ABSTRACT

Title of Thesis:	RUPTURES IN PSYCHOTHERAPY: THE EXPERIENCES OF THERAPIST TRAINEES WITH DIFFERENT ATTACHMENT STYLES
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In this study, we explored therapist trainees' experiences of rupture events in psychotherapy. Therapists-in-training were interviewed about the antecedents, management, and consequences of a rupture with a client. Data was analyzed using Consensual Qualitative Research (CQR; Hill et al., 1997; 2005). Therapists typically reported broad (i.e., session started in tense state vs. typical session) rather than specific antecedents to the rupture. In terms of management, therapists typically used immediacy and explored the rupture further as repair attempts. Negative consequences included therapists having anxiety about continued work with client and client not attending the next session. However, therapists also reported positive consequences, which included the therapeutic work becoming more productive. There were several meaningful differences found between attachment style subgroups. Implications for future research, doctoral training, and psychotherapy practice are offered.

RUPTURES IN PSYCHOTHERAPY: THE EXPERIENCES OF THERAPIST
TRAINEES WITH DIFFERENT ATTACHMENT STYLES

by

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Chapter 1: Introduction

"The patient questioned the usefulness of therapy and whether we were wasting each other's time," reads one therapist-reported rupture event from ongoing psychotherapy (Marmarosh et al., 2014, p. 4). Clearly, ruptures are unnerving events that can challenge a therapist's security, credibility, and even desire to continue with a client. Although not all ruptures are as severe as the one quoted above, therapists across all theoretical orientations are bound to experience many rupture events in their careers. Whether these ruptures are slightly noticeable tensions or are significant disruptions, it is important for therapists to understand and manage these events effectively since they influence the therapy process (Safran & Muran, 2000).

Ruptures in Psychotherapy

Ruptures (defined as the strains, tensions, or breakdowns in therapy that, when unaddressed, may interfere with ongoing collaborations between the therapist and client) are critical moments for the outcome of therapy (Safran & Muran, 2000). Unresolved ruptures have been linked with weakening alliances, dropouts, or unsuccessful outcomes (Safran, Muran, & Eubanks-Carter, 2011). A successful resolution, on the other hand, can foster change or insight for both client and therapist (Safran & Muran, 2000).

In their review, Safran et al. (2011) found that across eight studies using client, therapist, or observer reports, clients reported ruptures in 19% to 42% of sessions, therapists reported ruptures in 43% to 56% of sessions, and observers reported ruptures in 41% to 100% of sessions. It makes sense that there would be varying reports across clients, therapists, and observers: Clients may underreport due

to their lack of awareness of ruptures or because they feel uncomfortable reporting them, therapists could be influenced by the hope that their treatment is going well or could be self-critical, and observers provide a different, although equally subjective, view of what is happening in therapy. The outsider perspective is limited given that observers are not actual participants in the relationship and so they never really know how it feels to be in the room. In addition, their own transferences enter into their judgments. Although an exact frequency of ruptures has not been determined and the definitions are vague such that researchers vary in how they define ruptures, it is clear that ruptures, especially the major ones, are critical moments for the process and outcome of therapy.

Furthermore, rupture repair episodes have been linked with positive outcome. In their meta-analysis, Safran and colleagues (2011) found a medium effect size ($r = .24, z = 3.06$, 95% CI [.09, .39], $p = .002$) across three studies including a total of 148 clients, that indicated the presence of a rupture repair episode was positively related to good outcomes. Interestingly, these studies primarily relied on observer or client ratings of the rupture events, which, as noted above, have some major limitations. Extending the investigation to therapists' experiences with ruptures could be beneficial to provide an insider perspective on the process. It would also be important to understand how therapist factors relate to the therapist's understanding and management of ruptures. One such therapist factor is attachment style, which has been linked with the ability to endure conflict and regulate emotions (Mikulincer & Shaver, 2002).

Attachment Theory

The tendency to form and maintain relationships that provide a sense of security in times of distress is thought to be biologically wired within humans due to its evolutionary value (Bowlby, 1969/1982). Although a focus of attachment theory is on the relationship between child and parent, relationships throughout one's lifespan are also affected such that the need for attachment relationships continues "from the cradle to the grave" (Bowlby, 1988, p. 82). Furthermore, different individual attachment styles emerge in response to a caregiver's actions. As a child accumulates attachment interactions with their caregiver, these attachment patterns become part of the individual. These mental representations of attachment-related interactions, called internal working models, guide the individual in attachment interactions. Thus, adulthood attachment patterns comprise generalized thoughts, feelings, and expectations regulating how an individual engages in close relationships (Daniel, 2006). When the attachment system is activated by a perceived threat, the person's response offers insight into individual differences in attachment.

Brennan, Clark, and Shaver's (1998) factor analysis found two overarching dimensions of adult attachment: anxiety and avoidance. Anxiety is the degree to which individuals are sensitive to markers of rejection or abandonment from their caregivers. A person high in anxiety typically had a caregiver who was inconsistently available. In an attempt to get the caregiver to pay more attention to him/her, the anxious person learns to keep his/her attachment system chronically hyperactivated and thus intensifies bids for attention. Avoidance, by contrast, is the degree to which a person feels uncomfortable seeking support in times of need. A person high in avoidance typically had a caregiver who was consistently distant or unavailable. As a

result, avoidant individuals learn to block (deactivate) emotional states associated with threat so that they do not have to seek out help from their attachment figures. In contrast, securely attached individuals have positive mental representations of caregivers. When they perceive a threat, thoughts of comfortable proximity to caregivers, memories of emotional support provided by caregivers, and feelings of emotional balance are aroused and they feel comfortable seeking support from a secure base (Mikulincer & Shaver, 2002).

Therapist Attachment in Relation to Process and Outcome in Therapy

Because these attachment-related emotion regulation strategies are expressed in close relationships throughout life, it makes sense that attachment patterns can be activated in the therapeutic relationship. Indeed, researchers have examined how therapist attachment is related to different components of the therapy process. For example, Dunkle and Friedlander (1996) found that therapists' comfort with closeness was positively related to client ratings of emotional bond with their therapist. In contrast, Sauer et al. (2003) found that attachment anxiety was positively related to client-rated alliance in the beginning of therapy, but therapist attachment anxiety over the course of therapy was negatively related to client-rated alliance over time. Hence, there may be moments in therapy where therapist attachment anxiety can lead to benefits and other moments where it is detrimental (e.g., it may be helpful that anxious therapists work hard in the beginning to establish the relationship, but clients may experience this extreme effort as overbearing and inhibiting their autonomy if it continues throughout therapy). Of course, it should also be noted that Dunkle and Friedlander (1996) and Sauer et al. (2003) used different measures of

attachment (the Adult Attachment Scale; AAS; Collins & Read, 1990, and the Adult Attachment Inventory, AAI; Simpson, 1990; Simpson, Rholes, & Nelligan, 1992, respectively) and working alliance (the short form of the Working Alliance Inventory, WAI; Tracey & Kokotovic, 1989 and the original WAI, Horvath & Greenberg, 1989, respectively), so results might not have replicated due to differences in measures.

Researchers have also examined how therapist attachment is related to therapist behavior in session. Dozier, Cue, and Barnett (1994) investigated the association between therapist attachment and depth of interventions and attention to the needs of 27 psychiatric patients. They found that more avoidant therapists intervened in less depth and perceived less dependency needs from patients, whereas more anxious therapists intervened in more depth and perceived greater dependency needs from patients. Ligiero and Gelso (2002) found that level of secure attachment was negatively related to negative countertransference behaviors like rejecting the client. However, they did not find a relationship between insecure attachment patterns and countertransference behaviors, despite the fact that attachment theory would support the idea that insecurely attached therapists might engage in more countertransference behaviors. In a similar study, Mohr, Gelso, and Hill (2005) found that therapist dismissing attachment was positively related to therapist hostile countertransference as measured by supervisors. In addition, they found that the interaction between therapist and client attachment predicted hostile countertransference reactions, such that fearful or dismissing therapists with preoccupied clients had the highest countertransference reactions. These results suggest that therapist attachment may impact the therapeutic process in ways that

interact with client attachment, thus painting a complex picture of how therapist attachment manifests in treatment.

Therapist Attachment in Relation to Ruptures

Researchers have also begun to focus on the relationship between therapist attachment and ruptures. Using simulated rupture videos of staged psychotherapy sessions, Rubino et al. (2000) explored the association between therapist attachment, as measured by the Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994), and observer rated empathy of therapists' responses to ruptures, which was measured using a 5-point Likert scale where 1 = *not at all empathic* and 5 = *very much empathic*. They found that more anxious therapists were judged as responding less empathically than were less anxious therapists, but there was no difference between more and less avoidant therapists. Although these results point to a relationship between attachment anxiety and observer-rated empathy following ruptures, the findings are based on a simulated case where therapists did not have an actual relationship with the client and so the generalization to actual psychotherapy is not known.

Eames and Roth (2000) examined the association between therapist attachment, as measured by the RSQ, and therapists' perception of ruptures in ongoing psychotherapy. Preoccupied therapists (high on anxiety) reported many ruptures, whereas dismissive therapists (high on avoidance) reported fewer ruptures. These results suggest that a therapist's attachment could be related to the ways they respond to tension in relationships, which makes sense given attachment theory's explanation of anxious individuals' hyperactivating tendency in contrast with

avoidant individuals' deactivating tendency. Although Eames and Roth addressed the link between attachment and the perceived frequency of ruptures in a field setting, questions remain about how these therapists conceptualized and worked with ruptures in session.

Marmarosh et al. (2014) examined this process further, looking at how therapist self-reported attachment anxiety and avoidance, as rated by the Experience in Close Relationships Scale (ECR; Brennan, Clark, & Shaver, 1998), related to their perceptions of rupture tension, effort, and repair, as measured by Muran and colleagues' Post-Session Questionnaire (2004). They found that therapists high on both attachment anxiety and avoidance reported the most ruptures. In addition, they found a strong positive correlation ($r = .53, p < .05$) between therapist attachment anxiety and effort spent focused on the ruptures. They did not find a significant correlation between therapists' attachment anxiety and avoidance and rupture tension using the traditional p value of .05, but when using Cohen's d, they found a moderate effect size ($d = .30$) between attachment anxiety and rupture tension. These results suggest that therapists with different attachment styles do experience and work with ruptures differently, but more description about how therapists feel and react could provide more in-depth understanding of this phenomenon.

Purpose of the Present Study

Research indicates that ruptures are critical moments in the therapeutic process and can lead to unsuccessful outcome or dropout if unaddressed but can lead to positive outcomes if resolved. Since ruptures present critical moments in therapy, it is important to understand how different therapists experience and handle ruptures.

Although researchers have examined the relationship between therapist attachment and ruptures, there are several limitations to the extant research. First, the researchers only used standardized measures to examine the relationship between therapist attachment and therapist perceived frequency and tension of ruptures. There is therefore a lack of understanding of how therapists conceptualize ruptures above and beyond the frequency and tension as rated by such scales. In-depth interviews might lead to a greater understanding of therapists' experience. Thus, our first goal was to further examine from a qualitative perspective how therapist attachment is associated with the therapist's conceptualization of a rupture:

Research Question 1: How do therapists with secure versus insecure attachment styles conceptualize a rupture event?

The second major limitation in the research is the lack of understanding of the relationship between therapist attachment style and the management of ruptures, given that a simulated video of a rupture was used in one study and a single Likert scale question was used in another study to assess effort to repair the rupture. Hence, our second goal was to further explore from a qualitative perspective how therapist attachment is associated with therapists' resolution efforts:

Research Question 2: How do therapists with secure versus insecure attachment styles perceive that they manage rupture events?

Consensual Qualitative Research (CQR; Hill et al., 1997; 2005) was well suited for this study because extant literature does not have any qualitative analyses of how therapist attachment is associated with the conceptualization and management of ruptures. Although there is some evidence suggesting an association between

therapist attachment style and ruptures, no evidence exists about how this process

unfolds from the therapist perspective. Hence, in this study we aimed to address this

lack of depth in understanding by using CQR.

