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Discursive Subcultures in UK Counselling Psychology: a Profession and its Practitioners' constructions of Rupture in the Therapeutic Alliance

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Section C- Client Study

Table of Contents

Working with Complex Client presentation in an NHS setting: A modified Cognitive Behavioural approach to Borderline Personality Disorder.

Acknowledgements

Declaration

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Section A - Preface

This doctoral portfolio is about 'rupture in the therapeutic alliance' and the messy, fragmented, cracked relationships that as counselling psychologists we may not set out to build with our clients, but which can emerge. It proposes a journey into the hinterland of therapeutic alliance research, turning away from the robust alliance as predictor of positive outcomes in search of a different dialogue. Specifically, it seeks a dialogue about how the therapeutic relationship and its internal working mechanism, the therapeutic alliance, can rupture, break down or even break up. It is about witnessing, sitting with and deconstructing these moments when the practitioner and client find themselves off course relationally. This portfolio is not an attempt to undermine the value of a good, healthy therapeutic alliance but to problematise it in an attempt to expand our thinking as practitioners beyond the positive, caring and concerned. It considers an alliance with a client which is not exclusively characterised by respect and warmth, but can also be characterised by interpersonal difficulties and specifically rupture.

I first heard the term 'rupture in the therapeutic alliance'[1] in supervision at the end of my second year of training. A client's abrupt withdrawal from one session led me to describe it as a disappearance as I was unsure if she would return. My supervisor described it as a 'rupture in the alliance', a term which packed a therapeutic punch. As a technical label for my experience it left me feeling anxious, deskilled and even unprofessional, as if I had failed in a professional duty to secure a positive therapeutic alliance with my client. As a consequence of this anxiety, I consulted the wider psychotherapeutic literature and found interesting inconsistencies which intrigued me as a researcher. Firstly, although there appeared to be a great deal written on 'rupture', very little was written either specifically for, or by, UK counselling psychologists. Similarly, when I discussed the term with my fellow trainees, very few could remember using the term to describe problems in the therapeutic alliance either in supervision, lectures or with clients. How then to reconcile 'rupture' as an object which was well documented but potentially not spoken about in counselling psychology training? Secondly, a colleague referred to 'rupture' as the 'elephant in the room', reminding me that breakup and breakdown may be a powerful presence, but one which potentially lurks in the background of any relationship discourse.

[A1] 'Rupture in the therapeutic alliance' is the primary construct I have emphasised in quotations, given its position as the subject of my research. I have also used quotations when I wish to signify a problematising of other labels to the reader.

Indeed looking back over my training, I reflected on how the emphasis had always been on building a positive therapeutic alliance whilst negotiating cracks and tensions in the alliance seemed to be left to less public spaces, for example personal therapy or supervision. Why weren't we talking openly about 'rupture', or were we talking about it but using different terms? For example, in the supervision session above I used the term disappearance to describe 'rupture', positioning it as a client vanishing act, whilst my supervisor's use of a technical term constituted 'rupture' as a therapeutic act. This sensitised me to how we use language around clinical concepts to construct them in different ways and to achieve different ends. This observation, along with a desire to address the 'elephant in the room' as part of my professional and personal development led to 'rupture in the therapeutic alliance' becoming the focus of my first piece of work in this portfolio - the original doctoral research.

This in-depth, discursive, qualitative study explores UK counselling psychology expert texts and practitioners' constructions of 'rupture in the therapeutic alliance'. Initially I had considered an interpretative phenomenological analysis to explore counselling psychologists' experiences of the phenomena, however I realised that this would not allow for an exploration of how practitioners used the term and its function within counselling psychology. A discursive approach allowed for an interrogation of current conceptualisations of 'rupture' within counselling psychology by seeing it as discourse rather than truth, and in doing so nourished my critical awareness. Given that 'rupture' appeared to be missing from counselling psychologists' talk, this was deemed important. The study is informed by a critical realist constructionist epistemology and seeks to map the contemporary discursive terrain of 'rupture in the alliance' within UK counselling psychology through an analysis of its expert texts. It also explores how UK counselling psychologists' construct 'rupture' in their talk via semi-structured interviews and a focus group. These sites of analysis allow for an exploration of the wider discursive resources available to counselling psychologists and enable an investigation of how participants' choice (or resistance) of particular discursive practices impact their subjectivities. To explore this interface the study combines aspects of Foucauldian, discursive and critical discursive analysis which do not always sit in an easy epistemological partnership. However they allow for an approach which addresses how the language we use as practitioners might be influenced not only by our own

interactions but by the social, cultural and therapeutic discourses in which we are placed or place ourselves.

Results of the analysis indicated that rupture constructed as 'ending' belonged to a marginalised and fictionalised discourse of horror within both textual and individual accounts. In addition, the expert texts indicated a binaried, discursive terrain which tended to position participants as either 'diagnostician' or (ideal) 'relational being' in relation to 'rupture in the therapeutic alliance'. Although compelled to refer to them, participants sought to evade such fixed positions by positioning them as external to and limiting in the clinical space. New discursive repertoires of rupture as 'inter' and 'intrapersonal crisis' emerged in the analysis of their talk, making available alternative ways of being (practitioner as 'sinner', 'emotional being', 'dutiful soldier') which functioned to manage issues of accountability in relation to 'rupture'. I conclude that counselling psychologists are well placed to manage these fractured subjectivities since they are already required to negotiate fragmented professional identities (scientist-practitioner, reflexive-practitioner and researcher-practitioner). Such identities would seem to rupture, repair themselves and rupture again in the different discursive contexts of the workplace, clinical practice and research.

Choosing a critically realist informed social constructionist approach to inform my doctoral research was not easily reconciled epistemologically with the cognitive behavioural therapeutic work that is discussed in the second piece of work in this portfolio – the case study. I conducted this piece of work at the beginning of my final year when on placement in a NHS Community Mental Health Recovery service. It describes my work with a young woman who presented with anxiety, was regularly self-harming and with whom I experienced ongoing difficulties in establishing a therapeutic relationship. I have included this study not only because it reflects my experience of working clinically with 'rupture', but because revisiting it from a discursive perspective has enabled me to become more attentive to the therapeutic and social discourses I draw upon and impose upon my clients, enhancing my reflexivity. This case marks a pushing and pulling between the individualism of therapeutic practice and the socio, institutional discursive world that shapes what can or cannot be said. For example, within an NHS recovery focused discourse what could be said about 'rupture' was potentially limited, since it could be positioned as an obstacle to change and recovery.

In addition, this work signalled a foray into a more dilemmatic positioning between the medical theories of psychiatric diagnosis (the client had been 'diagnosed' with borderline personality disorder) as often deployed within the secondary care NHS context, and the postmodernist theories which inform counselling psychology as a profession, and which resist such medical discourses in favour of pluralism, critique and relational practice. Thus, there was the potential for the diagnosis to shape an expectation on both our parts that we would find co-constructing an interpersonal space difficult, and that that space would include conflict and even 'rupture'. This was compounded by the use of CBT as an approach which led to my own fractured subjectivity, as it positioned me within a discourse which made available both technical ways of doing and relational ways of being with the client in relation to 'rupture'. This brings to the fore the aspects of the work which requires us to accept the constant breakdown in and/or breaking up with the professional and personal roles that we are expected to play in the relationship with the client and the management of the professional anxiety which ensues if we deviate from them. I argue that 'rupture' can function as a discursive site in which these struggles and fractured subjectivities play out and might also potentially be resolved. Nevertheless, this work reflects the discomfort of trying to negotiate this relational space and reconcile my own fractured subjectivity with attempts to meet the client authentically and honestly.

Building on this thought, the final piece of work is presented as a theoretical paper for a journal and uses my research findings as a point of departure for critical reflections on professionalism within counselling psychology. It argues that professionalism can reside in discourses of success which are dominant in both places of employment through a dialogue of best practice and positive outcomes and in our training and regulating institutions in constructions of the healthy, robust alliance as normative and desirable. This article reflects on how 'rupture in the therapeutic alliance' can problematise such discourses by troubling normative notions present in cultural and counselling psychology discourses that position the practitioner as good and caring builders of a healthy, robust alliance. It argues that by interrogating discourses of success, critical openings arise through which rupture as 'crisis' emerges. This discursive process makes room for alternative professional subjectivities which might otherwise be edited out of a psychotherapeutic discourse if, as a system of meaning, it is used only to promote ideals regarding health and self (Avdi & Georgaca, 2009). Such fractured ways of being are both anxiety

provoking, since they potentially position the practitioner as outside of an institutional counselling psychology discourse, and also potentially liberating, as they allow for greater flexibility in the intersubjective space of the clinical room.[2] Embedded in a postmodernist and pluralistic framework, I argue that counselling psychologists have both the capacity to think creatively about how to facilitate alternative subjectivities and to withstand the constant rupturing and repairing of a counselling psychology identity, the purpose of which is to "hold rather than resolve tensions" (Orlans & van Scoyoc, 2009, p.vi).

This portfolio thus documents my academic and clinical journey into a fragmented and ruptured space within the therapeutic relationship. Such a process has been anxiety provoking and ripe with tensions. I remain aware, for instance, that social constructionism does not easily fall within the humanistic and phenomenological traditions of counselling psychology. At a clinical level this can leave me disorientated in my practice. However, moving towards a more pluralistic practice in which the therapist draws on a range of different understandings and methods to inform the work has created critical openings in my own work for multi-perspectives and flexibility, which is more easily reconciled with a critical realist informed construction. (Pluralism can also be considered a form of integrative therapy, in which there is a particular emphasis on collaboration and negotiation across the client-therapist relationship. This has been particularly helpful in ways which I attend to and negotiate 'rupture in the alliance' with my clients). I am still drawn to the discursive as a way to take into account the inescapably social aspects of individual experience, and I feel that this ought to form an integral aspect of what counselling psychology as a discipline can achieve. I would therefore continue to "encourage the audience . . . to step back and to distance itself from the drama going on onstage in order to perceive more clearly what the social, political and economic dynamics of the drama are" (Brecht, p.19, cited in Gatzambide, 2012).

On a final note, I might observe that from a postmodernist perspective in marriage, single sex or heterosexual relationships, who we are and what we mean to another in any given moment develops through our constantly shifting interactions with an- other. That some of those shifts are culturally emphasised as negative, distressing interactions to be avoided or tidied up inevitably spills over into the therapeutic encounter. In giving an amplified voice to the instable, imperfect and fragmented relationship, I hope to foreground the mess, distress and discomfort of ruptured

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[A2] Specifically the relational space between client and therapist within the therapeutic dyad.

alliances and the subjects of that 'rupture' in this portfolio. I also hope to foreground the sometimes inflexible and oppressive taken for granted theoretical binaries of good and bad, healthy and unhealthy relationships that keep us fenced in as people and practitioners.

Section B – Doctoral Research

B.1. Abstract

Understanding 'Rupture in the Therapeutic Alliance' within UK counselling

psychology: A discourse analysis

There is a distinct lack of empirical research pertaining to how UK counselling psychology and its practitioners construct 'rupture in the therapeutic alliance', and what the term accomplishes for those that use it. Arguably there is also the potential for discourses of 'rupture' to be overlooked within a profession whose regulating and training discourses prioritise the healthy alliance as normative and desirable.

Informed by a critical realist constructionist epistemology, this study explores how the profession and individual counselling psychologists construct 'rupture in the therapeutic alliance'. This exploration is in two parts: (i) a mapping of the contemporary discursive terrain of 'rupture in the alliance' through an analysis of the discipline's expert texts and (ii) an exploration of practitioners' constructions of 'rupture' via analysis of four qualified counselling psychologists' semi-structured interviews and a focus group with five trainees. These two sites of analysis permit an exploration of the wider discursive resources available to counselling psychologists and an investigation of how participants' choice (or resistance) of particular discourses and discursive repertoires impact their subjectivities and practices. To explore this interface a synthesis of Foucauldian, discursive and critical discursive analytic approaches was used.

Analysis of expert texts indicates a binaried, discursive terrain which draws on medical and relational discourses to position participants as either 'diagnostician' or (ideal) 'relational being' in relation to 'rupture in the therapeutic alliance'. In their talk, individuals evade such fixed positions by drawing on alternative discursive repertoires of rupture as 'inter' and' intrapersonal crisis'. These allow practitioners to take up alternative positions (e.g. practitioner as 'emotional being', 'dutiful soldier') from which to manage issues of accountability in relation to 'rupture' within the clinical space. This can lead to fractured professional subjectivities. Interestingly rupture constructed as 'ending' belongs to a marginalised discourse within both textual and individual accounts. The consequences of this marginalisation, along with the implications of practitioners' fractured subjectivities for the profession and practice of counselling psychology are discussed.

B2. Introduction

> Rupture in the therapeutic alliance can be broadly defined as a tension or breakdown in the collaborative relationship between patient and therapist . . . (Safran & Muran, 2006, p.288).

> He just clammed up in the session! For the last 15 minutes, no matter what I tried, he wouldn't answer me. And then he just fell asleep and started snoring! I can't believe how mad I am . . . I know I'm overreacting, but . . . (Friedlander, 2015, p.174).

> I knew she would not be back. It was an undisputed act of revenge to break off the treatment so suddenly, when I had every expectation of bringing the analysis to a happy conclusion, thus dashing all those hopes. (Freud, 1905, p.1993).

These accounts craft a compelling and conflicted entrance for 'rupture in the therapeutic alliance'. The first excerpt offers a broad definition widely cited within professional counselling text books and academic literature. It conjures up a mechanical object which sits in contrast to the highly emotional object constructed by a trainee psychotherapist in the second excerpt. Finally, the third excerpt constitutes 'rupture' as a dramatic and unforeseen ending, as reflected on by Freud following his client's (Dora's) unexpected departure from therapy. Viewed together these constructions offer up the ruptured therapeutic alliance as a site of therapist client disagreement, therapist hostility and even client dropout - packaged as revenge.

This sits in powerful opposition to the constructions of the healthy, caring therapeutic relationship[3] which prevails in the broader psychotherapeutic discourses or "systems of meanings that have been constructed by psychotherapy as an institution and which are maintained through psychotherapeutic practice" (Avdi & Georgaca, 2007, p.170). Such systems are arguably influenced by wider cultural, evolutionary and biological discourses which also prioritise 'healthy' relationships as normative and desirable. After all they offer the potential means of attaining romantic happiness, physical safety, reproductive security and evolutionary development (Gillies, 2010). These social, cultural and biological assumptions around

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[B3] Gelso & Carter (1985, p.159) broadly describe the relationship as '…the feelings and attitudes that counselling participants have toward one another, and the manner in which these are expressed'.

relationships can in turn be translated into psychological discourse. Notions of secure attachment are founded upon observational studies of the relationship between mother and child (Ainsworth & Bell, 1970; Bowlby, 1999). They provide evidence based research for theories which suggest that in order for adults to form healthy relationships they must internalise a strong sense of attachment gleaned from their own maternal bonding experience. Similarly, such psychological notions can form the basis for therapeutic discourses and their interventions, particularly in regard to the role of the therapeutic relationship. Holmes (2014) has argued for the need to provide a secure based attachment through which to explore the client's inner world, and states that the therapist offers this through a healthy therapeutic alliance.

Although not contesting the legitimacy of such a construct, Milton (2016) argues that to romanticise our relationships can serve to "limit our thinking to such positively constructed relational experiences as respect, love, care and concern" (p.185). In terms of the therapeutic relationship he adds that:

> The focus on the positive means that there is often a misconception that therapeutic relationships are 'nice' relationships; always valuable and important, exclusively characterised by respect and warmth. On the contrary they can also include or even be dominated by other feelings too - boredom, resentment, disgust, rage, disappointment, hate and the like (Milton, 2016, p.186).

In a similar vein Doran's (2016) historical review of the therapeutic alliance brought attention to the emphasis in the traditional alliance discourse on consensus and collaboration. She observes that this leaves little room for expressions of disagreement between client and therapist, which I argue might include 'rupture'. Doran adds that although current measures of the alliance can establish that disagreements occur, it remains unclear whether these disagreements are ever openly expressed by therapist or client and worked through in session. This raises questions as to how practitioners would talk about 'ruptures' if they were to express them and what language is available to them to achieve this.

An exploration of how UK counselling psychology and its practitioners construct 'rupture in the therapeutic alliance', as proposed by this study, provides a means of discursively interrogating this construct with a view to developing a better

understanding of it. For example, I am curious as to whether 'rupture' has the potential to become a marginalised discourse within counselling psychology, which as a discipline arguably places the ability to build a healthy relationship at the core of its ethical practice, research and training. Indeed as a profession it is represented by institutions such as the British Psychological Society (BPS) whose *Code of Ethics and Conduct* (BPS, 2009) guidelines encourage practitioners to "be mindful of the importance of fostering and maintaining good professional relationships with clients and others as a primary element of good practice" (p.10). By adopting a discursive approach to 'rupture in the therapeutic alliance', this study thus seeks to contribute to the continuing development of a distinctive counselling psychology ontology, with its emphasis on understanding and theorising subjectivity and inter-subjectivity and its goal of contributing to the therapeutic relationship and outcome (Martin, 2010).

2.1. 'Rupture' in review

Craven and Coyle (2007) observe that it can be helpful to present viewpoints in literature as constructions of one's research focus, and to "consider research not as revealing 'truth' but as positing and legitimising a particular version of events" (p.236). The following literature review thus provides an extensive, though by no means exhaustive account of 'rupture in the therapeutic alliance', both within the wider psychotherapeutic and counselling psychology literature. My intent is to "examine how certain kinds of explanation function, and how certain limits are set in place by those explanations" (Parker, 2005, p.147). I understand these limits to mean the subject positions and possibilities for the subjective experience of 'rupture in the therapeutic alliance' that are made available through different discourses.

This chapter is divided into two sections. The first begins with a definition of 'rupture' and how the term is applied to the therapeutic alliance, followed by a review of its constructions within the wider psychotherapeutic academic literature. The second section introduces counselling psychology and considers what potential influence, if any, discourses produced by its training and regulating institutions may have on constructions of 'rupture in the therapeutic alliance'. As part of this discussion how practitioners are positioned or position themselves in relation to 'rupture' is considered before finally the aims for the study and research questions are outlined. This includes a critique stating flaws and gaps in the literature to justify my own work.

2.1.1. Definitions of 'rupture'

From a postmodernist perspective, labels are argued to be discursive acts that are historically and culturally specific (Burr, 2003). 'Rupture' is a powerful word whose etymological roots rest predominantly in a medical context. The online Merriam-Webster medical dictionary (2016) offers a visceral definition of it as "the tearing apart of a tissue – rupture of heart muscle, rupture of an inter-vertebral disk." Within such a context, 'rupture' possesses an inbuilt pathology and is positioned as an active noun that rips, bursts and severs muscle and tissue abruptly, often without warning. Although such medical ruptures can be repaired and are not always life threatening, they carry inherent risk given that they can vary in size and severity. These are powerful connotations to carry over into a therapeutic clinical context where 'ruptures' are also constructed as events which vary in size, severity and frequency (Safran & Muran, 2006). Indeed, for counselling psychologists the deployment of a medical term in a clinical context potentially creates an interesting tension, given the profession's relational ontological stance which is rooted in a non pathologising, pluralistic practice (Lane & Corrie, 2006). It is potentially because of such a powerful medical association that in the English language 'rupture' is not used colloquially in reference to personal relationships. (La rupture in French means breakup). This also makes co-opting 'rupture in the therapeutic alliance' into a therapeutic context an interesting development as it positions it as a term belonging to the practitioner's lexicon, and potentially outside of a client's repertoire when describing difficulties in relationships. This offers a tentative explanation as to why certain practitioners have questioned its suitability as a therapeutic term:

> I have come to understand that the term "rupture" connotes a rather harsh or intense event for many, thereby failing to capture the subtleness with which problems in the alliance are often manifested in therapy . . . It may thus be that (alternative) terms may ultimately be more useful (Safran, 1993a, p.33).

Such an observation potentially sheds light on why within the psychotherapeutic literature 'rupture in the therapeutic alliance' is open to numerous interpretations, as discussed below.

2.1.2. What is in a therapeutic rupture? – 'A Slippery Concept'

An overview of the current psychotherapy literature (to include theoretical, empirical and clinical case studies) reveals rupture as a "very slippery concept" (Safran & Muran, 2006, p.288). Colli and Lingiardi (2009) observe that over time an "alliance rupture" has been defined as:

> . . . a tension or breakdown in the collaborative relationship between patient and therapist; a deterioration in the relationship (Safran & Muran, 2000a); a problem in the quality of relatedness as well as a deterioration in the communicative process (Safran & Muran, 2006, p.720).

Predominantly negative in tone, these definitions construct rupture in a number of conflicting ways; for example, it is both an 'act' of mechanical failing (e.g. "breakdown", "tension") and a 'process' which conveys a relationship problem (e.g. "deterioration in the communicative process").

In addition, some definitions of 'rupture' locate it as a technical term within a specific therapeutic approach – e.g. "transference–counter transference enactments" in relational psychoanalysis (Safran & Muran, 1996); "non-compliance" in second wave cognitive behavioural (CBT) approaches (Leahy, 2008), or "empathetic failure" on the part of the therapist in British object relations approaches (Kohut, 1984). Such technical terms are interesting from a discursive perspective because they attribute different levels of accountability to the therapist and client. For example, the label "transference and counter transference enactments" positions rupture as played out in the intersubjective space and in doing so attributes joint responsibility to each party within a relational psychoanalysis discourse. Conversely, "empathetic failure" locates rupture within the therapist and allocates greater accountability to the practitioner. In addition, within a CBT discourse, rupture as non-compliance situates it as originating in the client, who are subsequently positioned as resistant to the problem–solving techniques of the therapist (e.g. they are non-compliant in homework tasks).

A third way of describing 'rupture' emerges in the literature and draws on more colloquial repertoires to include: "misunderstanding events" (Rhodes, Hill, Thompson & Elliot, 1994); "impasses" (Hill, Nutt-Williams, Heaton, Thompson & Rhodes, 1996) and "alliance threats" (Bennett, Parry & Ryle, 2006). Although Safran

and Kraus (2014) neatly summarise these terms as "most commonly referred to in the psychotherapy research field as 'rupture in the therapeutic alliance" (p.381), such a range of terminology as presented above would seem to constitute a fluid construct which defies one particular definition. From a Foucauldian perspective, there would appear from the outset a broad range of conditions of possibility that enable people to speak of 'rupture' in different, albeit negative ways.

In their review of the literature, Lingiardi and Colli (2015) sought to organise these varied ways of speaking into two broad categories – the "rational" and the "relational" (p.318) - which they linked to different ways of conceptualising 'rupture'. Thus a rational viewpoint might view rupture as a failure to complete a task (an act), while a relational viewpoint would be less concerned about the nature or content of the disagreements than the way in which it was or was not being communicated (process). Certainly the ways in which 'rupture' has been constructed within the psychotherapeutic academic terrain would correspond to these 'rational' and 'relational' constructs, although I would argue that its slipperiness allows 'rupture' to move freely between these constructs. Such slipperiness is both potentially disorientating since it could rob the term of its significance to its users and useful in that it seeks to reconcile the relational complexity of the client therapist process with rational (theoretical and empirical) attempts at explaining 'it', as explored below.

2.2. Locating Rupture in the Academic Terrain – *both* 'relational' *and* 'rational' construct?

A systematic review of the literature via PsycARTICLES, PsychINFO, the American Psychological Associations pre-eminent database for psychological research and SciVerse Science Direct, using the search terms 'rupture', 'alliance ruptures' and 'rupture in the therapeutic alliance' returned over 250 hits. A large proportion of these articles were generated by the New School Center for Psychotherapy Research, a New York based programme run by Jeremy Safran, which over the past twenty five years has established itself as a dominant voice in alliance rupture research. This work is reviewed here since it has heavily influenced constructions of 'rupture' available in the wider psychotherapeutic terrain.

The Safranlab pioneered a second generation of alliance research that represented a shift in focus from empirical investigations of the alliance as a predictor of therapeutic outcome, to those mechanisms and processes which bring about change in the alliance. In their seminal paper Safran, Crocker, McMain and Murray

(1990) identified rupture and its repair as one such process, arguing for its place as a "therapy event for empirical investigation" (p.154). Interestingly the authors also conceptualise it within a relational, framework as an interpersonal process between client and therapist. 'Rupture' is then born out of an unusual combining of a constructivist epistemology with a scientific approach, setting it up as both a 'rational' construct to be considered from an empirical, positivist viewpoint and a 'relational', subjective construct which resists such a position.

2.2.1. Rupture as a 'relational' object

Muran and Safran (in press) argue that any discussion of alliance ruptures must begin with an attempt to contextualise the alliance construct itself. Although an exhaustive investigation of alliance history is beyond the scope of this literature review, specific areas of its theoretical development are explored below as pertinent to understanding Safran and colleagues' constructions of rupture as 'relational'.

One important development in alliance history which contributes to rupture as a 'relational' construct was Bordin's (1979, 1994) conceptualisation of the alliance as trans-theoretical. He defined the alliance as a change factor in all forms of psychotherapy consisting of:

> . . . mutual understanding and agreement about change, goals and
> the necessary tasks to move towards these goals, along with the
> establishment of affective bonds to maintain the partners' work
> (Bordin, 1994, p.13).

This moved the alliance on from a site of purely collaborative and task orientated consensus to one where the affective process of therapist and client was also taken into account. Thus the rigid distinction between general relationship factors and specific technical factors was eliminated allowing for the action of psychotherapeutic techniques to be intrinsically linked to the interpersonal context in which they occur (Safran et al., 1990; Safran & Muran, 1996). Within this newly renovated alliance, any rupture is similarly constructed as 'relational' insofar as it is positioned as a strain in the affective bond between client and therapist (e.g. a client feels patronised or misunderstood), and technical insofar as it can be a breakdown in the collaborative task (e.g. the client wishes to review their history while the therapist offers a present focused pragmatic solution). Rupture discourses thus potentially offer up dual ways of being for the practitioner which accommodate therapist as both

deliverer of technique and ability to just be with the client. This can also lead to tension between "being in relation" and "technical expertise" which is recognised within a counselling psychology philosophy (Strawbridge & Woolfe, 2010, p.5).

Bordin's concept of the alliance also emphasises the reciprocal and bi-directional nature of the relationship between client and therapist, influencing Safran's contemporary relational thinking around rupture which integrates American interpersonal, British object relations, self psychology and postmodern thinking (Mitchell, 1988; Safran & Muran, 2000b; Wachtel, 2008). Safran and Kraus (2014) describe the mutual influence between therapist and client who act as co-participants in the therapeutic process which constitutes a two person system. This can be traced to developments in postmodern philosophical thinking which have come to fundamentally challenge the assumption that human beings are independent and autonomous organisms, proposing instead that we are fundamentally and inextricably intertwined with others in our world (Baudrillard, 1993, cited in Cooper, 2004; Gergen, 1999). Safran also draws on developmental attachment theories (Bowlby, 1999) and biosocial studies of infant-mother dyads (Tronick, 1989) which suggest maladaptive interactions with important attachment figures can lead to the development of schematic representations of self and others. These are known as "relational or interpersonal schemas" and can become dysfunctional in new situations (Safran, 1998; Safran & Muran, 2000b). Alliance ruptures are associated with the activation of these maladaptive interpersonal schemas (Safran, 1993b; Young, Klosko & Weishar, 2003) with both client and therapist potentially becoming involved in complementary negative reactions, for example client hostility being met with therapist counter hostility (Binder & Strupp, 1997). Thus 'rupture in the therapeutic alliance' can be understood as "enactments that are shaped by disassociated aspects of both therapists' and patients' experiences in interaction with one another" (Safran, Muran & Shaker, 2014, p. 213). This constructs rupture as an interpersonal object for which therapist and client have mutual responsibility.

Finally, Bordin's conceptualisation of the alliance as a dynamic, fluctuating construct positions it as a site of constant pull and push and ongoing negotiation between client and therapists. Doran (2016) argues that this shift in constructing the alliance as a site of negotiation as opposed to collaboration allows for the possibility of disagreements or 'ruptures' to emerge. Thus Bordin (1979) speaks of the "tear and repair processes" in the alliance and elsewhere 'rupture' has been conceptualised

across treatment sessions as "fluctuations in the quality of the alliance between therapist and client" (Safran et al., 1990, p. 154). This positioning of 'rupture' as a dynamic process is arguably further legitimised by alliance development researchers who use statistical analyses to study the pattern of the alliance and ruptures over time (Stiles et al., 2004). These patterned understandings of rupture can again be specifically tied to relational concepts where the client and therapist are regarded as interacting in a relational matrix (Mitchell, 1988). Rupture is therefore constructed as a fluid process or intersubjective negotiation between client and therapist. It is simultaneously positioned as a mechanism for change since it affords therapists and clients a flexible, rather than broken clinical experience, during which they can constructively negotiate the competing needs of self and other (Safran 1993b; Safran & Muran, 2006).

In summary, 'rupture in the therapeutic alliance' emerges within this theoretical discourse as a relational, intersubjective and dynamic construct which would appear consistent with the constructivist epistemology that informs Safran and his colleagues work. However, such a constructivist paradigm would seem opposed to the "purported objectivist and positive cast of traditional psychotherapeutic research" (Wachtel, 2008, p. 208) and its rational empirical gaze, within which 'rupture' is also constructed within the literature.

2.2.2. Rupture as an 'empirical' object

In this section, I consider how scientific discourses are also drawn upon to position 'rupture' within a positivist framework as an empirical object for investigation. I argue that such discourses work to "categorise and bring (rupture) as a phenomena into sight" (Parker, 2014, p.5). In doing so these studies potentially mitigate against claims, also prevalent in the literature, that therapists can have considerable difficulty in recognising moments of rupture in the alliance (Safran, Muran, Samstag, & Stevens, 2001). A review of the literature reveals three specific methodological paradigms which Eubanks-Carter, Muran and Safran (2010, p. 75) argue "elucidate rupture as a phenomena." "Elucidate" infers a hidden object made visible and the first of these research paradigms - naturalistic observation methodology - arguably functions to bring rupture into sight by using direct and indirect reports from therapists, clients and independent observers to identify episodes of 'it' in sessions of therapy (e.g. Muran et al., 2009; Muran, Safran, Samstag & Winston, 2005). Task analysis offers a second research paradigm which seeks to progress rupture from a

visible construct to a manageable one by developing a workable model of rupture resolution (e.g. Safran & Muran, 1996, 2000a). Finally a smaller set of randomised controlled studies test the effectiveness of rupture resolution interventions and treatment (e.g. Henry, Schacht & Strupp, 1986; Safran, Muran, Samstag, Winston, 2005). Since this study does not seek to explore how counselling psychologists construct rupture-repair, I focus on how 'rupture' is constructed within the first two types of empirical gaze.

