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Research Paper

Client Perspectives on Therapeutic Ruptures in Psychotherapeutic Relationships

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ABSTRACT

The therapeutic relationship is a secure base and safe haven for clients undergoing psychotherapy. The current study uses an interpretive phenomenological design to explain the meaning-making process of clients during negative experiences of therapy and its effect on the therapeutic relationship. 11 participants from various parts of India have been recruited for the study. They were interviewed about their negative experiences in therapy, special emphasis was given to the client therapist relationship. Insight into the perception of therapy events can help therapists detect negative feelings before it leads to breakdown therapeutic relationships. Participants who face negative experiences in therapy showed low motivation to seek therapy in future. The findings suggest that ruptures can have multiple origins and that they have very important implications for psychotherapy practice. The origins of such ruptures that emerge from different therapy events perceived by clients are explained in the current paper. The different therapy events are techniques, structure of sessions, tools, feedback and therapist presence. Clinicians need to be more mindful of the clients' perspective on techniques, assessments, therapeutic presence and power issues to avoid ruptures. Current research can inform protocols for rupture prevention, repair and termination.

Keywords: *Client-therapist relationship, Ruptures, Psychotherapy, Tailoring Treatment*

Psychotherapy is a transformative experience for most. However, it is evident that the efficacy of psychotherapy is severely affected when there is disengagement, termination or negative feelings about therapeutic experiences. This has an impact on the way psychotherapy is viewed. The voice of the client in a therapeutic setting has not been considered for a long time in the literature whereas the therapist's perspective has been emphasized (Eastwood et al., 2020). Clients often report not feeling heard or of not being taken seriously because of their psychopathology (Wilmots et al., 2020). Such issues of power and agency can come up very easily in a psychotherapy setting given the nature of engagement making client experiences an important area to study.

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Bordin (1979) in defining a therapeutic relationship laid emphasis on the nature of transaction between the two agents in a therapeutic relationship.He Proposed that the working alliance comprises three key ingredients: an agreement on the goals that the therapist and client must work on, a collaboration on the tasks that must be worked on to achieve goals and an overall bond that facilitates the collaboration between the therapist and client. Ruptures act as blocks in the flow of therapeutic exchange. The client's unresolved feelings about psychotherapy could hinder the trajectory of healing. A rupture in a therapeutic alliance refers to the deterioration of the quality of the relationship between a patient and a client (Safran & Muran, 1996).

As much as therapeutic relationships can heal and provide safety, ruptures could demotivate the client to seek help. Clients are not passive recipients of therapy like in the case of traditional medicine. In psychotherapy clients actively interact with the treatment and are partly responsible for its outcome. It is well acknowledged that clients are the best judges of their own experience (Henkelman & Paulson, 2006).

It has been well observed that unresolved ruptures directly lead to negative termination of therapy. Knox et al., (2011) studied client perspectives on psychotherapy termination by comparing positive and negative terminators. Findings suggest that positive terminators reported strong therapeutic relationships while negative terminators reported a rupture in the therapeutic alliance. Hence, the therapeutic relationship is the most important common factor.

In the area of disengaging experiences of psychotherapy a study by Frankel & Levitt (2009) suggested that disengagement is used as a defense to avert threat. A similar study by Williams & Levitt (2008) suggested that clients became more vigilant for difference of opinion with the therapist, avoiding confrontation during differences. Clients do not share their frustration if they think it will upset the therapist or the process of therapy. From this it is understood that disengagement is a protective mechanism and it comes out of a threat in the psychotherapy environment or the therapeutic relationship. There is no clear evidence on why and how disengagement happens.

What leads to such a threat in the psychotherapy environment is another area of study in the literature. Hardy et al. (2019) explored the risk factors for negative experiences during psychotherapy by juxtaposing client and therapist experiences of therapy. It was found that there was a lack of fit between patient needs and therapist skills. During issues of power and control patients felt unduly cut off, dismissed or blamed or even belittled. This led to a loss of hope and poor engagement. The current literature tells us what leads to disengagement but not how psychotherapy events correspond with the meaning making process of the client. Another study by Coutinho et al. (2011) investigating client and therapist experiences found that clients feel abandoned, unheard and helpless while therapists feel confused, ambivalent and incompetent to deal with the rupture. Notably, confrontation was perceived as too intense. Another study by Chen et al., (2016) showed that therapists' recognition of ruptures canceled the effect of ruptures. Hence, it will be helpful to understand what leads to the perception of dissatisfaction and how clients expect therapists to deal with ruptures.