Chapter 2: Method

Design

Therapist trainees from counseling and clinical psychology doctoral programs were recruited for this study and completed Muran et al.'s (2004) Post-Session Questionnaire once a week to identify if they had a rupture with a client. Once a therapist indicated having a rupture, they had an initial interview within the following week and a follow-up interview two weeks later. We used consensual qualitative research (CQR; Hill, 2012; Hill et al., 2005; Hill, Thompson, & Williams, 1997) to analyze interviews.

Participants

Interviewees. Interviewees for this study were 14 therapist trainees (9 female, 5 male; 8 European American, 3 Asian International, 2 Asian American, and 1 African American; Age $M = 27.36$, $SD = 2.82$). Interviewees were in their second to fifth year of their doctoral programs in counseling or clinical psychology. They were seeing 3 to 9 clients per week at settings including counseling centers, university health centers, community clinics, and hospitals.

Using 5-point scales (1 = *low*, 5 = *high*), interviewees reported belief and adherence to the following orientations: psychoanalytic/psychodynamic ($M = 4.21$, $SD = 0.70$), humanistic ($M = 3.86$, $SD = 0.77$), feminist/multicultural ($M = 3.57$, $SD = 1.22$), and cognitive-behavioral ($M = 2.50$, $SD = 0.94$). In terms of attachment, four therapists were high on avoidance (i.e., at least one-half standard deviation above the mean of the sample) whereas six therapists were low on avoidance (i.e., at least one-half standard deviation below the mean of the sample). With regard to attachment

anxiety, five therapists were high on anxiety whereas five therapists were low on anxiety.

Interviewers. Interviewers for this study were two 24-year-old female European American counseling psychology doctoral students (one in second year and one in third year of the program). Both interviewers had previously participated in CQR studies and had experience interviewing participants.

Research team. The primary research team of nine individuals (5 female, 4 male; 5 European American, 1 African American, 1 Hispanic, and 2 International; Age $M = 26.22$ $SD = 4.35$) consisted of five doctoral students in counseling psychology, three undergraduate psychology students, and one post-baccalaureate applying to graduate school in clinical psychology. The judges were all from the same mid-Atlantic U.S. public university and were interested in the research topic and learning CQR.

Prior to analyzing the data, research team members wrote about and discussed their biases (i.e., "personal issues that make it difficult for researchers to respond objectively to the data," Hill et al., 1997, p.539) and expectations (i.e., "beliefs that researchers have formed based on reading the literature and thinking about and developing the research questions," Hill et al., 1997, p. 538). A few research team members felt that they had a bias toward dealing with conflict in relationships indirectly. That is, they placed a high value on "tiptoeing" around conflict. Thus, those team members watched out for having negative perceptions of therapists who might address ruptures immediately and directly in session. Half of the team members valued conflict and believed that meaning could develop from it, whereas the other

half felt more uncomfortable with conflict and have a harder time seeing positive consequences from it. In addition, because half of the team members were also therapist trainees like the interviewees, they thought they might be inclined to side with the therapist and more readily blame the client for the rupture occurring. Nevertheless, all team members expected that, in some way, both client and therapist dynamics would contribute to the rupture occurrence and subsequent rupture management. Overall, all team members expected ruptures to be difficult events for the interviewees because interviewees were therapists-in-training. Specifically, they expected the interviewees to place a lot of blame on themselves and to not be very adept in managing the rupture in session. Finally, all team members expected that weaker therapeutic relationships would lead to more intense ruptures and an inability to recover from the strain. After discussion, team members attempted to bracket (i.e., set aside) these biases and expectations as best as they could in order to focus on what interviewees actually said. Team members did not know the interviewees' attachment styles throughout the data analysis.

  Auditors. The two female auditors were experienced in CQR. The first auditor (25-year-old in the second year of doctoral program in counseling psychology) was the principal investigator who served as both an interviewer and oversaw the primary research team during data analysis. The second auditor was a 67-year-old female professor in counseling psychology. In terms of biases and expectations, the first both auditors believed that ruptures are difficult events for both clients and therapists, and that the rupture processes and outcomes would vary

according to the therapists' attachment styles given that these are difficult interpersonal moments when attachment systems likely get activated.

Measures

The **Experiences in Close Relationships Scale** (ECR; Brennan, Clark, & Shaver, 1998) is a 36-item self-report measure of attachment style that was used to measure attachment for interviewees in this study. Brennan, Clark, and Shaver (1998) developed the ECR on the basis of a factor analysis of 14 self-report attachment measures. The ECR consists of two 18-item subscales: Anxiety and Avoidance. The Anxiety subscale measures the degree to which respondents fear being rejected, abandoned, or neglected by others (e.g., "I worry about being abandoned") and the degree to which respondents desire more closeness to their partners than that desired by their partners (e.g., "My desire to be close sometimes scares people away"). The avoidance subscale measures the degree to which respondents feel comfortable with interdependence and emotional closeness in close relationships (e.g., "I get uncomfortable when a romantic partner wants to be very close"). Items are rated on a 7-point scale from 1 (*disagree strongly)* to 7 (*agree strongly*). Respondents are asked to report, "How they generally experience relationships, not just in what is happening in a current relationship." In terms of validity, the ECR subscales have been positively related with touch aversion (Brennan et al., 2000), self-concealment and personal problems (Lopez et al., 2002), ineffective coping (Wei, Heppner, Mallinckrodt, 2003), maladaptive perfectionism (Wei, Mallinckrodt, et al., 2004; Wei et al., 2006), negative mood (Wei, Russell, Mallinckrodt, & Zakalik, 2004) and depression (Zakalik & Wei, 2006), but negatively related to self-efficacy and

emotional self-awareness (Mallinckrodt & Wei, 2005). In terms of reliability, researchers examining attachment for therapists-in-training have reported Cronbach's alphas of .90 to .92 for Avoidance and .91 for Anxiety (Marmarosh et al., 2014; Mohr et al., 2005). In the present study, Cronbach's alphas were .92 for Attachment Anxiety and .84 for Attachment Avoidance.

The **Post-Session Questionnaire** (Muran, Safran, Samstag, & Winston, 2004) has one section assessing therapist-perceived ruptures. The first question asks about rupture presence: *Did you experience any tension or problem, any misunderstanding, conflict or disagreement, in your relationship with your client*? *Yes or No?* The second question asks about rupture intensity and is scaled on a five-point Likert scale (1 = *not at all;* 5 = *very much*): *Please rate how tense or upset you felt about the problem during session.* The third question asks for an open-ended description of the conflict reported: *Please describe the problem.* These three questions were modified for the present study to indicate sessions with clients from the last week of therapy. For example, the first question read: *Did you experience any tension or problem, any misunderstanding, conflict or disagreement, in your relationship with any of your clients this week? Yes or No?*

Demographic Form. This form included questions regarding age, sex, and race/ethnicity. Interviewees were also asked about theoretical orientation and what year they were in their program.

Interview Protocol. The interviews were semi-structured, such that there was a standard set of questions along with probes to elicit further individualized responses (e.g., "Tell me more about that," "What do you mean by that?"). For the interview

protocol (see Appendix B), the groups of questions were categorized into rupture antecedents, understanding the rupture, consequences, and final questions related to the therapist-client attachment match and supervision related to the rupture. There was also a follow-up interview protocol (see Appendix C) to inquire about resolutions efforts and the effects of the interview on conceptualizing and addressing the rupture.

After piloting the interviews some minor changes were made, including asking briefly about the rupture event before asking about its antecedents, and adding potential probes for some questions. For example, for the question, "What was happening internally for you during the rupture?" potential probes for thoughts and feelings were added. Also, some questions were made into two questions. For example, one question used to be "In what way did this rupture trigger your own personal issues, or did your own personal issues trigger this rupture?" and later became two questions, "In what way did this rupture trigger your own personal issues?" and "In what way did your own personal issues trigger the rupture?"

Procedures

Ethical considerations. The University Institutional Review Board approved this study. After therapists agreed to participate, they were assigned code numbers to protect confidentiality. Therapists were only referred to using their code number during data analysis and all identifying information was removed from the interview transcripts.

Recruiting interviewees. The first author recruited therapists by sending an email and/or visiting externship sites of one counseling and one clinical psychology program. Interviewees were told the purpose and time commitment of the study. No

compensation was given for participation. Interviewees were sent the Post-Session Questionnaire at the end of each week to monitor if they had a rupture. Once they reported a rupture, an interview date was scheduled within the next week and they were sent a copy of the interview protocol to give them the opportunity to reflect about the questions. Twenty-one therapists were recruited and monitored on whether there were any ruptures. Of the 21, only 14 reported a rupture across a period of six months.

Data collection. Participants first signed a consent form and then completed the demographics questionnaire and ECR. Next, participants completed the Post-Session Questionnaire at the end of every week to see if they had a rupture with any client they saw that week. Thus, participants kept track of all of their clients in terms of rupture events. Once a therapist reported a rupture, an interview was scheduled within the next week. Two weeks after the first interview, therapists had a follow-up interview. The first interviews lasted 75 to 90 minutes, and the second interviews lasted 10 to 15 minutes.

Research assistants transcribed the interviews, noting nonverbal behaviors such as pauses and laughter, but excluding minimal verbal behaviors (e.g., "mm-hmm"). All identifying information was removed from the transcripts, and recordings of the interview were erased after they were transcribed. To ensure that interviewees were not linked to the transcripts in any way, code numbers were used to identify transcripts.

Recruiting and training coding team. Once the interviews were conducted, the first author recruited the research team by making an announcement in graduate

and undergraduate courses in helping skills. Potential team members were interviewed to see if they were a good fit for the project (i.e., had research experience, understood the time commitment, expressed interest in the topic, and had a GPA of 3.5 or higher). Before analyzing data, all team members met to discuss the CQR process. For each main step (i.e., creating domains, core ideas, and cross-analysis), team members read the respective chapter of Hill (2012) explaining the step and then engaged in a discussion about the process.

Data analyses. The research team consensually drafted a list of domains (i.e., topics discussed during the interviews) by reading aloud several transcripts and discussing and suggesting possible domains. Once a stable list emerged, the whole team assigned each thought unit from two transcripts into one or more domains. Once team members understood how to assign data to domains, the research team split into two groups and consensually assigned thought units from transcripts into one or more domains. The auditors monitored both teams' work.

Once all transcripts were domained, the research team constructed core ideas (i.e., summaries or abstracts in fewer or more concise terms) from the domained data for the first two interviews. Once team members understood the coring process, the team split into the same two teams as described earlier and constructed core ideas for the remaining transcripts. The auditors audited all consensus versions (i.e., core ideas with domains for each individual case), and the primary research team discussed feedback and consensually agreed about revisions. Auditors examined changes until convinced that the data reflected domains as thoroughly as possible.

The next step was cross-analysis where core ideas for each domain were gathered across interviews into a master list (i.e., for each domain there was a list of core ideas for all interviews). During this step, the primary research team examined the core ideas in each domain and consensually constructed preliminary categories and subcategories to represent the themes in the data. The external auditor reviewed the initial list and provided feedback. Once the list seemed representative of the data, the research team consensually coded each unique core idea into one or more categories for each domain. The external auditor reviewed cross-analyses, and the research team consensually made any revisions. Finally, the team members returned to the original transcribed interviews to ensure all of the data was captured and placed accurately in the cross-analyses. Both auditors reviewed the findings again and made final revisions until they were satisfied that the final cross-analyses adequately represented the data.

