the next two or three sessions she was very careful with what she was saying.

Q: So, she did become rather careful with you?

R: Yeah, she did.

Q: You said that you were scared, maybe you didn't realise it, after a few minutes that you were maybe quite scared of her anger. Had you picked up on any signs of her anger, until that moment?

Interpretation as Sensing Therapist's vs. Client's Needs

Interpretation as Protecting Therapist from Fear of Anger but Hurting in Anger as usual

Re-enactment of Relationship with Father in Relationship with Therapist

Transference

Therapist Becoming the Abusive Father who Disregards Client, Intrudes, Violates

Therapist Experienced as Threat

Therapist's Scared of Client's Anger

Acting Out vs. Containing Anger / Anxiety

Gaining Control Pending Client's Reaction

Impact

Client's Curious / Withdrawn

Rupture Experience

Tension Negativity / Duality Reaction

Fear Anger

Therapist's Negative Feelings

Therapist's Vulnerability

Strong Countertransference

Hindering Attunement

Fear, Anxiety

Sense-Making

Transference / Countertransference Dynamics

Re-Enactment

Rupture's Impact

Client's Withdrawal / Self-Conscious

R: She has been aggressive in the past=

Q: =with you?

Client Verbally
or Sexually
Aggressive in Past

Therapist Underestimated
Size/Intensity of
Client's Anger/Rage

Client's Anger/Rage
or Ability to Contain It

Client's Anger/Rage
or Ability to Contain It

Client's Anger/Rage
or Ability to Contain It

Client's Anger/Rage
or Ability to Contain It

Client's Anger/Rage
or Ability to Contain It

R: With me (Q: Uh). Verbally aggressive, um, um, verbally and sexually aggressive (R: Um), so, um, I've got a taste of it, if you like, and I know that the taste I got is just a, a=

Q: =a glimpse=

R: =the tip of the iceberg, that there is so much more anger and rage and hate underneath

(Q: Uh). And although I say to myself that, you know, "I'm fine, I can contain this anger, let's bring it out", in reality, as it became obvious [nervous laughter] I'm really scared of it.

Q: Yeah, it sounds like you did get scared and you also experienced, you know, this fear internally, as well. You said you became very anxious and tense at the time.

R: Yes, yes.

Q: How are you dealing with all this verbal and maybe sexual manifestations of her anger?

Client's Controversial
Attacks

Therapist
Froze, Surprised,
Immobilised

Therapist
Froze, Surprised,
Immobilised

Therapist
Froze, Surprised,
Immobilised

Therapist
Froze, Surprised,
Immobilised

Therapist
Froze, Surprised,
Immobilised

R: The few times it happened, um, I froze, I froze. It was so unexpected. It was, it came from nowhere, I was surprised, I could not react to it at all and actually, you know it took and I had to go to supervision to find the words to talk about it again. I could not react and I could not think about it, at all. So it was as if the attack was on, on my capacity to think about it as well, not only, um, against me, but in my therapeutic capacity. That doesn't make any sense.

Q: I think, it sounds to me like those attacks almost internally immobilised you. Like both emotionally and cognitively, and therapeutically.

R: Yes, yes.

Q: And you are completely stuck=

Therapist
Paralysed

R: =yes, paralysed=

Q: =yeah, paralysed.

Therapist
Paralysed

Therapist
Paralysed

Therapist
Paralysed

Therapist
Paralysed

Therapist
Paralysed

Therapist
Paralysed

Therapist
Paralysed

Therapist
Paralysed

Therapist
Paralysed

Therapist
Paralysed

Therapist
Paralysed

R: Yes. And the way I made sense of it, is that probably that's how she felt during the abuse; completely paralysed, unable to react, to think, to make sense of it (R: Um). And probably those aggressive attacks was the way she has to communicate to me how it was for her.

Q: Uh, uh. By actually making you feel the way she felt /at the time.

R: /how she felt at the time, yes.

Q: You said that, because you, you kind of froze, you sought for supervision. How did you deal with that after your supervision and I suppose after you had the opportunity, you know, to relax and get it together again?

R: Um...actually [sighs], during supervision...no, there are many different instances, um. Anyway, in one of these attacks, we decided that it was best for the moment, not to make,

Sense-Making
underestimation of
Client's Anger
Overestimation of
Ability to Contain It

Client's
Controversial
Style
Attacks on
Therapist's
Emotional,
Cognitive,
Therapeutic
Capacity

Sense-Making
Transference/
Countertransference
Dynamics

Supervision

Learning to wait
Not commenting on attacks
being abusive herself. That this is something that she cannot tolerate it for the moment; to realise that she has become the abuser. Um, and actually that was a year ago and still a year later, as I said, she's still, she still finds it very difficult. So, um, so that was the way=

Respect for Client's Pace, Needs

Client scared of abusive part not able to withdraw. Realisation that she's the abuser

Q: =you made the call not to deal explicitly about it with her.