The temporal dimension of the development of a dissatisfied experience needs to be delineated. How does disengagement happen and what does it mean for a client to be dissatisfied? What makes up dissatisfaction or disengagement and what is its effect on the clients and the perception of psychotherapy as a whole. More importantly what leads to safe

establishment of the therapeutic relationship and what derails it. Alternatively, if repair is possible in a certain period of time. These were the most important research questions of the study.

METHODOLOGY

Sample

11 young adults aged between 18-30 years who have attended a minimum of 4 psychotherapy sessions were asked to appear for semi structured interviews. The interviewees were screened by using a survey form with inbuilt inclusion and exclusion criteria. Participants who have terminated psychotherapy or have had negative experiences of therapy were selected for the study. Those in the age range of 18-30 years and who had taken at least 4 sessions with a therapist in India were selected. All those participants with neurological and psychotic disorders or with a history of in-patient admissions and those inconsistent with psychotherapy were excluded.

Procedure

Participants were approached via email. A screening for all potential participants was carried out via a survey form. The inclusion and exclusion criteria were embedded in the survey form**.** A detailed consent form containing information about the research, risks/benefits and rights to the participants was provided. Further clarifications were also provided.

Those who consented to participating in the study were interviewed using a semi structured interview both online via zoom meets due to pandemic restrictions. Three experts were consulted for expert validation of the interview protocol and the details of the study. A sample expert, methodological expert and field expert.

The interviews were recorded, transcribed and stored with the consent of the participant. On an average each interview lasted 45 minutes. The longest one took up 1 hour 15 minutes. The sequence of questions and the flow of the interview was kept free. The following domains were looked into while drafting an interview schedule: trustworthiness, respect, usefulness of therapy, warmth, empathy, genuineness and positive regard. These domains were examined in the context of different psychotherapy events through the course of therapy. Institutional review board approval was sought and granted to the researcher by Christ University. The researcher then circulated a G-form containing demographic questions and informed consent with an inbuilt exclusion and inclusion criteria. A total of 27 responses were recorded. Out of 27 responses 19 were selected for the interviews. Those who did not meet the inclusion criteria were not included. Out of 19 interviews three of the participants did not want their interview used for the purposes of the research due to the sensitivity of their narrative that was realized in the interview. A few other interviews were not analyzed as they pertained to the death of the therapist, a case of misdiagnosis by multiple practitioners and in-patient accounts. These accounts would distort the homogeneity of the sample.

A qualitative approach to inquiry embedded in an interpretivist phenomenological paradigm has been used for this study. Phenomenological approaches can explain in depth the meaning making process of client experiences. They aim to understand how the clients perceive the therapeutic relationship and how they construct or make meaning out of therapeutic events, techniques and gestures. It is a descriptive analysis of the experience.

The researcher chose to position herself in the study as an interpretivist. The researcher realizes that reality cannot be captured objectively but only its representations can be sought scientifically. The interpretive paradigm aims to recognize and narrate the meaning of human experiences and actions (Fossey et al., 2002).

The ideas of confirmability, trustworthiness have been kept in mind in the process of data collection and analysis. Precautions to make the data credible and transferable. This is ensured by check out questions at the end of the interviews. The researcher summarized what was understood and confirmed such a summary from the participant. The researcher-maintained field notes and audio recordings of interviews. The field notes chronicle the decisions taken in the course of the research and general impressions.

Interpretive phenomenological analysis takes into consideration textural and quality related aspects of a clients' experience. The interview was open ended and non-directive, semi structured interviews. Consent for audio recordings, transcription and presentation was obtained from the participants. Participants were informed that their confidentiality and anonymity will be maintained throughout the period of the study and after the presentation of findings. Data is encrypted and stored in a protected folder. Participants reserved the right to withdraw from the study at any time without any repercussions. The participants were told that there is no monetary compensation for participating in the study.