Determining Subgroups. We split therapists into groups of high/low anxiety and high/low avoidance. There were four therapists labeled high on avoidance (i.e., at least one-half standard deviation above the mean of the sample), and six therapists labeled low on avoidance (i.e., at least one-half standard deviation below the mean of the sample). With regard to attachment anxiety, there were five therapists labeled high on anxiety (i.e., at least one-half standard deviation above the mean of the sample), and five therapists labeled low on anxiety (i.e., at least one-half standard deviation below the mean of the sample). It is important to note that all subgroups were determined after the cross analyses were completed. Hence, the coding team was not aware of therapist attachment while they were coding the data. Marmarosh et

al. (2014) also assessed a group of therapist trainees on the ECR and found an Anxiety mean of 3.07 ($SD = 1.08$) and Avoidance mean of 2.90 ($SD = 1.03$). Fraley, Heffernan, Vicary, and Brumbaugh (2011) reviewed the means for the ECR-RS, a newer measure assessing multiple attachments. In their sample of 21, 838 online participants (Age $M = 31.35$ $SD = 11.28$), their means suggest that the average person is secure (Anxiety $M = 2.53$ $SD = 1.19$; Avoidance $M = 3.18$ $SD = 0.96$). Compared to both of these samples, the present sample was higher on Anxiety ($M = 3.75$, $SD = 1.19$) but lower on Avoidance ($M = 2.51$, $SD = 0.62$).

Chapter 3: Results

Table 1 shows each therapist's reported rupture. Table 2 shows all of the domains, categories, and subcategories, as well as the frequencies for each of these for the entire sample, as well as the attachment subgroups (high versus low anxiety, and high versus low avoidance). For the total sample, results that applied to at least 13 participants were considered *general*, those that applied to 8 to 12 were considered *typical*, and those that applied to 2 to 7 were considered *variant*. For the analyses of attachment style subgroups, general required all participants, typical required more than half, and variant required at least two up to the cutoff for typical.

We also examined differences between attachment style subgroups, requiring at least a 30% difference to be considered meaningful (as suggested by Ladany, Thompson, and Hill, 2012). For example, if a category applied to 1 participant from the low avoidance subgroup (25%) and to 4 participants from the high avoidance subgroup (67%), then this would be considered a meaningful difference. Out of 34 comparisons, 8 meaningful differences were found between high and low anxious attachment subgroups (24%) and 7 were found between high and low avoidant attachment subgroups (21%).

In the text, we first present results for the entire sample for each domain. Next, we present meaningful differences between the attachment anxiety and avoidance subgroups for the domains. Unless we specifically mention differences between subgroups in the text, readers can assume that there were no differences.

For each domain, we provide quotes from the interviews. To ensure confidentiality of the therapists and to allow readers to connect quotes across domains, we identify quotes using labels Case 1 through Case 14. Ellipses (…) are shown when interview data were deleted for efficiency and clarity in presenting the results. We also deleted phrases such as "you know" and "like" to facilitate reading.

Therapy Context

When describing the therapeutic relationship, therapists reported both positive and negatives aspects. Therapists typically reported that they had established some trust or rapport with their clients. For example, Case 6 said "He trusts me more than probably most other people he interacts with, and we have a pretty good relationship…he has stated that he looks forward to sessions, and has said things like 'You're the only person I can talk to who's not mentally ill'…so I think it's a good relationship." In terms of negative aspects, therapists generally reported distance or a lack of connection in the relationship. Case 11 said, "He does not really look at me in session, so he talks in a very quiet tone, and it makes me feel that he is not fully there in the relationship with me," and Case 5 said, "She definitely feels like I don't completely understand where she's coming from."

Antecedents

Therapists typically reported tension at the beginning of the session. Case 3 said, "We were walking together from the waiting area into the therapy room, and he was already upset because of the schedule change . . . we also had to meet in a different room . . . and he didn't like that aspect." Case 9 described, "I was going into

the session feeling nervous about bringing up client's missed session last week . . . I was feeling nervous to even have a conversation with her about our relationship."

In contrast, therapists variantly reported that they thought the session was progressing like a typical session before the rupture occurred. Case 4 described, "I thought the session was good. He was reflecting on how he brought up his needs and why he doesn't feel comfortable expressing them to his girlfriend . . . so he, just right before the rupture, was talking about what that was like." Similarly Case 5 indicated, "I felt like I was engaged . . . I felt an affect toward her situation . . . I wasn't thinking that that was the direction it was going to go."

Differences were found in the antecedents based on attachment anxiety. Therapists higher on attachment anxiety more often than those lower in attachment anxiety reported that the session was progressing like a typical session before the rupture, whereas therapists lower on attachment anxiety more often than those higher on attachment anxiety reported that the rupture session began in a tense state.

Rupture Event

Therapist Experiences. Therapists typically reported experiencing lowered self-efficacy and an inability to handle the situation during the rupture. One therapist (Case 1) said, "I felt lost and kind of brain-dead . . . for the first time in a long time I felt shaken, like I didn't know what to do."

Therapists also typically experienced anger and frustration toward the client during the rupture. Case 10 illustrated,

It was frustration . . . that he was a different person in the first five sessions . . . that makes me frustrated because I was trying really hard to build a

relationship with him and I felt like I was knocking on a closed door . . . and I find out that he's been high the first sessions. In this session, I was like you're such a different person, if you were like this maybe we could have found something more active in the past sessions . . . so yeah, that's more resentment towards him.

In addition, therapists typically reported feeling anxiety and discomfort during the rupture. For example, Case 2 described, "Oh my god, I was freaking out . . . my thoughts were overtaken by anxiety."

Therapists also typically mentioned that, during the rupture, they were debating what course of action they should take. For example, Case 6 thought, "Should I just express that I'm sorry to him because I am, and because we're two people? Should I try and get him to process it? Should I push him to try to tell me what feelings it brought up? I was just, I guess trying to figure out—yeah, where to go."

A variant category of feeling hurt and devalued emerged. One therapist (Case 12) said, "I was offended . . . she wasn't respecting the work, and then I felt like she wasn't respecting me when she was laughing at me . . . we talked all semester about going all the way to the end of the semester, and then for her to so abruptly decide to cut things off when I saw that there was so much more work to be done . . . I was just so shocked and offended."

A second variant category of self-regulation also emerged. For example, Case 1 remembered trying to self-regulate by saying, "Remember your training . . . this is the hard part right here." Similarly, Case 2 said, "Okay, I really need to manage this."

A third variant category involved the therapist experiencing concern for the client. Case 8 described a sense of urgency to get the client to continue therapy because of having so many issues, "There was this sense of urgency in the way she was presenting that I felt I needed to say this to keep her showing up . . . and for her to get help."

There was one meaningful difference for attachment avoidance and anxiety. Therapists who were lower on attachment avoidance more often than those higher on attachment avoidance mentioned that they expressed concern for their clients. Also, therapists lower on attachment anxiety more often than therapists higher on attachment anxiety reported feeling discomfort and anxiety.

Client experiences. Therapists typically reported that their clients expressed anger or frustration with the therapist or the therapy. Case 7 described, "She [client] was like 'that' [client's decreased sex drive after having baby] is absolutely not a point of comparison . . . how dare you even begin to use those two [client not wanting sex with partner versus her partner not wanting to go to the grocery store together] in . . . relation to one another' . . . she was feeling really frustrated."

A variant category emerged involving clients expressing hurt, rejection, and devaluation. Case 1 illustrated the hurt, "Deep down she was experiencing a rejection I think that she, that in some way, feeling valued and cared for is equated to being taken care of, and so because of the fact that I wasn't giving into that, I think that she was feeling rejected and devalued."

In addition, clients variantly were reported to have expressed sensitivity about the therapist's feelings. Case 5 said, "She was like 'No, no, no.' I mean it seemed

like she was saying it more for my benefit than for hers, that she was trying to assure me like, 'Don't you worry, don't worry about this. Let's just move on, we don't need to talk about this anymore. I appreciate that you're trying to understand me, but we can talk about something else now.'"

Therapists also variantly thought that clients expressed unclear or muted feelings. For example, Case 4 reported feeling "unsure about what the client was feeling," and Case 12 said, "I was struggling to pick up on what my client was feeling."

One meaningful difference emerged for avoidant attachment subgroups. Therapists who were lower as compared with those who were higher on attachment avoidance more often reported that their clients expressed sensitivity about therapist's feelings during the rupture.

Repair Attempts

Therapists typically indicated that they used immediacy to try to repair the ruptures. Case 14 explained, "Later in the session . . . I brought this [unspoken conflict] to the surface, although it did not lead to any resolution in that session, but I did bring it up and asked how the client felt about it, and I also shared a little bit of my own feelings . . . I said, 'I realize here that we had a very heated discussion and it seems that we really did not quite agree on this' . . . my personal style is that when I run into some problems I . . . at some point in time I do want to talk about it."

Therapists also typically said that they facilitated exploration about the rupture. For example, Case 11 said to the client, "'I really want to know more about what makes you ask [for a referral]' . . . I maintained my openness and curiosity and

he was able to tell me . . . I allowed him to acknowledge his frustration with the therapy."

Therapists also variantly reported that they apologized and acknowledged their wrongdoing. For example, Case 7 said "I apologized three times in a row…I was like 'You were right, that was entirely insensitive of me, and I should have thought more about that.'"

In addition, therapists variantly did not try to repair the rupture. Case 12 explained, "It's not like I could express my anger and my frustration because I feel like she is very fragile, but I guess I was so consumed with my own frustration that I didn't think to separate myself from it and be objective enough to kind of explore that interaction cause it really was so telling that that's how she interacts with people and I didn't feel like going there."

Finally, therapists variantly modified their behavior to try repairing the rupture. Case 11 said, "After that rupture moment and of course with the help of my supervisor . . . he has been telling me that this client is crying for somebody to tie it back together for him . . . I've known this and I've been working for ways that I can be more of an expert for client that client needs."

In terms of meaningful differences between subgroups, therapists who were lower compared to those who were higher on attachment avoidance more often reported facilitating exploration as a repair attempt. Also, therapists who were lower versus higher on attachment anxiety more often used immediacy and facilitated exploration of the rupture as repair attempts.

Consequences

Therapists typically said the rupture made them anxious about their continued work with the client. Case 1 explained,

I am more wary when working with her. I am almost afraid that I will set her off again . . . two weeks later [after the rupture] I saw her in therapy and at that time she was talking about these problems she had at work . . . it was all kind of surface level information and I kind of let her stay there for longer than I might normally because I had this, I was scared if I brought up the frustration again, I would feel it directed toward me.

One typical positive consequence of the rupture was the therapy becoming more productive. Case 14 described,

It led to a significant change in the level of the work. And to me, it was also a very transforming experience too, because I, in the next session after the rupture, I was really going into the rupture without confrontation like, 'Okay, I'm gonna do this with you,' and then also feeling the client's own power to really understand it, make sense of it, and to even make all these very insightful connections, and I was like, 'Oh, this is really beautiful," and almost became one of my best sessions.

Another typical consequence was a strained therapeutic relationship. For Case 12, "I never felt particularly connected to her . . . we never had a good real relationship, but I thought we had an okay working alliance . . . this [the rupture] shattered that . . . it just felt like it broke down the whole relationship." Similarly, Case 6 said the rupture caused "the relationship to feel pretty tenuous . . . the relationship is strained, and we're kind of in a limbo."

A variant category involved a strengthened therapeutic relationship. For example, Case 14 said, " I really feel that this strengthened the therapeutic relationship a lot and it's somewhat icebreaking . . . this helped us to be more genuine with each other."

Therapists also variantly reported gaining a better understanding of the client as a result of the rupture. Case 9 explained, "It was just a matter of using that feeling of the rupture to guide me in understanding how she feels on a regular basis. Like the up and down, the liking, the disliking, the emotional roller coaster is what she feels all the time."

Another variant category was the client not attending the session after the rupture session. Case 1 said, "The client didn't come to therapy the week later . . . I think that she maybe needed some time apart to sort out what she was thinking, how she felt about therapy. I don't think it was easy for her to struggle like that in front of someone else and not be taken care of."

The last variant category for consequences was the therapist having lingering negative feelings toward the client. Case 12 indicated, "I was annoyed about it, and I was also hurt about it … it just kept coming up for me." Similarly, Case 9 said, "the emotional reactions I had in session were lingering well after session and still present now, so feeling angry, hurt by her."