Naturalistic observation methods "track the natural occurrence of rupture in therapy and examine their relationships to outcome" (Eubanks-Carter et al., 2010, p.83). The use of the word "outcome" positions rupture as a measurable construct while the use of "natural" positions it as an organic process, but one which is also elusive since it must be tracked. This requires a tracker, which within these studies can include direct patient and therapist self-reports or independent observer based measures to identify 'rupture'. Any reports of it are then recorded by in session impact questionnaires (PSQ: Muran, Safran, Samstag & Winston, 1992) which measure the occurrence, intensity and extent to which the rupture is resolved. This potentially positions 'rupture' as a tangible and identifiable construct which can be first spotted by observers and then managed. Conversely, this objective status is challenged when contemplating the results of these observation studies since clients and therapists do not seem to view 'rupture' in the same way. For example, Muran and colleagues (2009) used client and therapist self-report measures of the alliance to establish it as a common phenomenon which occurred frequently across three different treatments (Brief relational, CBT and brief dynamic therapy) but was observed and identified by only 37% of patients in comparison with 56% of therapists. A similar study conducted in the UK by Eames and Roth (2000) found therapists reported ruptures in 43% of sessions while patients did so in 19%. Eubanks-Carter et al. (2010) suggest that such discrepancies may be due to clients' lack of awareness or discomfort in acknowledging ruptures. Horvath (2000) also suggests that clients tend to judge the therapeutic relationship less harshly in comparison to their other social relationships. Conversely, he argues that practitioners view the alliance through an idealised theoretical lens that makes them more likely to find faults in their relationships with clients as not measuring up to an ideal way of practicing. Such observations reveal tensions as to whether 'rupture' can be positioned as an empirical object that can be viewed objectively.

As a way of addressing these discrepancies observer based methods were introduced where, via transcripts (Colli & Lingiardi, 2009) or the use of highly trained independent clinicians (Somerfeld, Orbach, Zim & Milkulincer, 2008), a coding system is deployed to record instances of 'rupture'. Again this method positions 'rupture' as an object that can be made visible, as impartial experts look out for rupture markers and then offer a consensus of opinion. This expert gaze arguably reinforces 'it' as a robustly identifiable construct. However, when Somerfeld et al. (2008) directly compared the difference between independent observers and five clients' reports of ruptures in a study of 151 psychodynamic sessions of therapy, they again found discrepancy. Observers reported ruptures in 77% of sessions, while clients in only 42%.

Such discrepancies indicate a tension in the literature as 'rupture' slips between a measurable, identifiable object and a construct that eludes recognition. This might speak to an intrinsic methodological difficulty that resides in such research that even when evaluative measures are reliable, valid and thus psychometrically sound, different people (observer, therapist, client) evaluate relationships differently. Thus, a relationship's valence becomes a state of the evaluator, rather than an objective characteristic (Stiles & Goldsmith, 2010). This speaks to cultural influences since assigning some degree of positive or negative values to an object and event is often judged psychologically as its most salient quality (Zajonc, 1980). Consequently, it could be argued that no matter how hard the process of empirical investigation and its systems of measurement try to position 'rupture' as an objectively identifiable object, an overriding binaried, social discourse of what constitutes a 'good' and/or 'bad' relationship or therapeutic alliance may prevail.[4] Indeed the label 'rupture' potentially already operates as an evaluative device since it implies deficit, and as such demands a position along culturally implicit dimensions of good and bad (Gergen, 1990).

Nevertheless, attempts to construct an objective view of 'rupture' and what it looks like continue. This has led to task analysis studies which position 'rupture' as having identifiable qualities but with a view to rendering them repairable. Task analysis (Rice & Greenberg, 1984) integrates quantitative and qualitative methods to develop and refine models of rupture resolution. This has resulted in a series of US (Safran & Muran 2000b; Safran, Muran & Samstag, 1994) and UK based studies (Aspland,

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[B4] Colli and Lingiardi (2009) have developed a transcript based method of assessing alliance ruptures, the Collaborative Interaction Scale (CIS) which attempts to address this by assessing both patients' and therapists' negative and positive contributions to the therapeutic process.

Llewelyn, Hardy, Barkham & Stiles, 2008; Bennett et al., 2006; Cash, Hardy, Kellet & Parry, 2014) in which rational models of rupture and its repair are developed from clinical theory and become subject to empirical testing. Relevant sessions of therapy are videotaped or transcribed to examine how these models conform or depart from theory and how, following an empirical analysis of the data, they can be refined accordingly. From a discursive perspective such an approach draws strongly on a scientific discourse ("rational", "model", "empirical testing") constructing 'rupture' in two potentially interesting ways. Firstly, it is rendered a categorisable object since different subtypes have emerged from task analysis studies, to include "confrontation" and "withdrawal ruptures", both of which are located in the client's behaviours (Safran & Muran, 1996). In a withdrawal rupture clients are positioned as moving away or toward the therapists in ways which deny aspects of their experience, e.g. they might fall silent or become over-compliant with therapists' requests. In contrast, with a confrontational rupture the client is positioned as moving against the therapist and might express anger, resentment or may even walk out (Eubanks-Carter et al., 2010). This has led to 'rupture' being associated with common patterns of behaviours that can be reliably identified by an observer based coding system (Mitchell, Eubanks-Carter, Safran & Muran, 2012). This categorisation of 'rupture' behaviours is reminiscent of the medical model of mental health where it is has been argued that distress can be explored via empirical research as a means of providing symptoms for conditions that can then be correctly identified (Cosgrove, 2005). This allows for appropriate interventions to be applied, consistent with the aims of task analysis studies to produce 'treatment' models of 'rupture'.

This leads to a second interesting construction of rupture as an event that the therapist can manage in specific ways. Indeed Safran, Muran and Shaker's (2014) review of task analysis studies (including UK studies) found a consensus in the techniques that they recommend for handling 'rupture'. These recommendations were formulated as a list of eight items, some of which are summarised here:

1. Therapists explore and admit responsibility for their own contributions to ruptures and impasses.

2. Therapists remain non-defensive in their handling of rupture, especially as it is important that clients verbalise their negative feelings about the treatment or relationship.

3. Therapists work collaboratively with patients to co-construct an understanding of any unformulated fear leading to negative feelings about the therapist (Safran et al., 2014, p.216).

The listing of such guidelines positions 'rupture' as a manageable construct if the therapist has the requisite relational skills, and attributes responsibility to the practitioner to acquire these therapeutic skills. However, Prilleltensky (1994) warns against the setting up of human behaviour as controllable within a scientific setting as it leads to assumptions that it can be applied to the real world (or in this case the therapeutic realm). This speaks to apparent tensions within task analysis studies which position 'rupture' as manageable, but in doing so risk categorising it to such a degree that subjective constructs of 'rupture' are overlooked. It recalls how naturalistic studies also negotiated tensions as they constructed 'rupture' as an identifiable construct, but one which was viewed differently by clients and therapists. Interestingly, a tension then becomes apparent in the literature between ongoing attempts to pin 'rupture' down within an empirical gaze, only to reveal that as a construct 'it' remains partially invisible, overlooked and elusive.

In summary, relational constructs of 'rupture in the therapeutic alliance' have developed in alignment with Bordin's concept of the alliance, making for a pan-theoretical, dynamic object where the technical and affective elements of the therapeutic relationship meet. Rupture is also constructed as an empirical object that can be observed, categorised and handled, although it can be argued to resist attempts to fully pin it down. Its ability to slip between scientific and relational discourses is perhaps not unusual for an object born out of the unusual combination of a constructivist epistemology with a scientific approach. However, there is little commentary in Safran's literature which addresses the potential ideological dilemma of its positioning in *both* scientific *and* relational discourses. In contrast, this 'both/and' positioning of 'rupture' could be of particular interest to counselling psychology whose phenomenological and empirical epistemological roots can be argued to position the counselling psychologist in similarly conflicted discursive territory as *both* scientist *and* practitioner.

The second section of the literature review moves on from constructions of 'rupture in the therapeutic alliance' within the wider psychotherapeutic domain to its construction within UK counselling psychology. It begins with a brief history of counselling psychology and its specific focus on the therapeutic relationship.

2.3. Brief history of UK counselling psychology and the therapeutic relationship

Counselling psychology attained its divisional status within the BPS as recently as 1994 (BPS, 2010a), and it could be argued that as a discipline it constructed an identity via a 'rupture' with other psychology professions, specifically clinical psychology. Rupture here functions in a philosophical sense and recalls Foucault's discursive discontinuities in history which are possible "only on the basis of rules that are already in operation" (Foucault, 1972, p. 171), and does not signify absolute change, but rather a "redistribution of the [prior] episteme" (Foucault, 1970, p. 345). This is potentially reflected in the findings of Pugh and Coyle's (2000) discourse analysis study which showed how counselling psychologists construct their profession as both similar to and different from other psychology disciplines.

One of the ways in which counselling psychology might construct itself as "different from" is by drawing on a humanistic discourse, as propagated by humanistic thinkers such as Maslow (1966) and Rogers (1951). They sought a re-engagement with subjective experience and emphasised "the importance of subjective and intersubjective perspectives" (Orlans & van Scoyoc, 2009, p.101). Prior to this psychology was defined as a behavioural science embracing a positivist-empiricist philosophy where true knowledge could be discovered through objectively observed facts verifiable against sense-experience (Erwin, 1999). Arguably humanism, and its emphasis on the phenomenological, offered a means by which counselling psychology could redistribute positivist epistemes. Thus, the determinism perceived within behaviourism, psychoanalysis and the medical model could be challenged by emphasising the significance of the therapeutic relationship (Strawbridge & Woolfe, 2010).

In the most recent review of the profession, Jones-Nielsen and Nicholas (2016) state that the therapeutic relationship is the main vehicle through which "psychological difficulties are understood and alleviated" (p.261), and conclude that counselling psychology places relational practice at its centre. In a similar vein Larsson, Loewenthal and Brooks' (2012) discourse analysis study observed that the building of a healthy therapeutic relationship with the client represents one of the most pertinent and highly valued discourses in counselling psychology. Such observations also find support in evidence based research which reports that it is the quality and strength of the client-therapist relationship that most consistently

predicts good outcomes (Cooper, 2004; Roth & Fonagy, 2005). Similarly, a good therapeutic alliance (broadly defined as the overall bond between therapist and client that evolves during the process of therapy) is also a robust predictor of therapeutic outcome (Horvath, Del Re, Flückiger & Symonds, 2011). Finally, counselling psychology acknowledges its ethical duty to provide therapy "grounded in the primacy of the [robust] counselling or psychotherapeutic relationship" *(Division of Counselling Psychology (DCoP) Professional Practice Guidelines,* BPS, 2006, p.1).

Thus within a counselling psychology discourse a 'healthy' therapeutic relationship/alliance is positioned as a scientific vehicle for change, a potentially curative phenomenological experience, and an ethical value in which the profession and its practitioners are arguably heavily invested. Those that can deliver such an alliance have been positioned in the literature not just as good professionals but "pioneers" of the "successful" therapeutic relationship (du Plock, 2006, p.22). Indeed, within a discursive study which explored how counselling psychologists constructed their profession, Hemsley (2013) reported individuals drawing on repertoires of 'counselling psychology as saviour of the people' to position themselves and the discipline as reliable and influential advocates of the relational. This raises questions as to how 'rupture' and its association with discourses of deterioration, poor outcome or patient dropout (Henry et al., 1986; Muran et al., 2009; Safran et al., 2005) is currently accommodated within a counselling psychology discourse that appears so heavily invested in the 'healthy' therapeutic alliance.

Sims-Schouten, Wiley and Willig (2007) argue that within a critical realist research paradigm, such as the one which informs this study, a literature review should take into account any elements of institutions and materiality that may impact on individuals' talk. Pertinent to this study are academic or training texts generated by universities, or literature generated by regulating bodies such as the Health and Care Professions Council (HCPC). Given that these texts are also data for analysis in this study, this literature review widens the brief to review how broader theories of professionalism (in training and the workplace) may influence constructions of 'rupture' and ways of being in relation to that construct. Notions of institutional power as a potential material influence upon rupture discourse (Sims-Schouten et al., 2007) are therefore introduced.

2.3.1. Professionalism and training in counselling psychology - institutional influences on constructions of 'rupture in the therapeutic alliance'?

Professionalisation is the process whereby an occupation gains its characteristics (Hamilton, cited by Keogh, 1997). Several key developments in counselling psychology reflect its increasingly professionalised status. Firstly, the awarding of the Royal Charter in 1965 functioned as a symbol of state approval by attributing responsibility to the profession for the application of pure and applied psychology for the public good (BPS, 2010b). In turn, this positioned the profession as a moral guardian of public wellbeing. Secondly, UK counselling psychologists' requirements for qualification have now reached the level of a doctorate (BPS, 2011). Finally, consistent with the professionalisation of therapy as outlined by Parker (2002), the introduction of state regulation for counselling psychologists (via the UK Health Professions Council in 2009) further legitimised the activities of the profession.

The professionalisation of counselling psychology offers the potential for a number of extra discursive influences on 'rupture' discourse in counselling psychology. Firstly, the universities might be regarded as producing a specific type of professional socialisation. Du Toit (1995) argues that training "is essentially an acculturation process during which the values, norms and symbols of the profession are internalised" (p.164), thus transforming the novice or moulding the student into a good professional (Sparkes, 2002). Professional socialisation via education is therefore relevant to a review of 'rupture' because it suggests that although there may be room for resistance, counselling psychologists are likely to adopt the discourse and values most consistently upheld by their profession.

I argue that one such value potentially internalised before any other by trainees is that of being able to build a healthy psychotherapeutic relationship. Given that 'rupture' is constructed broadly in the literature as a negative process or as something going wrong in the alliance, there is the potential for it to challenge notions of expertise. If current counselling psychology training institutions, regulating bodies or places of employment (such as the NHS) are invested in producing professionals whose expertise is to build a strong, healthy alliance, does such expertise open the way for an abuse of power (Hansen, 2006)? For example, counselling psychologists may not be encouraged to critically question their professional assumptions around 'rupture' within such institutions because to do so challenges their role as agents of social regulation and guardians of the 'healthy'

alliance. Within their clinical practice could they then seek to explain 'rupture' as the client not being ready for therapy, rather than as a problem in the relationship? In her discursive study of how UK counselling psychologists construct their responsibilities to the wider world, Hore (2014) argued that practitioners who challenged the authority of the institution which invested them with professional expertise risked challenging their own discourse of professionalisation. However, expertise could also function conversely as a container for therapist anxiety in relation to 'rupture' by arming therapists with the "certainty of therapeutic truth-claims" (Ryan, 2011, p.43). Such claims may encourage belief in the value of the healing powers of the good relationship and thus afford protection from the doubts of both the client and themselves. Professional expertise might therefore be considered as a defence against a position of vulnerability, and non-expertise potentially offered up by a discourse of rupture.

What has been observed in the literature is that in discourses of professionalism generated by universities or the NHS, where many counselling psychologists find employment, a discourse of success prevails - whether it be the professional discourse of positivity, best practice and good outcome favoured by the NHS (Rizq, 2013), or the discourse of success which permeates counselling training texts as observed by Spellman and Harper (1996). Rizq (2013) argues that such discourses leave precious little room for discussions of distress, which I argue might include 'rupture in the therapeutic alliance'. It might even offer a tentative explanation as to the apparent paucity of literature about 'rupture' within UK counselling psychology. In 2008 UK counselling psychologist Cooper (2008) wrote that whilst rupture research was an exciting area of development in the psychotherapy research field, "the concept of alliance ruptures may be unfamiliar to many counsellors, counselling psychologists and psychotherapists" (p.119). Eight years later, this sentiment is mirrored by McLeod (2016) who observes that therapist initiated ruptures represent processes that are still not sufficiently acknowledged in the counselling canon. It seems to be missing from UK counselling psychology's regulating bodies' discourses and is not mentioned within the *Division of Counselling Psychology Professional Practice Guidelines* (BPS, 2006)*,* the *HCPC's Standards of Conduct, Performance and Ethics* (2016) or its *Professional Standards for Proficiency for Practitioner Psychologists* (2015) guidelines. Similarly the latest edition of the *Handbook of Counselling Psychology* (2016) contains no direct reference to

'rupture'.[5] Even a search of the UK counselling psychology theoretical and clinical literature revealed only two studies which were authored by UK counselling psychologists and specifically discussed 'rupture in the therapeutic alliance' (Richards, 2011; Siddiqui, 2012).

In Siddiqui's (2012) study rupture was constructed as a felt sense (Gendlin, 2003) or "urrghh" moment in therapy. It served as a sign to the therapist to initiate a change in their approach from the logico-deductive practice of second wave CBT to the felt sense more accessible via third wave approaches. Thus rupture was positioned as an internal dissonance in the therapist's therapeutic process, rather than a process or event located within the alliance between the client and therapist. In contrast Richards' (2011) theoretical paper *'Alliance Rupture: Etiology and Resolution'*, which is also used as data in this analysis[6] gives a far more in-depth analysis. Importantly, she offers an argument as to why UK counselling psychologists should incorporate theories and clinical practices around 'rupture in the therapeutic alliance' into their work. Since it is positioned as pivotal to the relational aspects of therapeutic change across models, Richards (2011) argues that, "it is incumbent upon practitioners to familiarise themselves with the causes, and resolutions of, alliance ruptures" (p.56). "Incumbent" draws on a moral discourse to position the practitioner as both simultaneously uninformed and professionally, even morally accountable, for not knowing about 'rupture'**.**

'Rupture' would therefore appear to be positioned as either missing or potentially overshadowed by constructions of the 'healthy' alliance within a current counselling psychology discourse of professionalism. This endorses the importance of a discursive piece of work which allows for the emergence of potentially marginalised (and dominant) discourses. In addition, Hore (2014) reminds us that professionalisation is not just bestowed upon practitioners by training or regulating bodies, but also created and enacted by individuals through the creation and manipulation of certain subjectivities. This raises the question as to how practitioners are currently positioned or position themselves in relation to 'rupture', as discussed in the next two sections of this review. An overview of this aspect of the literature is justified in a discourse analysis study where developing therapists' self-narratives as sites for understanding interactions and integrations between the

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[B5] The third edition of the Handbook of Counselling Psychology refers to 'rupture' and has been used as a text for analysis.
[B6] Please see methodology section for explanations as to how texts were chosen and why Siddiqui (2012) was not selected as a text for analysis.

personal, social and theoretical realms of psychological counselling is potentially useful (Turner, 1998).

2.3.2. Positioning the practitioner in relation to 'rupture' – a question of professional and personal responsibility?

Within the literature the role of therapist in relation to 'rupture' is heavily scrutinised. In their pilot study of attachment patterns and perceived ruptures Marmarosh and colleagues (2015) set the tone by arguing that "since ruptures are inevitable and failing to repair them can hinder the relationship (Muran et al., 2009); it is critical to understand what therapist factors influence both the detection of ruptures and the facilitation of repairs" (p.140). This would seem to attribute to the practitioner a professional responsibility in relation to 'rupture' encouraging them to take up a position of vigilance in regard to their own behaviour. A Foucauldian consideration of power may be appropriate here when the population is controlled by freely subjecting themselves to scrutiny by experts or through their own self-scrutiny.

In their study Colli and Lingiardi (2009) suggested two discernible but interdependent areas of therapist influence over the alliance and potentially 'rupture', which I argue could become areas subject to expert or therapist self-scrutiny. These include the therapist's relational abilities (e.g. empathy, attunement, warmth) and their technical knowledge (e.g. type and focus of intervention). In the latter case, when evaluating the relationship between therapist interventions, alliance rupture and collaborative processes, Colli and Lingiardi (2009) found significant correlations between therapist negative interventions and patient alliance ruptures. This misapplication of techniques can take the form of unyielding attempts to link a patient's inappropriate reactions toward the therapist with earlier, conflicted relationships with parental figures (Marmar, Weiss & Gaston, 1989); a lack of responsiveness to clients' feelings (Piper et al., 1999); or an over-adherence to techniques, which when applied in specific contexts play a role in maintaining and potentially increasing alliance ruptures (Constantino et al., 2008).

A construction of rupture as a 'technical error' on the therapist's part can deny practitioners access to the position of professional. It may also position 'rupture' as a taboo topic given observations that talking about our mistakes as therapists is not widely practised (Spellman & Harper, 1996). This is further supported by Friedlander's (2015) qualitative study of supervisees' experience of rupture in their supervisory relationship that found trainee supervisees actively self-censored

because they found 'rupture' a difficult object to bring to supervision. This was because they felt it was expected that they should be good at resolving relationship issues within therapy. This highlights the positioning of 'rupture' as wrong doing by trainees rather than as a normal part of therapy. However, a criticism of this study is that trainees may be more likely to report reticence in this area given their desire to pass exams and prove themselves. Such findings may differ in regard to more experienced practitioners.

Other studies also position the behaviours of the therapist as in some way responsible for contributing to 'rupture in the alliance'. Henry et al. (1986) authored the first of a series of research projects which became known as the Vanderbilt Studies. Their quantitative analysis of data from eight clients and four therapists coded moment-by-moment interpersonal behaviour assumed to underpin the alliance, and found that therapists in low change cases were more belittling and blaming (and less affirming, less supportive). They suggested that this was evidence of hostile complementarity (Kiesler, 1996) (e.g. therapists meeting client hostility with counter hostility) which has been associated with poor outcomes (Binder & Strupp, 1997; Safran et al., 2001). Such findings offer support for Strupp's (1980) earlier claims that: "therapists' negative responses to difficult patients are far more common and far more intractable than has been generally accepted" (p.954).The language again draws on a discourse of blame, attributing responsibility for 'rupture' to the therapist.

Moving on from issues of technical to personal responsibility, Ackerman and Hilsenroth (2001) offered a comprehensive examination of the therapist's personal characteristics that negatively (and positively) influence the therapeutic alliance, and how such personal qualities can influence the identification or exacerbation of alliance ruptures. They found that therapists' contributions related to alliance strains were similar to those reported to contribute negatively to the alliance. For example: being unresponsive, closed off and non-accepting (Rhodes et al., 1994), or angry (Hill et al., 1996). Indeed, they conclude that such personal attributes are likely to lead to a therapist overlooking ruptures or assuming that they have not contributed to the breach, which can lead to the eventual breakdown of the alliance. These would seem to draw on a more personal discourse of accountability which potentially positions the therapist as emotionally accountable or uncaring and not just professionally compromised. Such a discourse is potentially strengthened by the

fact that some of these studies rely on external judges or observers to rate the therapist's contribution to rupture, suggesting that they are being judged fairly.

'Rupture' as the therapist's fault is also reinforced by studies where clients draw on a blaming discourse when narrating their experiences of 'rupture'. For example, Rhodes et al. (1994) used retrospective client self-report questionnaires to explore patients' memory of resolved and unresolved therapeutic misunderstandings. A misunderstanding was considered unresolved when the patient perceived an unsatisfactory outcome and felt communication with their therapist was diminished. They reported that precipitants of all the misunderstandings could be classified as the therapist doing something the client did not like or want (e.g. not being attentive) or not doing something that they liked or expected (e.g. forgetting important facts). All clients reported experiencing negative feelings toward their therapist. However, if they were able to raise this with the therapist who then responded in an apologetic or non-defensive manner, this was correlated with resolved ruptures. In the unresolved cases clients either suppressed their feelings and blamed themselves, or were met with a closed off and non-accepting response by the therapists. This supports Safran and Muran's (1996) task analysis model for rupture resolution in that the therapist must be prepared to apologise and to admit their part in the 'rupture', if it is to be repaired. Rhodes et al.'s (1994) study differs from the work of Safran in that it is the client who is left to identify and express the 'rupture', whereas in Safran's work the therapist is attributed responsibility for drawing attention to a patient's negative reactions (Safran & Muran, 1996, 2000a). Moreover, the clients used in Rhodes' study were therapists in training or practising clinicians meaning they may be more likely to express their negative sentiment. Studies of a real client population suggests that clients are more deferential (Rennie, 1994) potentially positioning them as unable or disempowered when challenging therapists over 'rupture in the therapeutic alliance'.

What is also interesting in Rhodes' study is the observation that 'rupture' can result from the therapist not behaving as the client expects, suggesting that cultural expectations of the therapy are at work on the part of the client. If such expectations were that your therapist is always kind and caring, this could be problematic; especially as Ackerman and Hilsenroth's (2001) conclusions support the notion that 'rupture in the alliance' is a common and expected part of the therapeutic process for therapists. This would position the therapist's expectations of the therapeutic process and alliance as potentially in direct conflict with that of the clients.

Finally, the only discourse which mitigates against 'rupture' being positioned as the fault of the therapist lies in attachment studies, which draw on biosocial discourses to emphasise the internal world of the therapist. Eames and Roth (2000) were the first to study how therapist attachment relates to the perception of a rupture for 11 therapists working with clients in a clinical setting. They found that the more preoccupied therapists reported more ruptures whilst the more dismissing therapists reported fewer ruptures (in the initial sessions of therapy). In addition, Marmarosh and colleagues (2015) conducted a pilot study of novice therapists' perceptions of rupture and found a strong positive correlation between therapist attachment anxiety and effort spent focussing on perceived ruptures. The word 'perceived' positions 'rupture' as in the eye of the beholder, tentatively supporting previous constructions of 'rupture' as a more subjective object that resists the objectifying empirical gaze. 'Rupture' is thus located in the therapist's internal world as part of their subjective makeup, and draws attention to the uniqueness of the client–therapist alliance as both a personal and professional interaction. Arguably these attachment studies do not construct 'rupture' as a professional mistake on the part of the therapist, but as part of their biological make-up. Whilst this potentially wards off blame for making mistakes (after all therapists are human beings too), it does make a case for the importance of self-reflection and awareness as part of a practitioner's responsible professional behaviour.

2.3.3. Practitioners' Talk – how they position themselves in relation to 'rupture'

This section reviews qualitative studies which focus on therapists' own accounts of 'rupture', and how they potentially position themselves in relation to it.

In the only UK qualitative study to date, Haskayne, Larkin and Hirschfeld (2014) explored clinical psychologists and their clients' experience of rupture in psychodynamic therapy. They observed that therapeutic ruptures were accompanied by painful emotional experiences for both clients and the clinical psychologists delivering therapy. This could manifest as unexpressed emotion for the therapist that might include frustration or despair; constructing 'rupture' as an emotional struggle, and therapists as participants in that struggle. In conclusion, the researchers argued that emotional meaning of rupture for clients and therapists was overlooked by its definition as "a strain or breakdown in the collaborative process between client and therapist, and deterioration in the quality of their relatedness"

(Safran, Muran & Proskurov, 2009, p.210). From a discursive perspective, one might ask if this finding speaks to a potential difficulty in accommodating a therapist's frustration (and despair) within a therapeutic discourse. In addition, whilst 'rupture' as an emotional struggle can be accommodated within a psychodynamic discourse (as focused on by Haskayne et al., 2014), which naturally emphasises as part of its process an affective attunement with the client (Holmes, 2001); would rupture as an emotional struggle have emerged in a similar study drawing on CBT practitioners' discourses?   Indeed Lingiardi and Colli (2015) argue that there is the potential for 'rupture' to mutate in accordance with a particular theoretical perspective. For example, a CBT practitioner's therapeutic process (e.g. a client agreeing to a task) can become a psychodynamic therapist's rupture (e.g. client acquiescence can be recast as a withdrawal rupture in psychodynamic approaches).

Hill et al. (1996) explored impasses from a therapist's perspective and found that they characterised them as on-going disagreements, thus potentially positioning themselves as locked in an interpersonal struggle with their client. Issues of power and pathologisation are raised in this study since one of the ways in which therapists positioned rupture as 'struggle' was in terms of the client presentation (e.g. having a personality disorder). Indeed, a number of clinical researchers have noted that because personality-disordered patients present with longstanding and inflexible patterns of emotional and interpersonal difficulties (Livesley, 2001; Millon & Davis, 1996, cited in Muran et al., 2009), they invariably pose great challenges to therapists, especially with regard to the therapeutic alliance (Muran, Segal, Samstag, & Crawford, 1994). There is certainly prevalence in the literature of exploring 'rupture' in association with personality disorders (Coutinho, Riberio, Hill & Safran, 2011; Muran et al., 2005). This potentially runs the risk of locating and pathologising 'rupture' within a certain presentation of clients.

Coutinho et al.'s (2011) qualitative study also explored rupture experiences within a sample of CBT trained therapists working with clients with borderline presentations. They combined a rupture rating system with an analysis of interviews by five judges, using consensual qualitative research (CQR; Hill, 2011) to compare a therapist's and client's experience of the same rupture event. This study is of interest in that it focused particularly on participants' internal experiences of rupture. In both withdrawal (WD) and confrontation (CF) ruptures therapists reported feeling strong negative internal reactions which led to feelings of confusion and an uncertainty of what to do. This resulted in feelings of guilt and incompetency. Such feelings were

more prevalent in confrontational than withdrawal ruptures. In contrast, clients felt sad and helpless, or abandoned and criticised specifically in relation to CF events. Thus, while therapists in this study reported more feelings related to their professional role, clients reported more feeling related to their role as clients. This is consistent with other studies where 'rupture' has been positioned as a kind of internal collapse of a therapist's therapeutic strategies (Safran & Muran, 2000a) or has led to feelings of incompetence (Thériault, Gazzola & Richardson, 2009).