Themes were arrived at through the process of finding similarities among each participant's experience and arriving at ordinate themes. These themes were further put into clusters based on commonalities in order to find the superordinate themes.

The researcher has avoided quasi therapeutic relationships. In such a situation the participants were debriefed and the study will be discontinued. The researcher did not engage in diagnosis or correcting diagnosis of a participant or in criticizing another mental health worker. No names or identifiers of any mental health professional was asked. The interviews were securely encrypted on zoom meetings.

RESULTS

Table 1 Participant Demographics

Name	Age	City	Complaint nature
AMR	**29**	Hyderabad	Emotional
AR	**22**	Hyderabad	Emotional
AC	**21**	Hyderabad	Emotional
NP	**22**	Bangalore	Work related
SS	**20**	Gujarat	Career related
RS	**22**	Pune	Work related
M	**22**	Kerala	Work related
MM	**21**	Hyderabad	Emotional
PP	**23**	Bangalore	Emotional
PJ	**25**	Mumbai	Work stress
TM	**18**	Hyderabad	Emotional

Table 2 Factors that facilitate establishment of therapist client relationship

Superordinate Themes	Sub-themes
Phenomenological nearness	Feeling understood, emotional synchrony
Therapist expertise	Trust in expertise, ability to understand experience of client, therapist consistency
Skill building	Specific skills

Table 3 Factors that derail the maintenance of the therapeutic relationship

Themes	Sub-themes
Environment	Consistency Attentiveness Invalidating confrontation Repetitiveness Rigidity of process Debate like atmosphere
Collaboration factors	Feedback specificity Lack of synchrony

In the current study, the age range of participants was 18-30 years. The average age of participants was 22 years. The participants were from various parts of India. Those who came with stress related concerns preferred a more open and flexible approach towards psychotherapy geared towards skill building and radical self-exploration while those who came in with emotional concerns wanted an approach to psychotherapy that gave them space and helped them understand their emotions in a non-confrontational manner. These findings along with others will be described below.

The themes that emerged from the study were 10 in number. These themes reflect the reasons for therapeutic ruptures and problems that clients encounter throughout their experience in therapy. The themes are therapist consistency, jumping to conclusions, repetitiveness of technique, invalidating confrontations, taking feedback, hyperfixations, synchrony, loss of space, dismissal and termination reactions.

Establishment

This theme explains how the relationship was established and its basis. Across cases expertise, warmth and non-judgmental disposition of psychotherapy was viewed favourably and based on these factors it was easy for clients to negotiate trust with the therapist.

Phenomenological nearness

The emotional synchrony the client feels with the therapist is called phenomenological nearness. While, warmth and a non-judgement make a safe therapeutic environment. In most cases, it was the client's perception of the person of the therapist that determined the perception of safety in the client therapist relationship. Furthermore, clients feel heard because of the therapist's facial expressions, tone and presence. One client felt like the therapist was phenomenologically near the emotion the client was feeling. "*They are*

getting.". This feeling of "getting me" is what made this client feel like they can trust this person. Trust, safety and understanding are intertwined. *"She had kind eyes. When this person is listening, you know they are listening. They are getting what I am saying. They are feeling what I am saying. They are trying and it is visible."* says NP.

On the other hand, another client also appreciated the effort the therapist invested in understanding them. "*They tried to understand how my days are and you know just asking me simple things. I think I felt comfortable."* Says SS. Hence, this subjective feeling of phenomenological nearness is needed to establish the foundation of a therapeutic relationship.

Expertise

This sense of relief is key in building trust from the client's perspective: *"So, she did the testing and everything else and she told me that there were some psychological issues I was going through……And for that very reason. I thought she was a good therapist as she was able to tell what the issue was. For the first two sessions I was able to trust her." says AC.* Clients need to gain clarity about the working of their psyche and the therapist's quickness and accuracy in pointing out specific facts of client experience is also seen as important to the client's perception of a productive therapeutic relationship. "*The first four sessions I felt like oh my God they have all the answers". Says SS.*

Skill building

Specific skills

Another client felt like the therapist bought a change in her thinking and it helped her view life from a different perspective. *"She led a paradigm shift in my thinking...The first two sessions were brilliant with her". When I learnt cognitive behavioral techniques, they were life changing."* Another client felt equipped to view situations from an objective lens, which she says really benefited her. She finds the said technique useful years after therapy. *"…That helped me a little at some point of time in the pandemic".* This highlights the fact that clients who felt empowered in the initial parts of psychotherapy or felt curious felt motivated enough to continue with therapy.