R: Yes.

Q: A year later, like now, with the example that you brought up, what has changed? How did you handle, um, that, you know, the latest rupture that you talked about?

Rupture Resolution

Acknowledging / Taking Responsibility For Mistake

Importance of Timing / Pacing

Correct Interpretation

but wrong time

(Useless Intervention) If Client Cannot Make Use of It

Client's n. Therapist's Needs

Underestimation of Interventions Impact on Client

Rushing (Time)

Therapist Discovers Like Abuser

Client Reluctant to Forgive

Opportunity for Exploration

Corrective Relationship Learning Experience

People May Begin to Do Make Mistakes but Still Have Capacity for Metabolization

Client Gradually Realigning n. Reconnecting

R: Um... [long pause]...um, I think I always have Winnicott on my mind (Q: Uh). Um, I think he said that it's very helpful when we acknowledge our mistakes to clients, um, so I acknowledged my mistake. Um, you know, it might have been a correct interpretation, but it was at the wrong time.

Q: Uh.

R: So it was the wrong intervention, at the end of the day. Um, so I acknowledged that it was a mistake from my part (R: Um) and at, at that moment, I didn't realise how much painful

that was for her (Q: Uh), um, and, um, and that I rushed into something that she wasn't prepared to talk about, and that yes, indeed, at that moment I was, in a way, abusive as her father was. Um, in the beginning she said "So what now, just because you acknowledge your mistake, am I supposed to forgive you?" (Q: Uh) Um, and she was right...So we talked about the importance of, um, of being able to stay with her anger but at the same time preserve in her mind the idea, um, that it is possible for mistakes to take place (Q: Uh). So we can both be angry and know, um, something about the other person's intentions (Q: Uh). Um...um she didn't say anything about it but gradually she allowed herself to fall back into the session and, and she relaxed a little bit. So I think there was...we did something about this rupture.

Q: Uh.

R: Yes.

Q: So you took responsibility about what happened (R: Yes) and you openly acknowledged it (R: Yes) and discussed it with her.

R: Uh-huh.

Caring / Taking Responsibility For Mistake

Timing of Interventions

Q: And you were even like brave enough to say "Look, I may have made a mistake". And there's also something you said earlier and now, as well, that, maybe, I hear from you that maybe repairing is about, um, first of all, like, picking up when to deal with what is happening or maybe leaving it aside for later.

R: Uh-huh.

Q: And also when you do decide to pick it up, like to do it in an open and honest way.

R: Uh, yes, yes.

Rupture Resolution Acknowledging Mistake

Pacing Therapy

Exploration

Metacommunication

Reconnection

Taking Responsibility

Appendix 10 - Table of Superordinate Themes and Subthemes from Rose

Themes	Page/Line	Key Words
<p><u>The Rupture's Experience/ Perception</u></p> <ol style="list-style-type: none"> 1. Withdrawal 2. Breakage 3. Misattunement 	<p>4, 15-16 3, 22-23 3, 14-15</p>	<p>client's withdrawal and refusal to talk it could actually blow up the relationship I fail to be attuned to the client's internal world</p>
<p align="center"><u>Negativity</u></p> <ol style="list-style-type: none"> 1. Negative Emotions 2. Power Struggle 	<p>6, 4-10 10, 29</p>	<p>feel the tension...started shaking...anger So we were in this kind of competition</p>
<p align="center"><u>Responsibility</u></p> <ol style="list-style-type: none"> 1. Therapist's Contribution 2. Client's Contribution 3. Mutual Contributions 	<p>12, 15 11, 29 4, 21-22</p>	<p>did not feel secure in my own role he was perverse, he was sadistic client might even wish for the rupture to happen...therapist's job to be attuned</p>
<p align="center"><u>Sense-Making/ Understanding of Rupture</u></p> <ol style="list-style-type: none"> 1. Transference/ Countertransference 2. Negative Complementarity 3. Strong Countertransference 4. Therapist's Vulnerability 5. Timing/ Pacing of Interventions 	<p>6, 24 11, 4-5 11, 26 12, 16 8, 11-12</p>	<p>fearing the anger, I became the abuser he was pushing the boundaries...I had to be very firm and keep the boundaries it was a countertransference reaction I felt extremely vulnerable as a therapist correct interpretation, but... at the wrong time</p>
<p align="center"><u>Factors Contributing to Rupture Resolution</u></p> <ol style="list-style-type: none"> 1. Awareness/ Acknowledgment 2. Taking responsibility 3. Apologising 4. Metacommunication 5. Pacing therapy 	<p>15, 32-33 15, 19-20 8, 10 16, 2-3 6, 15</p>	<p>aware about therapeutic significance of rupture taking responsibility acknowledge our mistakes to clients think about what happened with the client and attach a meaning to it I don't need to rush and make the connections for her</p>
<p align="center"><u>Impact of Rupture Resolution</u></p> <ol style="list-style-type: none"> 1. Therapeutic progress and movement 2. Learning experience for therapist 3. Relational experience for client 	<p>9, 25 16, 32 9, 20</p>	<p>offer a therapeutic opportunity If we survive that, there is a beauty inside could act as these optimal frustrations</p>