It also alerts us to the way in which emotions can be constructed within a postmodern perspective to achieve certain functions (Edwards, 1999) – for example Coutinho et al. (2011) reported that therapist's felt guilt in relation to 'rupture'. Discursively, this raises questions around the function of therapist guilt in this context – did it serve to defend practitioners from constructions of 'rupture' as a threat to their professional competencies? However, it is worth noting that the therapists used in the study were doctoral students whose inexperience may have made them more susceptible to perceived threats.

Issues of professionalism were also observed in Binder, Holgerson and Nielsen's (2008) study which explored how therapists work with ruptures in adolescent therapy. They used a descriptive hermeneutically informed phenomenological approach to analyse nine psychotherapists' transcripts and found that therapist vulnerability and fear of hearing things that are personally embarrassing or may hurt professional competence could pose a hindrance to exploring rupture. Therapists thus positioned themselves as vulnerable, even wary in relation to 'rupture' within the clinical space. This resists alternative constructions of 'rupture' in the literature, as a critical opportunity for exploration and therapeutic change, and thus to be embraced (Leiper, 2000; Safran et al., 2002). It also raises questions as to how practitioners, including counselling psychologists, negotiate 'rupture' as a discursive site of personal and professional issues of responsibility and fallibility.

Finally, the most recent study to date was carried out by US counselling psychologists. Bartholomew, Gundel and Scheel (2016) used a mixed methods design to explore how alliance ruptures are related to "hope for change" in clients through counselling. Qualitative and quantitative data indicated that alliance ruptures are related to lower degrees of hope for change for clients, and that their perceptions of ruptures fostered disengagement and mistrust of therapists. However, when therapists act to repair ruptures they may effectively re-engage

some degree of hope for change. This positions 'rupture' and the therapist simultaneously in a discourse of hopelessness and mistrust as well as a discourse of opportunity and hope, since it highlights the role of clients' persistence in therapy despite experiencing ruptures. What is interesting in this study is that such persistence is silent in nature since the clients do not openly talk of 'rupture'. This raises questions as to how clients and therapists use (or do not use) language to speak about 'rupture' with each other in the clinical context.

2.4. Discursive perspectives of 'rupture' - a macro and micro gaze

Language as discourse and conversation is argued to be similar to client and therapist talk in therapeutic encounters since they both "constitute an intersubjective space with shared context of meanings and potential for moments of construction and struggle" (Martinez, Tomicic & Medina, 2012, p.116). In the broader psychotherapy literature discourse analysis has emerged as a useful tool to illuminate these therapeutic moments of construction and struggle (Avdi & Georgaca, 2007). So far a purely micro-analytic approach to language in therapeutic practice called dialogical discourse analysis (DDA) has been used in studies of rupture in the alliance. This process has been used to try and identify the discursive features of 'alliance rupture'.

In their study of therapeutic change and episodes of alliance rupture, Martinez et al. (2012) identified specific discursive markers through a DDA microanalysis. Interestingly, ruptures were characterised by the presence of a third external voice in the dialogue invoked by the therapist. This voice had the effect of giving a monological objectivity, in other words when somebody imposes an argument that is presented as the only possible and objective perspective and eliminates the chance of incorporating alternative perspectives in the dialogue. Although this functioned to add legitimacy to the therapist's position (e.g. by citing external psychological theory to explain the patient's behaviour), it also contributed to the rupture (Martinez et al., 2012). In contrast, in episodes of alliance rupture-repair it was observed that dialogical discursive markers (which allow and accept the possibility of other perspectives or several truths) restored the intersubjective field (Martinez et al., 2012). Thus 'rupture in the alliance' can be linked to changes in therapeutic dialogues between client and therapist within the therapy room. In addition, findings would appear to resonate with the positioning of 'rupture' as a site where the

negotiating of relatedness (e.g. reconciling the needs of the self in relation to other) has broken down (Safran & Muran, 2000b).

Georgaca (2012) though has criticised such micro-analytic studies for not taking into account the institutional frame of psychotherapy. She offers a re-reading of Martinez et al.'s (2012) findings emphasising issues of power in the rupture episode. She argues that the therapist's monological stance, or introducing a third part, is less a discursive process constituted in the here and now of the therapeutic exchange, and more a function of an institutional discourse at play where the therapist resumes their prescribed role within a wider psychotherapeutic discourse by adopting the institutional role of the expert therapist. Thus, while Martinez et al. (2012) construct 'rupture' as a negotiation and resolution of subjectivity, Georgaca (2012) reframes it as a negotiation of power within institutional discourses that offer up specific ways of being to therapist and client. In doing so she draws attention to the limit of an implicit constructivist viewpoint which focuses on internal dialogues as individual constructions, and relegates interactional, discursive and socio-cultural processes to the mere context of the construction of the self (Avdi & Georgaca, 2009).

This would seem to indicate a gap in the discursive literature around 'rupture in the therapeutic alliance' in which any new knowledge in this area would be best produced by a macro discursive focus that makes explicit the links between psychotherapy as a practice, and wider systems of meaning, institutions and power relations. Such an approach addresses criticism that a micro-analytical approach to therapy overlooks the social, cultural and institutional context of therapy talk and ignores issues of power and ideology (Avdi & Georgaca, 2007). Being attentive to power relations and their effects also offers the opportunity to subvert dominant narratives and accomplish deconstruction in practice (Kogan & Gale, 1997, cited in Avdi & Georgaca, 2007).

This is exemplified by Gatzambide's (2012) study that elucidates a model of culturally conscious rupture resolution. This model posits that ruptures in psychotherapy with ethnic minorities not only point to tensions emerging in the therapeutic alliance, but also re-orientates the treatment dyad toward broader socio-cultural realities. Thus, while Safran and colleagues posit that rupture can lead to change in the client's interpersonal schemas by providing a corrective emotional experience, Gatzambide argues for the repositioning of the intersubjective experience within a broader political and social context so that it might lead to a

culturally corrective experience. This constructs 'rupture' not just as a clinically relevant intersubjective object, but also as a politically and socially important construct.

I also heed Hepworth's (1999) warning that adopting a post-structuralist framework to investigate a phenomenon can become part of the framework that one wishes to challenge. Taking on a purely macro approach has the potential to overlook the implications for clinical practice which would seem important in a piece of research carried out by a counselling psychologist steeped in *both* researcher *and* practitioner ways of being. I thus propose an analysis which incorporates both a macro and micro social constructionist viewpoint as a means of offering new perspectives on UK counselling psychologists' constructions of 'rupture', which given the paucity of literature in this area would prove beneficial.

2.5. The Aims of the study

My aims for this qualitative study are thus twofold. Firstly, I seek to explore how 'rupture in the therapeutic alliance' is currently constructed within UK counselling psychology expert texts and to map out the discourses and related subject positions that are made available in relation to 'rupture' in the current discursive terrain. Secondly, I wish to investigate how counselling psychologists construct 'rupture in the therapeutic alliance' and in doing so pose questions around the relationship between how people think and feel (the subject positions) and what they do (Willig, 2008). By exploring counselling psychologists' choices of whether they take up or resist particular discursive practices or repertoires made available to them to achieve interpersonal and social objectives, this study also considers the wider social and institutional frameworks within which such practices are produced. Specific research questions include:

- What are the available discourses that are offered up by UK counselling psychology expert texts?
- What subject positions, practices and possibilities for subjective experience are made available by these discourses?
- How do participants use discourses/interpretative repertoires to construct 'rupture in the therapeutic alliance'?

B3. Methodology

This chapter is divided into two main parts. In part one a rationale is given for a qualitative approach to the topic followed by a description of the study's theoretical and methodological framework. This includes an exploration of moderate, critical realist ideas within social constructionism, and a discussion of the three major approaches to discourse analysis drawn on in the analysis: Foucauldian Discourse analysis (FDA), Discursive Psychology (DP) and Critical Discursive Psychology (CDP).

Part two gives an overview of the particular methods used to conduct the research.

3.1. Part One – Methodological overview

This study explores how UK counselling psychologists construct 'rupture in the therapeutic alliance'. In addition it maps out discourses around 'rupture' in UK counselling psychology's expert texts and explores how they might position participants and with what consequences. By taking into account both "the situated nature of accounts as well as the institutional practice and social structures within which they are constructed" (Burr, 2003, p.22), this study seeks to further enhance counselling psychologists' understanding of 'rupture in the therapeutic alliance' (Couture & Strong, 2004), and thus potentially create space to explore alternative ways of framing 'it' discursively within training institutions, clinical practice and supervision.

To address the questions laid out on p.42, expert texts were sourced to gain an understanding of any prevailing discourses that counselling psychologists might draw upon to shape their constructions of 'rupture', and the data analysed using Foucauldian discourse analysis (Parker, 1992; Willig, 2008, 2013). Semi-structured interviews and a focus group with qualified and trainee counselling psychologists respectively were also conducted to explore how participants constructed 'rupture' through their use of language and what was accomplished by them in their talk (Edwards & Potter, 1992). In regard to this data, I further developed the analytic procedure to combine aspects of Foucauldian Discourse analysis, Discursive Psychology (Edwards & Potter, 1992; Potter & Wetherell, 1987) and Critical Discursive Psychology (Edley, 2001; Wetherell, 1998). Influenced by Budds, Locke and Burr (2014) this combined approach is an attempt to synthesise macro and micro approaches to language and thus orientate my analysis towards "positions

taken by the participants, whilst also maintaining an awareness of the ways in which speech constitutes and represents the negotiations of identity . . . power relations and institutional structures" (Roy-Chowdhury, 2006, p.156-157).

Below I[7] develop my rationale for adopting a qualitative, discursive approach.

3.1.1. Why a qualitative, discursive study?

The critical literature review revealed that to date there is a paucity of literature within UK counselling psychology which considers the function and meaning of 'rupture in the therapeutic alliance'. I have therefore employed a qualitative, discursive approach to explore alternative constructs of 'rupture' to those provided by task analysis studies (Cash et al., 2014; Safran & Muran 2000b); naturalistic observation studies (Muran et al., 2009) and randomised control trials (Safran et al., 2005). I argue that these studies embed 'rupture' within a scientific discourse as an object about which taken for granted truths can be established. Practitioners can be positioned as recipients of these truths which potentially limit their understanding of 'rupture' and what they can do or feel in relation to it. Discourse analysis offers a way of interrogating 'truths' since its aim is to look for the processes by which claims become communicated as fact and thereby empowered as "truth" (Wetherell & Potter, 1992, p.62). Rather than categorising 'rupture' further as an "explanatory resource" (Potter & Wetherell, 1987, p.20) it is therefore approached discursively as a topic whose function can be explored.

I also seek to move beyond the lived experience of an individual - as explored by phenomenological methods which have looked at therapists' and clients' experience of rupture (Coutinho et al., 2011; Haskayne et al., 2014). A discursive analysis can identify implications of control and social order, as well as consider the power relations that are the result of language in relationships (Burr, 2003). If constructing a healthy alliance between client and therapist is a central tenet of counselling psychology, the suggestion of 'rupture' in this alliance could give rise to underlying discourses of power within the therapeutic alliance that can usefully be explored. In doing so there is the potential to inform therapeutic practice since it enables counselling psychologists to consider what discourses around 'rupture' are (or are

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B7 I use the first person to encourage methodological reflexivity. It is also consistent with social constructionists' views that as the author I am implicit in the research process and can only ever give an 'authored' account (my own) of 'rupture in the therapeutic alliance' from the many versions available.

not) available to them, and how that impacts their understanding of their own and the client's experiences of therapy. This was deemed important given the lack of knowledge and previous research in this area. Furthermore, the specific discursive analytical procedure developed in this thesis seeks to contribute to the "diversity of approaches in discursive work within psychology" (Riley, Sims-Schouten & Willig, 2007, p.143) and in doing so makes possible other forms of social theory and research (Pujol & Montenegro, 1999).

By positioning 'rupture in the therapeutic alliance' as a psychological construct whose functions vary according to situation and context, this study situates itself within a social constructionist tradition. Within this tradition I adopt a moderate approach that emphasises critical realist over relativist ideas. A rationale for the ontological and epistemological positions which underpin this qualitative approach is given below.

3.1.2. Theoretical framework - Social Constructionism

Social constructionism is a theoretical orientation indicating a radical, postmodernist shift from traditional beliefs of knowledge and truth conceived in the Age of Enlightenment. During this modernist period of history, it was assumed that the nature of the world could be discovered by the testing of hypotheses and the controlling of variables (methods of observation and reason) to uncover an absolute, objective and definable truth. Hence science was heralded as the new source of knowledge and power (Gergen, 1999). Within psychology, this remained the dominant philosophy until the 1970's, when the seminal writings of Gergen (1973) and later Potter and Wetherell (1987) introduced social constructionist thinking and the turn towards language. Language was viewed as important because how we made sense of our identities and the world was seen as constructed through social interaction. Language was no longer conceptualised as a realist labelling of the speaker's internal world but as a performative act and "something that people do together" (Burr, 1995, p.8). Social constructionism offered an alternative, critical framework of understanding which generated the possibility of radically different accounts of many psychological and social phenomena.

Burr (2003) and Potter (1996) both postulate that there is no single way of defining social constructionism, however building on Gergen (1999), Burr (2003) identifies four broad areas of consensus among those who call themselves social constructionists, as described below:

1. *A critical stance is taken toward 'taken for granted' knowledge.* Social constructionism challenges empiricist and positivist beliefs that the knowledge that we have about the world is revealed through objective, unbiased observation and is a result of a "direct perception of reality" (Burr, 2003 p.6). Instead social constructionists argue that our knowledge about the world is a product of social processes and interactions in which people are constantly engaged with each other (Burr, 1995).

2. *Our understanding is historically and culturally specific.* Social constructionists maintain that there is no one way of understanding the world, and that our knowledge of the world is instead constantly reshaped and redefined by shifting historical and cultural contexts. Thus any concept of 'truth' is problematical insofar as what we know to be true or real will vary across historical epochs, cultures and societies (Burr, 2003). This has implications for our own identities that are conceived as fluid entities which change over time.

3. *Knowledge is sustained by social processes* and it is "through the daily interactions between people . . . that our version of knowledge becomes fabricated" (Burr, 2003, p.4). Viewing interaction as actively constructing the world between us highlights the salience of language, as it is "basically the most basic and pervasive form of interaction between people" (Potter & Wetherell, 1987, p.9). Language thus becomes a form of action that constitutes the world rather than represents it (Danzinger, 1997). This challenges more mainstream psychological views that language is merely the direct expression of internal thoughts, attitudes and emotions.

4. *Knowledge and social action go together* insofar as each different construction of the world brings with it a different kind of action for human beings. Some constructions sustain some patterns of social action whilst excluding others. Thus, our constructions of the world are inextricably linked with power relations as it makes certain social actions possible whilst restricting others (Burr, 2003).

As social constructionism problematises the existence of an ultimate and objective truth and constructs a knowledge of the world through interaction (Burr, 1995), ontologically and epistemological speaking, it has been broadly aligned with a relativist philosophy. However, Nightingale and Cromby (2002) acknowledge that a continuum of ontological standpoints exist in constructionism from postmodern relativism (radical social constructionism) through to the post-positivist critical realism (moderate social constructionism). Positioning myself along this continuum has not proved easy. Below I outline why an emphasis on critical realist rather than relativist ideas was deemed theoretically and methodologically more appropriate for meeting the research aims of this study.

3.1.3. Building a rationale for a moderate critical realist approach

A relativist ontological and epistemological positioning which regards knowledge as constructed through interaction initially appeared consistent with one aspect of my research which sought to explore how 'rupture' might be constructed through talk as an event or action (Burr, 1995). However, Edwards, Ashmore and Potter (1995) argue that a radical, relativist positioning cannot accept the existence of a "bedrock of reality" (p.26) since all references to physical or material realities are in themselves discursive constructs. Sims-Schouten et al. (2007) add that from a relativist position material objects and practices are only produced by discourse, and therefore do not have an ontological status outside their place in discourse. Thus, a non-discursive world is effectively positioned as subordinate to the discursive, and in this context relativism espouses Derrida's (1976) notion that "nothing exists outside of the text" (p.158).

To remain consistent with the first aspect of my research - to interrogate the wider cultural and psychological discourses of 'rupture' potentially available in expert texts – I required an ontological stance that *acknowledged* the existence of a material reality outside of the text. Only then could I "attend to the conditions which make the meanings of text possible" (Parker, 1992, p.28). Cromby and Nightingale (1999) argue that a material embodied reality does exist, and that it cannot be reduced purely to text as a physical world puts constraints upon, as well as creates opportunities for the constructions we make, and therefore the actions we take. Willig (1999a) refers to such material reality as the "underlying biochemical, economic or social structures" (p.45) upon which our social constructions are based whilst Parker (1992, 2014) defines them in terms of the organisations and

institutions that shape our physical and social environment. Since a relativist position would not enable me to consider these institutions (in this case universities or places of employment and their role in constructing discourses of 'rupture') I sought a more moderate, critical realist position. This stance permits me to undertake research that not only describes constructions, but also takes into account the material and social structures involved in such constructions (Bhaskar, 1975).

Such a moderate position was also important if I wanted to account for power processes in discourses of 'rupture'. Cromby and Nightingale (1999) argue that although a relativist stance describes power, it does not attempt to go beyond this description and therefore cannot interrogate how things come to be as they are and in what ways they then might be improved (Willig, 1999b). A moderate stance was thus deemed necessary if I wanted my research to account for power within 'rupture' discourses and how they might be "grounded in social and material constructions such as institutions (e.g. universities) and practices" (Parker, 1992, p.28). I hoped that this would aim towards social critique (and change) since it created the opportunity to challenge any "dominant categories and their associated practices" (Willig, 1998, p.94) which were potentially revealed.

Finally, adopting a critical realist stance allowed for a more dynamic view of the individual and account of their subjectivity. From a relativist position individuals cannot be separated from their social, cultural, material and historical worlds, and as such it excludes subjectivity and the notion of the 'self' essentially disappears (Cromby & Standen, 1999). However, Cromby and Nightingale (1999) argue that critical realism allows us to question the extent to which we have to reduce people entirely to social and cultural processes. This allows for more dynamic notions of self since discourse analysts can consider "how an individual acts upon himself" (Foucault, 1988, p.19). Without room for this notion of subjectivity, we cannot account for why people choose to use certain constructions over others that are available to them (Willig, 1999b). Again an emphasis on critical realist over relativist ideas seemed more consistent with my research aims which sought to explore whether participants were taking up (or resisting) available discourses/repertoires when speaking about 'rupture in the therapeutic alliance' and the implications for their subjectivity.

In summary, critical realist ideas assert that whilst we are only able to access the world through our representations of it, a real world does exist independently of these representations (Parker, 1992). Acknowledging such ontological realism does not however exclude the possibility of an epistemological relativism (Parker, 1992), since language is still understood as "constructing our social realities and text provides the raw material from which we may structure our understanding of the world through discourse" (Burr, 2003, p.97).

Thus, within this critical realist framework I maintain an epistemological relativism by seeking access to the way in which language constructs versions of reality and to the links between discourse, subjectivity, action and "the material conditions within which such experiences may take place" (Willig, 2013, p.138). This access is invariably gained through a discourse analysis of text and talk.

3.1.4. Discourse and Discourse analysis

Discourse analysis is a particular research method that views language as "worthy of analysis in its own right" (Dickerson, 1998, p.212). Broadly speaking discourse analysis rejects the idea that language is simply a neutral means of describing the world, but rather emphasises its constitutive nature in building versions of it (Coyle, 2007).

To this end, discourse analytic researchers are primarily concerned with the analysis of discourse that can take the form of talk, text, spoken and written language and communication. Although the term 'discourse' can have a multiplicity of meanings (Mills, 2004), it is inherently conceived as constitutive insofar as it is a "system of statements which constructs an object" (Parker, 1992, p.5). In all cases discourse analytic researchers pay attention to the functional and constructive aspects of language in use, as well as to what versions of the world are produced. To achieve these ends, a plethora of discourse analysis techniques exist as a "set of methods and theories for investigating language in use and language in social contexts" (Wetherell, Taylor & Yates, 2001, p.i).

When choosing a method for this study, exploration was limited to those approaches within the field of psychology and social psychology where it is common to distinguish between what Wetherell (1998) describes as "ethno-methodological and conversation analytic traditions and analyses which follow post-structuralist or Foucauldian lines" (p.388). Foucauldian Discourse Analysis (FDA) and Discursive

psychology (DP) are described below, paying particular attention to differences in terms of their implications for human agency, experience (Willig, 2013) and power (Cromby & Nightingale, 1999). Critical discursive psychology (CDP) is also introduced as a discourse analysis technique that attempts to reconcile these two approaches and their theoretical differences. I then offer a rationale as to why I developed my analytic procedure from a purely Foucauldian analysis of the expert texts to a combined analytical approach drawing on FDA, DP and CDP to analyse the interview and focus group data.

3.1.5. Foucauldian Discourse Analysis

Foucauldian Discourse Analysis (Parker, 1992; Willig, 2008) is influenced by post-structuralism and in particular the work of Michel Foucault (1972). Its focus falls on what Burr (2003, p.184) refers to as the "macro structures" of our social and psychological lives and is concerned with the way in which language and discourse constitute versions of our social worlds, and how as individuals we draw on available discourses to make sense of the world around us (Willig, 2013). Within FDA discourses are conceived as a set of discursive resources or linguistic systems that "form the object of which they speak" (Foucault, 1972, p.40). Such discourses also construct an "array of subject positions" (Parker, 1994, p.245) which both enable and constrain certain ways of seeing and being in the world for those individuals that take them up (Willig, 2013). Thus, discourses can limit and facilitate what can be said and by whom (Parker, 1992), which has implications for subjectivity since discourse "makes available a space for particular types of self to step into" (Parker, 1992, p.9). It can also limit and facilitate what people can do or have done to them (Burr, 2003); once taken up the subject positions created within discourses allow for different sets of rights, obligations and possibilities for social action (Willig, 2013).

Consequently, as Foucault (1972) observes certain discourses within culture will inevitably become bound up with power. Since more prevalent discourses will privilege certain ways of being and seeing the world over others, it is inevitable that particular discourses or versions of events will dominate, whilst others will become marginalised (Willig, 2013). This does not exclude the possibility of alternative discourses emerging over time however. Weedon (1997) posits that changes to dominant discourses begin at the individual level through resistance, and usually develop when there is a gap between the subject position being offered through discourse and the individual's own interests. On a wider level, Foucault (1972)

emphasises a historical notion of rupture as "the active force of separation and discontinuity in history" (Duncan, 2008, p.3) that enables the emergence of new knowledge, new discourses and new modes of subjectivity. This Foucauldian notion of 'rupture' has interesting connotations for its function within a counselling context as to the extent to which it could enable an emergence of new knowledge or even individual resistance.

Foucauldian discourse analysis thus permitted an exploration of power through the effects of wider societal discourses that was useful to this study. Taking a macro approach to language enabled a mapping of the available psychological, cultural and historical discourses around 'rupture' offered up by counselling psychology expert texts and an exploration of the subject positions, practices and possibilities for subjective experience or ways of being they made available to participants (Willig, 2013).

It has been argued that FDA has limitations, primarily in its theorisation of subjectivity and agency. Burr (2003) contends that FDA sets limits on the speaker, positioning them as largely passive since their subjectivity is constrained by pre-existing societal discourses. Hall (2001) concurs, maintaining that these fixed notions of subjectivity enable a consideration of a limited form of agency. This would seem to sit in tension with Foucauldian notions of historical 'rupture' which potentially allow for individual resistance (as discussed above). Such tensions are not uncommon within the work of Foucault who firstly advised "getting rid of the subject itself" (1980, p.117) before later encouraging a focus on ethical ways of being and morality as a way of self-governance, or relationship to the self. This changed focus would seem to offer a greater scope for agency, but Miller (2008) has argued that even though this "technology of self" potentially grants greater freedom to individuals to reflect on how they are subjectively positioned in relation to discourses and power, it remains "a freedom within limits" (p.26).

Taking this into consideration, I debated whether employing a purely FDA analytical approach to the group/interview data in this study would permit participants a sufficiently active role in constructing and negotiating meaning around 'rupture' and so provide an adequate understanding of how people construct subjectivities in social interaction to particular ends (Budds et al., 2014). Accommodating issues of agency was deemed important as 'rupture' is currently constructed in the literature as a relational configuration where individuals negotiate a tension between the need

for agency versus the need for relatedness (Safran & Muran, 2000b). Incorporating discursive psychological approaches provided a way in which to address these limitations.

3.1.6. Discursive Psychology

Discursive psychology is influenced by the principles of ethnomethodology and conversation analysis and focuses on the localised deployment of discourse. Discursive psychologists emphasise "the performative functions of language" (Burr, 2003, p.17) and the social actions people accomplish through talk (Edwards & Potter, 1992). However, unlike mainstream cognitivist assumptions that talk is an accurate representation of cognitions, feelings, memories or beliefs; discursive psychologists make no claim as to an individual's motivation for their social actions. Rather it conceptualises people as drawing on psychological constructions such as identity, experience or memory to construct different versions of reality. As described by Edwards (2006, p.43), "It is the primary work of language to make all those 'other' phenomena accountable". DP thus offers a different way to theorise and study traditional sites of interest in psychology by focusing on how an individual's account is action orientated and how individuals deploy discursive strategies (e.g. justifying, blaming, rationalising etc.) to manage their interests in the microcosm of conversation (Edwards, 2006). This requires a micro-analysis of texts to allow for consideration of the specific discursive and rhetorical devices that are used by individuals to achieve these aims.

If FDA focuses on discursive resources that are available to people and the ways in which they construct subjectivity and power relations, DP focuses on discourse practices, situated language use and what people do with language (Willig, 2008). When employing discursive or micro approaches to language, individuals are thus afforded a greater sense of agency as they are regarded as "active agents who use discursive strategies to manage a stake in their social interactions and experiences" (Willig, 2008, p.107). This allowed for a micro-analysis of the processes by which 'rupture' was talked into being by participants through the use of discursive practices, and an understanding of how people construct subjectivities in social interaction to particular ends (Willig, 2013).

DP also has shortcomings to address in that it restrains the analysis of discourse to what goes on between individuals in their localised interactions. It has been argued that this leads to an apolitical and reductionist analysis of the data (Parker, 1992,

1997; Speer 2005; Wetherell, 1998) since a micro focus fails to account for the wider, cultural discursive resources or structures of power which shape the discursive devices that are made available to individuals (Parker, 1997). In terms of this study, failure to locate counselling psychologists' accounts of 'rupture' in wider psychological discourses would therefore not allow for an interrogation of the role of social institutions (e.g. universities) in generating discourses of 'rupture' which participants then may or may not take up. This was deemed important if I intended to map the discursive terrain around 'rupture in the therapeutic alliance'. In addition, a purely discursive approach failed to account for subjectivity; as identities are constructed moment to moment in talk, Willig (2013) argues that it is unable to theorise a sense of self and thus account for why individuals pursue particular discursive objectives. Since I sought to understand why counselling psychologists might resist or take up particular discourses of 'rupture' and the consequences for their experience, access to subjectivity was important.

Having described the limitations of using an exclusively Foucauldian or discursive approach to discourse analysis in this study, the following section now considers how these approaches were usefully combined to overcome theoretical tensions and to meet my research aims.

3.1.7. Combining Discursive Approaches – overcoming theoretical tensions

Potter and Wetherell (1995, p.81) observe that the distinctions between FDA and DP should not "be painted too sharply" and have argued for a synthesis of discursive and Foucauldian-inspired influences to overcome the limitations of using each in isolation. Discourse analysts have argued that reconciling theoretical differences between FDA and DP is possible since both share an interest in understanding how discourse does things in the social field and to what effect (Budds et al., 2014; Le Clezio, 2014). Budds et al. (2014) posit that conceptual issues of agency can be resolved as both FDA and DP are concerned with the action orientation of discourse. In this sense they become compatible, "with the difference lying in the degree to which participants are considered to have agency with respect to how social actions are achieved" (Budds, 2013, p.74). This allows for a more in-depth consideration of participants' subjectivity since interrogating what ways of being are made available "through the discourses on offer" informs how individuals are able to make sense of their experience (Budds et al., 2014 p.11). This proves useful for a research question that considers the dialogical

relationship between the discursive field and the agents positioned in it. As argued by Le Clezio (2014, p.58) "it opens the space for these agents to be both regulated by discursive practice but also to explore how they resist this regulation".

Edley (2001) and Wetherell (1998) have developed Critical Discursive Psychology (CDP) to provide researchers with a flexible methodology that bridges macro and micro discursive approaches and seeks to resolve conceptual tensions of agency. This approach is discussed below.

3.1.8. Critical Discursive Psychology

CDP promotes a theoretical stance from which a researcher can consider both the wider social contexts which constrain the language available to participants, but also recognises the agency that they have to draw on specific psychological and institutional discursive resources (Budds et al., 2014). It achieves this by acknowledging that whenever people talk and construct objects and events, they do so within a specific social and historical context (Edley, 2001; Wetherell, 1998). This addresses the criticism that discursive psychology fails to take into account the context in which talk is done and social acts are discursively negotiated. Critical discursive psychologists thus allow people agency in choosing which discursive devices they draw upon to construct different versions of the worlds for different interactional ends. They do however acknowledge that the discourses individuals have to choose from are limited by the particular repertoires of cultural discursive and linguistic resources made available to them by their wider contexts (Edley, 2001). By extension, people's sense of subjectivity and identities may also be constrained by the stories and narratives of identity that are available in culture (Wetherell & Potter, 1992; Wetherell, 2005).

CDP thus provides a means of resolving conceptual issues between DP and FDA by offering a dual focus on the nature of discourse.

> Discourse is deemed both constitutive, in the sense that it, to some extent, shapes, enables and constrains possibilities of identities and social action, yet also constructive. That is, it can be a tool used by participants within social interactions to achieve particular effects (Budds, 2013, p.76).

CDP was deemed appropriate to my analysis of the focus group and interview data since it permitted me to move between the micro and macro discursive processes at work within this data. For example, I could draw on a micro perspective of participants' discourse by acknowledging the subject positions created by talk in local interactions, but also draw on a post-structuralist or macro perspective to give a broader account of "Why this utterance here?" (Wetherell, 1998, p.15).