A few meaningful differences emerged for consequences between high and low attachment avoidance and anxiety subgroups. Therapists higher as compared with those who were lower on attachment avoidance more often said that they gained a better understanding of the client and that their client did not attend the session after

the rupture. In terms of attachment anxiety, therapists higher as compared with those who were lower on attachment anxiety more often reported that their clients did not attend the session after the rupture. In addition, therapists lower as compared with those who were higher on attachment anxiety more often reported that the rupture left them with lingering negative feelings about their client, but eventually the rupture strengthened their therapeutic relationship.

Client Contributions to the Rupture

Therapists generally mentioned that clients had interpersonal problems that manifested in the therapeutic relationship. Some clients exhibited a sense of distrust, as illustrated by Case 3 ("He tends to feel like people let him down a lot . . . that he just felt this was another incident in which therapist disappoints me, therapist can't help me, therapist doesn't care enough about what I want or what I need."). Some had hostile interpersonal problem (e.g., Case 9, "Client . . . felt hurtful . . . what she said felt intentional in some ways, like she was provoking me and somewhat manipulative with my time in the sense that she knew this information and the way she said it would be hurtful, and that was something that she wanted to do."). Others had critical interpersonal problems (e.g., Case 1, "She's very much, 'It's my way,' or 'You're less than me,' or 'You're not my kind of person.'").

Therapists also typically mentioned that the client's resistance to therapy and lack of motivation contributed to the rupture. Case 10 said, "Client didn't really value the therapy . . . he was stoned in those sessions and so he wasn't really present." Similarly, Case 8 described, "On her part, it was the lack of communication . . . she

wouldn't even cancel sessions, she would just not respond to a message and would just really leave me hanging."

The client having unrealistic expectations about psychotherapy emerged as a variant category for client contribution. Some clients had the expectation that they would start seeing immediate changes from psychotherapy, as noted by Case 5, "She wasn't seeing huge immediate changes in how she's feeling and how she's able to navigate her world, and I think that might be a little frustrating for her that she finally was able to work up the strength to go and seek help, and now that she's in help it's not like an immediate fix."

The client having difficulty expressing emotions was a final variant category. Case 3 explained, "It's really hard for him to express dissatisfaction with people. He has these moments where he'll get really upset with people and then think that he shouldn't be upset with them or that he doesn't have a right to be. So that may have been duplicated in our relationship."

In terms of meaningful differences for the subgroup comparisons, therapists lower as compared with those higher on attachment avoidance more often commented that the client's unrealistic expectations about therapy contributed to the rupture.

Therapist Contributions to the Rupture

Therapists typically mentioned that they contributed to the rupture by poorly managing their own reactions. Case 4 said, "During therapy I try to be neutral, but I wasn't able to be neutral about client's relationship . . . I was leaning towards questioning whether they may not be a good fit . . . and I think that made the client defensive." Similarly, Case 10 said, "I wasn't really too aware of what I was feeling .

. . and that probably pushed me to be more immediate with him in the session . . . So I feel like I kind of jumped into immediacy a little fast. I haven't done any immediacy before this session with him, so it could also be that he was startled that I was saying that."

Therapists also typically mentioned that their lack of attunement with the client contributed to the rupture. For example, Case 7 explained that she was "not being fully attuned and missing some of client's microcues . . . like picking up on the fact that she was already starting to get frustrated, and not in that kind of healthy way that we could work through . . . also I was carrying this expectation that her frustration tolerance is always going to be incredibly high . . . in another moment, she might have been able to tolerate something like that . . . I wasn't really tracking and being like 'Okay no, this is, she's getting defensive, so don't push as much today.'" Case 2 similarly explained, "I knew going into the session that the client didn't have much trust for me at all, and I didn't really quite appreciate how much of a central issue this is for the client. I think a lot of it was me taking it personally at that point in the therapy as opposed to really knowing that this is the core theme, and to really approach it."

Therapists variantly reported that one of their contributions was avoiding talking about important issues with the client. Case 8 illustrated,

I generally as a therapist am terrible about addressing lateness, lateness and attendance with patients. So this is . . . my contribution definitely. I'm afraid to bring it up and I don't want to be critical of them or shame them or make them feel bad because I believe therapy is, it's your prerogative how you want

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to use it to your advantage. So I had not been as firm with her as I should've been from the beginning about cancellations and how we handle the cab and all this stuff and I've always just, I've always found her to be a good patient so I just want to keep her coming.

Another variant category for therapist contribution to the rupture was that therapists fulfilled their own needs. Case 13 explained wanting to feel special to the client,

I've actually given him many gifts . . . At one point my supervisor asked me if I was going to give him my car next. I think this is indicative of what is playing out between us . . . he is wanting on some level to feel special, and that pulls from me, I want to feel special. I want to feel special to my client. That's sort of how I thought about this but also kind of, as far as kind of a protective feeling from me that I think makes it come to this rupture or just this sense of tension I felt of, can I ask or should I ask this client to do more, or should I find some way to protect him again?

A final variant category was the therapist colluding with client. Case 9 described how the client would talk about others as mean and nasty. The therapist said,

I would have disbelief in how she would interpret situations that seemed kind of ambiguous and she would interpret them as an attack specifically on herself and . . . the types of questions I was asking . . . it was more so aligning with her and her feelings against these people and not necessarily opening the door

to see if, kind of almost like the reality of what might actually be happening or new ways of looking at some of these types of situations.

In terms of meaningful differences, therapists lower as compared with higher on attachment avoidance more often said they contributed to the rupture by avoiding talking about important issues with the client.

Experiences of the Interviews

Table 3 includes the results for therapists' experience of the interview, along with a comparison of attachment subgroups. Therapists generally said that the interview made them think more deeply about this rupture event or ruptures in general. For example, Case 8 said the interview "gave me more insight about how I might have been received by my client, and what insecurities I might have that could have impacted my affect or presentation, and how that mixes with my client's stuff." Case 6 said that after the interview, "I was paying more attention to ruptures in therapy . . . and the interview got me thinking a lot about ruptures . . . and so I have a lot more questions now."

Therapists also typically said the interview helped them to process the rupture event. Case 1 said, "Just being able to voice it helped me to put some pieces together . . . I knew that countertransference was at play but I hadn't voiced it at length."

Therapists typically thought the interview experience was positive (i.e., it was pleasant, engaging, interesting). Case 9 said,

It was fun, well maybe fun is a weird word because I'm kind of talking about something that's not really pleasant to talk about, but I found it easy to talk to you. I found the questions engaging and making me think about things that I

haven't previously thought about with ruptures, like what it triggered in me personally and how do my personal issues then contribute to the rupture . . . so enjoyable in that sense.

Therapist variantly said that parts of the interview were difficult. For example, Case 2 said, "I think that it was challenging to reflect on a challenging moment in therapy, so it was definitely difficult to talk about in certain ways."

Finally, therapists variantly mentioned liking the interviewer. Case 7 said, "I think your ability to hear the message and kind of synthesize what I've been saying is impeccable. Because I feel like I'm going off places and then you bring it back and make it dead on."

A few meaningful differences were found among the attachment style subgroups. Therapists higher as compared to lower on attachment anxiety mentioned the interviewer being good. Therapists higher versus lower on attachment avoidance more often mentioned the interviewer was good, and less often said that there were parts of it that were difficult.

Reasons for Participating

Table 3 includes the results for why therapists participated along with a comparison of attachment subgroups.

When asked about their reasons for participating, therapists typically said they wanted to help the researcher. For example, Case 9 said "I want to help another grad student out."

Therapists variantly mentioned that they participated for research karma (i.e., others will help you if you help others), as described by Case 3, "I don't know if I

fully believe this is a thing, but I'm starting to I think, the whole 'research karma' thing. It's very silly but I believe it."

Therapists also variantly said they participated because ruptures are an interesting and important topic. Case 14 explained, "I think it's a very interesting topic to me . . . given my psychodynamic interpersonal orientation, I think that it's a very important topic so I think it's highly scientifically valuable."

Another variant category was therapists participating because they wanted to process the rupture. Case 13 said, "It seemed like it would be a good chance to also process my own client."

Finally, therapists variantly mentioned they participated because they had a relevant example of a rupture. Case 3 said, "This particular client . . . is the king of the ruptures. I kind of thought if I do the study I'll certainly have one pretty soon probably with him because that is just the way that our therapy works. So I figured it would be helpful for the researcher."

A few meaningful differences emerged between the subgroups. Therapists lower as compared with higher on attachment anxiety more often reported participating for research karma. Therapists lower as opposed to those higher on attachment avoidance more often reported participating because of research karma and wanting to help the researcher.

Chapter 4: Discussion

Therapist trainees reported ruptures more infrequently than expected. In Safran et al.'s (2011) meta-analysis, they found that therapists reported ruptures in about half of their sessions. However, in this study it took therapists two months on average to report a rupture when they were seeing anywhere from three to ten clients in a variety of settings including counseling centers, community clinics, and hospitals. Seven of the therapists who were tracked never reported a rupture across a period of six months. These seven therapists were slightly more anxiously attached on average than those who reported ruptures. Hence, it is possible that this group was particularly careful about avoiding conflict.

Explanations for why the therapists tracked in this study did not report ruptures as frequently as in other studies could be that therapists in general were very careful about avoiding conflicts. Alternatively, it could be that they were not aware of conflicts that arose. Given that this sample of therapists reported ruptures relatively infrequently, these trainees might view ruptures as larger rather than smaller conflicts in the relationship or therapeutic work. This view contradicts Safran and Muran's (2000) view that very small conflicts are ruptures. Nevertheless, it could be that therapists did not think it would be very informative for the study to be interviewed about a smaller conflict that they believed would not have a significant impact.

It is also important to note that the ruptures in this study fall more in line with Safran's (1993a, 1993b) definition of confrontational ruptures rather than withdrawal ruptures. That is, clients in this study expressed some dissatisfaction with the therapist or therapy, rather than emotionally withdrawing. It is possible that withdrawal

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ruptures are harder to pinpoint or are less emotionally arousing for a therapist, and thus impacted the frequency of ruptures reported. In addition, it could be that therapist trainees view ruptures as more hostile events. Indeed, before therapists participated in this study, they mentioned that they were unsure if they had ever experienced a rupture before because they thought of the term rupture as something very grand and combative. Hence, it is important to think of the present findings in the context of confrontational ruptures.

In the following sections, we first review the results for the total sample. We then review the results for the attachment style subsamples. Finally, we discuss the limitations of the study, and provide implications for training, practice, and research.

Total Sample

Examining the results for the total sample, these therapists did not indicate very specific antecedents to their reported ruptures. Rather, they reported that the session began as either a typical session or a session that started in a tense state. When the session began in a tense state, it was typically viewed as being due to the client carrying over negative feelings from previous sessions (e.g., a buildup that therapy tasks were seemingly irrelevant to the client) or the client experiencing negative emotions related to things outside of therapy (e.g., client having a fight with their partner).

With respect to experiences during the rupture, these therapists typically indicated they had lowered self-efficacy, frustration and anger, and discomfort and anxiety. Therapists also variantly reported feeling hurt, trying to self-regulate, and

feeling concern for the client. Hence, not surprisingly, ruptures were unnerving events for these therapists, who seemed to be juggling many thoughts and emotions.

When asked about their client's experience during the rupture, therapists typically indicated that their clients expressed anger or frustration toward them or the therapy. They also variantly reported that the client seemed hurt or rejected, was concerned about how the therapist was feeling in the moment, and expressed unclear feelings. In sum, therapists were faced with a range of mostly negative emotions from both themselves and the clients invoked by the rupture.

Despite the many negative emotions experienced during the rupture, these therapists typically tried to repair the rupture by using immediacy and exploring the rupture further. They also variantly reported that they acknowledged their own wrongdoing in the session and modified their behavior to accommodate client in sessions following the rupture. These results suggest that all but two therapists tried to intervene to manage the rupture, rather than ignoring it or hoping that the rupture would resolve on its own. The two therapists who did not try to repair the rupture felt it was too delicate and would not result in any recovery.