Appendix 11 - Example of Master Table of a Superordinate Theme and Subthemes for the Group with Quotes

Superordinate Theme 1: The Threat		
Subtheme: Withdrawal		
Participant	Page/Line	Quote
Elaine	10, 10-16	“But, but it was then and I knew when there was a rupture because he was, he would go, he would disappear... He would move away like I did, so we were both go, physically as well, I mean we wouldn’t leave our chairs but, you know, you could see him going backwards.”
Mia	3, 18-19	“To me can be...can have the symptom of the client’s DNaying for few sessions or disappearing from therapy completely...”
Christina	16, 1-3	“So I think at the time there was no, yeah, it was just a massive elephant in the room. None of us touched it and therefore none of us got anything out of each other. ”
George	3, 17-19	“It’s the unspoken, which creates confusion, avoidance, anger, walls, distance. I think, actually, in therapy that’s the worst thing, the worst I don’t like to, you know, it’s not about good or bad but it’s, um, this is what makes things more difficult. ”
Sara	6, 7-13	“And I think that...um...but I also experienced at the beginning some, something completely, something very solid and unmovable about this suffering; that, although my client was a, a very kind, very, very sweet girl who had a real intention to help herself, my, I remember that for a long time in therapy, my, I had an image of a huge mountain that would never be moved; it would always be there and, um, I think rupture came at a point where I really was tired of trying to, um, I don’t, with my little shovel try to slowly scrape the mountain, you know. ”
John	7, 32-36	“...But every time there was a hint of, let’s say, that she would bring up something, um, that kind of touched more into a deeper understanding, whatever, however you want to understand that, um...[pause]...it would, also, almost...kind of lead her to back off probably within the session...”
Stella	7, 13-17	“And let’s say, as a metaphor, I would feel that I was very far from this client. Um, and for him, I would feel that he was in the bubble that we, we were talking before, um, and not expressing his true self. So not being able to actually, he would, I think, that’s very common with clients being on their heads and not their senses and not into their bodies and not into their emotions. ”
Maria	3, 24-25	“... Gradually the problem was that he was cancelling all the time, the, the, the session. He was trying to transfer the sessions within the week. ”
Rose	3, 22-23	“At times this might be just a small rupture and it might not even be noticed. It might just be noticed in the very brief silences that follow a comment I make, that it didn’t make any sense to the client and he just disregarded it. ”
Angela	2, 37	“The client leaves the session, and they never come back... ”

Subtheme: Breakage

Participant	Page/Line	Quote
Elaine	2, 34-36	“Um, if something happens, so if a client criticises me then potentially, I can’t think of an example, but potentially I might feel hurt and might back up a bit.”
Mia	3, 12-14	“I think rupture is a very strong word. Um...and it’s, it feels like...so even irreparable, so I don’t know; it’s like breaking a glass and trying to put the pieces back together. You will never make it. ”
Christina	3, 21-22	“The rupture...no the, um, the reason for the rupture was the financial arrangement between us.
George	14, 26-31	“... There is tension in the relationship and if I don’t manage that, it can be a rupture, very easily with her... I mean sometimes I have found myself being on the border with her. One wrong, um, one wrong manipulation of mine, therapeutic manipulation and we can have problems...or I can, she can even terminate or get distant or whatever. ”
Sara	5, 5-9	“So the first thing that came to my mind, while I was brainstorming, was the sudden and sometimes even violent rupture of somebody leaving and saying “Ok”... Something irreversible, that’s correct, yes. Um, I suppose probably because these are the times that I have felt more, um, more anxious and, um, I have questioned deeply how I handled the case and if I could have done something different. ”
John	4, 27-31	“... But sounds as if rupture is something, you know, unfixable. Something breaks, something ruptures you know, and it’s; the way I, I hear it, um, so my, for example, I don’t know, my mind would go somewhere, um, like, um, I’m just trying to think of an example. You know, a client not, for whatever reasons, I would say not, not coming back. So something as, what’s the word, severe? ”
Stella	5 & 6, 31, 1-2	“I would define ruptures as tension... Ok, I do, it doesn't have to be that you fight with a client, or they have sexual desires or whatever in order to have an actual rupture. ”
Maria	2, 10-19	“Um, how would I define ruptures? Um I think it is, I’m thinking of Heraclitus [laughs] who said that the beginning of all is war. And war meaning, um, a rupture, where there is this flash, where the flame is created. And so, um, even if they are difficult for me, um, I, I feel that they are very useful when they come. So rupture can be... Um, rupture can be, um [pause] disagreeing on the logistics of therapy; time, money, um sequence, all this, boundaries, in general or can be a person who can become angry for, for, for, um, for my reaction or a question or, um, that I do. ”
Rose	4, 10-11	“It could be a very clear and direct opposition to what I said. Um, it could be, um, a sarcastic comment from the part of the client. ”
Angela	3, 1-2	“I don't know anything could go wrong. They can hit you, they can leave, storm out of the door, they can shout at you, um, what else? ”