In summary, CDP provided me with the theoretical (and methodological) framework to consider both the wider context which shaped and limited the discourses of 'rupture' on offer to counselling psychologists, as well as recognising 'the agency participants have to draw on specific psychological and institutional practices' (Budds, 2013, p.78). This enabled me to make greater sense of counselling psychologists' constructions of 'rupture' and so answer the call to "constantly question our practice . . . in terms of our therapeutic skill but also in terms of the political and cultural discourses that influence our work" (Besley, 2001, p.73).

3.2. Part Two - Methods

This section considers the specific methods and analytical procedures employed and the rationale for their use.

The study comprised of two stages: the mapping of the discursive terrain around 'rupture in the therapeutic alliance' through a Foucauldian analysis of expert texts, followed by a combined analytic approach (drawing on Foucauldian, discursive and critical discursive psychology) to data generated by focus groups and semi-structured interviews. Willig (2008) notes the appropriateness of these data collection methods when researching the relationships between expert discourses and the ways in which participants take them up.

3.2.1. Stage one – A Foucauldian analysis of expert texts.

Here my aim was to identify the available discourses offered up by UK counselling psychology expert texts about 'rupture' and consider the ways in which they might position counselling psychologists and with what consequences. For reasons of clarity and transparency I have described the methods used in the data collection of the expert texts below.

3.2.2. Methods used in analysis of expert texts

3.2.2.1. Location of texts

The predefining of data in terms of a period of time and national context was driven by an intent to map a particular discursive economy – in this case texts produced for the purposes of knowledge and training, and readily accessible to counselling psychologists in the UK. Certain institutions were identified as most likely to generate relevant texts since they arguably positioned themselves and their texts as truthful, and supported by rigorous evidence. They were deemed potential crucibles for dominant discourses of 'rupture' and warranted a critical gaze. These included UK universities offering a counselling psychology doctorate; professional governing bodies such as the Health and Care Professions Council (HCPC); British Psychological Society (BPS); National Institute for Health and Care Excellence (NICE), and counselling psychology collectives such as the Division of Counselling Psychology (DCoP).

Willig (2008) asserts that the choice of texts must be informed by the research question. As my interests lay in identifying constructions of 'rupture', I identified expert texts as those most clearly focused on the object of research and most likely to provide variability in terms of constructions identified. I looked at texts dating back to 1994 as this was the year that UK counselling psychology emerged as a distinct profession and was officially recognised by the BPS as having a unique identity and philosophy of practice (Corrie & Callahan, 2000).

Such considerations led to my decision to analyse a sample of contemporary, professional, academic and cultural texts – including academic journal articles, counselling psychology handbooks and training books, ethical and practice guidelines issued by governing bodies (e.g. HCPC, DCoP and BPS). I believed that these would provide access to a range of discursive constructions of 'rupture' sold as knowledge within the field of counselling psychology (e.g. academic, clinical and ethical). Given that such texts already exist within the online public domain, City University's Research and Ethics Committee advised that ethical approval was not needed for this stage of the study.

3.2.2.2. Sampling

As I sought access to contemporary discourses of 'rupture' generated by and conveyed to UK counselling psychologists specifically, searches were limited to academic texts published in Britain and included peer reviewed counselling psychology journal articles published in the English language in the time period specified (1994 – December 2015). Two parallel sampling strategies were used to locate professional texts in the form of academic journal articles suitable for analysis. A search of the BPS published, *Counselling Psychology Review (CPR)* was carried out on the DCoP website using the terms "rupture in the therapeutic alliance" and "alliance rupture/s" (http://www.bps.org.uk/networks-and-communities/member-microsite/division-counselling-psychology). This search located one text (Richards, 2011)[8], which was included in the study. To exhaust all lines of enquiry, access was also gained to the online bibliographic databases PsycINFO, PsycARTICLES, Medline via City University and PsychSource via the BPS which provide citations, references and abstracts for journal articles, books, book chapters and research papers in psychology and psychological aspects of related disciplines (e.g. medicine, psychiatry, nursing, sociology, health). Search terms as above were utilised and 150 journal articles were identified. Of these only seven studies were generated in the UK, and only one of these (identified above) was included as it was authored by a UK counselling psychologist. The remaining texts were found in journals such as *Psychotherapy Research* which did not specifically represent UK counselling psychology and were therefore not included.

Sampling of UK published counselling psychology textbooks and handbooks also followed a parallel process. Firstly, I searched for recommended reading lists provided by UK universities offering a counselling psychology doctorate (including City, East London, London Metropolitan, Metanoia, Manchester, Regents, Roehampton, Teeside and the University of Surrey) to identify the common handbooks, training texts and reference books recommended to counselling psychology trainees. I selected those authored by UK counselling psychologists/institutions and then searched them manually or electronically for references to "alliance rupture(s)" or "rupture in the therapeutic alliance". I also

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[8] Siddiqui (2012) was not identified until after the completion of the analysis, since its title did not contain the word 'rupture'. It has been reflected upon in the literature review and discussion, given its relevance. This raises questions around other texts that may have been missed if 'rupture' was not the focal point of the title. I sought to address this by regularly rechecking my searches, and using search criteria that allowed for a search within documents for the word 'rupture'.

searched on City University library databases using the term "counselling psychology + rupture in the therapeutic alliance", and applying the following filters: "English"; "psychology"; "handbooks"; "textbooks" and "reference books". This generated 107 returns. Again I disregarded those published outside of the UK and focused on those generated by UK counselling psychology bodies and/or authors. I then searched (either manually or electronically) in the texts selected for direct references to "alliance rupture/rupture in the therapeutic alliance". I sought to ensure variability of data by selecting texts, that where possible, reflected different features of practice e.g. supervision, clinical and ethical. This resulted in five primary texts for analysis to include three reference/handbooks[9] and two texts which considered practitioner ethics.

Texts produced by governing bodies that influence counselling psychology practice and ethics were sourced using a single sampling strategy. The websites of the HCPC, BPS and NICE and DCoP were searched using the terms 'alliance ruptures'/ 'rupture in the therapeutic alliance'. On each of these sites their guidelines for clinical, supervision practice and ethics standards were also searched. A further search for counselling psychology discussion groups on this topic was conducted on the DCoP website. The search returned one reference to "alliance ruptures" that was an advert in the Psychologist for a training workshop to be held by Jeremy Safran in May 2015. I included this as a text for analysis, reasoning that members of the BPS and counselling psychologists regularly read this journal, and therefore it contributed to contemporary discourse among UK counselling psychologists.

The searches above located far fewer UK counselling psychology texts that made substantial reference to 'rupture in the therapeutic alliance' than I had anticipated (in my analysis I reflect on what this lack of material might mean for constructions of 'rupture'). This may have been because the term (as picked up on in the literature review) can be an umbrella term for other references such as 'impasse'. However, given that this research is on 'rupture in the therapeutic alliance', I decided to exclude articles that did not use 'rupture' as a discrete term within the text. I was also very specific in using only texts which were generated by those authors or institutions deemed as having an influence on the professional and clinical development of the UK's counselling psychologists. Although I recognised that UK counselling psychologists could access a number of other research journals,

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[9] The most recent edition of the Handbook of Counselling Psychology (2016) was not used since it was published after the analysis was completed. However it is referred to in the literature review.

including a wider body of research generated by the American Division of Counseling Psychology on 'rupture' (e.g. in the *Journal of Counseling Psychology*), I did not include these texts in my analysis. This is because counselling psychology training programmes, research traditions and culture might be assumed to be specific to their country of origin and therefore have less cultural influence over contemporary UK counselling psychologist discourses of 'rupture'. Hore (2013) observes that counselling psychology professions in the U.S. and the UK appear to have a different pedigree and the extent to which U.S. discourses have had an impact in the UK remains unknown. An exception was made for a paper authored by US researchers published in the *Counselling Psychology Quarterly* for two reasons. Firstly, this peer reviewed journal has a significant number of UK counselling psychologists on its editorial board which made it relevant to UK discourses, and secondly the content of the article concerned 'rupture' in a supervisory context which I believed added to the variability of the data.

Given the paucity of texts, I also chose to extend my search to the internet to include any texts that I may have missed. I used the following search terms on Google and Google scholar search engines – "ruptures + therapeutic alliance, rupture + UK counselling psychology". In addition to material previously identified, this located a website set up by a group of therapists and researchers at the University of Sheffield Centre for Psychological Services Research. They were funded by the UK National Institute for Health Research (NIHR) to undertake research into Understanding and Preventing Adverse Effects of Psychological Therapies. Their website included a page on 'rupture'. I included this page for analysis because the text was produced in a UK academic context but provided on a website for clients as well as therapists in the context of 'safe therapy'. This again offered a pertinent and interesting discursive context and added to the variability of the data. (For the final list of nine texts chosen for analysis see Appendix B1).

My analytic procedure in regard to the expert texts is described in a later section. Data collection for the interview and focus group that formed stage two of the study is described below.

3.2.3. Stage two - Focus groups and semi-structured interviews

In stage two of the study I conducted four in-depth semi-structured interviews with qualified counselling psychologists and a focus group of five counselling psychologists at various stages of their training. My aim was to interrogate further

discursive practices used to construct 'rupture in the therapeutic alliance' and explore whether the discursive resources identified within expert texts were taken up, resisted or renegotiated by participants. A discussion of the different methods of data collection follows, along with a summarising rationale for using mixed methods.

3.2.4. Rationale for semi-structured interviews

Semi-structured interviews were considered to be the most appropriate qualitative research method with which to explore qualified counselling psychologists' accounts of 'rupture in the therapeutic alliance'. Methodologically speaking they offered appropriate discursive spaces for participants to raise issues that they felt were relevant to them, as well as allowing me to follow unexpected avenues opened up by them (Smith & Osborn, 2015).

Conversely Speer (2007) has criticised the use of interviews as failing to generate naturalistic talk, and Potter (2004) advocates the turning away from interviews to "focus on materials less affected by the formulations and assumptions of the researcher" (p.206). However, I concur with Wood and Kroger (2000) who maintain that discourse analysis interviews can be both viewed and executed as conversational encounters, since an "active" interview is one in which the interviewer and interviewee are seen as equal partners in co-constructing "a meaning making conversation" (Holstein & Gubrium, 2016, p.70). In terms of this study, semi-structured interviews (and focus groups) were also viewed as compatible with the method of discourse analysis chosen which intended to focus on the micro action orientation of dialogue.

Interviews also enabled me to acknowledge "the creative potential of my presence" as both researcher and fellow trainee counselling psychologist (Griffin, 2007, p.253). Therefore as interviewer I did not assume the objective, observer role advocated by interviews in mainstream psychology, but rather saw myself as taking an active, orientated role in the knowledge being generated around rupture through talk; what Griffin (2007, p.255) terms a "researcher inspired conversation". Consequently, utterances from the interviewer were also analysed and considered as important as the participants' responses (Potter & Hepburn, 2005; Potter & Wetherell, 1987).

To develop my "creative potential" I conducted two one hour pilot interviews with peers on my training course. These allowed me to develop my interview skills, pre-empt certain problems and open up certain discursive contexts which I had not

previously considered – for example, how 'rupture in the therapeutic alliance' might be constructed in the context of the participant's relationship with their personal therapist as well as with a client. One of the interviews was recorded and transcribed. A preliminary analysis was carried out to identify constructions and discourses following Willig's (2008) first and second stages of Foucauldian discourse analysis. This alerted me to the construction of 'rupture as the elephant in the room' and primed me to expect a potential anxiety around rupture and how it is spoken about. I wondered to what extent both I and the interviewee would defend against anxiety by taking up a position of 'knowing' in relation to rupture. This became an important area for on-going critical reflexivity during the interview process in which I had to continually negotiate positional tensions inherent in the therapist-researcher position. These are alluded to in the analysis and reflected on in depth in the discussion.

3.2.5. Rationale for Focus Groups

Wilkinson (2008) described focus groups as engaging a small number of people in a carefully planned group discussion that is focused on a particular topic. Its purpose is not to build a consensus on a topic but to obtain a range of opinions (Vaughn, Schumm & Sinagub, 1996) that enable the researcher to gain rich, discursive data from a number of participants at once. Discussion is usually based around a series of questions constituting the focus group 'schedule', with the researcher acting as group moderator by posing questions to keep the discussion flowing and to encourage participation (Krueger & Casey, 2014; Vaughn et al., 1996; Wilkinson, 2008).

Wilkinson (2008) posits that focus group research conducted within a constructionist framework does not assume that pre-existing knowledge is located inside people's heads, rather it posits that meaning-making is produced collaboratively over the course of social interactions. Thus, although focus groups are limited in their potential for understanding individual thought or feelings, they are helpful in analysing processes of social interaction (Hollander, 2004). In addition, Smithson (2000, p.105) maintains that focus groups can be conceived as "social events that pick up performances", and in doing so provide a useful setting in which the researcher can observe how participants' socially constructed shared understandings are used to do things (Potter & Wetherell, 1987).

In terms of this study, a focus group allowed me to trace ways in which meanings around 'rupture' are collectively constructed through language as well as considering the interaction between participants as a source of data (Willig, 2008). This addressed any partiality on my part as it gave control to the group and ensured discourse was participant led and explored "in their own vocabulary" (Andreasen, 1995, cited in Barbour & Kitzinger, 1998, p.5). Such a method of data collection was also deemed well suited to counselling psychology trainees used to engaging in peer group discussions.

3.2.6. Developing a mixed methods of data collection

A mixed approach to data collection granted me access to different types of discourse, insofar as interviews encouraged personal narratives, whilst focus groups drew on opinions or views (Puchta & Potter, 2004). This enriched my understanding of 'rupture in the therapeutic alliance', consistent with Potter and Wetherell's (1987) observations that collecting documents from different sources and combining them with interviews provides a much fuller picture of the way participants' linguistic practices are organised. Gaining access to different speakers at different stages of their career (in training and qualified) also generated alternative insights and allowed for different discursive constructions (and functions) of 'rupture' to emerge (Willig, 2013). Thus, the methods of data collection employed in this qualitative research were not adopted randomly, but with the view that each would contribute something unique to my understanding of 'rupture in the therapeutic alliance'.

3.2.7. Methods used in interview and focus group study

3.2.7.1. Sampling and Recruitment

Participants for both the focus group and the interviews were recruited using the following procedures:

- *Recruitment via university.* The programme administrators at five different universities distributed explanatory letters and flyers (see Appendix B2a/b) which outlined the project. These flyers were posted on the electronic notice board inviting counselling psychology trainees in all years of study to contact me if they wished to participate in the research. The researcher did not have access to these potential participants' details, thus preserving their anonymity.

- *Recruitment via opportunistic sampling.* Participants were recruited via word of mouth by the researcher and via my own social network of trainee peers asking if they knew of potential participants. Such a localised and homogenised site of recruitment was deemed suitable since it was consistent with the exploratory nature of a study that relied on the participants and researcher being part of a shared discursive field.

- *Recruitment via the DCoP.* The research was advertised on the BPS DCoP website including an advert placed in the news e-letter distributed by the DCoP (see Appendix B3). This invited volunteers to contact me directly, thus protecting their anonymity.

- *Recruitment via a Facebook group.* The DCoP has set up a Facebook group that one has to be invited to join, and is only accessible to registered members of the division. Again my post invited volunteers to contact me directly, protecting their anonymity.

The inclusion criteria for qualified counselling psychologists was that they had to have held a qualified role for at least a year, whilst counselling psychologist trainees could be in any year of study but had to be currently enrolled in a UK university counselling psychology doctorate programme. The aim was not to compare these groups, but to gain access to as many relevant groups and therefore different discourses around 'rupture' within the UK counselling psychology community as possible. This is consistent with Potter and Wetherell's (1987) observations that the interest in discourse analysis is in language use, rather than language users.

3.2.7.2. Participants

A total of four qualified counselling psychologists and eight trainee counselling psychologists showed an interest in the project as a result of these recruitment methods and requested further information via e-mail. Information sheets (see Appendix B4) were distributed and follow-up phone calls made to discuss the research and emphasise the voluntary nature of participation. Dates were arranged for the interview/focus group. Three potential participants dropped out due to logistic issues. Interviews were eventually set up with four chartered counselling psychologists (two male, two female) who qualified between two and fifteen years ago. The focus group included five trainees (one male, four female) from three

different universities. Amongst them was one first, two second and one final year student. Two participants did not speak English as their first language. Potter and Wetherell (1987) observe that within discourse analysis it matters less who does the telling and more what is in the telling. Further explicit demographic information was therefore not considered necessary.

3.2.7.3. Semi-structured interviews procedures

Participants were given a choice over the location of the interview with two choosing to conduct it at their home, one at work, and one at a location of my choosing. When possible I chose to avoid spaces directly linked with universities or professional forums to mitigate against individuals only taking up a position of professional expert in relation to 'rupture'. Prior to the interview, all participants were asked whether they had had the chance to read the information sheet that they were sent via email one week before. The aims and rationale behind the research, along with the research procedures and plans for the data were then briefly reiterated before their understanding of the research and what was expected of them (Kvale, 2007) was checked. Following this, participants were asked to sign an informed consent form (see Appendix B5).

With permission from the participants all of the interviews were audio-recorded as providing a transcript of the interview was essential for an in-depth discourse analysis. Each interview lasted 60 minutes and the questions were informed by my analysis of texts drawn from my experience in the pilot interviews, and through knowledge gained from reviewing the existing literature. The interviews were based upon a loose interview schedule (see Appendix B6) designed to encourage participants to consider 'rupture' in different contexts (supervision, personal therapy, clinical work), with a view to accessing as many constructions and functions of 'rupture' as possible. Willig (2013) advises restating participants' comments and answers as a means of conveying that you are taking note of their answers and understanding them correctly. I employed this technique as a way of establishing rapport, whilst follow up questions were used as a way of posing alternative views or problematic views for the participant, thereby gently challenging constructions so that others might appear. This is consistent with Potter and Wetherell's (1987, p.166) observations that the researcher should try to generate interpretative contexts in the interviews in such a way that "the connection between the interviewees discursive practice and variations in functional context becomes clear".

I wrote field notes and recorded my thoughts and feelings as part of my reflexive practice immediately after each interview. This allowed me to reflect on my own role in constructions of the object and make a note of any emergent discourses.

3.2.7.4. Focus Group procedures - size and setting

Focus groups should be conducted at a convenient location that is easy for participants to find and get to (Krueger & Casey 2014; Vaughn et al., 1996), though Fern (2001) notes that a setting can affect an individual participant's personal space and privacy, and I was mindful that placing trainees in an institutional setting (City University) may affect their talk. The focus group was therefore conducted at a neutral setting of my choosing - a private room away from other people where discussion would not be interrupted or overheard.

One focus group with five participants was conducted. This was deemed an adequate number to meet Willig's (2013) guidance on sample size that relates to the ability of the sample to meaningfully respond to the research questions. It also enabled all participants to remain actively involved in the group discussion (Willig, 2008). The group was recorded on audio tape so that non-verbal communications such as hesitations and pauses could be captured, adding to the richness of the data (Willig, 2008). Given the small group size and the parameters of the discussion topic in this project, it was decided that 1.5 hours was a suitable length of time for the group.

3.2.7.5. Conducting the group

The aims and rationale behind the research, along with the research procedures and plans for the data were reiterated at the start of the discussion. Informed, written consent was then obtained before the group began (see Appendix B7). As moderator, I introduced group members and the focus of the study; the opening question was one that the entire group answered. Ground rules were set at the beginning of the session to establish a group understanding of confidentiality. I sought to instil in participants that any information/identities shared in the group should not be discussed outside the group setting (Wilkinson, 2004), repeating that the participants also had responsibility for confidentiality as a part of their participation (Krueger & Casey, 2014). Given the group setting, participants were also made aware of the limits of the researcher's ability to ensure total confidentiality, and that anonymity from one another could not be obtained. Finally,

they were asked to observe the anonymity and confidentiality of any clients discussed.

My aim for the group was to generate a discussion amongst participants that could then be subjected to a discourse analysis in order to produce discursive constructions, discourses and subject positions. Morgan (1997) emphasises that if the goal of the group is exploratory in nature it calls for a less structured, open-ended form of questioning which encourages self-reflection rather than eliciting socially desirable responses (Puchta & Potter, 2004). Within this environment the moderator can abstain from leading the group and thus appear to relinquish a position of 'knowing'. Such a stance seemed important as it accurately reflected my status as a fellow trainee and also allowed for any questions I did engage with to become part of the data set and thus subject to analysis, reducing the potential for researcher bias. (See Appendix B8 for the focus group agenda).

My status as fellow trainee also gave me cause for reflection in regard to my interviewing technique. During the semi-structured interviews (which took place prior to the focus group) I noticed an increasing tendency to ask participants for definitions of rupture (e.g. "How do you define rupture?") which potentially reflected my positioning within a trainee discourse as one who expected qualified practitioners to provide me with answers. During the focus group discussion I sought to counter this by asking questions about the way 'rupture' was used, rather than defined, taking up a more curious stance and encouraging participants to tell stories of 'rupture'. This curious stance also allowed me to observe the non-verbal dynamics of the group. I invited comparisons to encourage variability in responses and was sensitive to group think by ensuring reserved members were not overlooked (Onwuegbuzie, Dickinson, Leech & Zoran, 2009). I also ensured that participants did not make themselves unduly vulnerable and that all participants' contributions were respected (Smithson, 2000). They were informed that they were not obliged to answer any questions that they found uncomfortable or upsetting.

3.2.7.6. Ethics for Interviews and Focus group

Ethical approval was sought from the Research Ethics Panel within the School of Psychology at City University. For both the focus group and interviews the University Ethics Panel granted ethical approval (see Appendix B9).

Interview research (whether group or individual) is filled with ethical issues arising from the complexities of investigating private experience and placing accounts in the public arena (Mauthner, Birch, Jessop, & Miller, 2002). One such issue was highlighted when my supervisor urged me to consider what I would do if a participant spoke of 'rupture' in a way that suggested poor or unethical practice. Interestingly, this mirrored constructions of 'rupture' in the literature where the therapists can be positioned as potentially at fault. While informing participants during our confidentiality agreement at the beginning of the interview/focus group of the course of action I would take if such a situation arose (e.g. report to supervisor), I was aware that this warning might then affect how participants consequently talked about 'rupture'. For example concerns that they would be judged on their practice, or the fear of having done something wrong (potentially particularly pertinent issues for trainees) may have inhibited open discussion. In a Foucauldian sense my professional counselling psychology responsibilities positioned me within an ethical discourse which was necessary, but in turn positioned participants under my gaze as necessarily self-policing of their behaviour in relation to 'rupture'. On reflection, more self-disclosure of my own experiences of 'rupture' may have helped to put them at ease and address any potential power imbalance or inhibiting self-surveillance.

I was also aware that the topic of 'rupture in the therapeutic alliance' might call to mind moments in therapy that were painful or concerning to participants and that this could be the first time that participants were recalling these moments with peers. This was addressed in my debriefing, however I concluded at the time that both qualified and counselling psychologists in training would be familiar enough with discussing aspects of their work in group settings and supervision practices that risk of disturbance would be minimal.

The only risk to me was that I conducted interviews with participants alone in a location of their choice. To protect myself from risk I advised my supervisor and/or member of my family of the dates and times of the interviews that I had planned - contacting them both prior to, and after the interview to advise that it had been completed safely.

3.2.7.8. Debriefing and Right to withdraw

On completing the focus group/individual interviews, participants were thanked and given a debriefing form (see Appendix B10) which provided further information on

the project and offered information on sources of emotional support should they be required. They were all invited to ask final questions about the study for the dissemination of findings and to this end my contact details were provided.

Participants were also advised that their participation in the research was entirely voluntary, and that they had the right to withdraw from the study at any stage of the research without consequence to them.

3.2.7.9. Anonymity, confidentiality and storage of data

Each participant was given an ID on recruitment so that their anonymity was protected on any material - written or audio, and no identifying information was featured on the transcripts, results or final publications. Only the researcher had access to the participants' recruitment information and raw data so as to protect confidentiality and anonymity. Participants were advised that all information relating to them would be treated as strictly confidential by the research team, comprising of the researcher and research supervisor and that this information would only be shared with others should the research team feel it was necessary to ensure an individual's safety.

All electronic data (including transcripts of interviews, analysis of data, audio recordings) was stored on a password protected computer, and backed up on a password protected hard drive. All hard copy data, including a hand written diary of my process and original audio recordings were kept in a locked filing cabinet to which only I had access.

3.3. Analytic Procedures

This section summarises how the analysis of the expert texts was carried out. Firstly, it details the transcription conventions and coding systems before giving a detailed overview of the analytic procedures taken.

3.3.1. Transcription

The text materials for the first part of the study did not require transcribing but were copied and pasted into separate word documents and given a standard text format. All four of the semi-structured interviews and the focus group discussion were transcribed by an external agency, following their agreement to a confidentiality agreement (see Appendix B11). However, to ensure immersion in the data in preparation for the analysis, I re-listened to all of the audiotapes and annotated the

transcribed interview and focus group data with the appropriate transcription notation myself. The transcription process itself is considered a reflexive act (Bucholtz, 2000), and as such I reflected on the system of transcription that would best serve the data analysis. I was hesitant to use a full transcription notation such as that developed by Jefferson (1985) as it adheres to the principles of the fine-grained conversation analytic style of analysis and provides a detailed record of interaction; this would potentially interfere with the readability of the transcript and undermine my dual focus by privileging the micro practices, whilst distracting from the wider discursive meanings of the text. I therefore used a lighter version of the Jefferson notation system as developed by Potter and Wetherell (1987). During transcription I attended to vocal actions (pauses, emphases, laughing, interruptions etc) that emphasised the function of the speaker's discourse. (See Appendices B12a/b for a table of transcription notations and an example of an interview used in the analysis).

3.3.2. Familiarisation and coding

My initial analysis involved familiarising myself with the data. Texts were read in their entirety to permit me to experience as a reader "the discursive effects of the text" (Willig, 2008, p.99). This process created the potential for recognising recurring discourses as "systematic ways of talking about topics" (Harper, 1995, p.347), and enabled me to become aware of what the text is doing and how it was doing it. For example, I began to notice a pattern in how the texts and participants sought to construct 'rupture' as an illness which was denoted by a variety of descriptions that used health metaphors, descriptions of symptoms and loss of capacity.

Coding is regarded as a necessary "analytical preliminary" (Potter, 2004, p.210) whose description provides validity and a way of managing the data into more manageable chunks (Wetherell & Potter, 1987). Guided by Vingoe (2008) the expert texts' data set was subdivided into four groups and each group was coded with letters: academic journal articles (A); handbooks/reference (H); website forum (W) and ethical practice (E). Each data sample was given an arbitrary numerical value (e.g. the academic article by Richards (2011) was given the code A1.) Texts were then divided into sentences, each of which were numbered and coded (see Appendix B13). The interviews were given numbers (P001-4) and the focus group numbered P005. Participants were given pseudonyms – e.g. (P001, Ian). The data was then divided into sentences and numbered.

3.3.3. Stages of Analysis for expert texts

This section includes a discussion of the analytic procedures used in the analysis of the expert texts. In the interest of transparency I have described the six stages of Foucauldian discourse analysis, as set out by Willig (2001, p.109) that were used. Analysis was also guided by immersion in methodological texts and the conceptual categories that I sought. Thus, I acknowledge that providing a neat definition of analytic procedure can obstruct its iterative nature, as shown below (Potter & Wetherell, 1987).

Stage 1 - Discursive constructions

The first stage identified the different ways in which the discursive object ('rupture in the therapeutic alliance') was constructed through language. All references to 'rupture' in the texts, however oblique were underlined. Next, I made hand-written thematic notes on the right hand side of these highlighted sections of the transcript. These notes later aided in the grouping of discourses into themes. I extracted from the interview texts all references to 'rupture' and noted the line numbers (see Appendix B14a).

Stage 2 - Discourses

The second stage sought to locate the various discursive constructions of the object within wider discourses. When analysing the texts my use of the term 'discourse' indicates an allegiance with Foucauldian approaches that are more preoccupied with the institutionalised nature of discourse and their power to regulate selves and social practice (Parker, 1992). I named the different discourses that were being used in each of the discursive constructions of 'rupture' identified in stage one and then wrote descriptions of these discourses (see Appendix B14b). Examples included medical and scientific discourses.

Stage 3 - Action orientation

This was concerned with the "action orientation" of the text and sought to elucidate what the various constructions of 'rupture' were capable of achieving within the text (Willig, 2008, p.116). I also considered the function of the different discourses and their relation to other discursive constructions in the text (Parker, 1992). For example, a scientific discourse might be drawn on to shore up claims by the author that the expert texts are reliable.

Stage 4 - Subject positions

The fourth stage identified subject positions afforded to the reader and authors of the texts by discursive constructions and discourses identified in earlier stages. Willig (2008, p.113) describes how "discourses make available ways-of-seeing and ways-of being". For example, a medical discourse made available the position of diagnostician capable of diagnosing 'rupture'.

Stage 5 - Practice

Next I considered how the discourses and associated subject positions related to practice – ". . . what can be said and done" (Willig, 2008, p.117). For example, by deploying an ethical discourse the texts constructed 'rupture' as a moral obligation. Within this discourse an ethical practitioner was obliged to identify and repair it, as to do nothing was to be positioned as professionally neglectful. I found that this stage overlapped considerably with stage 6, possibly because what can be said and done depends to a large extent on an individual's subjective experience.

Stage 6 - Subjectivity

This final stage explored the relationship between discourse and subjectivity and traced the consequences of taking up various subject positions for the participant's subjective experience – "or . . . what *can* be felt, thought and experienced from within various subject positions" (Willig, 2008, p.117, italics in original).

My intent was that by collating the analytic data generated by each of these stages for each text, I would create a map of the discursive landscape around 'rupture in the therapeutic alliance'. This would serve to orientate both myself and the reader, as well as informing and enhancing the second stage of analysis which focused on the data generated by the focus groups and interviews.