Therapists reported both positive and negative consequences of the rupture. For negative consequences, therapists typically reported feeling anxious about their continued work with the client and that the rupture strained their therapeutic relationship. In addition, therapists variantly reported the client did not attend the following session and that they (the therapists) had lingering negative feelings toward the clients. However, on the positive end, therapists typically indicated that the therapeutic work became more productive, and variantly indicated that ruptures

eventually strengthened the therapeutic relationship and helped them understand the clients better. These results suggest the ruptures can have both positive and negative consequences.

Furthermore, perhaps not surprisingly, therapists reported that clients' interpersonal problems, resistance, lack of motivation, and unrealistic expectations contributed to the ruptures. These findings suggest the importance of therapist's developing compassion and tolerance for client problems, as well as educating their clients about the therapy process.

Therapists also acknowledged their own contribution to the ruptures. They talked about poorly managing their own reactions, not being attuned with their clients, avoiding talking about important issues with their client, fulfilling their own needs, and colluding with the clients. These results suggest that these therapists had both internal (i.e., managing own emotions) and external factors (i.e., intervening in an empathic way) to improve upon when working with ruptures in therapeutic relationships.

The overall results converge with previous literature in a few ways. First, in terms of consequences, several cases were able to work through the rupture, which eventually led to deeper therapeutic work, a stronger therapeutic relationship, and a better understanding of the client. These findings resonate with Safran and Muran's (2000) review that a successful resolution of a rupture can foster growth for both the therapist and client. Second, Safran and Segal (1990) said that ruptures are associated with the activation of a client's dysfunctional interpersonal patterns. Indeed, we found that every case but one reported that the client's interpersonal problems manifested in

the therapy and contributed to the rupture. Hence, client's dysfunctional patterns seem to be important in understanding and managing ruptures. Finally, our findings about therapist repair attempts converge with Safran et al.'s (2001) suggestions for therapeutic practice in a few ways. According to Safran et al., it is important for clients to express negative feelings about the therapy or the therapist. Thus, this sample's attempts to explore the rupture further by opening up the space for the client to talk about their negative feelings were helpful in theory. Safran et al. also suggests that therapists explore what is transpiring in the therapeutic relationship, which several of these therapists did by using immediacy. Finally, Safran et al. suggests that therapists accept responsibility for their part in the rupture. Only a few therapists in this study acknowledged their wrongdoing, but this could be a function of suitability. That is, it may not be appropriate for the therapist to always say what they did wrong for some rupture events. Overall, despite these therapists not having training specifically focused on rupture repair, they still were able to engage in helpful repair processes.

Attachment Anxiety

Twenty-four percent of the results showed meaningful differences between attachment anxiety subgroups. Therapists lower on anxiety compared to those higher on anxiety more often used immediacy and facilitated exploration of the rupture as repair attempts. Given that anxiously attached individuals are sensitive to markers of rejection or abandonment (Brennan et al., 1998), they might have been overwhelmed by a rupture event and thus were less inclined to explore the rupture further or use immediacy since it can be a vulnerable intervention. The therapists lower on anxiety

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might not have been as activated as therapists higher on anxiety, and consequently were able to attempt a thorough repair.

Another interesting finding was that therapists higher on attachment anxiety, which is partially defined as a fear of abandonment (Brennan et al., 1998), more often had clients who did not attend the next session. Hence, it is possible that the rupture reinforced this fear. In addition, we found that therapists lower compared to those higher on attachment anxiety had lingering negative feelings toward their client, although the rupture ultimately strengthened their relationship. It is possible that these therapists were more able to tolerate the conflict and allow themselves to have negative feelings, but eventually were able to move past them. These therapists might have been more able to be empathic with the client's situation in the rupture, whereas therapists higher on anxiety attachment might have been so caught up in their own fear of rejection that they were then unable to gain as much from the rupture.

One perplexing finding was that therapists lower compared to those higher on attachment anxiety more often reported experiencing discomfort and anxiety during the rupture. However, perhaps feeling anxiety has more to do with the content of the rupture. That is, it is possible that the ruptures experienced by therapists lower on attachment anxiety were more related to their own interpersonal issues. In addition, therapists lower on anxiety attachment generally said their sessions started in a tense state whereas therapists higher on anxiety attachment said they were having a typical session before the rupture occurred. Again, perhaps this finding is speaking more to the nature of the rupture than therapist attachment. In this case, a rupture that lasts

throughout the session would incite more anxiety than a rupture that only takes up part of the session.

Attachment Avoidance

Twenty-one percent of the results showed meaningful differences between attachment avoidance subgroups. Therapists lower as compared with those who were higher on attachment avoidance more often reported concern for client. Since attachment avoidance is associated with a blocking of internal experience when conflict arises (Mikulincer & Shaver, 2002), it might be that therapists lower on attachment avoidance were able to feel more empathy toward client in this conflict.

Therapists lower on attachment avoidance compared to those higher on avoidance also more often reported that their client expressed concern about the therapist's feelings. Given that attachment avoidance is associated with the degree to which a person feels comfortable with emotional closeness (Mikulincer & Shaver, 2002), it makes sense that therapists low on attachment avoidance would more readily pick up on the emotions and intentions of their clients. It is also possible that clients felt more comfortable to express such emotions with a non-avoidant therapist.

For repair attempts, therapists lower on avoidance compared to therapists higher on avoidance more often facilitated exploration about the rupture. Perhaps higher avoidantly attached therapists disengage from conflict given their tendency to deactivate their emotions when faced with conflict (Mikulincer & Shaver, 2002). It is possible these therapists reacted by shutting down and not exploring the rupture further.

For rupture consequences, therapists higher compared to therapists lower on attachment avoidance more often reported a better understanding of the client and the client not attending the next session. It is possible that major conflict can actually help the more avoidant therapist to open the door to greater emotional closeness with the client, and consequently help them to better understand the client. As with more anxiously attached therapists, therapists who were higher on avoidance also more often reported that their client didn't attend the next session. This could be related to the less securely attached therapists less frequently reporting repair attempts during the session in which the rupture occurred. Perhaps their clients were upset with the therapists not attempting to address the conflict when it arose, and led to the client's desire for a brief break from the therapy.

In terms of client and therapist contribution to the rupture, there were a couple of perplexing differences found between higher and lower attachment avoidance. Specifically, therapists lower compared to therapists higher on avoidance more often reported that the client's contribution was their unrealistic expectations about psychotherapy, and that their own contribution was avoiding talking about important issues with client. It is possible that the client's contribution does not have much to do with therapist's attachment style, and more likely speaks to the client's own attachment style. For the therapist's contribution, despite these therapists being lower on avoidance, perhaps the topics they were avoiding were hot buttons for these therapists.

Limitations

Because all of the participants were therapists-in-training, the results may not generalize to experienced therapists. For instance, it is possible that experienced therapists are more aware of how their attachment styles relate to problems that arise in the relationship. Thus, their experience of conceptualizing and repairing ruptures could differ from trainees who are relatively novice in handling their personal reactions in session. It is also important to note that these trainees primarily identified as psychodynamic and interpersonal in their theoretical orientation. Hence, an examination of cognitive-behavioral therapists who experience ruptures might reveal different results. In addition, because this was a descriptive field study, we could not establish causal relationships among therapist attachment style and the management of rupture events, although we did provide a rich description of therapists' experiences.

Another limitation was using a self-report measure for therapist attachment style. Given the interpersonal nature of therapeutic work, social desirability might have influenced therapists' responses on the ECR. Hence, an attachment measure that is not self-report, such as the Adult Attachment Interview (George, C., Kaplan, N., & Main, M., 1985), could have been a more valid measure of attachment. However, given the amount of time required to learn how to administer this interview and to interpret the data and because an extensive body of research exists using the ECR, we used the ECR.

Other limitations involve the research team and procedures. It is possible that the interviewers influenced what emerged during the interviews (e.g., probing certain points more than others). In addition, given the coding team was primarily from one

counseling psychology doctoral program, it is likely that the results were influenced by the training principles of this program. For example, the coding team placed a high value on using immediacy to address conflict in therapy, whereas other trainees might not place such a high value on this intervention. In order to address this limitation, the research team reviewed their biases and expectations in an ongoing manner during the coding process.

It is also possible that tracking therapists for ruptures could have influenced their reports. For instance, it is possible that therapists felt inclined to report a rupture, even if it was not a major event, in order to help a fellow graduate student researcher and contribute to the study. In addition, social desirability could have influenced interviews. Given that ruptures are somewhat vulnerable topics for a trainee, trainees could have been motivated to paint a rosy picture on how they managed the event. However, it is also likely that therapist trainees felt more comfortable speaking with other trainee interviewers than they would have with experienced interviewers.

Finally, it is important to note that therapist trainees recruited for this study were generally unfamiliar with the definition and meaning of ruptures. They had a lot of uncertainty about the definition of ruptures and asked many questions before participating. This was somewhat surprising given that the recruited therapists were from psychodynamic-interpersonal training programs that focus a lot on the therapeutic relationship. Hence, this lack of knowledge could have influenced the results.

Implications for Training, Practice, and Research

In terms of training, it seems that trainees could benefit from learning more about ruptures in their doctoral programs given that they had so many questions about definitions. In addition, despite these therapists generally reporting that they experienced intense negative emotions, only a few of them reported attempting to self-regulate and manage what was happening for them internally. Hence, programs may want to provide clinical training on what to do with negative emotions and how to use them to the advantage of the therapeutic work.

For practice, this study suggests that ruptures are not purely negative events that should be avoided. In contrast, ruptures are grist for the mill. If therapists can manage the conflict effectively, then it is possible for therapeutic progress to follow. In sum, it could be helpful for trainees to look at ruptures as part of the therapeutic process rather than as a mistake that will permanently damage or even end the therapy.

For research, this study suggests that there are differences between therapists of different attachment styles in how they experience and manage ruptures. Thus, it is important to continue this examination to studies of larger, different samples (e.g., therapists of different theoretical orientations, more experienced therapists, or open-ended versus short-term treatment). In addition, it would be useful to see how the interaction of therapist and client attachment styles relates to the prevalence and management of ruptures. It is possible that certain pairings of clients and therapists with respect to attachment styles result in more or fewer ruptures, as well as differences in management. Finally, it would also be helpful to more closely examine the different parts of rupture events (e.g., repair attempts and consequences). For

instance, researchers could closely track the interventions therapists use in response to a rupture and see which interventions are most effective for different clients and at different points in therapy.

Appendix A

Literature Review

In this section, I will expand on the relevant studies to provide a greater context for the present study. Following the outline of the introduction, I will review ruptures in psychotherapy, attachment theory, therapist attachment in relation to psychotherapy process and outcome, and finally therapist attachment in relation to ruptures.

Ruptures in Psychotherapy

Safran and Muran (2000) defined ruptures as the strains, tensions, or breakdowns in therapy that, when unaddressed, may interfere with ongoing collaborations between the therapist and client. Although ruptures may be the most common term used to describe these types of events, they have also been referred to as empathic failures, transference-countertransference enactments, and misunderstanding events (Safran & Kraus, 2014). The intensity of ruptures lies on a spectrum from minor to severe, and they are found in all treatment modalities. Because ruptures are associated with the activation of dysfunctional interpersonal patterns, they provide moments of potentially productive exploration for the session (Safran & Segal, 1990). Hence, if ruptures are detected and successfully negotiated in therapy, they can cultivate growth and insight for both the client and therapist. On the other hand, researchers have started to show that unresolved ruptures might lead to weakening alliances or dropout (Safran et al., 2011).