Maintenance factors

Therapist consistency

Most participants felt that the therapist's warmth was not consistent throughout the period of therapy. The waxing and waning of attention lead to a feeling of not being heard.One client mentioned that she had initially felt heard when the therapist had touched her hand and had comforted her in the first few sessions. The client had initially felt she could talk to this therapist. *"Then after the 4th and 5th session she was not really paying attention to what I was saying."* MM. The client perceived a change in body language of the therapist. Therapists' initial closeness as indicated by the touch was not maintained throughout the period of therapy. The therapist came across as disinterested. There was no emotional response from the therapist as was expected after the first session. *"I would want her to listen to me instead of checking her phone. I was not liking all of it. I wanted her to listen." Says MM*

After the initial sessions of venting, RS felt like her therapist by now had become someone who was *"very presumptuous"* and someone who did not take her seriously enough. The client felt this because the therapist kept smirking at the client's exposition of her mental

distress and also began completing her sentences. This made the client feel disrespected and not heard.

Jumping to conclusions

"But that was a very, very short time to know me and based on that in and that will save a 30 minute session…..And I realized in the second session that she very quickly came to a conclusion and kind of guessed that okay…I do not feel that I am being heard". Says PJ. The client felt unheard when the therapist prescribed activities without spending enough time with the client or helping the client trust the process or approach.

Repetitiveness of technique

"It's like, essentially, like giving an antibiotic for any kind of human. That is all she was doing." PJ In another case*, "It was like self-help books." says SS.* The client felt their experience was not "unique" and that they were not "special" in their own right when the same technique was prescribed to them in every situation. Client feels prototyped if the therapeutic advice was not tailor made to their needs.

Invalidating confrontation

TM another participant was experiencing panic attacks and had expressed that she had fallouts with her friends and a few things about her past were irritating her. She could not express the need to explore the origins of her fear and anxiety. The environment for the client was very confrontative and she felt she did not get space to speak. The reverence for the therapist's qualification and power led to a feeling of self-doubt. *"When she said that I felt maybe it was me."* She did not feel her therapist understood her or even tried to do so. *"She was pushing for I am choosing to have anxiety in a way".*

In another case, the therapist smirked at the client's difficulty in resolving her anxiety. *"What is there to laugh here I am being entirely serious right now. I don't think she should be taking this lightly at all."* This participant experienced the event as hostile and belittling leading to a communication deadlock.

Hyperfixation

The client felt that other aspects of the clients' experience were not given enough attention and only certain parts were attempted to be resolved. Therapists' priority took precedence over the clients' emotional needs. *"She was hyper fixated on my ADHD and the hyper fixation on childhood."* Another client wanted to discuss things that don't involve her primary diagnosis. The fixation on executive dysfunction made the client feel ignored and not cared for. She felt her therapist was not invested anymore. *"My emotional problems were discussed in the context of my executive dysfunction."* Another client TM *"They decided what was the problem and how they wanted to fix it."* The client wanted to be asked and prompted in directions she was bringing up in therapy. When the client's direction was dismissed, it led to a subjective feeling of therapist lack of investment in client's overall wellbeing.

Dismissal

The distinction between feeling heard and being respected was shown by participant RSs' experience. The client felt she was heard as she was not interrupted but not respected due to therapists dismissing laughter. *"..heard but I'm not sure about respect. I was heard because I was never interrupted. Again there was a bit of laughter involved.,,".*

On the other hand, client TM expressed the need to talk about her childhood but was not encouraged subsequently leading to feeling dismissed. She felt like a problem that needed resolution. The client felt that their therapist only wanted to hear about a specific problem but not about her as a whole person. O *"All she wanted was for me to stop having panic attacks so I can attend school. They were only bothered about fixing this problem".* In the Indian context it is necessary for the client to be seen as a whole person and solution focused approaches tend to be invalidating.