3.3.4. Analytic procedures for the interview and focus group data

My analytic procedure for the interview and focus group data asked a series of additional questions of the texts consistent with pluralistic accounts where importance is placed on gaining the most out of the data (Frost, 2011; Willig, 2012). In this stage of the analysis I sought to combine macro and micro approaches to the texts. Jørgensen and Phillips (2002) describe this as the point where a "post-structuralist interest in how specific discourses constitute subjects and objects is

combined with an interactionist interest in the ways in which people's discourse is oriented towards social action in specific contexts of interaction" (p.5).

Willig (2008) observes that as discourse analysts we must discuss and define our work in relation to existing discourse analytic research, thus I drew on previous analytical procedures as developed by Budds et al. (2014), Wetherell (1998) and Edley (2001) when developing my analytical procedure. To achieve a combined approach to discourse analysis, Wetherell (1998) and Edley (2001) identify three particular concepts when analysing language – interpretative repertoires (Gilbert & Mulkay, 1984; Potter & Wetherell, 1987); ideological dilemmas (Billig et al., 1988) and subject positions (Davies & Harré, 1990), which I incorporated into six stages of analysis (see below). These should be regarded as ways of approaching the text rather than as recipes for producing 'correct analyses' (Willig, 2008). At each stage I endeavoured to move between micro and macro approaches to language; to aid me in this process and to encourage movement I also developed a table of questions (Appendix B15).

3.3.5. Stages of analysis for the focus group/interview data set

Stage 1 - Discursive constructions

The first stage of my analysis was similar to the first stage of Foucauldian discourse analysis as outlined on p.70. All explicit and implicit references to 'rupture in the therapeutic alliance' were again selected and highlighted. Attention was also paid to covert references and occasions when 'rupture' might be implicitly constructed within the texts since what is not said is also important for describing patterns about what is said (Billig, 1991).

Stage 2 - Discourses/ Interpretative repertoires

When analysing the interview and focus group, I used the term 'discourse' when describing parts of the terrain that were more hegemonic and spoke of practices and legacies of power. This is consistent with the highly organised Foucauldian notions of discourse. However, I also looked for 'interpretative repertoires' which are conceived as building blocks of talk, since they are selectively employed by participants to construct their versions and accounts in talk to achieve particular social actions (Wetherell & Potter, 1992). Certain researchers consider that discourses and interpretative repertoires overlap (Burman & Parker, 1993; Parker, 1992; Parker, 2014) since both represent "repositories of meaning" (Edley, 2001,

p.202) which are made available to individuals through culture. Edley and Wetherell (2001) argue that interpretative repertoires allow for greater discursive flexibility for the speakers, and thus more room for emergent spontaneity and variability in their construction of meaning across different sites. I thus identified them as the point at which discursive constructions of 'rupture in the therapeutic alliance' could be broken down into smaller units and recurring patterns across people's speech (Edley, 2001). This could include recurring images, metaphors or figures of speech. I aimed to exhaustively incorporate all examples of discursive constructions for each participant, only stopping when all references to 'rupture' made by a participant could be described by a discourse and/or repertoire. This cyclical process enabled me to see any emerging groups of repertoires.

At the end of this stage the discourses from the analysis of the expert texts and the discourses/interpretative repertoires in this data were considered together as a means of understanding to what extent, if at all, participants were drawing upon existing discourses when constructing 'rupture'.

Stage 3 - Action orientation and dilemmas

I paid attention to the action orientation of discourses/interpretative repertoires by asking: 'what is gained from constructing the object in this particular way at this particular point in the text?'. Consistency in interpretative repertoires suggested that participants were drawing on a limited number of resources (Potter & Wetherell, 1987), but I also remained alert to dilemmatic features in these constructions so that variations in the constructions of 'rupture' could emerge. Such ideological dilemmas (Billig et al., 1988) were useful to this study as they allowed some access to the contradictory and competing common sense constructions of the discursive object and how participants navigated them in the discursive field through a constant process of negotiation.

Stage 4 - Subject positions and variability

My focus here was on what ways of being or subject positions were being made available by the interpretative repertoires/discourses identified, and what ways of being were being denied or taken up by participants. This is consistent with Foucauldian macro approaches to the text. I also focused on the "variability of accounts and formulations" from different subject positions (Wetherell, 1998, p.401) within an interactional moment as a means of understanding how subject positions

and subjectivities can change over a period of interaction. I was interested in what implications these subject positions could have for participants' subjectivity - and whether it was possible in the text to discern what could be experienced and thought from these subject positions.

Stage 5 - Practice

This stage allowed me to consider the possibilities or lack of possibilities for practice opened up by the discourses/interpretative repertoires identified. Although again consistent with macro approaches to language, Wetherell (1998, p.22) also notes that repertoires can act as a "back-cloth for the realisation of locally managed positions in actual interaction". Thus attention was also paid at a micro level to how participants orientated towards the text by focusing on the discursive and linguistic devices they utilised in constructing their accounts of 'rupture'. This was further developed in stage six below.

Stage 6 - Discursive accomplishments

Stage 6 represented a further shift of focus towards a more localised analysis of the texts and the shifting and situated nature of the discursive constructions, more akin to discursive psychological approaches to text. In this stage I focused on how participants used language (in particular rhetorical devices) to achieve particular functions and social acts within the interactional setting (e.g. reported speech, disclaimers, three part lists and extreme case formulations). Within this context attention was also paid to a more discursive and localised concept of action orientation in terms of what participants were able to achieve within the interaction at hand.

These six stages were repeated for each of the participants. Kelly (1999) argues that saturation or exhaustion is conceded at the point at which nothing new seems to emerge from the analysis and as such I stopped the analysis when the same patterns repeatedly re-emerged. After analysing the individual interviews and the focus group, I created an analytic summary of themes for each which helped in identifying unifying and differing themes between them. These formed the basis for the analysis chapter.

3.4. Methodological Reflexivity

By way of summary and as a way of allowing for greater reflexivity, I now reflect on the challenges of delivering transparency in analytical procedures and resolving theoretical tensions within a methodology informed by critical realist, Foucauldian, discursive and critical discursive research perspectives.

Woodworth (1921) warns against creating "menacing psychological nouns, where we go hunting for things we have just invented" (p.11), and initially I had to resist the temptation to pin 'rupture/it' down. Instead I shifted my research focus to how it was being constructed by counselling psychologists. To answer this I originally believed that I had to "push my nose up against the exigencies of talk-in-interaction" (Wetherell, 1998, p.401), and explore how in the interaction between counselling psychologists 'rupture in the therapeutic alliance' was being negotiated and talked into being. This inferred relativism and a micro-analysis of language best addressed by discursive approaches which allowed for greater agency. I was also interested in what set limits on the participants' agency; what wider discourses existed around 'rupture'; to what extent were such discourses generated (or not) by institutions such as universities, and how did they constrain or limit ways of being and doing available to counselling psychologists? Here my focus appeared to fall on the macro aspects of language, where a Foucauldian approach to discourse analysis seemed more consistent with my aims to interrogate 'rupture'. Epistemologically, it also situated me in a critical realist camp.

My aims created a theoretical tension in terms of agency and power and methodological challenges in terms of how I moved between a micro/macro focus on language. To address these I embraced a combined approach to discourse analytical techniques - critical discursive psychology, that provided a reconciling position from which I could look at the local organisation of talk *and* the organisation of the broad social structures and culturally resonant interpretative resources that participants draw upon (Edley & Wetherell, 2001).

Although Burman and Parker (1993) warn against blurring approaches that subscribe to specific and different philosophies, I concur with Jørgensen and Phillips (2002). They argue that by combining different discourse analytical approaches to form a "multiperspectival framework", research can "cast light on a phenomenon from different angles and thus take more account of the complexity of the phenomenon" (p.4.). Parker (2014) also acknowledges that existing approaches to

discourse analysis are already contradictory and the better for it. Nevertheless, I attempted to address the resulting conceptual and methodological tensions by constantly weighing up approaches against each other and remaining aware of these tensions during the analysis (Jørgensen & Phillips, 2002). Consistent with Bailey (2011), my approach sought to give primacy to researching relations between structure and agency rather than choosing one over the other. Thus, I attempted to contribute to the debate that Willig (2001) has already drawn attention to - whether the differences between macro and micro approaches to discourse analysis should represent shifts in analytical emphasis rather than fundamental differences in theoretical frameworks. This felt in keeping with the spirit of discourse analysis as advocated by Wetherell and Potter (1988) which ". . . often involves hunches and the development of tentative interpretative schemes which may need to be abandoned or revised" (p.177).

It was also important to acknowledge my position, identity and status in relation to the topic (Pugh & Coyle, 2000), particularly owning to the impact it can have on research aims and procedures and on the analysis of data (Wetherell et al., 2001). As a trainee counselling psychologist, I shared the same community as some of the participants, and as such potentially had social discourses in common. During data collection and analysis, this insider's perspective was both advantageous in that it allowed me to assess the quality and claims of participants but I also had to be careful not to present them as truths when writing up my research (Wetherell et al., 2001). To acknowledge my active role in the co-construction of research findings I paid attention to my interviewing styles and included my questions in the transcript and data analysis (Willig, 2008). I also sought to preserve a constant awareness of my own subject positions by maintaining a dual focus on the constitutive and constructive nature of language when moving between micro and macro processes during the analysis. This helped me to avoid taking an objective view of the data which runs counter to the researcher's position within a discourse analysis study. Such movement also permitted me to consider the world from different analytical positions and reflect on them accordingly, thus embedding subjectivity into the research process in the form of reflexivity (Parker, 2014).

B4. Analysis of the Expert Texts

Mapping the discursive terrain of 'rupture in the therapeutic alliance': an analysis of expert texts within UK Counselling Psychology

An analysis of expert UK counselling psychology texts was conducted to map out the wider discursive terrain of 'rupture in the therapeutic alliance' in order to better understand the discursive resources available to counselling psychologists, their function and what subject positions they make available to readers of the text - including myself. It also explores the potential consequences for individual and institutional subjectivities and practice.

I drew on the six-stage Foucauldian analytic strategy proposed by Willig (2008) to analyse nine texts authored by UK counselling psychologists or produced by organisations representing UK counselling psychology. My aim was to orientate myself and the reader before negotiating the second stage of analysis which focused on the data generated by the focus groups and interviews. This is consistent with observations that an understanding of participants' localised discursive accomplishments can only be achieved by acknowledging the availability of the discursive constructions that govern them (Budds et al., 2014).

4.1. Overview of Discursive themes

A discursive object can be constructed in a number of intersecting ways of speaking and in these expert texts 'rupture' was identified at the intersection of a number of different and often conflicting discourses (Parker, 1992). I have attempted to hold in mind the different ways of constructing events, people and processes (Wetherell & Potter, 1992), whilst trying to avoid becoming lost in the multiplicity of meanings available for each discourse and "the infinite regress of possible interpretations" (Wetherell, 1998, p.388). Although imposing a structure on any text is inevitably artificial, Wetherell and Potter (1992) suggest that coherence is one way of assessing the usefulness of an analysis. I have therefore separated the discourses identified into distinct themes with the following constructions appearing to prevail in a majority of texts, as follows:

- Rupture as 'other'
- Rupture as 'illness'
- Rupture as 'relational process'

A fourth emerged as a marginalised discourse that was also of interest.

- Rupture as '(horror) ending'

I have grouped these subthemes around two discursive meta-themes, as follows:

Rupture constructed as external to the therapeutic alliance – 'other'/'illness'

The first of these discursive groups explores the various ways in which 'rupture' is constructed as external to the therapeutic alliance. I argue that this is achieved by drawing on two distinct discourses. Firstly, a discourse of otherness is mobilised to construct rupture as 'other' which through its positioning outside of the alliance alerts the reader to a potential risk, but does not make available the subject positions from which they might handle such a threat. Secondly, medical discourses construct rupture as an 'illness' that is also positioned as external to the alliance, this time however as a locatable object of scrutiny (Foucault, 1975a). This discursive object differs from rupture as 'other' in that it offers possibilities for treatment.

Rupture constructed within the therapeutic alliance - rupture as 'relational process'/rupture as '(horror) ending'

The second meta-discursive theme considers how 'rupture' is recruited back into the alliance. By deploying relational discourses that position it within a discursive space between client and therapist, I analyse how it can be constructed as a 'relational process' leading to change and repair or a troubled interpersonal process, which indicates the 'ending' of the relationship. Again this has implications for how the reader/counselling psychologist is positioned in terms of their professional subjectivity and their ability to take therapeutic action.

The final section explores how the positioning of 'rupture' inside and outside of the alliance creates a discursive tension in the texts. This has significant implications as to how readers/counselling psychologists are positioned to manage such ideological dilemmas.

These themes are explored in depth below.

4.1.1. Rupture as external to the therapeutic process – rupture as 'other'

'Rupture in the therapeutic alliance' is indicated negatively across the data set, in terms of deficit or what is lacking (e.g. "negative reactions", "negative feelings" "lack of trust and empathy" (W1, H3, A1). Discursively it is often positioned in the prefixes

which undo the value of therapeutic words such as (dis) attachment (A1), (mis) understanding (A2), (mis) communication (A2), and as such it is positioned as both lacking in therapeutic values and external to the therapeutic process. In their discursive accounts of singleness, Reynolds (2013) and Reynolds and Wetherell (2003) observe that women's experience of their relationships evolved in the shadow of the powerful set of regulations inherent within dominant discourses of heterosexual partnerships. Similarly I would argue that in these texts, 'rupture' is discursively positioned in the powerful shadow of the therapeutic alliance, as exemplified below:

Excerpt 1

The therapeutic alliance is central to the practice of counselling psychology, indeed it is encapsulated specifically for counselling psychologists within the UK Health Professions Standards of Proficiency for Practitioner Psychologists, which states that counselling psychologists are expected to 'understand the therapeutic relationship and alliance as conceptualised by each (psychotherapeutic) model.'

But what is the therapeutic alliance, and how may its formation go awry and further be resolved again? (A1, lines 17-18)

Excerpt 2

A good therapeutic alliance has been shown to predict effective therapy. This two day workshop provides a systematic framework for understanding factors contributing to problems in the alliance and how to resolve them. (A3, 8-9)

Across the data set the alliance is sequentially positioned first, as indicated in these excerpts, and in the construction of the compound noun "alliance rupture" in several other texts (H3, H2, E1). Edwards and Potter (1992) claim that through such sequential positioning certain categories of object are fore grounded achieving the discursive effect of persuading the reader to orientate towards them as desirable. This is consistent with constructions of the alliance in the excerpts above as "good", "effective" and "central", with these texts drawing on the power implicit in institutional discourses ("UK Health Professions Standards of Proficiency for Practitioner Psychologists") to add weight to the argument being constructed that the alliance is

an object of worth with the capacity to "predict effective therapy". Equally, these discourses are mobilised to construct the alliance as a discursive object that determines the criteria of normality within the profession ("central to the practice of counselling psychology"). The declarative nature of the statements (the alliance "is" not "can be") and categorical words "indeed", "specifically" and "states", as used in excerpt one, also persuades the reader of the legitimacy of the account and resists any attempts by them to construct the alliance differently.

By way of discursive counterpoint 'rupture' lacks an explicit label in these excerpts, invoking a systematic vagueness that renders its account more problematic and arguably less reassuring (Edwards & Potter, 1992). Indeed, it is constructed explicitly as "problems in the alliance" or implicitly as an invisible discursive object whose presence is only indicated by the verb "awry". "Awry" allows for disembarkation from the norm, again reinforcing a problematic, risky presence that is then positioned as having the power to subvert the "formation" of the alliance. In contrast, the alliance is positioned as "encapsulated" and "within the UK Health Professions Standards of Proficiency for Practitioner Psychologists"; it constitutes an object which is discursively contained within a set of institutional structures and thereby afforded status. An otherness discourse is thus mobilised to construct rupture as 'other' and external to the alliance and the academic and institutional discourses that construct this "good" alliance. In this discursive no man's land, rupture is stripped of both the status and the power such discourses afford, and conversely is attributed the power to trouble the therapeutic process; even challenge the status of the "good alliance" (A3) as the norm since it is positioned as an object outside of institutional control. This is consistent with Finken's (2003, p.59) observations that by investigating "institutional domains and their discursive practices, one can construct a position from where one might disturb things taken for granted". This positioning also alerts the reader to rupture as a legitimate problem worthy of their attention, as indicated discursively through the use of "what" questions in excerpt one above, and in other texts below:

> Excerpt 3
>
> But what is the therapeutic alliance and how may its formation go
> awry and further be resolved again? (A1,18)

Excerpt 4

What is rupture in the alliance? How can it be managed? (W1,58)

These questions construct rupture as a pre-existing problem that must be accounted for before it can be managed and would seem to attribute responsibility to the reader for this by directly addressing them. However, I argue that the "what?" can serve different discursive functions. Within discourses of otherness it can act as a genuine question – what can be known? - indicating an object that can be constructed in infinite ways. This constructs rupture as ultimately unknowable insofar as even when named, yet more answers or explanations lie beyond the language of the text, especially as rupture as 'other' can only be constructed as what it is not (rather than what it is). This renders the reader's position as one who must answer such a question as potentially an impossible one.

Within these discourses of otherness the reader is thus effectively silenced or disempowered and left unable to give an account of rupture as 'other'. In the face of such uncertainty they are denied positions of informed therapist and potentially deskilled. Rupture is thus constructed as an elusive problematic 'other' insofar as it is an uncertain presence about which there is "disagreement" (see excerpt five below) and which even within a scientific discourse, as indicated by the use of statistics, citations and factual language ("indeed", "reported") can be hard to spot, as exemplified below:

Excerpt 5

Indeed there seems to be some disagreement as to whether a rupture has in fact occurred, with one study finding that therapists reported ruptures in 43 per cent of sessions, but clients reported them in only 19 per cent of sessions (Eames & Roth, 2000). (A1, 31)

The "what?" in excerpts three and four (cited on p.80 of this chapter), can also be used rhetorically to indicate what *is* known. Within this latter context "what is rupture?" infers a discursive object about which things *are* known by the text, resisting earlier constructions of rupture as unknowable, problematic 'other'. This recalls rhetorical devices used in advertising where the reader is asked to evaluate what knowledge they require to solve a problem and offered solutions in the form of products (Tom & Eves, 1999). The products on offer in these expert texts are answers to the question – what is rupture? - answers made available only by

reading the texts or attending the BPS workshop as advertised in text A3 (see excerpt two, p.79). Such questions also allow for the texts to set themselves up as expert in relation to the reader, a credible position from which they can persuade them of the legitimacy of their own textual accounts of rupture (as problem) and simultaneously justify their account of ways to manage that problem.

Shifting between questions that serve a genuine and then rhetorical function contributes to the slippery nature of 'rupture', positioning it as a discursive object which can be constructed as both 'unknowable' and 'knowable'. To counteract this discursive slipperiness, I argue that the texts mobilise alternative empiricist discourses (by which I mean medical and scientific). Constructions of rupture as 'not knowable' within otherness discourses can be resisted by deploying the power inherent in these hegemonic discourses, whilst constructions of rupture as a 'knowable' object are fortified. This leads to the second discursive theme where rupture is still positioned as external to the therapeutic alliance, but this time is constructed as a locatable object of scrutiny (Foucault, 1975a), most notably as an 'illness' within medical discourses. These discourses make new positions available to the reader and counter those of the disempowered practitioner made available within otherness discourses, as explored below.

4.1.2. Rupture as external to the therapeutic process – rupture as 'illness'

By drawing on powerful hegemonic medical and scientific discourses, four of the nine texts sought to construct rupture as an 'illness' rendered manageable or treatable through diagnosis, potentially mitigating against constructions of rupture as 'other', as discussed above. This was powerfully reinforced in the longest of the texts by using the term "etiology", as seen below:

> Excerpt 6
>
> Theoretical Paper - Alliance Ruptures: Etiology and Resolution
>
> (A1, 2)

"Etiology" is a feature of medical discourse which constructs an illness with "specific, diagnosable conditions which has a given . . . prognosis and treatment" (Georgaca & Avdi, 2012, p.152). Rupture was thus positioned within a medical discourse from the outset in this text as an object whose symptoms could be diagnosed. List formulations were also deployed in several of the texts (A1, H1, A3, A2, W1) that

recall the lists of symptoms used in the *Diagnostic and Statistical Manual of Mental Distress* (5th ed.; DSM-5; American Psychiatric Association, 2013), as exemplified below:

> Excerpt 7
>
> We will now turn to the actual cause of ruptures drawing from both my clinical practice within a busy clinic in the NHS and the established literature.
>
> CAUSES OF ALLIANCE RUPTURE
>
> 1. The therapist and client have different frames of reference.
>
> RESOLUTIONS OF RUPTURE
>
> 1. The client confronts the therapist . . . (A1, 33-35/310-311)

These lists overtly labeled behaviours associated with ruptures, consistent with Harper's (1994) observations that a diagnosis is partially constructed by transformation of behaviour into symptoms. Within medical and scientific discourses the use of lists also performs an act of discursive categorisation of an object, so that such discourses may find a way of "defining what it is talking about, of giving it the status of an object and therefore making it manifest, nameable and describable" (Foucault, 1972, p.46). By deploying these discursive devices, the text reinforces its construction of rupture as an 'illness' which can be made visible for assessment and diagnosis, and serves to provide human sciences with a locatable object of scrutiny (Foucault, 1975a). This positions rupture as external to the alliance and the therapeutic process, as within these discourses it is granted "ontological status as a 'thing' that exists independently in the world" (Craven & Coyle, 2007, p.8), most notably as an illness.

Transforming behaviours into symptoms can also render "complex and ambiguous psychological difficulties controllable by professionals . . . [enabling] them to do something by treating it" (Harper, 1994, p.135). Having constructed rupture as an 'illness' diagnosable through its symptoms, several of the texts then attribute responsibility for diagnosis and treatment of these symptoms to the individual counselling psychologist rather than the wider institution of counselling psychology, as shown below.

Excerpt 8

As counselling psychology is particularly concerned with the relational aspects of therapeutic change, as well as more technique based interventions, it is incumbent upon practising counselling psychologists to familiarise themselves with the causes and resolutions for ruptures. (A1, 5)

In this excerpt the counselling psychologist is positioned as morally obligated to take up the position of vigilant professional as indicated in the use of the word "incumbent" which draws on a moral discourse. The imperative tone of the text wards off attempts by readers to position themselves differently, e.g. outside of the institutional gaze of counselling psychology. (This recalls how the "we" used in excerpt seven (p.83) seeks to recruit the reader to an in-group where they can be positioned alongside the author as knowing expert). Rupture is constructed within this institutional gaze as a discursive object, separate to the alliance (note the use of "ruptures" not "ruptures in the alliance") and as an illness with "causes and resolutions". The use of the word "familiarise" positions counselling psychologists as experts who should arm themselves with knowledge. This further recalls medical discourses in which medical experts take up the position of a diagnostician who remain vigilant for signs of illness. It is a position from which action can be taken as within such discourses, professionals can use expert knowledge to diagnose and treat, whilst clients are positioned as patients who both have a right to expect this care, but whom are also exempt from responsibility for their actions due to their illness. To resist the position of vigilant observer is to be positioned outside these medical, moral and institutional discourses and to risk taking up the role of bad practitioner who is morally and professionally neglectful. So that the reader might further avoid this positioning of bad practitioner, the texts offer up checklists for treatment (as illustrated in excerpt seven, p.83 - "Resolutions for rupture – 1."). These checklists draw on emotional and psychological discourses to construct ways in which professionals can monitor their internal self, recalling Foucault's (1975b) panopticon form of discipline where individuals are required to internalise rules that allow them to police themselves (and others). Internalising rules for self-monitoring also recalls medical 'at risk' discourses within which the individual is allocated responsibility to take up the position of rational social actor who assesses for, and avoids risk - both for their own good as well as the greater good (Lupton, 1993). Thus the therapist, "assumes responsibility for the constraints of power" (Foucault,

1972, p.202) - a power which is difficult to challenge in this context because of its benevolent goal of maintaining a healthy alliance. This is consistent with Fairclough's (2013, p.41) argument that institutions "simultaneously facilitate and constrain the social action of its members; it provides them with a frame for action, without which they could not act, but it thereby constrains them to act within that frame".

The deployment of medical discourses as a "frame for action" within counselling psychology texts also gives rise to an ideological dilemma since it denies access to an idiosyncratic account of 'rupture' where meaning is allocated to behaviours. Constructing rupture as a 'diagnosable illness' or locatable object of scrutiny may reassure the reader that it can be treated by limiting the number of possibilities for understanding it, but it also shuts down possibilities for exploring the problem (Avdi, 2005). It positions the counselling psychologist as diagnostician rather than one who can search for meaning by prioritising the subjective experience of the client, as they are positioned within a counselling psychology discourse.

4.1.3. Recruiting 'Rupture' back into the Therapeutic Alliance

Constructed as 'other' and 'illness', 'rupture' was positioned as external to the therapeutic alliance. This analysis now turns its attention to how the texts deploy a relational discourse to recruit 'rupture' back into the therapeutic alliance insofar as it intimates a therapeutic space between and not beyond the therapist and client. This leads to two further constructions of rupture as a 'relational process' and rupture as (horror) 'ending' that are discussed in relation to each other below.

4.1.4. Rupture as 'relational process' / Rupture as '(horror) ending'

Discursively the use of verbs across the texts that by their nature require reciprocation ("communicating", "exploring", "collaborating") constructed an interpersonal interaction between the therapist and client. However, the nature of this interaction was often constructed as problematic. Using overt labelling, rupture was constructed as "relational difficulties" or "disagreements" (A1); a "separating" of client and therapist into "different frames of reference" (A1) and as a "breaking up of the contractual bond" (H3). Indeed, several of the texts actively deployed discourses of interpersonal struggle, as exemplified below:

Excerpt 9

> Clients may then challenge the relationship by confronting the
> therapist or withdrawing (Harper, 1994). If the therapist recognises
> the challenge, it may prove to be an important opportunity for
> therapeutic interpersonal learning. Ruptures in the client's
> relationship with the therapist (one could say in the 'transference')
> may recapitulate the client's difficulties outside therapy. More
> generally recognising, acknowledging and overcoming relational
> difficulties can provide valuable experiential learning in the here and
> now of the session. (H3, 11-13)

In this excerpt, the deployment of verbs such as "confronting" and "withdrawing" construct rupture as a combative relational process. This potentially serves to trouble the therapeutic norm of client/therapist relational processes constructed as empathetic, warm and collaborative within wider psychotherapeutic discourses. The active nature of the verbs ("recognising", "overcoming") and the use of the present tense also constructs a therapeutic space that is in flux and constantly changing, allowing for constructions of rupture as a dynamic relational process, located temporally in the here and now and thus subject to change from one moment to another. Psychological and psychodynamic discourses ("transference") are then drawn upon to attribute meaning to this interaction, insofar as within psychological discourse nothing is random and all behaviours have meaning (Avdi, 2005). By attributing "interpersonal" meaning to behaviours, rupture constructed as a 'relational process' finds ways of problematising medical discourses. For example, here 'rupture' is framed as interactively triggered ("relational difficulties"), attributing responsibility to both parties (client and therapist), whereas within the medical discourses, symptoms were located solely within the individual client's pathology. This positioning of rupture as a process within the specific context of relationship means it is less likely to be "viewed as a dispositional pathological trait" (Avdi, 2005, p.503) and a more dynamic understanding of 'rupture' becomes possible.

In excerpt nine rupture as a 'relational process' also allocates choices to the individual client and therapist, positioning them as active agents who can choose and learn through engaging with rupture as "interpersonal learning". This constructs a joint therapeutic enterprise and the text seeks to ally itself with the reader ("one could say") as a way of encouraging and persuading them to orientate towards this

enterprise - positioned as a "valuable" and "important opportunity". Such adjectives discourage the reader from making alternative choices, since within these discourses of relational engagement rupture is constructed as an object that can be worked through ("acknowledging", "recognising", "overcoming"). Just as the medicalised 'frame of action' discussed earlier allowed for treatment, so action framed within relational and psychological discourses allows for rupture to be constructed here as repairable, opening up possibilities for change and personal growth or "valuable experiential learning".

Choice also involves risk as indicated discursively in the use of "if", "may" and can" in excerpt nine (p.86). Billig (1999) encourages the analyst to think about what is not being said and "if" arguably points to an alternative discursive possibility in which 'rupture' is not recognised, acknowledged and overcome by the therapist. This constructs rupture within a discourse of risk as a missed opportunity for which the therapist is attributed accountability and sits in contrast with medical discourses discussed earlier whereby accountability can be shifted to the external agent (illness). An illness that is caught rather than contracted by activity over which the subject is seen to have choice is more forgiving in the personal accountability stakes (Lupton, 2012).

Differences in attributions of accountability within the discourses that position 'rupture' as external to, and those that recruit it back into the alliance are further exemplified in the excerpts below:

> Excerpt 10
>
> Unless recognised and managed, ruptures in the therapeutic relationship can result in progress stalling, the breakdown of the alliance or the premature ending of therapy. (W1, 20)
>
> Excerpt 11
>
> Ruptures in the therapeutic alliance may occur when previously hidden negative feelings emerge or when the therapist makes a mistake or fails to act as the client expects or wishes. (H3, 9)

Excerpt ten deploys mechanical discourses to construct a rupture as a mechanical fault ("breakdown", "stalling") and arguably locates blame for the breakdown within an external stressor. Being stalled or broken down involves an image of a car

engine that suddenly stops working, rendering the driver and operator unable to use it. To construct rupture as a mechanical problem mitigates against the therapist (and client) agency in the breakdown, and shifts attributions of blame; a broken down car is so because of something that has happened to it and the driver, not because of something they have done. Constructing rupture as a mechanical breakdown also allows for the possibility that it can be repaired like parts of an engine. However, it is worth noting that even though within a mechanical discourse the therapist cannot be attributed complete responsibility for the initial "breakdown", they are very much positioned as accountable for its repair ("unless recognised and managed").