Safran, Muran, and Eubanks-Carter (2011) completed several reviews that offer insight into the nature of ruptures. First, they examined the prevalence of ruptures in therapy as evaluated by the therapist, client, and observer perspective. In the studies examining the therapist or client perspective, researchers had the therapist or client complete post-session self-report measures of the alliance or self-report indices measuring the occurrence of ruptures, rupture intensity, and the extent to which ruptures were resolved. For example, one of the studies included in their

review obtained frequency of reported ruptures by having 44 clients complete the

Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) after each of their

30 sessions of treatment (Stevens et al., 2007). Ruptures were defined as a decrease of

at least one point on the WAI in one session, or more than one point in one or more

consecutive sessions. Thus, if the client-rated working alliance dropped one point or

more in a session, a rupture was counted for that session. For observer-rated methods,

studies included in the review had sessions transcribed and coded by judges using the

Collaborative Interaction Scale (CIS; Colli & Lingiardi, 2011), Harper's (1989a,

1989b) unpublished coding system, or the Rupture Resolution Rating System (3RS;

Eubanks-Carter, Muran, Safran, 2009). For example, Sommerfeld et al. (2008) had

judges identify confrontation and withdrawal ruptures using Harper's coding system

in 151 sessions from five clients in psychodynamic psychotherapy.

Across eight studies examining the frequency of reported ruptures, Safran et

al. (2011) found that clients reported ruptures in 19 to 42 percent of sessions,

therapists reported ruptures in 43 to 56 percent of sessions, and observers reported

ruptures anywhere from 41 to 100 percent of sessions. There are several reasons why

reported ruptures would vary depending on perspective. For the client, it is possible

underreporting happens because of their lack of awareness of ruptures or because they

feel uncomfortable reporting them. For the therapist, it is possible they generally

report more than the client because they are particularly evaluative of what is

happening in the relationship. However, therapists might report less than observers

because they are influenced by the hope that the treatment is going well. For the

observer, it is possible they report the most ruptures because their feelings are not at

stake. However, this outsider perspective is also limited given that observers are not actual participants in the relationship.

In one of their meta-analyses, Safran and colleagues (2011) examined the relationship between rupture repair episodes and psychotherapy outcome. Studies included in this meta-analysis defined rupture-repair episodes based on session-to-session fluctuations in client-rated alliance scores and explored the relationship between the presence of these episodes and outcome. There were several outcome measures in these studies with a few of them being the Inventory of Interpersonal Problems (IIP; Horowitz, Rosenberg, Baer, Ureño & Villaseñor, 1988), Global Symptom Index (GSI) of the Symptom Checklist 90-Revised (SCL-90-R; Derogatis, 1983), and Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss, & Cohen 1976). Across three studies including a total of 148 clients, they found a medium effect size ($r = .24$, $z = 3.06$, 95% CI [.09, .39], $p = .002$) that indicated the presence of a rupture repair episode was positively related to good outcomes. This provides support for the idea that, if identified and successfully resolved, ruptures provide opportunities for client improvement in psychotherapy.

In their final meta-analysis, Safran and colleagues (2011) reviewed the effect of rupture resolution training on client outcomes across seven studies that compared between groups, where one group of therapists received training in rupture repair and one group did not. In these studies, therapists received training that had a component specifically focused on repairing alliance ruptures. For example, in one of the studies, Castonguay et al. (2004) integrated procedures to repair ruptures in a previously established treatment of cognitive therapy for depression. Similar to Safran and

colleagues' (2011) previous meta-analysis, outcome measures in these studies included the IIP, GAS, and GSI. They found a small effect size ($r = .11$, $z = 2.24$, 95% CI [.01, .21], $p = .03$) that indicated treatments that trained in rupture repair led to small but significant client improvements relative to treatments with therapists who did not have such training. Hence, there is evidence to suggest that training in rupture repair is important to psychotherapy outcome.

In sum, the prevalence of ruptures in the therapeutic relationship differs according to the therapist, client, and observer perspective. These meta-analyses suggest that rupture repair can be helpful for psychotherapy outcome, and that therapists who are trained in rupture repair have better client outcomes than those who are not trained in rupture repair. Hence, it is important to develop further knowledge on how to train therapists to repair ruptures. One potential avenue is to understand how therapist factors relate to the therapist's understanding and management of ruptures. One such therapist factor that has gained recognition in relation to the therapist's process of identifying ruptures and facilitating repairs is attachment style.

Attachment Theory: An Overview

Attachment theory, which was originally developed to describe the bonding between infant and parent, is based on the belief that humans have a biological predisposition to form and maintain relationships that provide safety and security in times of distress (Bowlby, 1969/1982). The attachment system is thought to be most intensely activated when one is in need of care. For example, when one is vulnerable, ill, or distressed, their inclination to seek comfort and care from an attachment figure

is strengthened. Once the goal of acquiring a sense of security is reached, the attachment system is deactivated. Although the attachment system is most important during the first years of life, it is thought to be activated over one's life span and is exhibited in thoughts and behaviors related to care seeking from close figures like romantic partners. Hence, Bowlby (1988, p. 82) described the need for attachment relationships to continue "from the cradle to the grave."

What characterizes an attachment figure is the need to maintain proximity to that person, the feeling of distress upon separation and pleasure upon reunion, and the experience of grief at their loss. In addition and perhaps most importantly, an attachment figure serves as a secure base from which to explore the world (Daniel, 2006). Furthermore, attachment figures provide a safe haven in times of distress. Throughout one's life, a person can have more than one attachment relationship, and attachment figures tend to change throughout development. Typically, a parent starts off as a child's primary attachment relationship, but when the child becomes an adult, their romantic partners or close friends serve this role (Ainsworth, 1989).

Attachment Theory: Individual Differences

Bowlby (1973) described differences in the functioning of the attachment system that result from a caregiver's actions. Interactions with caregivers who are sensitive to one's needs, available in times of distress, and responsive to one's attempts at closeness, result in attachment security. Consequently, attachment security provides the feeling that the world is generally safe, and when it is not, a caregiver will be there to help. It makes exploring and engaging with the world easier. Furthermore, attachment security leads to one having positive views of the self as

valued and worthy of care. These positive mental representations of the self and expectations of attachment-related interactions, called internal working models, guide the individual in other attachment relationships. In addition, affect-regulation strategies are organized around these positive beliefs (Mikulincer & Shaver, 2002). In contrast, interactions with attachment figures who do not provide sensitivity to one's needs and who are unavailable in times of distress, result in a lack of attachment security, or attachment insecurity. Hence, negative internal working models are developed (i.e., the person questions their worth and others' intentions), and strategies of affect regulation other than proximity seeking are adopted. These strategies, known as secondary attachment strategies, are conceptualized in terms of two dimensions: anxiety and avoidance.

Attachment anxiety is the degree to which individuals are sensitive to markers of rejection or abandonment from their caregivers. A person high on anxiety typically had a caregiver who was inconsistently available. In order to adapt to this caregiving environment, the anxious person learns to keep their attachment system chronically hyperactivated and intensifies bids for attention. Attachment avoidance, by contrast, is the degree to which a person feels uncomfortable seeking support in times of need. A person high in avoidance typically had a caregiver who was consistently distant or unavailable. In order to adapt to this caregiving environment, avoidant individuals learn to block (deactivate) emotional states associated with threat so that they do not have to seek out help from their attachment figures. Bartholomew (1990; Bartholomew & Horowitz, 1991) offered a helpful framework for conceptualizing patterns of adult attachment in terms of anxiety and avoidance levels. *Secure*

attachment is characterized by a pattern of low anxiety and avoidance, while *fearful* attachment is characterized by a pattern of high anxiety and avoidance. These attachment styles form one of the two poles describing overall degree of attachment insecurity. On the other pole lie *preoccupied* and *dismissing* attachment styles. Preoccupied attachment is characterized by high anxiety and low avoidance, while dismissing attachment is characterized by high avoidance and low anxiety. Preoccupied, dismissing, and fearful attachment styles are all considered patterns of insecure attachment since they all involve high levels of anxiety and/or avoidance.

The Relevance of Attachment Theory to Psychotherapy

Bowlby (1988) believed that the attachment system is likely to be activated in psychotherapy because, similar to parenting, it involves caregiver and care-seeking interactions. For instance, if a client has an internal working model that caregivers are unreliable, that client may not trust that the therapist will be a good support system. Indeed, Bowlby wrote about many of the attachment concepts in how they were applicable in psychotherapy. For example, Bowlby discussed how the therapist acts as a secure base and should aim to cultivate a secure attachment relationship with their client. Bowlby also expected that negative internal working models would manifest in therapy with clients who have difficult relationship histories.

Just as the client's attachment patterns manifest in therapy, so do the therapist's. Ruptures are a primary example of when the therapist's attachment system may be activated in therapy. Because ruptures are a threat to the continuation of the therapeutic relationship and the therapy, therapists may respond differently to such a threat depending on their attachment style. Furthermore, a therapist's internal

working models of what to expect in close relationships may influence interpersonal interactions with clients. Indeed, researchers have found that attachment security is linked to variables related to relationship success including the ability to regulate emotions, tolerate conflict, and accurately perceive others' intensions (Mikulincer & Shaver, 2007). Consequently, researchers have begun to examine how therapist attachment is related to the process and outcome of psychotherapy.

Therapist Attachment in Relation to the Therapeutic Alliance

There is a significant body of research that suggests that therapist attachment is related to psychotherapy process and outcome (Daniel, 2006). Several researchers have specifically studied the relationship between therapist attachment and the therapeutic relationship. Dunkle and Friedlander (1996) were one of the first to examine how therapists' attachment security was related to client ratings of emotional bond with their therapist. Participants in this study were 73 therapists (34 men, 39 women; age $M = 34.56$) from 15 university counseling centers and six training clinics. Twenty-one percent had bachelor's, 42.5% had master's, and 35.6% had doctorates. The clients were 31 men and 42 women who primarily reported problems with depression, romantic concerns, and academics and/or marital/family concerns. Therapists first completed the Adult Attachment Scale (AAS; Collins & Read, 1990) to assess attachment. After sessions 3 through 5, therapists and clients completed the short form of the Working Alliance Inventory (WAI; Tracey & Kokotovic, 1989). They found that therapists' comfort with closeness was significantly positively related to client-rated working alliance ($r = .39$, $p < .01$). Furthermore, they found that therapists' comfort with closeness significantly predicted the bond of the working

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alliance (β = .38, p = .01). Thus, clients whose therapists reported greater comfort with closeness were more likely to rate the emotional bond positively.

In a similar study, Sauer et al. (2003) examined the relationship between therapist attachment style, as measured by the Adult Attachment Inventory (AAI; Simpson, 1990; Simpson, Rholes, & Nelligan, 1992), and the working alliance as measured by the Working Alliance Inventory (WAI, Horvath & Greenberg, 1989). Thirteen therapists (3 men, 10 women, age M = 29.15) and 17 clients (6 men, 11 women, age M = 32.75) were in the study. The therapists had a range of experience from one to five or more years, with the majority of them enrolled in a graduate program in clinical or counseling psychology. Both therapists and clients completed the AAI. After the 1st, 4th, and 7th therapy sessions, clients and therapists rated the working alliance. They found that therapist attachment anxiety was positively associated with the working alliance for session 1 (r = .40, p < .05). However, hierarchical linear modeling results indicated that therapist attachment anxiety had a significant negative effect on client-rated working alliance over time (t = -3.77, r = .69, p <.001). Client-rated working alliance was not related to any other therapist or attachment variables.

Black, Hardy, Turpin, and Parry (2005) examined how the therapist's perspective of the working alliance was related to their attachment style. They distributed an online questionnaire comprised of the Attachment Style Questionnaire (ASQ; Feeney et al., 1994), the Agnew Relationship Measure (ARM; Agnew-Davies et al., 1998), and the Brief Eysenck Personality Questionnaire (EPQ; Eysenck & Eysenck, 1969) to 1,400 psychotherapists listed on three registers for accredited

therapists in the UK. A total of 491 psychotherapists (146 men, 345 women, age *Median* = 46) responded. They found that the ASQ Confidence scale, representing secure attachment behaviors like trust in others and belief in self worth, was significantly positively related to therapist-rated alliance ($r = .44$, $p < .001$). In addition, the ASQ Need for Approval and Preoccupation with Relationships scales, representing preoccupied attachment behaviors, were negatively related to therapist-rated alliance with correlations of $r = -.28$, $p < .001$ and $r = -.32$, $p < .001$, respectively. Finally, the ASQ Discomfort with Closeness and Relationships as Secondary scales, representing dismissive attachment behaviors, were negatively related to therapist-rated alliance with correlations of ($r = -.26$, $p < .001$) and ($r = -.18$, $p < .001$), respectively.