Loss of space

Clients reported feeling like psychotherapy was a debate. More specifically, where the client lost space in therapy. The debate was perceived as a struggle for power and space in the conversation. SS says **"***I had five minutes to say everything I wanted to say and after that she would speak for half an hour. She was literally speaking for half an hour or more during that time."* Another client describes the atmosphere saying *"It lacked the environment of two friends talking but in a professional way. The environment you have in which you feel comfortable."* Clients do not feel respected when they are not given enough space to express or articulate their views. Clients also tend to perceive the process of psychotherapy is very rigid. *I wasn't really able to explain to them but they kept cutting me off. It turned out to become a debate but the conclusion was she always correct. Her process was very rigid".* Clients feel a lack of space at home and see the therapeutic room as a place where they can express their views freely. Therapy runs the risk of paternalism if therapy mimics traditional family systems. Since the current demographic are young adults they are in a phase of identity exploration and hence an invalidating space is not appreciated.

Termination reaction

Interview revealed three forms of reaction to rupture or request for termination……..The defensive response *"she went back to the point that I know you're an organisational psychology student, that doesn't mean you understand everything. I hope everything works out for you. And thanks. That's all she said."* Another client said *"She told me I am playing a victim and all that. Later on she told me if you need any help I am here for you. She said the same thing again. That is when I told her ki maam I never felt like you heard any of my sessions and whatever I used to tell you. She did not want to continue the conversation". Another reaction was detached in the case of NP "*She was all chill so its okay. Wish you luck for your future endeavors?"

Collaboration factors

Feedback Specificity

Specificity of feedback has been suggested by clients as an alternative to the no feedback or perfunctory or surface level feedback. This is seen in the case of NP *"I don't know so be more specific. So, okay we are talking about ADHD. Are you fine with it? Do you like how I am handling this? Should I do something differently."* Similar problems were brought to light by PJ *"I mean, not in the sense that. I mean, it was it was very often off hand and tried…But not where we are going about the process."* Most therapists were unable to detect rupture.

Most of them never enquired about the process and content of the session and the clients felt disconnected with the therapist in the process.

Synchrony

Clients and therapists differ in goals and this leads to a sense of invisibility and dismissal in the eyes of clients. *"She wasn't taking up the issues I was bringing to her. one of the biggest thing…at that time I had a really toxic bad relationship, physical, sexual and verbal abuse type."* A sense of invisibility dawned on the client and she stopped going. *"I'd rather suffer through my depression rather have someone invalidate it...I feel betrayed. So "Betrayed" that word expresses it perfectly".* Says PP.

The significance of urgency with regards to the clients problems can be seen in the case of *AR. "..a person in front of you is more interested to know about what has happened in your past life than the current life. The main focus should be on the current situation where the problem is right."* This made the client feel dejected, as the therapist was not focusing on the urgent present but the past.

DISCUSSION

The rationale for this study was to highlight the barriers that stand in the way of establishing a safe psychotherapeutic relationship. Grounded theory and other positivist approaches look at the dynamic processes that lead to rupture. Mixed method studies under review have tried to compare client and therapist's interpretation of the therapeutic relationship and psychotherapy situation. Phenomenological approaches aim to understand how the clients perceive the therapeutic relationship and how they make meaning out of therapeutic events, techniques and gestures. Hence, the researcher aimed to study the affective, perceptive and processual factors that derail the maintenance of a safe therapeutic relationship eventually leading to a therapeutic rupture. The literature makes it clear that a handful of studies have been conducted where only the client experiences have been studied. There were no such published studies in India.

Studies on authenticity and client centered therapeutic relationship reveal that there is a strong association between client therapist relationship and authenticity (Bayliss-Conway et al., 2020). However, there are no qualitative studies on how client experiences authenticity or what makes up therapist authenticity for the client. In the current study, it was found that authenticity is perceived when there is realness with an ability to understand the client, the ability to apologize, reduced defensiveness or the ability to be human and openness to take feedback from the client. Such elements make the client feel like psychotherapy is a human endeavor.