In excerpt eleven relational discourses are drawn upon to construct rupture as "emerging" from within the client ("hidden negative feelings"), or within the relational space created between two people with "expectations" of each other. 'Rupture' is thereby recruited back into the alliance where it potentially has higher risk implications for the therapist, since within relational discourses someone has to be attributed responsibility for making mistakes. This recalls how the breakdown of relationships in cultural discourse is commonly treated as an accountable matter that leads to the termination of socially valued forms of interaction (Mckinlay & Mcvittie, 2008). Divorce equally requires people to make sense of breakup in a way that is recognisable by courts (Wharton, 2006), and which necessitates the attribution of blame (Buttny, 1993). Likewise someone must be held accountable for the end of a therapy relationship, and in these texts blame is allocated to those afforded the greater degree of agency in the texts - the therapist - who as stated in excerpt eleven above "can make a mistake, or fails to act as the client wishes." The only discursive means of mitigating potential accusations of failure is for the practitioner to accept accountability and admit to their mistakes, as exemplified below:

> Excerpt 12
>
> Sharing an awareness of mistakes, inattention or breaches in communication can represent a powerful means of repairing otherwise damaging ruptures to the therapeutic process. (H2, 8)
>
> Excerpt 13
>
> An ethic of relational trust leads to an emphasis on mediation and dialogue in cases of relationship breakdown. Totton is of the opinion

that most complaints would be avoided if we focused on how to repair breakdown through acknowledgement of hurt and dialogue (2012, p.12) (E 1, 8-9).

Within these excerpts, legal and moral discourses are deployed to construct rupture as "mistakes, inattention, breaches or lack of trust" which "can be" warded against by therapists assuming responsibility ('acknowledgement of hurt'). Hence these discourses again make available the subject position of the self-regulating professional who administers their own self-punishment. To avoid this responsibility is to court risk. Lupton (1993, p.429) argues that any "voluntary courting of risk" simultaneously positions the individual as a sinner within a moral discourse, since risk can be seen to replace notions of sin in a modern, secular society. Thus in excerpt thirteen, therapists are positioned as potential sinners in danger of violating "ethics of relational trust". Acknowledging sin makes available the path of restitution, and similarly here by acknowledging potential mistakes, therapists can be forgiven and reinstated to a position of trust ("most complaints would be avoided if we focused on how to repair breakdown through acknowledgement of hurt and dialogue"). In contrast, within these legal and moral discourses clients are positioned as plaintiff or wronged party and thus exempt from accusations of blame. Such discourses thus mitigate against rupture as a damaging construct in favour of constructions of it as repairable, making available the position of healing practitioner who can bring about therapeutic change and resist positions of failure.

Indeed, rupture as repairable or treatable is the preferred 'ending' as constructed within medical, legal, moral and relational discourses across the data sets. Whether rupture is positioned as external to the alliance or recruited into it, it is constructed as having to be "worked through", "repaired", "attended to" or "handled", as exemplified in several texts (H3, A1, A2). This potentially serves to reassure the reader of its legitimacy as an object of study and reinforces expert texts' claims that the ways in which they construct rupture as manageable are valid. These claims are given weight and authority by the deployment of scientific discourses (""effective", "factors") in the excerpt below:

Excerpt 14

One of the relational factors that has been found to be probably effective is the capacity to repair alliance ruptures (p.120 see also Norcross, 2002, pp 3-16). (E1,6)

I would argue however that the spectre of rupture as 'ending' (a discursive object which cannot be managed or repaired) is never fully banished and sits just below the surface of all these texts as a marginalised discourse. It is indicated only by the "probably" in excerpt fourteen and the deployment of cautionary tales such as the extract below from *One Flew over the Cuckoo's Nest* (Kesey, 1962), which is cited at the beginning of the academic text (A1).

Excerpt 15

' . . . the nurse stands this as long as she can; then she comes to the door of the Nurses' Station and calls across to him that he'd better help the men with the housework. He ignores her . . . 'Mr McMurphy, I'm warning you!' Everybody's stopped what they were doing. She looks around her, then takes a step out of the Nurses' Station towards McMurphy. 'You're committed, you realise. You are . . . under the jurisdiction of me . . . the staff'. She's holding up a fist, all those red-orange fingernails burning into her palm. 'Under jurisdiction and control.' (Kesey, 1973, p.135) (A1, 9-16)

In excerpt 15 rupture is constructed as the 'ending' of a relational process (*"He ignores her"*). An example of extreme case formulation (Edwards & Potter, 1992), this fictional text functions as a warning to those health care professionals who let rupture in the alliance spiral out of control. It draws on psychiatric and psychological discourses (*"committed, nurse, staff, jurisdiction"*) to construct the relationship between nurse and patient as in crisis (*"I'm warning you"*). The relational space between the two protagonists is constructed as visceral (*"red-orange fingernails burning into her palms"*), damaging (*"burning"*) and on the verge of being out of control (*"He ignores her . . . 'You're committed, you realise. You are . . . under the jurisdiction of me . . . the staff"*). Within this institutionalised discourse of mental health, the usual position of caring professional is resisted by the nurse, who instead takes up a position of being on the edge of control and abusive of the power available to her, implicit in the role of medical expert. Rupture as 'ending' functions both as a warning to the reader of what can go wrong therapeutically, but also serves to legitimise any claims to action the academic text goes on to make as to how to act to keep the alliance alive and healthy. Interestingly, the use of italics creates a discursive border between this quote and the main text, separating and marginalising this fictional account of rupture as 'ending'. This reinforces the

construction of rupture as dangerous, but also ring fences it. Thus, rupture as 'ending' still unsettles the reader's imagination and potentially troubles the constructions of rupture as 'repairable' (a construction the main body of the text seeks to position as the norm), but it does so from a safe distance and from within a marginalised, fictionalised discourse.

4.2. Managing ideological tensions - constructions of 'rupture' inside and outside the alliance

Certain ideological dilemmas become apparent in these expert texts when discussing the discursive themes that emerge around 'rupture in the therapeutic alliance' and the relationship between them, particularly in regard to what competing subject positions are made available, and how the reader is then left to manage and negotiate such discursive tensions.

Within medical and scientific discourses 'rupture' is positioned as a discursive object that through an empiricist gaze not only becomes a legitimate object of study, but also one that is rendered manageable through its diagnosis/identification. Within such discourses the reader can thus be empowered to take action based on knowledge provided by the texts; this in turn resists a position of helplessness and inaction evoked through discourses of otherness that construct rupture as a potentially risky 'other'. This can result in a reified language or type of empiricist accounting (Edwards & Potter, 1992) where phenomena are treated as agents in their own right and any subjective investment is played down, as seen below:

> Excerpt 16
>
> This article will give a necessarily brief overview of that alliance, and the ruptures in it which were formerly known as 'resistance' (Aspland et al., 2008), and are now defined by Safran and Muran (1996) as the 'deterioration in the relationship between therapist and patient' (p.447) (A1, 38)

In this excerpt rupture is constructed as an entity or psychological noun ("deterioration", "resistance") which can be "defined". This sits in tension with its construction elsewhere as a dynamic, relational process which resists such fixed categorisations and definitions. Billig (2009, p.7) observes that processes "are essentially events that extend over time and involve changes". Change is key within therapeutic and psychological discourses that seek to attribute meanings to

behaviour and thus allow for change to occur. Within these discourses, subject positions are made available which position the reader not as diagnostician but as relational beings and decipherers of different and infinite meanings. From such a position counselling psychologists can prioritise the subjective experience of the relationship and avoid pathologising or reifying rupture. Potentially they can then take up a relational way of being that functions as the ideal in counselling psychology discourse, insofar as it is positioned within the discipline's expert and regulating texts as a highly valued and desirable subjectivity and part of the profession's distinctive identity. However, in drawing on relational discourses, the door is then open to endless possible constructions of 'rupture'; a limitless potential of understandings which make working through it or handling it a complex, riskier undertaking. Within this discourse of risk, rupture can be constructed as both a repairable and a potentially irreparable process - either way the therapist/reader is held accountable. Thus one might speculate as to whether within a medical discourse where rupture as 'illness' can be spotted, practitioners might feel more reassured that they can do their jobs as professionals and act to repair the rupture. Rupture as a 'relational process' could potentially be less reassuring, particularly for inexperienced practitioners, because it opens up multiple possibilities including rupture as irreparable 'ending', even loss. Although a marginalised discourse, this discursive construction of rupture as 'ending' also troubles more dominant constructions of rupture as repairable which the texts all seek to promote, as exemplified below:

Excerpt 17

This article has discussed the various circumstances of both personal and task-related alliance ruptures, and has sought to provide [a limited number of] methods of resolution. (A1, 523)

Here the normally declarative, factual function of a concluding statement is undermined by the inclusion of "[a limited number of]". Within this sentence rupture is constructed as an object for which only limited causes and solutions can be found - indicating a discursive space beyond the text in which other causes and solutions could emerge. Within one statement rupture is thus constructed as both known and unknown, and the reader is positioned as being both informed and not fully informed. The only potential solution to this ideological dilemma is offered in excerpt

eighteen below which seeks to break down any binaries used to construct rupture (e.g. healthy/illness; good/bad; known/not known):

Excerpt 18

Therapeutic relationships develop in patterns related to Erikson's (1963) epigenetic (i.e. systematically emerging) sequences of the life cycle.

Psychotherapeutic relationships progress through issues of trust versus mistrust, autonomy versus shame . . . generativity versus stagnation . . . with each resolution constituting the seeds of the next conflict. (H3, 6-7)

The "versus" in this excerpt is discursively neutralised by the notion of fluidity introduced by the use of the words "through" and "progress". "Develop" and "generativity" also locate both rupture and the alliance in a discourse of growth ("with each resolution constituting the seeds of the next conflict"). In a wider sense, I argue that this resists binaried constructions of rupture and allows for its movement between constructions of 'illness', 'other' and 'relational process', even to move from outside into the alliance and vice versa. This fluidity between discourses and how they break with each other and overlap to construct 'rupture' in multiple ways may well have implications for agency, accountability and responsibility as counselling psychologists seek to construct meaning around 'rupture in the therapeutic alliance' in their interviews. To better understand this, I turn to the second stage of analysis to see which discourses and interpretative repertoires participants took up (or resisted), and what it accomplished for them.

4.3. Interview and Focus Group Analysis

Utilising and resisting discourses/interpretative repertoires: agency, accountability and subjectivity

This section includes an analysis of four semi-structured interviews (with chartered counselling psychologists) and focus group data (generated by five counselling psychologists in training) with a view to understanding how participants used discourses/interpretative repertoires to construct 'rupture in the therapeutic alliance'. The analysis of this data sought to incorporate an additional analytic focus linking the micro processes of social interaction with the broader macro movements of ideology (Edley, 2001; Wetherell, 1998) to develop a dual perspective of discourse as social performance, and discourse as a wider and potentially limiting resource. One of the ways in which I attempted to achieve this dual perspective was to focus on how participants deployed both discourses and interpretative repertoires. I set out to use interpretative repertoires as an exclusive analytic category that addressed both the wider discursive terrain and the agency of people in it (Potter & Wetherell, 1987). They offered an interface between individual and institution and more room for emergent variability in the participants' constructions of 'rupture' across contexts. Like Le Clezio (2014) I used them to denote parts of the discourse of rupture that were more "partial, situated and malleable by discursive agents" (p.79). I also found that during the analysis the more Foucauldian analytic category of discourse as defined by Parker (1992) was better suited when describing hegemonic parts of the discursive terrain which discussed practice and legacies of power. I have thus used both terms.

4.4. My role as interviewer

I could not ignore my dual roles as interviewer and fellow trainee counselling psychologist. Consequently, I have commented where appropriate upon my role and any influence insofar as potentially co-constructing 'rupture' in certain ways. I was also mindful that although all participants self-identified as either a counselling psychologist or counselling psychologist in training that:

> '. . . it would be a mistake to assume that, just because all the participants in (the) study were counselling psychologists, they spoke consistently from that position throughout their interviews' (Craven & Coyle, 2007, p.239).

4.5. Overview of discursive themes

Participants largely framed their accounts of 'rupture' within a counselling psychology discourse, although within this analysis emotional, experiential and crisis interpretative repertoires also emerged. The interviews/focus group were found to contain many of the same discourses and constructions mapped out in the previous section, but rather than utilising these in a straightforward fashion, participants could be seen to struggle with them in a dynamic and complex way. This section focuses upon the major struggles describing instances of resistance and how taking up various discourses/repertoires affected subjectivity and corresponding opportunities for, and limitations to, action. Counselling psychology discourse traditionally seeks to reconcile potential tensions between empiricist and humanistic discourses as well as other discourses, as identified in previous discursive research (e.g. see empiricist/contingent discourse (Craven & Coyle, 2007); institutional/maverick (Moore & Rae, 2009). Although there were other potential discursive themes that emerged in this analysis, those focused upon have been chosen because they further illuminate discursive tensions inherent in counselling psychology discourses, and potentially have the greatest implications for the practice of Counselling Psychology.

The meta themes used to organise the analysis of the expert texts have been retained as helpful and relevant in organising the interview and focus group discursive themes, as summarised below:

Rupture as external to the alliance - 'technical object'/'illness'

Participants drew on the same medical discourse to construct rupture as 'illness'. They also drew on technical, jargonised repertoires to construct rupture as a 'technical object'. They positioned 'rupture' as external to the alliance, and functioned to establish a theory of 'it' as a knowable discursive construct which they could invest in and control (Horton Salway, 2001). I argue that this allowed them access to a professional subjectivity that offered to resolve issues of accountability via expert positions and practice.

Rupture recruited back into the alliance – 'inter and intrapersonal crisis'

Paradoxically, participants also drew on relational discourses, identified within the text analysis to once again position 'rupture' discursively in what Yalom (2002, p.46) refers to as "in-betweeness - the space between me and you", or client and

therapist. Participants expanded this discursive terrain to include the intrapersonal discursive space by deploying experiential, emotional and crisis repertoires. Rupture was thus constructed as both 'inter and intrapersonal crisis' and as a potentially out of control, messy object. By drawing on these repertoires participants were able to negotiate alternative subject positions in relation to rupture' than those made available by discourses in the expert texts. For example, within a military crisis repertoire, they were able to position themselves as dutiful soldiers in the therapeutic trenches in relation to 'rupture'.

Resolving issues of agency, responsibility and accountability – emotional work

A discursive tension between rupture as 'knowable' (via its constructions as 'illness' and 'technical object') and rupture as 'inter' and 'intrapersonal crisis' inevitably raised issues of agency, responsibility and accountability. For example, participants sought to manage potential conflict between being positioned as expert within institutional discourses (which potentially mitigated against attributions of blame), or positioning themselves within emotional repertoires as a caring, human practitioner (which increased the risk of blame). How participants used guilt to accomplish a relationship to 'rupture in the therapeutic alliance' that manages these dilemmas is explored in the final section of the analysis.

These themes are now explored in depth below.

4.5.1. Rupture as external to the alliance – a 'technical object'

Participants across the data set drew on a technical interpretative repertoire to overtly label 'rupture' as "technical jargon" (P004, line 87), "a useful concept" (P003, 346) and "clinical term" (P001, 211**)**. This repertoire served to construct rupture as knowable, and as an interviewer I also drew on it to co-construct rupture as a knowable entity, as indicated by my first question to all the participants:

> Excerpt 1
>
> Interviewer   1 What does the term (.) rupture in the therapeutic
> alliance mean to you as a counselling psychologist? (P003, line1)

The use of the interrogative "what" and "mean" constructs rupture as an object about which there is shared, pre-existing meaning; a "term" that is potentially known to both the participants and myself. By adding "counselling psychologist" (instead of asking "What does it mean to you?"), I am also positioning myself and the

interviewee within a wider professional counselling psychology discourse, as well as drawing on the psy-complex, a network of theories and practices wherein professionals are expected to have knowledge and skills about the domain of the psychological (Rose, 1985; Parker, 1997). Although consistent with my research question, one can be positioned within such a discourse as a professional in possession of knowledge about 'rupture/it', or conversely as unknowing (and therefore potentially at risk of seeming unprofessional). By drawing on a wider psychological discourse my question thus functions to monitor and regulate the participants' responses. It serves to set up expectations from the outset that rupture can be constructed as 'technically knowable', and that participants must take up a position of knowing about 'it'. Indeed in response to this question, participants often drew on the power inherent in the scientific and psychological discourses to persuade me/the interviewer of the validity of their claims, as exemplified below:

Excerpt 2

P002 Interviewer: =Okay(1), that's interesting because I guess that kind of brings (.) me onto what, as a counselling psychologist, it means to you this term (.) rupture in the therapeutic alliance?=

Eleanor: =Yeah (1) I guess it's something about a disconnection in the therapy. Umm (3) So whether that's by someone feeling that they're not understood, by someone starting to, I don't know, (inaudible) through transference or whatever, starting to feel that, (2) I don't know, that this is not for them. (.) It can be as simple as that or I guess you can even look at is as a rupture of their commitment to the therapy as well (.) missing a session. (.)The first thing that comes to mind is through the therapeutic relationship aspect, (1) so the rupture in the kind of relating between the client and the therapist. But I guess it can be shown in so many different ways. And I work in an NHS mainly, my main job is NHS now and we have to give those questionnaires, the IAPT questionnaires in the beginning, (.) and I find that often an indicator of possible rupture or low motivation. That's something to watch= . . .

(Eleanor, lines 8-16)

In the latter part of this excerpt Eleanor draws on scientific discourses ("indicator", "questionnaires") to construct rupture as quantifiable, positioning it within an empirical and institutional gaze e.g. IAPT, NHS where 'it' can be measured in terms of outcome. She also potentially draws on a medical discourse to locate symptoms of 'rupture' within the client ("missing a session", "low motivation") and so construct it as an observable event ("something to watch for"). The use of nouns ("disconnection", "rupture") as opposed to the verb 'rupturing', further function to reify rupture as an 'it' by constructing it as a static event rather than a fluid process. Across this data set both interviewer and other participants consistently construct rupture as having "markers", "red flags" (P001, lines 51/56), recalling how in the text analysis rupture was constructed within a medical discourse as a categorisable object. By deploying a list formulation to attribute identifying features to 'rupture' in this excerpt, Eleanor constructs a factual account which can be viewed as external to her desires and concerns (Potter, Edwards & Wetherell, 1993), and so positions herself as speaking from a more knowing position. For example, her use of the word "transference" draws on a wider psy-complex discourse (Parker, 1997) that serves to imbue her with expertise and thus qualify her as someone who can speak authoritatively. By making use of such a discourse it can be argued she discursively attempts to create an epistemological orientation that renders her claims more credible, (Potter, 1996) and also wards off criticism that rupture cannot be constructed as a 'knowable' construct. Through categorisation an object can also be normalised, rendered predictable and therefore potentially more manageable. Within scientific, medical and psychological discourses Eleanor can thus take up the position of good practitioner who can do their "main job" by watching out for and identifying 'rupture'. Thus, she is acting in accordance with NHS institutional practices which positions rupture as an object that must be handled by vigilance, as indicated by the use of imperatives and declarative statements in line 13 (my underlining) ("We <u>have to</u> give those questionnaires, the IAPT questionnaires in the beginning, and <u>I find</u> that often an indicator of possible rupture or low motivation. <u>That's</u> something to watch").

A discursive tension or resistance becomes apparent in the text when Eleanor draws on personal, experiential interpretative repertoires of 'rupture' as indicated by "I" and "come to mind". These pronouns would appear to signal an interface between individual and institution; Eleanor must manage contradictions between her view of 'rupture' and that of this shared knowledge of wider institutional (medical,

psychological and scientific) discourse. Thus, when she constructs rupture as "a kind of relating", it functions to both unpin it from its moorings as a static entity (the verb "relating" denotes a process) and to construct rupture as a more uncertain ("kind of") object. By drawing on experiential repertoires, Eleanor thus separates or distances herself from rupture as 'knowable' only through technical repertoires, or hegemonic scientific, psychological or medical discourses, and constructs a more idiosyncratic account of 'rupture'. Within these experiential repertoires, rupture can be constructed as *both* "a kind of relating" *and* as "disconnection", "lack of understanding". Arguably this dual positioning constructs rupture as a more fluid and potentially ambiguous construct, consistent with relational/humanistic discourses of counselling psychology, within which objects are positioned not as categorisable objects but as dynamic processes. Within a relational discourse (as exemplified in excerpt two by the words "through the therapeutic relationship aspect"), Eleanor can take up the position of the not knowing and explorative practitioner who tolerates ambiguity, a position that is not accessible to her via scientific or medical discourses where not knowing potentially leads to a deskilled expert who can be held accountable for mistakes. However, whilst a not knowing stance is legitimised within a counselling psychology discourse, it remains risky as there may not be an obvious designated course of action available for rupture as a "kind of relating", potentially making attributions of personal responsibility more likely and leading to more anxious ways of being. It can be argued that Eleanor uses vagueness ("I don't know", "I guess") as a rhetorical device to negotiate this tension between rupture as 'knowable' and 'unknowable' as well as minimise her personal responsibility.

Similar discursive tensions emerged within other participants' accounts, as exemplified below:

Excerpt 3

P004 Amy: =I don't know whether if I was talking to another counselling psychologist (.) and they used the word rupture I would feel that I would just have to answer there and then. Err (1) It wouldn't feel right to say to them, what do you mean by that? (3) It's sort of,(.) it feels like you would just have to jump in, yeah, (.) and then you're saying something quite sort of disingenuous and like what's the point really? (.) But, yeah, it is a, (.) it's one of those, it's part of the lingo. (Amy, lines 314-317)

In this excerpt Amy deploys a technical repertoire to construct rupture as "part of the lingo", positioning it as a professional jargon recognisable or comprehensible only to an in-group of counselling psychologists. This technical repertoire functions as "an index for membership" (Parker, 2002, p.331) since it makes available the position of informed expert, from which active distributing of professional knowledge to others within the in-group can occur. Equally, she acknowledges that to resist this positioning is to risk both one's membership to this professional group, but also one's moral positioning (e.g. "it wouldn't feel right to say to them, what do you mean by that?"). It is therefore perhaps unsurprising that taking up a position of not knowing about 'rupture', or as Amy points out, not having the "answer", would be potentially resisted as it denies access to an ethical position and a professional in-group. Once positioned as outside the in-group, sanctioned ways of handling 'rupture' may no longer be available, positioning the therapist as without access to approved tools required of an expert. Indeed Amy's phrase, "it feels like you would just have to jump in" indicates the discursive presence of a collective or institutional body into which you jump in or affiliate to as a means of potentially accessing ways of being and practice which are authorised and morally sanctioned. This is consistent with Parker's (2002) observations that jargonising functions to reassure speakers, giving them access to professional or expert ways of being, as well as limiting and containing ways of constructing a object.

Discursive tensions between the individual and institution become apparent again when Amy calls into questioning this positioning of therapist as expert by saying, "then you're saying something quite sort of disingenuous and like what's the point?". "Disingenuous" infers incompatible presences, which in this case might indicate Amy's struggle to reconcile rupture as a 'thing' that can be known objectively ("when talking to other counselling psychologists") and one that is part of her and the client's intersubjective process. This recalls a wider ideological dilemma within counselling psychology discourse, as identified by Craven and Coyle (2007) who observed that counselling psychologists seek to reconcile empiricist discourses (which stress objectivity and science) and contingent discourses (which stress subjectivity and personal investment) when constructing mental distress. While empiricist discourses can make available positions of knowledge for the practitioner, they can also function to disempower the client by overlooking their subjective experience. Similarly, in this study it would seem that while constructing rupture as "part of the lingo" locates it as a signifier of professional technical expertise,

participants were also aware labelling 'rupture' as a knowable, technical object made it inaccessible to their clients. Several construct it as too "powerful" (P005,76) a term, or one that must be made "palatable" (P001, 101) or "softened" (P003,46) for the client. In her account, Eleanor constructs it as an alienating object with the power to distance or scare off clients:

> Excerpt 4
>
> P002 Eleanor   {Umm} And I found that when I've used the kind of psychology words, as I put it [mimics apostrophes], people get scared. (.) They look, there's this look of kind of, "What?" That they switch off.
>
> (Eleanor, lines 45-46)

Technical repertoires are drawn on here ("psychology words") that construct rupture as professional jargon (note the mimicking gesture partitioning it from lay terms). Rather than serving a reassuring function, in this case jargonising performs an alienating function by excluding those who do not understand what it means (Parker, 2002) ("they switch off"). This raises issues of power - if only therapists have access to rupture as a 'knowable' object and the technical language which constitutes it, the client is effectively silenced. How then can jargonising serve to illuminate or construct a client's experience of 'rupture', or even enable a shared discourse around 'rupture'?

This again illuminates ideological tensions within a counselling psychology discourse between its scientific discourse which empowers the therapist through knowledge, and its egalitarian discourse which advocate an approach to therapy that is transparent, accountable and deconstructs limiting descriptions of life (White, 1997). This offers one potential explanation as to why, when I as interviewer demarcate between the clinical and the technical, Eleanor again takes up the opportunity to actively resist constructions of rupture as 'technically knowable':

> Excerpt 5
>
> Interviewer: {And you are basing that on your clinical experience or reading books?}
>
> P002 Eleanor {Yeah} I'm not a huge reader but I find that I'm quite reluctant to kind of go to any psychological literature so I'm not one of

those people. (.) So, umm (.5) but yeah, in the kind of the reading that I do, rupture is not really mentioned. (.)Yeah, it's very much through experience and discussion. (2) I think for me that's kind of how I learn.

Umm (.5) Kind of when I first saw your study I thought, "Well, what do I know about rupture?" [thoughtfully] (1) And then sort of now talking and thinking about it today, actually yeah, (.) there's a fair bit of experience but it's not explicit, if that makes sense? It kind of comes in round the side as you see more and more people.

(Eleanor, lines 60-67)

In this excerpt she rejects an academic, psychological discourse ("psychological literature") and the position of expert health professional which it makes available ("I'm not one of those people"). Instead she locates herself outside of such discourse and firmly within an experiential interpretative repertoire ("talking, "experience"). These repertoires would appear to serve a liberating function since they allow Eleanor to construct 'rupture' in terms of her relationships with people and not books ("Actually yeah, there's a fair bit of experience. . . It kind of comes in round the side as you see more and more people"). In turn she gains access to the subject position of the reflective, curious, internally resourced practitioner, a position rendered legitimate since it is consistent with counselling psychologists who construct their subjectivity in terms of the experience of the relationship, not the depersonalised contextualisation of scientific discourses.

This would suggest that being positioned within wider empiricist (scientific) discourses or positioning themselves as expert within technical repertoires is a double edged sword for participants; although it allows access to professional ways of being and practice which position rupture as a knowable object that can be dealt with, those same rules and regulations also limit them in terms of how they are then able to construct rupture within the clinical space. When positioned by my questions as expert Eleanor asks, "Well, what do I know about rupture?", but when drawing on her own experiential repertoires within the clinical space she can answer, "actually yeah, there's a fair bit of experience". These limitations on agency are explored further in the section below.

4.5.2. Rupture as 'illness'

Another tension became evident within the data set between medical discourses deployed to construct rupture as an 'illness' and an emerging repertoire of crisis, as exemplified below:

> Excerpt 6
>
> P001 Interviewer: (.) so it can be, it can be something that you can mark. You begin to mark or it has markers when you're in a session=.
>
> Ian =I mean I've definitely had situations where I've not caught it and I've been too embroiled in the acting out with the other person or trying to sort of fire fight or trying to bring them round to, you know (1), restating my um (.) intention which maybe they've (.5) which has been received by them in a way that I didn't intend and (.1) it's been marked by them leaving the room or telling me [smiles] to, you know what they think of me [laughs] or something along those lines. So I suppose, (.)um it could be marked by either of those things.(.5) So sometimes maybe I don't catch the rupture early enough or the rupture is identified once it's occurred. Um (.) and sometimes I suppose if you catch it whilst it's in process or if you catch it in the lead up to it= =although I'm not sure whether [intake of breath]…(2) I suppose if you catch it in the lead up to it then perhaps ideally the rupture wouldn't occur. So that's maybe just more relationship management stuff. (.) Maybe I'm thinking that by definition a rupture has to have sort of occurred and there are obvious markers of it yeah.
>
> (Ian, lines 51-57)

In this excerpt Ian constructs rupture as a diagnosable condition or 'illness' that can be "caught" and recognised through visible, behavioural symptoms ("marked by them leaving the room, or telling me what they think"). Arguably my question also co-constructs rupture as diagnosable via "markers". This recalls how rupture is constructed as 'illness' in the expert texts and how here it can be also positioned as a locatable object, with both interviewer and interviewee using the power inherent in medical discourse to legitimise our claims. Such claims are further validated by its formulation as a regulated, scripted event ("by definition a rupture has to have sort

of occurred and there are obvious markers of it, <u>yeah</u>"). This positions 'rupture' as a product of a recognisable world rather than a product of biased reporting (Edwards, 1995), which as Parker (1997) observes is important in relationship accounts since within such accounts speakers must manage self-interest with facts.

Rupture as diagnosable 'illness' also has implications for issues of agency and accountability since as an illness that can be "caught", it is positioned as outside of the practitioner's (Ian's) control. This helps him ward off attributions of blame by locating 'it' in the other, in this case the client "with the occurrence of symptoms being constructed as the end point of analysis" (Ussher, 2003, p.389). This recalls Horton Salway's (2001) observations that an illness narrative can act as a defensive disclaimer against accusations of individual accountability by attributing external causes for rupture rather than internal psychological ones (although responsibility for spotting and managing the symptoms is still attributed to the individual health practitioner ("So sometimes maybe I don't catch the rupture early enough or the rupture is identified once it's occurred").

Conversely, Ian also deploys considerable hedging ("I guess, I suppose, maybe, it could be marked"). Hedging refers to words or phrases "whose job it is to make things fuzzier" (Lakoff 1972, p.195, cited in Hyland, 1994) and here indicates an uncertainty concerning the factuality of Ian's statements; functioning to trouble claims that rupture can be constructed as a diagnosable condition. Indeed, Ian's use of the word "ideally" discursively allocates such constructions to an ideal textbook world, a discursive terrain effectively separate to and outside of the therapeutic or clinical discursive space. Hence rupture as locatable/definable through its symptoms is called into doubt ("maybe", I suppose") and positioned as an illusion which potentially bears no resemblance to constructions of 'rupture' within the clinical discursive terrain of the therapeutic dyad.