In the aforementioned studies, therapist attachment style was related to both the client and therapist rated alliance. Specifically, Dunkle and Friedlander (1996) and Black et al. (2005) found that attachment security was positively related to client rating of emotional bond and therapist rating of the alliance, respectively. Although Sauer et al. (2003) found a contradictory finding that attachment insecurity, specifically attachment anxiety, was positively related to the alliance after session 1, they also found similar to the other two studies that attachment insecurity had a negative influence over time.

Therapist Attachment in Relation to Therapist Behavior in Session

In addition to studying the relationship between therapist attachment and the therapeutic alliance, researchers have also examined how therapist attachment is related to therapist behavior in session. Dozier, Cue, and Barnett (1994) investigated

the association between case manager attachment and depth of interventions and attention to the needs of 27 psychiatric patients. Eighteen case managers (six men, 12 women; age $M = 35$) and 27 clients (21 men, 6 women; age $M = 34$) were interviewed with the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985) to assess attachment style. Once a month for five months, case managers were interviewed about their most recent sessions with their clients. They were asked about issues that arose in the session and to discuss how they handled the interaction. Raters coded the depth of interventions discussed in the interviews using a scale ranging from 1 = *low intervention depth* to 4 = *high intervention depth,* as well as whether or not the case managers attended to clients' dependency needs.

They found that more dismissive case managers intervened in less depth and perceived less dependency needs from the client, whereas more preoccupied case managers intervened in more depth and perceived greater dependency needs. Hence, insecure case managers' own countertransference seemed to manifest in their interventions. In addition, the insecure case managers intervened in greater depth and perceived more dependency needs from preoccupied clients compared to dismissive clients. However, the opposite was found for secure case managers. That is, secure case managers intervened in greater depth and perceived more dependency needs from dismissive clients compared to preoccupied clients. Bowlby (1988) suggested a primary task of the therapist is to help clients identify and change their maladaptive interpersonal patterns. One way to achieve this is for the therapist to adopt a stance (i.e., noncomplementary) that is in contrast to the client's inflexible expectations of others. Dozier et al.'s (1994) results show that secure therapists were more able to

provide this noncomplementary stance than insecure therapists, thus challenging the client's maladaptive interpersonal patterns.

In a similar study, Mohr, Gelso, and Hill (2005) investigated therapist and client attachment style as predictors of countertransference behavior in 93 first sessions of therapy. Participants included 27 graduate-level therapists-in-training (6 men, 21 women; age $M = 25.14$), 93 undergraduate student clients (37 men, 56 women; age $M = 18.72$), and 12 supervisors (6 men, 6 women; age $M = 33.73$) of whom 11 were advanced doctoral students and one was a male clinical psychologist. Therapists and clients completed the Experience in Close Relationships Scale (ECR; Brennan, Clark, & Shaver, 1998) as a measure of attachment, and supervisors completed the Countertransference Behavior Measure (CBM) after the first session of therapy, which was based on the Inventory of Countertransference Behavior (ICB; Friedman & Gelso, 2000). They found that dismissing therapists were generally more likely than others to engage in hostile countertransference. In addition, they found that the interaction between therapist and client attachment predicted hostile and distancing countertransference reactions, such that fearful or dismissing therapists with preoccupied clients had the highest countertransference reactions. This finding suggests that countertransference is most likely to occur when the therapist and client differ in their patterns of attachment insecurity. For instance, dismissing therapists were more likely to engage in negative countertransference behavior like being critical or hostile with preoccupied clients, whereas preoccupied therapists were more likely to engage in these behaviors with dismissive clients.

In another study examining therapist attachment and countertransference, Ligiero and Gelso (2002) found conflicting results to Mohr, Gelso, and Hill (2005). Participants were 50 therapists-in-training (13 men, 37 women; age $M = 27.54$) from master's level and doctoral level programs in counseling or clinical psychology, and 46 supervisors (17 men, 29 women; age $M = 40.86$). Therapists completed the Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991) as a measure of attachment style, and the WAI-short version for one of their clients with whom they had attended between three and nine sessions. Supervisors completed the WAI-short version and the Countertransference Index (CTI; Hayes, Riker, & Ingram, 1997) and the ICB for the same client the therapist indicated. They found that level of secure attachment was negatively related to negative countertransference behaviors ($r = -.28$, $p < .05$) like being excessively critical towards a client. However, they did not find a relationship between insecure attachment patterns and countertransference behaviors.

In sum, the literature shows that securely attached therapists can effectively use countertransference (Dozier et al., 1994). Attachment insecurity, however, is more complex. Whereas Dozier et al. (1994) and Mohr et al. (2005) found that insecurely attached therapists had more negative countertransference, Ligiero and Gelso's (2002) results did not support this finding. Differences in findings could be due to the different measures of attachment used (i.e., the AAI, ECR, or RQ) or the different time periods the therapist behaviors were measured (i.e., the first session of therapy, in the middle phase of therapy, or once a month for five months of treatment). Lastly, Dozier et al. (1994) and Mohr et al. (2005) suggest that the

interaction between therapist and client attachment styles influences therapist countertransference behaviors.

Therapist Attachment in Relation to Ruptures

There have been relatively few studies examining the relationship between therapist attachment and ruptures. As one of the first studies to examine this topic, Rubino et al. (2000) did an analogue study examining the relationship between therapists' resolution of ruptures and their attachment styles. They created four video vignettes that simulated alliance ruptures during psychotherapy sessions, with each vignette representing a client with one of the four attachment styles (i.e., secure, dismissing, fearful, and preoccupied). Participants were 77 clinical psychology graduate students (age $M = 29$) in their third year of a program at a British university. First, the therapist trainees all completed the Relationship Scales Questionnaire (RSQ; Griffin & Bartholomew, 1994) as a measure of their attachment style. Next they watched the four videos of the clinical vignettes, which were presented in a randomized order for each therapist. During the vignettes, participants were given background information about each client and instructed to respond as if they were the portrayed client's therapist.

Participants' responses were transcribed and independently rated by the principal investigator and two clinical psychology graduate students. Coders rated *response empathy* using a 5-point scale where 1 = *not at all empathic* and 5 = *very much empathic*. Coders also rated *response depth* using the Depth of Interpretation Scale (Harway, Dittman, Raush, Bordin, & Rigler, 1953), which is a 9-point scale comprised of three levels of interpretation (superficial, moderate, and deep).

Superficial ratings (1 to 3) were either restatements or repetitions, moderate ratings (4 to 6) provided a re-elaboration of the client's material, and deep ratings (7 to 9) reflected material of which the client did not seem aware. Intraclass correlation coefficients for the raters on response empathy ranged from .66 (secure client) to .76 (fearful client), and for response depth ranged from .80 (secure client) to .94 (preoccupied client).

Before assessing how therapist attachment style was related to vignette responses, Rubino and colleagues conducted a factor analysis on the RSQ items and found that two factors of attachment anxiety and attachment avoidance emerged. These findings are consistent with those of Brennan et al. (1998) and provide further support that self-report measures of attachment can be understood in terms of the anxiety and avoidance orthogonal dimensions. Next, they analyzed empathy and depth of response separately using GLM Repeated Measures ANOVA, with therapist attachment style (attachment anxiety and attachment avoidance) as the independent variable, and the attachment style of the client portrayed in the vignette (secure, preoccupied, fearful, or dismissive) as the repeated measures factor. They found a main effect of attachment anxiety with more anxious therapists responding less empathically than less anxious therapists ($F(1,72) = 4.04$, $p = .048$). Furthermore, more anxious therapists were particularly less empathic with secure and fearful clients, although there was no difference in response empathy between more and less avoidant therapists. Finally, depth of response was not related to either attachment anxiety or avoidance.

Eames and Roth (2000) examined how therapist attachment is related to their perception of the frequency of ruptures in the early phase of psychotherapy. Participants included 11 therapists (seven men, four women) who worked in outpatient clinics in the UK. Nine of the therapists were clinical psychologists with experience ranging from 1 to 23 years post-qualification, while the other two therapists were in their final year of training in clinical psychology. Therapists saw a total of 30 clients (13 men, 17 women; age $M = 34.7$) ranging from one to six clients each. After sessions 2 through 5, therapists completed one part of the Post-Session Questionnaire (Muran, Safran, Samstag, & Winston, 2004) that asks whether or not the therapist experienced any significant disruptions in the therapy session. They found a significant positive correlation between therapist preoccupied attachment and the frequency of reported ruptures ($r = .50, p < .01$), and a significant negative correlation between therapist dismissive attachment and the frequency of reported ruptures ($r = -.42, p < .05$). They did not find a significant correlation between therapist secure attachment style and frequency of reported ruptures. Thus, therapists with preoccupied attachment reported more ruptures, whereas dismissively attached therapists reported fewer ruptures, as would be expected based on attachment theory (Mikulincer & Shaver, 2002).

To deepen an understanding of ruptures in therapy, Marmarosh et al. (2014) examined how therapist self-reported attachment anxiety and avoidance related to therapists' perceptions of rupture tension, effort to repair, and resolution. Participants were 22 second-year doctoral-student therapists (3 male, 18 female, 1 transgender; age $M = 27.11, SD = 5.09$) from a university-based community clinic that trains

students in psychodynamic treatment. Participants rated on a scale of 1 to 10 how much they adhered to cognitive-behavioral (*M* = 5.25, *SD* = 2.07), psychodynamic (*M* = 7.68, *SD* = 1.29), and humanistic/existential theories (*M* = 4.75, *SD* = 2.45) theories when working with clients. Therapists' clients reported a range of issues including major depression, trauma-related disorders, adjustment disorders, anxiety disorders, and personality disorders. In terms of procedure, therapists first completed the Experience in Close Relationships Scale (ECR; Brennan, Clark, & Shaver, 1998) to assess attachment style. After the eighth session with their client, therapists completed one section of the Post-Session Questionnaire (Muran, Safran, Samstag, & Winston, 2004). In this questionnaire, therapists were first asked about rupture presence, specifically if they experienced any tension or problem, any misunderstanding, conflict, or disagreement in their relationship with the client. If they reported yes, therapists then described the rupture in their own words. Finally, therapists reported on a scale of 1 = *not at all* to 5 = *very much*, the degree of tension they felt based on the rupture, the extent to which the rupture was addressed in the session, and the degree to which the problem/tension was resolved.

In terms of number of reported ruptures, fearful therapists reported the most ruptures (five out of six fearful therapists reported ruptures) while dismissive therapists reported the least ruptures (one out of four dismissive therapists reported ruptures) compared to preoccupied therapists (one out of three preoccupied therapists reported ruptures) and secure therapists (four out of nine secure therapists reported ruptures). Using the traditional *p* value of .05, there were no significant correlations between therapist attachment anxiety and rupture tension ($r = .30$, $p > .05$) or

attachment avoidance and rupture tension ($r = -.06$, $p > .05$). However, because of the small sample of anxiously and avoidantly attached therapists, they relied on Cohen's effect size to determine the strength of the correlation. When using Cohen's description of effect sizes, they found a moderate effect ($d = .30$) between attachment anxiety and tension in the expected directions. They also found a positive correlation ($r = .53$, $p < .05$) that represented a strong effect between attachment anxiety and effort to address the rupture. However, there was no relationship between attachment anxiety and resolution of the rupture. Hence, anxiously attached therapists reported making more efforts than other therapists to address ruptures but did not report more resolution of the rupture. Finally, therapist attachment avoidance was not related to rupture tension, effort to address the rupture, or resolution of the rupture.