The crux of the study lied in how do clients perceive dissatisfying therapeutic events. Maintaining the therapeutic relationship includes giving agency to the client. Clients also need a caregiving environment which is not too threatening to them. Taking feedback is very important for different clients. It gives them the space to articulate distress. But if the feedback is not specific it is not perceived as helpful by the participants. In most cases, feedback was not taken. Some studies in the literature indicate that therapists do not have enough insight when ruptures occur or why they occur (Hardy et al., 2019). Hence feedback conversations need to be comprehensive. Therapist expertise and clients' vulnerability act as communication barriers. Feedback procedures across literature have highlighted the fact that taking feedback or not is based on theoretical orientation of the therapist (Hatfield & Ogles, 2007). The literature has also shown that structured feedback helps clients voice out frustrations (Sundet, 2012).

Furthermore, invalidating confrontations causes ruptures and makes the client have negative self-evaluations. They eventually chose to drop out of psychotherapy and sulk alone. A study by Möseneder et al., (2018) shows that confrontation temporarily impairs therapeutic alliance and it is important for therapists to resolve the rupture. Therapists who do not resolve the rupture show inferior outcomes. The current study has found that invalidating confrontation can lead to permanent ruptures in the absence of resolution attempts.

A mismatch between client complaints and therapists body language creates a feeling of emotional distance. Clients in the current study have felt invalidated in such instances. The discrepancy between verbal and non-verbal behavior leads to distance between the client and the therapist. The moment-to-moment presence is lost in such exchange (Greenberg, 2001). It is important to be in contact with the clients' emotions in therapy. To confirm another's experience is important. A lack of synchronization between clients ongoing needs and therapists narrow focus on one part of client's experience can lead to a feeling of detachment from the therapist or a loss of faith in the process. This lack of synchrony can feel like phenomenological distance or even avoidance.

Psychotherapy environment is crucial to the free flow of therapeutic exchange. Debate-like atmosphere and over reliance on instrumental procedures make clients feel like their feelings do not matter to the therapist. Fast paced discussions and interruptions create a feeling of dismissal. In the view of Greenberg (2001), Immersion is an important characteristic of presence. If the therapist is very technique oriented then maintaining presence is hard. Therapeutic presence is seen as a precondition for congruence. Therapeutic exchange in the Indian context can be seen as a bid to establish interdependence or closeness from the client's side.

Giving agency to the client and sharing control over psychotherapy decisions in terms of techniques used helps clients feel respected. A recent study from 2019 showed that clients' subjective feeling of agency in a psychotherapy setting has a positive association with therapeutic alliances. They in turn participated more in psychotherapy (Huber et al., 2019). Patients should be able to feel that they impact therapy. The current demographic is in a moment of transition as earlier more agency and power was given to the therapist where the counsellor is expected to act as a proxy adult authority alternative to another family member in the Indian context (Venkatesan, 2016). In 1960-90s authoritarian approaches to psychotherapy worked (Spang, 1965) but the current millennials prefer democratic approaches with equal power balances. Ruptures can be repaired if therapist awareness could be increased. Clients stay in psychotherapy hoping things will get better and also because they are partially dependent on the therapist. Outcomes of psychotherapy can be made more efficacious if therapists repair ruptures on time.

Furthermore, therapist's reaction to clients needing to terminate psychotherapy has been observed as defensive or detached. Both these reactions affirm the client's decision to leave. Most clients expected therapists to resolve the rupture or give an explanation but such reaction left them disillusioned. Current perception of psychotherapy is also affected by therapeutic rupture. Rupture anticipation is a common expectation from psychotherapy in general after initial rupture.

The strengths of the study lie in highlighting the experiential aspects of psychotherapeutic relationships through the different events that take place in psychotherapy. The study can inform rupture prevention and repair strategies. It can also inform therapists about the way

clients perceive lack of safety, respect and space during psychotherapy. Future researchers could explore the therapeutic needs from the therapist in the context of different symptom presentations. The limitations of the study include a small sample size and limited triangulation of data.

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Conflict of Interest

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