Instead within this discursive space Ian draws on crisis repertoires ("fire fighting") to construct rupture as a risky, unpredictable discursive object and potentially physically overwhelming force that is located on the edge of the therapist's capabilities to deal with. Similarly other participants constructed rupture as a medical crisis or contagion, with a capacity to escape its boundaries as a predictable diagnosable illness and overwhelm and kill off the therapist with its toxicity: "very physical, it felt very toxic like a poison" (P003, 85) and "something to survive" (P004, 220). Such constructions serve to ward off attributions of blame by positioning the

therapist as passive victim of a powerful external object. They also recall the constructions from *One Flew Over the Cuckoo's Nest* (Kesey, 1962), as highlighted in the text analysis, where rupture is constructed as 'ending' or even death of the alliance, rather than as treatable, recoverable from entity.

Establishing credibility via a firsthand testimonial is potentially required of Ian in excerpt six, since these powerful constructions of rupture as 'crisis' or 'contagion' resist earlier constructions of rupture within a medical discourse as a diagnosable and manageable 'illness'. Ian's sharp intake of breath, laughter and disclaimer ("Um and sometimes I suppose if you catch it whilst it's in process or if you catch it in the lead up to it= =although I'm not sure whether [intake of breath]") potentially demonstrates the tension between positioning himself simultaneously within a competing repertoire of crisis and medical discourse. It also indicates dilemmas of agency and accountability between discourse as social performance, and discourse as a wider and potentially limiting resource. For example, on a macro level Ian is positioned as a responsible health care expert whose professional ways of being and actions are both sanctioned and governed by the wider medical discourse within which he is positioned - this mitigates against accusations of blame and allows him access to control. This is consistent with Weedon's (1997) interpretation of Foucault, that "power is exercised within discourses in the ways in which they constitute and govern individual subjects" (p.113). On a micro level however, Ian takes up a position within crisis repertoires as an improviser who acts creatively and of his own accord (as indicated in the use of present tense - "acting out with the other person or trying to sort of fire fight or trying to bring them round to, you know (1), restating my um (.) intention"). This recalls the maverick positioning of counselling psychologists in Moore and Rae's (2009) discursive study of practitioners' discourse about their work. By taking up positions outside of established schools of psychological discourses, practitioners were granted more freedom to do their job, but also incurred risk. Like a maverick, therapist as improviser is afforded flexibility and creativity in therapeutic action but it also carries risk. Within a crisis repertoire Ian is able to take up a creative position from which he can save the day, but where he also risks losing all control, an act for which he could then be held individually accountable. Indeed Ian's concluding "yeah" ("Maybe I'm thinking that by definition a rupture has to have sort of occurred and there are obvious markers of it, yeah") is potentially an attempt to mitigate against this risk by relocating himself back within established institutional discourses and thus regain access to expert ways of

knowing. Indeed, Ian might perceive such an expert position as more acceptable to me, a scientific researcher, whose initial questions construct rupture as 'knowable'.

Thus, ways of knowing 'rupture' outside the clinical space (e.g. as a 'technical object' or diagnosable 'illness') would appear to sit in tension with constructions of 'rupture' by participants within the clinical discursive space, as exemplified below:

Excerpt 7

P001 Ian {Yeah} (1) It's interesting to think about it being a sort of theoretical and clinical term for something that happens in a way that you don't necessarily think about it when it is happening=.

(Ian, line 211)

Excerpt 8

P003 Jan (.) When you read the books, it's all about my reaction to the patient, but it's all so much more complex than that, (1) and I don't believe that you can just look at the counter transference..(2) there's something else going on.

(Jan, line 34)

In the excerpts above rupture within an academic discourse ("read the books", "theoretical") is constructed as an object to be thought about differently than rupture within the therapeutic discursive space where it is constructed as a more complex, elusive object ("something else going on"). A line is drawn discursively between the therapist who accesses technical terms, and the one caught up in the process of what happens with the client in the therapeutic moment. In excerpt eight, this is achieved via the minutiae of grammar and the shift from "you" who constitutes an objective professional, and the subjective "I" caught up in a process which is "going on". Here rupture as technical jargon ("counter transference") is positioned as inadequate ("I don't believe that you can just look at the counter transference") and ceases to perform a reassuring function. Instead, as Parker (2002, p.333) observes, it potentially serves here to intellectualise therapy so that, "a theoretical system that is used to guide the work can then turn into a grid that covers over and obscures", as indicated by Jan's comment "it's so much more complex than that".

By extension Parker (2002) argues that the universities that produce these theoretical systems may then propagate institutional practices which are at odds with the ethos of therapy. For example, they may play a role in supporting discourses of certain kinds, whilst closing down or omitting others. In this data set 'rupture' was constructed by participants as a void or silence within university training discourses, as exemplified below**:**

> Excerpt 9
>
> P005 Laura: =In my training so far I don't think we have spent, this could be my lack of attention [laughs] but according to what I am aware of we haven't spent much time talking about ruptures.(.). Yeah there is more emphasis on how to establish a positive, like a (.3) kind of therapeutic alliance but not so much yet yeah as on, if that alliance is broken or damaged somehow=
>
> (Laura, lines 55-56)
>
> Excerpt 10
>
> P003 Jan: (.) When I think back generally lectures or I can't remember rupture being mentioned a lot. I have to say (.2) I'm trying to think= =The only time it would be discussed it, you know, (inaudible) when things went wrong, so to speak.
>
> (Jan, lines 54-56)

These excerpts use minimising and negative language in relation to 'rupture' ("broken", ""wrong, "damaged"), and maximising language in relation to the alliance ("positive, more emphasis on") to position the latter as a more desirable norm. This renders it difficult for participants to take up an informed stance in relation to 'rupture' within a training discourse because it is positioned as both undesirable and unknowable ("the only time it would be discussed . . . when things went wrong"). It could therefore be argued that participants are positioned within a training discourse as disabled rather than as enabled in relation to 'rupture'. This mirrors how discourses of otherness in the expert texts also served to potentially disempower the reader by positioning them as unknowing in relation to rupture as 'other'. It may also offer one potential explanation as to why participants drew on crises repertoires within the clinical space since such repertoires could be argued to offer ways of

managing positions of disempowerment. The next section thus turns its attention to how participants construct rupture within the discursive clinical space as 'inter and intrapersonal crisis'.

4.5.3. Recruiting 'rupture' back into the therapeutic alliance - an 'interpersonal crisis'

Participants drew on military and fighting repertories to construct rupture as an 'interpersonal crisis', located within the relational space between client and therapist. Constructions of rupture as a troubled, 'relational process' or struggle were also present in the text analysis, but were never as extremely formulated as by the participants. This is potentially because, as seen in the excerpt below, my question uses the word "associations" which constructs 'rupture' as a metaphorical object, thus rendering a subjective response as legitimate. As a result, participants across the data set constructed rupture as aggressive combat, positioning themselves as subject to personal "attack" (F004, 189), "given both barrels" (P001, 60) or involved in a "clash like sumo wrestlers" (P003, 23). The intersubjective space was thus transformed into a gladiatorial arena or warzone, as below:

> Excerpt 11
>
> Interviewer: =What associations do ruptures have for you?
>
> P005 Mark: {Umm I think} (.) certainly for myself it's just about getting back in the trenches and trying to make right what was you know [sighs] wrong. (.) But metaphorically it feels like real dark clouds to me.
>
> (Mark, lines 28-30)
>
> Excerpt 12
>
> P001 Ian: So I find myself being the one, (1) ummm people kind of laugh, and in the team meetings, I'm the one that tends to put my hand up in the team meetings and say oh yeah when people are saying, <u>oh</u> I've got this really (1) .. difficult [sharp uptake of breath] patient.
>
> (Ian, line 92)

Here, military repertoires are deployed ("getting back in the trenches") to construct rupture as an 'interpersonal crisis', even conflict, with speakers positioning themselves as lone soldiers under attack and the client positioned as the enemy ("difficult [sharp uptake of breath] patient"). The accounts are personalised ("I'm the one", "certainly for myself") which serves to emphasise the phenomenological aspects of the narrative as a means of adding to its authenticity, and persuade the interviewer of the validity of the claim that 'rupture' is more crisis than controllable within the therapeutic "trenches". The sighs and intakes of breath draw attention to the fact that these extremely formulated constructions of 'rupture' might be perceived as inappropriate, and act to ward off potential criticism by providing somatic evidence to support their claims. These military repertoires also potentially serve to ward off blame for any action taken in relation to 'rupture', as speakers can position themselves as under orders and working in exceptionally difficult circumstances. Similarly, the meteorological metaphor "dark clouds" in excerpt eleven positions Mark as a potential victim of forces beyond his control. Participants also reclaim agency by "holding my hand up" and "getting into the trenches" which recalls the actions of a volunteer for the army, willing to put oneself in harm's way as part of their professional and moral duty. Such dutiful ways of being reinforces their positions as caring therapists who are prepared to fulfil their professional responsibilities and weather rupture as 'interpersonal crisis'. The speakers are thereby positioned as either potentially heroic figures that seek to "right a wrong", or as foolhardy - indicated by the laughter of others in excerpt twelve. The use of a moral repertoire within both excerpts serves to shore up participants' accounts of "trying to make it right", but as Parker (2002) warns such repertoires of right and wrong can also conversely function as a form of moralising, whereby the therapist runs the risks of becoming controlling and prescriptive about what is best for the client.

Drawing on military repertoires and such extreme formulations (Pomerantz, 1986) to construct rupture as 'interpersonal crisis' might also be argued to destabilise norms around the therapeutic space as a caring, empathetic environment, as well as disrupting norms around cultural expectations of the therapist. This is exemplified below:

Excerpt 13

P003 Jan: =It's interesting because none of us want to acknowledge that part of us that has anything but altruistic aspects, but if you're working in the NHS and you have a rupture, is that okay to have it out there? (.) Does that mean you're a bad Psychologist or you're not the best member of the team, or there have been two ruptures or incidents, or two difficulties, (.) or difficulties working with two people? (.) What does that say about you? Or if you're in private practice and people don't stay, what does that say about you? What does that say about your business?

(Jan, lines 154-156)

In this excerpt 'rupture' is positioned outside of therapeutic, cultural and institutional discourses through the use of locating prepositions ("is it okay to have it out there?"). This recalls rupture as negative 'other' in the text analysis which served to trouble therapeutic norms; once "out there", rupture is similarly constructed here as an object of negative connotations, a potential mistake ("incident") or risk ("difficulty") which troubles the position of therapist as "altruistic" practitioner within wider social and cultural discourses. As such, rupture is both constructed as 'crisis', and functions as crisis, initiating attributions of potential blame and punishment to the therapist for deviating from the norm ("What does that say about you?"). The series of questions work as three part list formulations (Jefferson, 1990), a highly persuasive rhetorical tool sometimes used in courtroom scenarios (Drew, 1985). Here they are deployed by Jan to build a case against herself, a discursive means of self-interrogation, potentially ending in attributing blame to self ("Does that mean you are a bad psychologist?"). This again evokes Foucauldian observations that institutional discourses of punishment or blame can be internalised by individuals as a set of rules which they then use to police themselves, ultimately finding themselves lacking ("you're not the best member of the team"). Here the cumulative discursive effect of each question is to persuade others that 'rupture' is a potential failure for which the therapist must be held accountable, and therefore calls into question the therapist's right to access the position of professional, made available by wider cultural and institutional NHS discourses ("if you're working in the NHS and you have a rupture, is that okay to have it out there?"). Murphy (2004) suggests that in today's society we are expected to minimise risk taking behaviour in relation to

our own health and that expectation becomes even more salient when you are responsible for the health of another e.g. as a therapist. It is inferred that allowing ruptures to escalate into crisis is morally questionable, making available subject positions of bad, uncaring or even monstrous therapists, as indicated below:

Excerpt 14

P005 Laura:....=this is old school right, old school sort of analysis, anything that comes up with the client is their, (.) is their transference and it's their projection and it's their denial=

=And I think that can be very dangerous.(.) And that can be something that can quite often probably create ruptures and, (.)yeah, that's, I've heard horror stories of people going to therapists who just sit there and stare at them coldly and everything is just thrown back on them and that I can't see that that can be a very good thing.

And the evidence, (.) evidence shows that isn't (1), that isn't actually a great way to facilitate anything.

(Laura, lines 250-253)

In this excerpt rupture is constructed as something from "horror stories" that is "created", recalling the Frankenstein monster of horror repertoires. The therapist takes up the position of the monster's creator (the ultimate perversion of the caring therapist). From such a position they can only act in a non-therapeutic manner towards the client ("stare at them coldly"). Such actions position the client as both a helpless victim and one who is to blame for their own fate ("it's their transference, their denial"). This horror repertoire thus functions to turn the therapeutic process into something that has gone dramatically wrong (note Laura's emphatic tone) and positions rupture as a "very dangerous" object. It also co-opts moral repertoires which are often concurrent with horror repertoires whereby the pure and good can be transformed by their proximity to the morally bad. These function as a moral warning that it is not a "good thing" to allow 'rupture' into the alliance. It is something to be avoided, positioned as it is as a grotesque object that perverts the therapeutic norm and denies access to the position of a warm, caring therapist who meets cultural norms and expectations.

Despite the discursive power inherent in deploying a horror repertoire, Laura is careful to police the border between fictionalised and more rational repertoires ("evidence", "facilitate"). Setting events in the past or as "old school" allows Laura to distance herself from the story, enabling her to ward off any potential criticism of her claims. Framing rupture within a fictional repertoire also recalls the way in which rupture as 'ending' was marginalised in the expert text analysis. Only here Laura is putting the bad therapist who risks moral harm to others behind fictional bars – effectively containing them to allow the caring and competent therapist to prevail, as further exemplified below.

> Excerpt 15
>
> P005 Fleur: =I was going to say (1) I think people want to become counselling psychologists for example (.) and there's a, (.) individually and collectively want to be seen as nice and caring and competent, (1) so I think anything that challenges (.) that and maybe brings us into contact with our boredom or frustration or irritation, failures and the kind of failures of the systems that we work in. {I think we don't really want to think about or talk about}
>
> (Fleur, lines 328-329)

Thus within repertories of 'interpersonal' crisis, therapists can be positioned as both heroes who work tirelessly to right a wrong or, as in excerpt fifteen, potential "failures" who are bored, irritated and frustrated. Worse still practitioners risk becoming monsters whose ethically challenged actions can escalate rupture as 'crisis' – a position which Fleur claims "we don't really want to think about or talk about". It could be argued that participants drew on emotional repertoires to construct rupture as 'intrapersonal crisis' to regain access to the position of caring, human practitioner and so resist being positioned as uncaring or incompetent experts. This required further discursive manoeuvrings on their part, as explored in the next section.

4.5.4. Rupture as 'intrapersonal crisis'

Rupture was constructed as 'intrapersonal crisis' in that it was positioned by participants within an internal private space, as indicated by the use of "my mind" or in me". Here it could be constructed as a felt sense, either physiologically ("gets

under my skin"), or psychologically ("emotional impact on the way I am thinking at the moment"), as exemplified below:

Excerpt 16

P001 Interviewer: {But yeah}, maybe it's 'cos it feels like a powerful term. I don't know. 225 But anyway. (1) Anything that you would like to add just to finish? Anything that=…?

Ian: =I mean I suppose the only thing I wanna add is it's horrible. It feels <u>horrible</u> as a therapist. Much as you wanna put it into technical terminology and explain what you do. There's a, in terms of that felt sense of when a rupture occurs, it's really unpleasant. (1)Something definitely for me at least, it taps into what's going on. It gets under your skin I suppose.... (1) It's tapping into something of your…(.) even if it's just your sort of therapist's ego and wanting to be the good therapist and feeling like you're failing them or what you have. (.) Like I don't know. (.) But it's a horrible, horrible feeling [pulls face].

(Ian, lines 224-230)

Excerpt 17

P002 Eleanor:(1)There's something about the way it impacts on both of us because that seems to have come out in all of this, the interview, so that it's not just the client who is fearful but it brings out the fear in the therapist, (.) in me. And that has a particular emotional, uumm(1) kind of ummm impact on the way I am thinking at the moment.

(Eleanor, lines 171-172)

Emotional repertoires are drawn upon ("feel", "felt sense", "emotional") by the speakers in both excerpts to construct rupture as an 'emotional crisis' and very much their own (as opposed to the client's), as indicated by the use of personal pronouns which point to a strong personal investment in these accounts ("I", "me", "for me"). Extreme formulations (Pomerantz, 1986) are also employed to reinforce the rhetorical impact of rupture as a negative emotional 'crisis' ("really unpleasant"), but also to strengthen the sense of 'self', reinforcing ownership of rupture as an emotional 'intrapersonal crisis'. To this end rupture is afforded agency, and in

Eleanor's case has an "emotional impact on her way of thinking" and possibly even on the decisions and actions that stem from such thinking ("it's not like me").

Arguably both speakers take up dual positions drawing on both technical therapeutic repertoires ("technical terminology", "impacts") to access the expert therapist positioning, and emotional repertoires to access the position of an emotional human being ("I/me"). Eleanor indicates distance or tension between the two by shifting discursively between "the" therapist, a third person effect and "in me" ("in the therapist, in me"), the 'in' suggesting movement from the outside inwards. This draws attention to the wider counselling psychology discourse within which 'being' present with a client and actively 'doing' as therapist have been observed as two subjectivities that reside alongside one another in an uneasy tension (Strawbridge & Woolfe, 2010).

Emotional repertoires also function here to trouble a professional discourse by positioning speakers at a distance from expert practice or ways of being. In excerpt sixteen, Ian makes this explicit when he claims: "Much as you wanna put it into technical terminology and explain what you do. There's a, in terms of that felt sense of when a rupture occurs, it's <u>really</u> unpleasant". The use of the present tense and the verb "is" rather than the speculative "can be" adds to the declarative nature of this statement and wards off alternative ways of constructing rupture as anything other than an "unpleasant" emotional construct. This functions to effectively distance Ian from expert ways of being and leave him unable to gain access to expert language and its "technical terminology". Instead he takes up a position within an emotional repertoire where rupture is constructed as a "horrible" feeling, potentially because he is distanced from an expert position and can only access ways of being wherein he feels deskilled and potentially unprofessional ("it's just your sort of therapist's ego and wanting to be the good therapist and feeling like you're failing them"). In a similar vein, Eleanor's construction of rupture as a fear based emotional 'crisis' ("it brings out the fear in the therapist, in me") also functions to isolate her from a professional way of being, as indicated by her distinction between the "therapist" and "me". McNaughton (2013) refers to a physiological emotional repertoire where emotion is located inside the individual, as part of our physical makeup and collective human experience. Within this repertoire, emotions serve a specific discursive function and are attributed the power to "connect to rational capacities in troubling ways" (McNaughton, 2013, p.74). Rupture as 'intrapersonal crisis' is thus potentially positioned by these participants as infiltrating the body and

mind and possibly overwhelming professional reason. This may offer a tentative explanation as to why as interviewer I also seem reluctant to draw on an emotional repertoire; it takes me until the end of the interview to address Ian's feelings by asking 'how does rupture feel?', and even then I do not ask it as directly as this, but by accident, "Anything you want to add?". It can be conjectured that this is potentially because taking up a position within an emotional repertoire might position me as his confidant and not as a professional conducting an interview, thus troubling my own "rational capacities".

Conversely, being positioned within emotional repertoires does grant access to more human ways of being. This reinforces norms set up within wider cultural and counselling discourses where therapists are expected not only to access their own feelings in order to take up human and reflexive ways of being, but use such reflexivity to reconcile this position with the professional, expert subjectivities also made available within such discourses. Thus, negotiating tensions between emotional and professional ways of being in relation to 'rupture in the alliance' became discursive work in which several of the participants engaged, as illustrated below:

> Excerpt 18
>
> P005 Eve   =It's really interesting and I'm thinking about a situation I've had where a client has become very (.) upset and angry about not feeling understood, and has missed a few sessions and in the end she came back, but (1) I don't know, for me that was a rupture, (2) but I don't know whether that was just who she is (.), and how she acts out in the world, and whether she even would have seen it like that(.) Because I think maybe all of her relationships have that quality.
>
> Interviewer   Did you take that to heart a little bit, or were you able to=?
>
> Eve   =I did initially and then through, I kind of find through supervision, you can almost when you're formulating, but then I wonder whether, sometimes I find the formulation of that distances you. 148 (1) It's a way of

saying, (.) you know it's not you. {It helps to allay the anxiety} [doubtfully]

Mark   {It gets in the way doesn't it?}

Eve   Maybe.

Mark   It's like there's something in between that's seems to kind of{}

Fleur   {}   (inaudible).

Mark   {}Yeah, arguably. In certain instances. In other words let's look towards repairing this, but {let's come up with a scientific formulation}.

Eve   {Yeah}, because then it contains <u>my</u> kind of discomfort.

Mark   That's it. That's it.

Eve   . (.5) =It kind of threw me into this, it just, yeah it threw me into just not knowing what had happened, and I didn't have the opportunity to, (1) I didn't know, I couldn't guarantee, that we were going to be able to come back into a room and resolve that, (.) so I had to kind of make almost a very neat scientific formulation around, you know this is why it's happened.

(Mark, Eve lines 143-159)

A medicalised repertoire is initially deployed by Eve to construct 'rupture' as having a list of behavioural and emotional symptoms that are located within the client's pathology ("angry, "missing sessions", "upset", "just who she is"). This makes available to her the position of knowing expert ("I think maybe all of her relationships have that quality"). However, my question, "Did you take that to heart a little?" introduces emotional repertoires (the heart is a cultural signifier of emotion) that Eve then draws on to construct rupture as 'intrapersonal crisis' ("anxiety", "kind of threw me"). In doing so she must then negotiate a tension between the position of expert and that of emotional, human therapist. Her doubtful tone both indicates this dilemma and arguably seeks to navigate it. Such a tone mitigates against potential

criticism for taking up too emotional a stance, but it also elicits agreement from her peer, Mark, which conversely provides a means of strengthening her emotional stance through consensus. Arguably access via emotional repertoires to the position of emotional, human therapist allows participants to do their job since within wider cultural and counselling psychology discourses practitioners are expected to have feelings. Indeed to take up an overly scientific, non-feeling way of being within these discourses is to be positioned as a bad practitioner ("Mark - (Formulating) gets in the way doesn't it, Eve: Maybe") and recalls warnings that a formulated therapeutic object becomes a deadened object (Parker, 2002). Within emotional repertoires, therapists are also positioned at risk, since rupture as 'emotional intrapersonal crisis' can lead to messiness, unpredictability, and even ending, which then exposes the practitioner to attributions of blame and failure ("I couldn't guarantee, that we were going to be able to come back into a room and resolve that"). This recalls cultural discourses of divorce (as identified in the text analysis) where an ending of relationships requires that someone be at fault.

To manage these issues of accountability Eve negotiates another discursive shift, drawing on technical repertoires to construct rupture as object which can be made "neat" again through formulation and supervision. Within these repertoires rupture is constructed as 'knowable' through formulation ("I had to kind of make almost a very neat scientific formulation around it") and reinstates Amy to the expert position. From this position she both accepts responsibility for repairing the rupture whilst also mitigating accusations of blame ("It's a way of saying this is not you, it helps to allay the anxiety") by attributing partial accountability to the client ("maybe all of her relationships have that quality"). Technical repertoires thus function to sanitise rupture and make it manageable, leading to positions of professional expertise, but also potentially serve to render temporarily inaccessible the position of emotional, human therapist prepared to work in the chaos of rupture as 'intrapersonal crisis'. Conversely, emotional repertoires allow access to human subjectivities but incur the risk of the individual being overwhelmed by crisis, jeopardising their position as expert able to prevent rupture as 'ending'.

This presents participants who self-identify as counselling psychologists with familiar ideological dilemmas around issues of subjectivity, as well as how to reconcile being positioned as both human practitioner and scientist within competing epistemological discourses. In this study it might be argued that Eleanor's fear and Eve's anxiety became a product of this discursive dilemma. The final section looks

at how participants sought to resolve these dilemmas, as well as managing attendant issues of accountability and responsibility.

4.6. Resolving issues of subjectivity and accountability

Guilt served a specific discursive function in offering participants one way of potentially reconciling expert and human ways of being in relation to 'rupture' within this data set, as exemplified below:

> Excerpt 19
>
> P003 Jan:. (2) I think that rupture can have a connotation of shame and guilt that something has pulled apart; something has gone wrong. Someone has to be accountable for this. (1) So am I the therapist, am I the one with all this knowledge? (.) How shall I let this happen? (.) When in actual fact, like I said, it can be the springboard for repair, work, and everything else. (.) But somehow there is that moment in time when the word rupture comes up, and shame or guilt might kick in, I think that's why we don't like that word ..(inaudible) challenge better(.5) So perhaps we avoid that word because it's more… whereas if we say this is a, this, this, (.) a very...really therapeutic challenge, somehow it doesn't have… (2) Challenge has the connotations of work to be done, of courage, of going in there and umm ... of hope. (.)Whereas rupture is as if something is cut.
>
> (Jan, lines 199- 203)

In this excerpt Jan draws on a moral repertoire ("guilt", "shame", "courage") to construct rupture as a professional undoing ("gone wrong"), positioning it as an ending ("pulled apart", "cut"). Jan attributes accountability for rupture as "gone wrong" to herself ("How shall I let this happen?"), although the rhetorical nature of this question also functions to ward off accusations of blame. As such she mitigates against being positioned within an institutional discourse (potentially that of counselling psychology as inferred through her use of "we" indicating both her and my position within a wider professional community), which demands that "someone must be held accountable". By drawing on moral repertoires Jan thus positions herself as a fallible human therapist, a position from which she can shows she cares but where arguably she risks being held to blame for mistakes. Conversely by drawing on therapeutic discourses to construct rupture as a "challenge", Jan re-

negotiates access to the position of technical expert who can act to repair rupture ("like I said, it can be the springboard for repair, work, and everything else"). In doing so she potentially loses access to the human way of being with a client as she cannot admit her part in the rupture. Indeed, within a therapeutic discourse of challenge and opportunity, rupture is positioned as something to "avoid" by the professional, even a silence as indicated by Jan's loss for words ("we avoid that word because it's more… whereas if we say this is a, this, this, (.) a very). . .therapeutic challenge".

This is where guilt "kicks in" which I argue performs a specific discursive function for Jan by allowing her to reconcile tensions inherent in her positioning as fallible, human practitioner and professional expert. This is because guilt allows Jan to bring emotion (as she is expected to do within counselling psychology discourses) without undermining her expert position. Guilt is compatible with the expert role because it positions Jan as able to acknowledge responsibility and accountability, therefore reinforcing the idea that a practitioner should know what they are doing and can rise to a "challenge", reinstating them to the position of expert. It also positions Jan as human because she feels bad when she doesn't know what she is doing ("How shall I let this happen?"). Other emotions such as anger or frustration would not achieve this discursive function. Therapist anger with the client would not be compatible with the expert position, indeed it directly challenges expert positions since it can result in actions that would subvert the norms of therapy – for example, the therapist shouting at the client or leaving the room. Equally, if therapists don't say how they feel, and only apply skills, then they cannot access reflexive, human ways of being expected of counselling psychologists.

In this way guilt offers a solution, providing the discursive means for Jan to draw simultaneously on therapeutic discourse and emotional repertoires without having to jeopardise or throw away one of them. Jan can also be positioned within a moral repertoire as in the wrong, even shamed and yet still assume responsibility, thus accessing courageous ways of being which allows her to carry on by "going in there and doing the work". Such positioning speaks to the medical at risk discourses where individuals who jeopardise their health through their own risky behaviour are positioned as sinners who can be both held to blame but also exonerated for their mistakes if they change their lifestyle (Lupton, 1993, 2012). Indeed one participant overtly draws on a Christian discourse to achieve similar discursive ends, accepting

responsibility whilst also managing accusations that they haven't acted professionally, as exemplified below:

Excerpt 20

P005 Mark: (.) So it's absolutely, it probably is even more critical for me and therefore I do take it as sort of a very personal, (2) it's very sorrowful to me, when that happens, and the rupture, as I've chosen to define it, has thank God, touch wood, rarely happened but when it has, it's sent me into a very, very (2) soul searching place.

(Mark, line 33)

Within this excerpt Mark deploys a Christian discourse ("sorrowful, thank God, soul searching") to construct rupture as a behaviour to be sorry for, potentially a moral error or departure from the right (eous) path of therapy ("it's sent me to a very, very soul searching place"). Within a Christian discourse Mark can take up the position of confessor ("sorrowful") from which he can repent and asks forgiveness for any wrongdoing. This resolves the tension between being positioned as either good or bad therapist since Mark becomes both good and bad, a repentant sinner who can be welcomed back to practice again because of his confession. This draws parallels with the concept of confession proposed by Foucault (1978), whereby people are required to express their internal suffering in order for it to be relieved. Such absolution would not be available to Mark within a scientific or medical discourse where he would only be able to access a position of failed expert.

A Christian discourse can also be synonymous with restorative repertoires which serve to open up new discursive terrain within which a further discursive reconciliation is achieved between rupture as 'ending' and rupture as 'opportunity' or 'growth', as exemplified below:

Excerpt 21

P005 Mark: I think it opens it up, certainly for me more of a spectrum where rupture takes place=...

Laura ={Breakthroughs.]

Fleur {You use breakthrough}. I think it's interesting that you started talking about rupture as a breakdown and it's almost now

120

synonymous with a breakthrough and that fits quite comfortably for me anyway how I see rupture as a breakthrough, (1) there's a break but then something, but it's like, (.) gives space for something else to emerge and to come through.