Subtheme: Misattunement

Participant	Page/Line	Quote
Elaine	2, 19-21	“A rupture might be a miscommunication, so very simple; I don’t know if it’s a real rupture, but a very small rupture might be someone not understanding or the therapist or the client not understanding, so it’s a miscommunication.”
Mia	3, 28-33	“I mean it can happen from one person only. So it can be only the client who doesn’t tell you when they feel that something has been ruptured in the relationship and they never know or it can be you coming in the relationship and, I don’t know, feeling that there is a difficulty in the connection with a client, um, but I think, one of the two would feel that there is something wrong and usually it would be the therapist picking it up and bringing it into the session, rather than the client.”
George	2, 21-29	“I think ruptures can be either the termination of therapy, the premature termination, um, either the stuckness during the therapy which I have experienced that sometimes, of course, um, or the, the tension but when I say tension I mean, you know, kind of misunderstandings, difficult to communicate, when I say something and the client, um, kind of misinterprets, misinterprets, what I’m saying; um, he or she thinks that I might want to put him down or that I’m, I’m doing an attack or maybe I recognise in myself, sometimes I kind of might be, my spot might not be appropriate, you know, it might be more angry or more distant or more, yeah; or maybe not so empathic, let’s say. Um, but I think yeah, I think it’s in the communication.”
Sara	2 & 3, 37-38 & 1-11	“I feel like I am doing my work. I am allowed to do my work, because, and I think, um, before I mentioned something about trying to kind of like find a connection as if in a phone line, you know, like being there struggling on the telephone [laughter]. Um, so, if there is no connection, um, yes, I often feel that I can’t work. Um, and of course I am trying to use that in therapy and to work with it, but I think the feeling is that, that, um, I am less touched, so there is no space for me...Yes, I feel, um, it feels strange sometimes. Um, it makes me wonder “Ok, so what, if there is no connection, what, what am I doing here”? or “What am I being asked to do here?... Am I asked to be a witness?” ”
John	12, 13-17	“And since we are talking about ruptures, I don't know, perhaps bringing communication into the equation and since I'm saying, you know, “I got that message from her” but obviously as things followed and happened, I suppose my message was incorrect; my, the perception of the message was incorrect, whether she didn't make it clear or I misunderstood it, well I couldn't tell.”
Maria	6, 19-21	“Doubting me all the time and not having a meeting point. Because if that's what is happening then you don't, actually, have a meeting point. You don't have the sense that you communicate. ”
Rose	3, 14-18	“Um, it seems to me that a rupture takes place whenever, um [long pause] I fail to be attuned to the client’s internal world; Um [pause] um [pause] so there are moments that this deeper connection with his world, um, fails and something, and, and in those moments, I lose my deeper understanding of what he’s saying, of what he feels and either, um, and I respond in a way that it is not attuned to his needs. ”

Appendix 12 - Table of Recurrent Superordinate Themes and Subthemes

Superordinate Themes & Subthemes	Elaine	Mia	Christina	George	Sara	John	Stella	Maria	Rose	Angela	Present in Over Half of the Sample?
The Threat	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Withdrawal	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Breakage	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Misattunement	YES	YES	NO	YES	YES	YES	NO	YES	YES	NO	YES
The Struggle	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Power Issues	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
The Dilemma	YES	YES	YES	YES	YES	YES	YES	YES	NO	NO	YES
Negative Emotionality	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
The Meaning-Making	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Intrapsychic Dynamics	YES	YES	YES	YES	YES	NO	YES	NO	YES	YES	YES
Interpersonal Dynamics	YES	NO	YES	YES	YES	YES	YES	YES	YES	NO	YES
Individual Vulnerabilities	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
Timing/Pacing of Interventions	YES	YES	YES	NO	YES	YES	YES	YES	YES	NO	YES
The Resolution	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
The Way Out	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
The Therapeutic Transformation	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES
The Learning Experience	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES	YES