In sum, the literature on the relationship between therapist attachment and ruptures is relatively small. There are some conflicting findings including which therapist attachment style perceives the most ruptures. However, given that Eames and Roth (2000) used the RQ, whereas Marmarosh et al. (2014) used the ECR, this discrepancy may be due to the use of different measures of attachment. Furthermore, Rubino et al. (2000) provided insight into how therapist attachment is related to rupture response in an analogue setting, but it is important to extend these findings to actual psychotherapy. Furthermore, it seems fruitful to use a qualitative, descriptive approach to provide a more in-depth description of therapists' experiences.

Appendix B

Recruitment Email

We all have tensions, problems, misunderstandings, conflicts, disagreements, and ruptures in our relationships with our clients. These experiences can be scary, awkward, painful, and opportunities for growth if we understand and resolve them.

We need to understand more about these events in psychotherapy to help therapists-in-training learn about how to handle them.

If you are interested in gaining a deeper understanding of these types of experiences, please consider participating in my master's thesis research.

Participation will consist of a brief self-report measure that determines your eligibility for the study. If eligible, you will complete the following questions once a week until we identify a misunderstanding/rupture event:

1. Did you experience any tension or problem, any misunderstanding, conflict or disagreement, with any of your clients this week? Yes or No? (note: only consider adult clients with whom you have had at least 3 sessions and are in ongoing psychotherapy with)

2. Please rate how tense or upset you felt about the problem during session on a scale of 1 = not at all to 5 = very much.

3. Please describe the problem.

Once we've identified the misunderstanding/rupture event, I will call you to schedule an hour-long phone interview. There will also be a 15 minute follow-up interview two weeks later.

We're excited about this study and hope you'll be interested in participating!

Please contact me if you are interested in participating or have any questions.

Appendix C

Interview Protocol

Initial Questions
1. Tell me about the client. (e.g., presenting problems, treatment goals, some relevant background, etc.)
2. Tell me about your therapy relationship with this client.
3. What theoretical orientation are you using with this client?
4. Where in the therapy are you? (e.g., session 3 out of 12?)
5. Describe the rupture.

Antecedents
6. What was going on in the session immediately before the rupture occurred?
7. How did you feel before the rupture occurred?
8. How do you think the client felt before the rupture occurred?

Understanding the Rupture
9. What do you think led to this rupture?
10. What was your part in this rupture?
11. What was the client's part in this rupture?
12. During the rupture, what was happening for you internally? (e.g., thoughts, feelings, etc.)
13. During the rupture, what do you think was happening for the client internally? (e.g., thoughts, feelings, etc.)
14. In what way did this rupture trigger your own personal issues?
15. In what way did your own personal issues trigger this rupture?
16. How did you try to repair the rupture during the session?

Consequences
17. What were the consequences of this rupture for you?
18. What were the consequences of this rupture for the client?
19. What were the consequences of this rupture for therapy?
20. What were the consequences of this rupture for the therapeutic relationship?

Final Questions
21. How did you think about the rupture outside the session? (e.g., self-supervision, peer supervision, supervision)
22. What do you think the client's attachment style is?
23. What do you think your attachment style is?
24. Why did you volunteer to participate?
25. What was your experience in the interview?

Appendix D

Follow-Up Questions

1. Is there an update on what we discussed in the interview?
2. Is this client continuing therapy?
3. How did the interview influence the processing and/or repair of this rupture?

Table 1. Ruptures Reported by Therapists on the Post-Session Questionnaire.

_____

Case 1 "Client wanted me to give her advice on career and interpersonal problems. This request occurred many times." *(Session 6, Community Clinic)*

Case 2 "Client ran a race this week. We talked about it briefly in session and then we moved on. Client became upset and said I didn't appreciate or understand how important the race was to her, and that her previous therapist would have understood." *(Session 4, Community Clinic)*

Case 3 "I was meeting a client on a day that we don't typically meet (I had asked him to reschedule because I had a prior commitment on the day I usually see him). He asked me if I could explain why I couldn't see him in our usually day and wondered about the "constant changing" (we had also recently changed our regular time). He seemed irritated with me and I responded by thanking him for being flexible." *(Session 56, Community Clinic)*

Case 4 "Client was talking about his girlfriend and I made an inaccurate reflection of feeling regarding the situation, which made the client defensive about his girlfriend." *(Session 7, Community Clinic)*

Case 5 "Client expressed that she did not believe that I understood the commitment it takes to be in her position. I tried empathizing but asking what it was like to speak to me when she believed that I had had such a different experience than her in college. She became very cold and aggressive, trying to change the subject. She stated that she didn't believe that I needed to be in a similar situation, but that I could still empathize with her. Based on her tone of voice and manner, I had trouble believing her." *(Session 4, Counseling Center)*

Case 6 "I was out sick this week and missed a therapy session with a client on Wednesday. Unfortunately the message that I was out that day did not get to him, and he was waiting at the regular time although I did not show up. When we met today he was quite angry. He didn't say it was because of the missed session but eventually it came around to that." *(Session 9, Hospital)*

Case 7 "I used a comparison between my patient and her boyfriend which was deeply offensive to her." *(Session 8, Hospital)*

Case 8 "My patient has had spotty attendance for several months and when I explained to her that I would need to discharge her should she miss any more sessions she became frustrated with me." *(Session 10, Community Clinic)*

Case 9 "Client disclosed she missed session to go shopping after previously being late to session the week before. Client shared therapy is a priority but something that she can miss without needing to tell me. Client disclosed she felt I was not providing alternate perspectives and that she felt she was not progressing. Client described feeling stuck and unsure how to apply what she learns in session outside of session. *(Session 5, Counseling Center)*

Case 10 "I found out that my client came in for an emergency session expressing suicidal ideation because he was caught smoking marijuana in the dorms. When he attended next session, he was a completely different person and I found out he had been high in our previous sessions. I was very upset and confused and questioned if I even knew who client really was. Client said he didn't remember anything from previous sessions and that it was all pointless." *(Session 6, Counseling Center)*

Case 11"Client asked me if he can be referred to an off-campus provider so that he can be seen by two people. I inquired about his intention to ask for that. He told me he did not think talking to me like this would make things better, so he wanted someone to work with him on medication and diagnosis."
(Session 5, Counseling Center)

Case 12 "The session was tense overall; although we had planned to have 4 sessions left, the client insisted on terminating at the next session, and was unresponsive to prompts, often changing the subject or showing resistance. She laughed at some interventions, but then stayed over the session time because she didn't want to go to her next class." *(Session 8, Counseling Center)*

Case 13 "The client is having a rough end to his semester and dealing with a lot of stress. He is considering transferring and mentioned that he almost wished that things wouldn't improve at current university to make his decision to transfer easier. In this line, one of the things I planned to work with him on was seeking referral for open-ended therapy. I felt some tension as to whether the client would perceive this as unwelcome, so we talked about his expectations. I perceived a potential conflict that would arise out of "pushing" him to seek the referral, and discussed this dilemma with him openly." *(Session 11, Counseling Center)*

Case 14 "Client and I engaged in an intellectual debate about something related to her symptom. It ended not well." *(Session 9, Counseling Center)*

Therapists' reported ruptures along with session number when rupture occurred and therapy setting is provided.

Table 2. Rupture event results for total sample and therapist attachment subgroups.

Domain/Category/Subcategories	Frequency	Therapist Attachment			
	Total Sample	High Anx	Low Anx	High Avd	Low Avd
Rupture Antecedents					
Session started in tense state	T (8)	1	G (5)*	V (2)	T (4)
Typical session	V (6)	T (4)*	0	V (2)	V (3)
Rupture Event					
Therapist experience during rupture					
Lowered Self-Efficacy	T (11)	T (3)	T (4)	T (3)	G (6)
Frustrated/Angry	T (10)	T (3)	T (4)	G (4)	G (6)
Discomfort/Anxiety	T (9)	V (2)	T (4)*	V (2)	T (4)
Debating course of action	T (8)	V (2)	T (3)	1	V (3)
Hurt/Devalued	V (7)	V (2)	V (2)	V (2)	V (2)
Self-regulation	V (4)	V (2)	V (2)	V (2)	V (2)
Concern for client	V (2)	1	1	0	V (2)*
Client experience during rupture					
Anger/Frustration with therapy/therapist	T (11)	T (4)	T (3)	T (3)	G (6)
Hurt/rejection/devaluation	V (6)	T (3)	T (3)	V (2)	V (3)
Sensitivity around therapist's feelings	V (4)	1	1	0	V (3)*
Unclear or muted feelings	V (4)	1	1	1	1
Repair Attempts					
Therapist used immediacy	T (8)	V (2)	T (4)*	V (2)	T (4)
Therapist facilitated exploration	T (8)	V (2)	T (4)*	1	T (4)*
Therapist apologized/acknowledged wrongdoing	V (4)	V (2)	1	1	1
Therapist didn't try to repair	V (2)	1	0	1	1
Therapist modified own behavior to accommodate					

client	V (2)	1	1	0	1

Consequences

Therapist anxious about work with client	T (10)	T (4)	T (3)	T (3)	T (4)
Therapy became more productive	T (9)	T (3)	T (3)	V (2)	T (4)
Strained therapeutic relationship	T (8)	V (2)	T (3)	T (3)	T (4)
Strengthened therapeutic relationship	V (7)	V (2)	T (4)*	V (2)	V (3)
Therapist gained better understanding of client	V (7)	T (3)	T (3)	T (3)*	V (2)
Client didn't come to next session	V (5)	T (3)*	1	T (3)*	1
Therapist had negative feelings toward client	V (4)	0	V (2)*	1	V (3)

Contribution to the Rupture

Client Contribution

Client had interpersonal problems (distrusting, hostile, critical)	G (13)	G (5)	T (4)	G (4)	G (6)
Client was resistant/unmotivated	T (8)	T (3)	V (2)	V (2)	V (3)
Client had unrealistic expectations about psychotherapy	V (6)	V (2)	T (3)	1	T (4)*
Client had difficulty expressing emotions	V (5)	V (2)	1	1	V (2)

Therapist Contribution

Therapist poorly managed own reactions	T (12)	T (4)	G (5)	G (4)	G (6)
Therapist wasn't in tune with client	T (10)	T (3)	T (4)	G (4)	G (6)
Therapist avoided talking with client about important issues	V (6)	V (2)	V (2)	1	T (4)*
Therapist fulfilled own needs	V (6)	V (2)	V (2)	V (2)	T (4)
Therapist colluded with client	V (4)	1	V (2)	1	V (3)

Note. * = meaningful difference between groups. 8 of 34 (24%) results showed significant differences between therapists with high and low anxiety. 7 of 34 (21%) results showed significant differences between therapists with high and low avoidance.

Table 3. Interview experience and participation reasons results for total sample and therapist attachment subgroups.

Domain/Category/Subcategories	Frequency	Therapist Attachment			
	Total Sample	High Anx	Low Anx	High Avd	Low Avd
Interview Experience					
Interview made therapist think more deeply rupture event/ruptures in general	G (13)	G (5)	T (4)	G (4)	T (5)
Interview helped therapist process specific rupture event	T (12)	T (4)	G (5)	T (3)	T (5)
Interview was positive (pleasant/engaging/interesting)	T (11)	T (3)	T (4)	V (2)	G (6)
Parts of interview were difficult	V (6)	T (3)	V (2)	1	T (4)*
Good interviewer	V (5)	T (3)*	1	T (3)*	1
Reasons for Participating					
Want to help researcher	T (9)	T (4)	T (4)	1	T (5)*
Research karma	V (4)	0	V (2)*	0	T (4)*
Interesting/Important topic	V (4)	V (2)	V (2)	1	V (2)
Wanted to process rupture	V (4)	1	V (2)	1	V (3)
Had relevant example of rupture	V (2)	1	1	0	1

Note. * = meaningful difference between groups. 2 of 10 (20%) results showed significant differences between therapists with high and low anxiety. 4 of 10 (40%) results showed significant differences between therapists with high and low avoidance.

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