(Mark, Fleur, Laura, lines 261- 263)

In these excerpts 'rupture' is not constructed as an end or an object that must be sanitised or subject to control, but instead the speakers draw on restorative repertoires to construct it as a "breakthrough". It is positioned within a space between client and therapist that is replanted afresh, recalling a growth of something new ("Something else to emerge") which in turn constructs it as a changing process rather than a static entity - an opportunity and not an end. This is consistent with wider counselling discourses where the therapist "takes up a position from which they can develop a conversational space to facilitate emerging dialogical concerns in which newness can occur" (Anderson & Goolishian,1992, p.28). This newness is neither positioned as good or bad and responsibility for its creation is attributed to client and therapist - a shared responsibility. Thus, 'rupture' within these restorative repertoires escapes binary constructions of either good or bad, and is repositioned on a "spectrum" of both good and bad, risk and opportunity, crisis and resolution. This recalls how one of the expert texts also sought to encourage a both/and stance in relation to 'rupture in the alliance'. 'Rupture' is freed from pathologising constructions of something going wrong to something going on, establishing it as a kind of relating, rather than the wrong kind of relating. Several participants argue that such a construction allows them to find a "foot in both camps" (P001 Ian, line 213) and take up a relationship with 'rupture' which recognises and manages the tension between being positioned as a human, fallible practitioner and a technical expert.

Excerpt 22

P005 Fleur   I think there's awareness to talk about it abstractedly but there's less of a willingness to engage with it professionally or more, so I don't know, (1) there seems to be a bit of a thing it's fine to talk about this one thing but then it's harder to operationalise and to really talk about what it actually is and the experience of it. (2) So for me it seems like there's two perspectives that maybe aren't kind of=

Mark   =And maybe that in itself is anxiety making. So we hold both
of those perspectives and we're constantly trying to manage both.
(Fleur, Mark lines 305-306)

B5. Discussion

5.1. Introduction

This chapter discusses the discursive themes that have emerged during the analysis. A central premise of this discourse analysis has been that the discursive positions assumed by individuals shape their subjectivity. This discussion focuses on how participants are positioned or position themselves in relation to 'rupture in the therapeutic alliance', and considers the implications for their identities and ways of practising.

Humes and Bryce (2003) speak to the post-structuralist respect for uncertainty when they argue that, "there will always be other perspectives from which to interpret the material under review; to seek a definitive account is a misguided undertaking" (p.180). Therefore, I do not seek to offer a view of the world in which one construction of 'rupture' and subsequent ways of being or practice are prioritised over any other. I present notions that have emerged from the co-constructive nature of the research process between the researcher, texts and participants (Mauthner & Doucet, 2003). Implicit in this process is the acknowledgement that there will be other constructions and discursive themes found by other researchers that will not be considered in this account.

This section also seeks to address notions of usefulness and applicability, particularly how a discussion of subjectivities might usefully contribute to a greater understanding of counselling psychology and its practice in relation to 'rupture in the therapeutic alliance'. Willig (1998) argues that discourse analysis is an attractive tool for critical psychologists because it allows us to challenge and question what is taken for granted in psychology, and thus make recommendations for improved social, political and/or psychological practice. Conversely, Widdicombe (1995) observed that researchers should not commit themselves to particular recommendations based on their research to avoid imposing categories upon others. Instead one should seek to contextualise the analysis as opposed to generalising. I incorporated into this discussion notions of "usefulness" (Misra, 1993, p.400) that encourage the reader to take from the discursive themes ideas and applications that they might find useful for their own theoretical thinking and practice. Implicit in this process is a reflection on how I might position myself within these discourses, (as scientist-practitioner, trainee counselling psychologist, human being

and researcher) and its potential consequences for my own subjectivity in relation to 'rupture in the therapeutic alliance'.

5.2. Discursive themes and usefulness for counselling psychology

What emerged from the analysis of UK counselling psychology's expert texts was that subject positions within medical/scientific discourses and relational discourses were the most readily available in constructing ways of being in relation to 'rupture'. These seemed to invoke the possibility a 'knowable' discursive object (which could be located through diagnosis and/or labelling) in relation to which the therapist could be positioned as informed expert, even diagnostician. Alternatively, rupture was constructed as a 'relational process', located in the intersubjective space between client and therapist. This positioned practitioners as interactive, involved, relational beings, rather than as objective observers or holders of the truth. Initially subjects were faced with a potentially binaried discursive terrain that foreclosed on their options to position themselves in discourses in anything other than a 'knowing' or 'being' way. This would seem to reflect the wider discursive terrain, as mapped out in the literature review. Here, as observed by Lingiardi and Colli (2015) 'rupture' was viewed either from a rational point of view, where a one person psychology positions the therapist as the holder of truth and alliance ruptures are derived from the patient's inability to accept what they propose; or from a relational two person perspective as the interruption of "an ongoing process of intersubjective negotiation" (Safran & Muran, 2000, p. 165). In a broader sense this also recalls the familiar dualism observed within a counselling psychology discourse, where potential ideological tensions become apparent in a discipline whose epistemological roots lie in both humanist and scientific discourses (Williams & Irving, 1996).

However, Wetherell (1998) suggests that such ideological dilemmas (Billig et al., 1988) offer an opportunity to transcend rather than get caught in the trap of binaries since they provide a resource for action. I argue that in this study participants sought to evade fixed positions as either 'expert/diagnostician' or 'relational being' in relation to 'rupture in the therapeutic alliance', and although compelled to refer to them, to carve out a new discursive space between client and therapist. Here participants favoured experiential, emotional and crises repertoires through which alternative positions in relation to 'rupture' could emerge (e.g. therapist as 'dutiful soldier'; therapist as 'emotional being'). Arguably such positions led to fractured subjectivities which could be anxiety provoking but also offered participants greater

flexibility in negotiating issues of accountability, responsibility and agency in relation to 'rupture'. These issues are explored below, as each discursive theme is discussed separately and in relation to existing literature.

5.2.1. Rupture as 'other' - Practitioner as 'othered'

In the analysis of expert texts a variety of legal, moral, medical and relational discourses were deployed to construct rupture in negative terms, or what Gergen (1990, p. 358) has referred to as "vocabularies of deficit". These positioned rupture on a spectrum of increasing negativity (e.g. from "minor lapses", "misalignments" through to "major breakdowns", "mistakes", "failures" or "complaints") consistent with its positioning in two person relational discourses as a discursive object whose negative effect can vary in form (e.g. how it is labelled) and intensity (Safran, Muran & Eubanks-Carter, 2011). As a consequence, its discursive positioning in prefixes undid the value of therapeutic words (e.g. the 'mis' in misalignment) so that rupture was effectively 'othered' in the expert texts as the 'wrong and bad' counterpoint to the 'right and good' alliance. Positioning rupture as 'other' is perhaps understandable given the prevalence of the 'healthy alliance' as a normative and highly valued construct within a wider counselling psychology discourse. It is also consistent with Staszak's (2008) observations that an 'other' is identified by its faults; devalued; stigmatised; even silenced because of them. Such silencing offers a potential explanation as to why within the regulating discourses of professional bodies such as the BPS there is no explicit mention of 'rupture in the alliance', but there is an emphasis on "the importance of fostering and maintaining good professional relationships with clients" (*BPS Code of Ethics and Conduct*, BPS, 2009, p.10). Its omission positions 'rupture' outside of these regulating discourses where it potentially functions as a risky 'other', troubling norms upheld by those institutions. For example, if in a counselling psychology discourse a 'healthy' alliance is positioned as normal and safe, then by extension 'rupture' is positioned as danger and risk. This is consistent with Douglas' (1982, cited in Ballinger & Payne, 2002) socio-cultural theories where the ways in which risks are responded to are dependent on cultural explanations about danger and 'otherness'.

By positioning rupture as 'other', the expert texts also opened up the potential for its construction as 'unknowable'. This recalls how in the wider discursive terrain (as discussed in the literature review) tensions became apparent between constructions

of rupture as a knowable 'empirical object' within scientific discourses, and its positioning as a more elusive object. Consequently, a position of 'not knowing' in relation to 'rupture' was made available to readers within the texts. Arguably this position proved difficult for the individual participants to negotiate and led to subjectivities that mutated according to their discursive perspective. For example, when participants were situated in discursive domains which lay outside of the therapeutic dyad, (e.g. within the technical repertoires of training institutions, or wider counselling psychology discourses of the regulating bodies) they sought to distance themselves from positions of 'not knowing'. One potential explanation for this is that in these discursive arenas a 'not knowing' stance runs the risk of failing to justify professional claims as to what the individual therapist can achieve. Instead individuals are compelled to take up a position outside of counselling psychology institutionalised discourse where they risk being denied access to the position of good practitioner who knows how to foster strong therapeutic relationships. By extension, it might be argued that this thesis works discursively to defend me against accusations of 'not knowing' in relation to rupture as 'other'. It serves to sustain not only my reputation as a professional who knows how to avoid risk to a healthy alliance, but also that of the institution that produces me.

Another potential explanation for distancing themselves from a 'not knowing' stance was participants' unwillingness to be held accountable for a discursive object which was also constructed within a moral discourse as 'bad' and 'wrong'. This was especially troubling for counselling psychologists since an ethical way of being is central to their profession and their identity. Some participants thus worked hard to avoid being positioned as a neglectful practitioner within a moral discourse by shifting responsibility or blame onto the employment and training bodies. For example, several participants said that they couldn't remember talking about 'rupture' in training. Arguably one cannot be held accountable for being positioned as 'not knowing' in relation to an object if it is not discussed in the institutions that train you. There is therefore the potential here to consider the "extra-discursive" (Sims-Schouten et al., 2007, p.103), and in particular how the training institutions may or may not enable participants' access to certain discourses in this study. Although what can be deemed discursive and extra-discursive is, as discussed later, a topic which is still being debated between discourse analysts, in this study participants did position themselves as potentially disabled or disempowered by the lack of discussion around 'rupture' in their training universities. Guilfoyle (2002)

observes that to an extent the places and institutions set up in society can structure what is considered reasonable or appropriate to say and do. If rupture is constructed as a 'silence' at the heart of training discourses, or as 'other' so that a dominant discourse of the healthy (non-ruptured) alliance prevails, this raises questions as to whether there is an element of material power present. These material practices may potentially subjugate rupture discourses, so as we saw in the text analysis predominant ways of talking about rupture focus on repairing 'it', rather than constructions of how rupture is experienced. These interpretations are made tentatively and acknowledge that the complexity of the role of language in constructing social reality means that one can only ever speak in terms of tendencies, rather than causal relationships (Alvesson & Sköldberg, 2009).

Conversely, for some participants taking up a 'not knowing' stance was potentially liberating, particularly in the clinical room, and aligns with a position counselling psychology chooses itself by suggesting that "knowing or theoretical knowledge is not primary to its practice" (Larsson et al., 2012, p.41). Indeed a 'not knowing' stance historically offers a legitimate way of being within a counselling psychology discourse, where the positioning of the therapist as knowing expert is resisted in favour of a "democratic, non-hierarchical client–therapist relationship" (Cooper, 2009, p.120). This is upheld within the discourse of the discipline's regulating bodies as a means of avoiding power imbalances and encouraging client empowerment (Harrison, 2013). In contrast, Brown (2007) argues that:

> . . . practitioners cannot waive responsibility and accountability for the
> influence of our own knowledge and power in the therapeutic work by
> claiming to 'not know' or to be responsible only for expert knowledge
> about process (p.12).

Brown (2007) adds that to do so, would be to implicitly assume that power in the hands of the therapist is always oppressive, causing the practitioner to distance themselves from what they know.

Guilfoyle (2005) potentially offers a conciliatory position arguing that even though a therapist and client cannot escape the power dynamic of the therapeutic relationship which positions the therapist as expert applicator of therapeutic discourse, a client can still access a position of empowerment. This is consistent with Foucault's (1980, p.100) concept of power and knowledge "as joined together in discourse" in a dynamic relationship. This allows for power to be recycled between two individuals

in a dyad, rather than attributing power to one party who then represses the other. Such an argument allows for 'rupture in the alliance' to be positioned *both* as the site from which the client enacts a position of power by asserting their dissatisfaction with their therapist, *and* as a site of potential client deference which also enacts power as it positions practitioners as having to do something to repair the 'rupture'.

Reconciling therapeutic ways of knowing (or not knowing) in relation to rupture as 'other' and negotiating attendant issues of power was thus a dilemma faced by participants in this study - one which they potentially attempted to manage by moving between medical and relational discourses and technical and emotional repertoires. This recalls Moore and Rae's (2009) discursive study of counselling psychologists' talk about their profession, where constructions of a maverick identity allowed individuals to position themselves as outside of traditional ways of looking at things, affording them a vantage point from which to hold disparate views - for example, knowing and not knowing in relation to rupture as 'other'. In theoretical terms this aligns with a position of negative capability which Kasket (2012) argues is a position from which ambiguity can be tolerated and thus should be cultivated by counselling psychologists. In clinical terms, a therapist's flexibility and ability to move between positions of 'knowing' expert and 'not knowing' non-expert has been argued to enhance the therapeutic relationship (Roy-Chowdhury, 2006).

Ultimately it could be argued that taking up a 'not knowing' stance becomes a defendable position if it is positioned as the norm, such that rupture as 'other' simply cannot be known in all its manifestations. Certainly in this study, 'rupture' took up residence in a range of discourses and interpretative repertoires, retaining an elusive quality, despite attempts to pin it down. The more labels 'rupture' accrued, the less it was 'known', as encapsulated by the participant below:

> P005 Eve: =the more we talk about rupture, the more lost I'm in what
> a rupture is. ....(1) and I'm just wondering what is even, yeah, how do
> we actually perceive a rupture? (.)or, I think most of the time we look
> at it as something going on in the client's life or something going on in
> <u>me</u>, as the therapist, but how the rupture is really in that
> intersubjective space, (2)but that's very hard to determine, like what's
> the client, what's the therapist and what's the alliance?
>
> (Eve, line 121)

This gives credence to Safran and Muran's (2006, p.233) observations that rupture is a "slippery concept" of "non-specific factors", but also goes some way to explain the effort that the texts, and at times the participants, make to pin 'rupture' down within a medical discourse and negotiate a more knowing stance in relation to 'it'. These medical notions of 'rupture' are discussed in the following section and reflect how discourses of health are often "contradictory blends of medical and mystical notions that exist in contradiction to one another" (Stainton Rogers, 1991, cited in Parker, 2016, p.215).

5.2.2 Rupture as 'illness' and 'technical object' - Positioning the practitioner as 'expert'

The analysis of expert texts mapped out a discursive terrain of 'rupture in the therapeutic alliance' was predominated by medical and scientific discourses. These constructed it as both an 'illness' and as a locatable object that could be identified through diagnosis and labelling. Consequently, it could be positioned as an object that was manageable and repairable. These discourses made available the position of self-regulating expert who could act to identify and manage rupture as 'illness'. This recalls the empiricist discourse observed by Craven and Coyle (2007) in which the psychologist is positioned as an expert who has the power scientifically and objectively to identify, categorise and treat psychopathology.

It perhaps follows that academic texts, handbooks and professional practice, as used in this study, would have an implicit institutional interest in constructing and regulating the self-managing professional/counselling psychologist, and would draw on medical and scientific discourses as consonant with this position. Generally academic journals play a part in reproducing a certain kind of professional subjectivity since psychologists read such articles as apparent exemplars of what they should aspire to (Davy, 2010). Thus these texts promote overt and covert norms about being a proper professional (van Langenhove & Harré, 1999), and make available to the reader positions from which they can act effectively as a good practitioner by observing practices of self governance (internalising the rules). Arguably such texts function as a 'technology of subjectivity' (Foucault, 1980), whereby psychological knowledge and practice are used to constitute a self that can be internally and externally regulated (Heenan, 2006).

Likewise, participants in this study positioned themselves as self-regulating within a medical discourse, and thus attributed to themselves responsibility for identifying

'rupture'. Conversely, they experienced themselves as unprofessional if they found themselves working with clients in ways not valued by literature (e.g. if they failed to spot or repair 'rupture'). In such a way a construction of self-management is not necessarily always a positive step in that it can foster self-blaming and guilt. It is possible that drawing on the power inherent in hegemonic medical and scientific discourses to position themselves as expert in relation to rupture as 'illness' provided a defence against accusations of being unprofessional and a failure. Participants negotiated access to this 'expert' status in two ways as discussed below:

5.2.2.1. Practitioner as 'institutional mouthpiece'

By constructing rupture as a knowable, 'technical object', participants gained access to legitimised, professional ways of talking about 'rupture' by recruiting it back into institutional discourses and their attendant authorised practices. Again from a critical-realist perspective institutional power may exist as an 'extra-discursive' influence here (Cromby & Nightingale, 1999), since as gatekeepers to expert language, training institutions were well positioned to actively exert a material influence upon participants' talk. This is illustrated in the way in which participants occasionally adopted specific psychotherapeutic, theoretical discourses within the psy-complex and their attendant specialist jargon to label 'rupture' in particular ways (e.g. "counter transference") within psychodynamic discourse. Such 'jargon' potentially served to bolster participants' claims to expertise, since as Boyle (2005) observes "when providing a name or label, a therapist conveys a powerful message that they are familiar with behaviour and experience and have seen them before" (p.242).

In addition, such technical talk allowed educational institutions to exert their influence by create a "hegemony of theory" or circumscription of thought around 'rupture' as an object (Thomas, 1997, p. 76). This offers a potential explanation as to why I also used expert jargon when talking about 'rupture', since like my participants it granted me access to a professional in-group, consolidating a position of expertise, thus legitimising their and my claims that 'rupture' was recognisable to us as a technical construct. By taking up a professional, expert stance in relation to 'rupture', both I and the participants sustained the reputation of the educational institutions and training course within whose discourses we are positioned. It could

be argued that discourses legitimise and reinforce institutional structures, and in turn these structures support and validate discourses (Willig, 2008).

However, Harper (2002, p.8) argues that expert or technical terms can cause practitioners to limit their horizons, potentially leading to a "tyranny in expert language" as they are recruited into dominant and expert ways of talking and practising. In other words one participant's construction of rupture as 'knowable' via a professional lingo serves to encourage its identification and idealisation by the practitioner as an object that *can* both be known definitively and handled in prescriptive ways (Parker, 2002). This draws attention to the way in which power constituted by institutions produce therapist positions and limit how certain problems are understood (Hook & Parker, 2002). Thus rupture is 'thingified' (Tillich, 1988) as a tool that can be developed and deployed by a technical expert following training. Such positioning is problematic and potentially limiting for the counselling psychologist for whom 'technical expertise' sits in tension with 'being in relation' (Strawbridge & Woolfe, 2010) – particularly if, as Martinez et al. (2012) observe taking up an expert position (what they refer to discursively as "monological objectivity", p.116) contributes to rupture. In this study participants appeared to manage this particular dilemma by separating technical discourse from its therapeutic context positioning it as unusable, even taboo with clients inside the therapy room. In doing so they appeared to acknowledge the huge gap between practical therapy as taught (contained, tidy, clear) versus everyday practice (uncertain, untidy and confusing) (Bostock, 1990).

This raises questions about the role of technical therapeutic discourse and the position of practitioner as 'institutional mouthpiece' it makes available. Does "the training of therapists emphasise the conceptual at the expense of the experiential" (Tufekcioglu & Muran, 2014, p.142)? Is it helpful for practitioners to use technical language even in supervision or training, if it is not used by clients? Parker (2002) argues that jargon obscures more than it reveals, lending tentative support to further observations that "narratives that we find in psychology textbooks are no more than fictions which lure readers into making them think they are talking about facts" (Parker, 2016, p.13). However it can also be argued that use of labels or jargon is unavoidable since we cannot have a debate about therapeutic constructs without first having an agreed upon language.

The expert texts in this study certainly deployed scientific and medical discourses to construct 'rupture' as an object about which there is a reality which has been or is about to be discovered (Boyle, 2005). Participants though found it difficult to reconcile this 'knowable' object with rupture as a messy 'crisis' they experienced in the clinical room. This offers a potential explanation as to why participants attempted to tidy up 'rupture' for supervision since "the elaboration of theory often operates as a form of defence" (Parker, 2002, p.235), and offers tentative support for Friedlander's (2015) observations that practitioners can be reluctant to bring 'rupture' to supervision. This raises questions as to how supervision is used in relation to rupture as a messy 'crisis' in the alliance. This study hints at a potential subjugation of rupture discourses such that supervision becomes the discursive site where institutional discourses wash their hands of the practitioner, positioning them as an individually responsible for any clinical mess, which as an institution they are not prepared to be held accountable for. This would appear incongruous with supervision discourses in wider counselling discourses as a place for sharing all professional concerns, and is potentially an interesting area for further research – how 'rupture' is constructed specifically in supervision.

In a similar vein this also raises questions as to how 'rupture' might be talked about within places of employment. In this study, only one participant referred to their place of work, positioning short-term therapy services as affecting their ability to deal with 'rupture'. Although this was not enough to work it up into an example in the analysis, it is perhaps worth also marking this as an area of future research. As noted in the literature review: how do we discuss rupture as potential ending, crisis, breakdown or mistake within what Rizq (2013) identifies as the "language of success" (2013, p.20) that currently prevails in NHS settings (e.g. "competence frameworks"; "best practice", 'positive outcome")? More specifically Spellman and Harper (1996) argue that once therapists become embedded in discourses of success, the "potential for proper diversity in accounts of therapeutic process is limited" (p.211). Thus, within a discourse of success it could be argued that rupture can only be constructed as a treatable 'illness' or repairable (as in the texts), not as emotional distress or 'crisis' (as it was by participants in this study), limiting ways in which 'rupture' can be understood through a diversity of constructions. Once again it is possible from a critical realist perspective to tentatively make the interpretation that these dominant discourses of success could potentially be greatly enabled by the NHS (and their outcome measures) and universities invested in sustaining their

reputation of producing 'expert' practitioners who can handle 'rupture'. However, they are also ultimately constraining of practitioners since if all that matters is what can be directly observed or measured, then there is a danger that unobserved, hidden processes and meanings are overshadowed by "bringing the client's subjective experience in line with an objective truth" (Parker, 2002, p.3).

5.2.2.2. Practitioner as 'diagnostician'

The deployment of a medical discourse to construct rupture as an 'illness' was arguably a double-edged sword for participants. Whilst they could position themselves as diagnosing experts who could identify 'rupture' through its symptoms, these negative emotional and behavioural markers ultimately became the means by which rupture was constituted as a disordered discursive object (Deleuze, 1988, cited in Graham, 2005), effectively pathologising it. This was problematic for counselling psychologists whose responsibilities to self and society, as laid out in the *Division of Counselling Psychology Professional Practice guidelines* (BPS, 2006, p.7) are to "challenge the views of those who pathologise". Equally, it raised questions as to how counselling psychologists retain access to the authentic, meaning making values of the humanistic and relational discourse within which they are also positioned if they introduce the notion of rupture as 'disordered'.

What was particularly difficult for participants in this study was that in constructing rupture as 'illness' they ran the risk of placing the source of distress within the individual, which risked disregarding the value of understanding the social context and interpersonal relations as "sources of unhappiness" (Hare-Mustin & Marecek, 1997, p.109). By placing the problem within the personality structure of the individual, professionals also risk suggesting to people that interpersonal problems are intractable (Sparkes, 2002). This offers tentative support for observations made in the literature review that singling out borderline personality presentations as those most likely to experience 'rupture' may risk pathologising this group. Participants in this study mitigated against blaming clients for 'rupture' but had to reconcile these efforts with avoiding being positioned as accountable for it themselves. This sits in tension with the rupture repair task analysis literature that suggests therapists must be prepared to admit accountability and say sorry for their part in ruptures in order to resolve them (Safran et al., 2014). In this study a medical discourse arguably allowed participants to position themselves as responsible for treatment without being held responsible for rupture as 'illness'. However, this position of diagnosing

expert called into question Rizq's (2006) notion of a truly 'postmodern' philosophical and epistemological value base in counselling psychology, for as demonstrated by the participants' talk, there always seemed to be an empiricist (scientific or medical) discourse present which would negate the postmodern. This can be related to assertions by Spinelli (2001) and Williams and Irving (1996) that counselling psychology itself is epistemologically conflicted, arising from an ideology grounded in both a logical empiricist and phenomenological framework. This was exemplified by the way in which the texts and the participants drew simultaneously on a relational discourse to ward off the pathologising effects of a medical discourse.

5.2.3 Rupture as 'relational process' - Positioning the therapist as '(ideal) relational being'

Relational discourses were deployed by the expert texts to construct rupture as a 'relational process' and locate it in the intersubjective space between client and therapist. These discourses opened 'rupture' up to idiosyncratic meaning making and resisted the attempts to reify 'it' within medical discourses. This repositioned the therapeutic relationship as a discursive site that could be used to challenge assumptions and supposed supremacy of knowledge (Golsworthy, 2004); practitioners were positioned within relational discourses as curious, makers of meaning (as opposed to expert diagnosticians) who "valued a search for understanding rather than demanding universal truths" (Rafalin, 2010, p. 41). Thus, a de-medicalisation of psychological theory took place which offered a relational way of being as a plausible alternative to the medical professional (Wampold, 2001), and upheld the practice of stressing the subjective and phenomenological (Lane & Corrie, 2006) which is a common rhetoric in counselling psychology discourse.

In addition, the relational discourses of the expert texts attributed shared responsibility for 'rupture' to both client and therapist. This reflects the positioning of 'rupture' in the wider psychotherapeutic literature as "the function of both patient and therapist contributions with the relative contributions varying from case to case" (Safran & Muran, 1996, p.447). Rupture as a co-participatory 'relational process' also offers an alternative to medical discourse and its attempts to locate blame within the client. The expert texts thus appeared to make readily available the position of therapist as 'relational being' in relation to rupture, as perhaps was to be expected given counselling psychology's co-opting of a relational identity as central to its practice (Jones-Nielsen & Nicholas, 2016).

However, I argue that the relational discourses made available to the participants by the texts offered up an idealised (or textbook) relational way of being which participants found difficult to reconcile with their constructions of rupture as 'inter' and 'intrapersonal crisis'. This potentially reflects fundamental tensions negotiated by all counselling psychologists as they seek to reconcile the complex, relational processes of therapy (to include 'rupture') with the individualised view of the scientist-practitioner model, which is immersed in a discourse which encourages the classification of objects, as illustrated below:

> As a practitioner, it is valuable to be able to develop the ability to take
> a step back from the emotive-relationship-based aspects of applied
> psychology and explore client responses, behaviours and sessions
> from a scientific viewpoint. (Petersen, 2007, p. 763).

Such tensions became apparent in this study in the way participants sought to embrace experiential and crisis repertoires to construct rupture as a more idiosyncratic construct, but were equally compelled to construct rupture as a 'classifiable' relational experience. This they achieved by deploying psychological and medical discourses to position rupture as a relational process which met a specified criteria, offering tentative support for Ussher's (2003) observations that both discourses can serve to reify an object and prevent attempts to fully understand it.

In addition, being positioned as an ideal relational being in relation to 'rupture' was limiting to participants in that it potentially reinforced client's expectations of how therapists should act, as set up within wider social and cultural discourses. The role of culture in shaping psychotherapy has long been acknowledged in the relevant literature (Georgaca, 2012; Raggatt, 2007). It was potentially indicated here when once positioned in cultural discourses as warm, caring professionals, participants were denied access to the fallible human practitioner who might enter into rupture as an 'interpersonal crisis'. The promotion of the 'warm and caring' practitioner as normative within cultural discourses arguably becomes possible when alternative positions of the angry, frustrated and bored therapist are either sanitised (e.g. idealised ways of being) or effectively kept 'in house' – that is to say only discussed within professional forums such as clinical supervision or personal therapy, and not disseminated into wider public and social discourses. Indeed, such subject positions risk being edited out of a psychotherapeutic discourse when as a system

of meaning it is used to promote "ideals" regarding "healthy or ideal selves" (Avdi & Georgaca, 2009, p.662).

Studies like Ackerman and Hilsenroth's (2001) in which the therapist is positioned as having clearly identifiable negative (or positive) personal characteristics which can lead to 'rupture' could be argued to result in a Jekyll and Hyde positioning of therapist as either good, (and caring) or bad (and confrontational) within professional as well as cultural discourses. This 'good /bad' binaried positioning of therapists has potentially negative consequences if practitioners internalise an overly ideal relational way of being as a professional imperative, and cannot then access alternative ways of being for fear of not being 'good' enough. Similarly, if clients internalise an idealised therapist, it may prevent them from engaging with aspects of therapeutic work which places this pedestalled practitioner in jeopardy. This offers a potential explanation for Rennie's (1994) observations that clients defer to therapists in order to keep the alliance intact rather than risk rupture: that clients are invested in constructions of the therapist as 'good' and 'caring' too, and are thereby enacting a position from which they can get the healing that they need.

5.3. To blame or not to blame - 'Rupture', responsibility and accountability

How participants negotiated issues of responsibility and accountability in regard to 'rupture' was a complex issue and one that arguably they were left to negotiate alone. As discussed, the expert texts clearly positioned practitioners as self-monitoring individuals in receipt of their advice, and as such shifted responsibility for 'rupture in the therapeutic alliance' to them (Sneijeder & te Molder, 2005). The texts also constructed rupture as a mechanical breakdown that with the right tools could be fixed, the responsibility for which was again firmly attributed to the individual therapist. Positioning the individual practitioner as responsible is also reflected in the most recent amendments made within the institutional regulating discourses of the HCPC, as exemplified in the extract below:

> 8 Be open when things go wrong
>
> 8.1 You must be open and honest when something has gone wrong with the care, treatment or other services that you provide by:
>
> – informing service users or, where appropriate, their carers, that something has gone wrong;

– apologising;

– taking action to put matters right if possible;

– making sure that service users or, where appropriate, their carers, receive a full and prompt explanation of what has happened and any likely effects.

(*Standards of Conduct, Performance and Ethics*, HCPC, 2016, p.8)

By using the word "you", and deploying discourses of moral responsibility ("honest"), the individual practitioner is positioned as accountable for events or processes that go wrong within the clinical arena. Participants in this study worked hard to take on responsibility whilst avoiding being held entirely personally accountable for 'rupture'. Arguably this required flexibility in discursive positioning not afforded by the (idealised) relational or medical discourses of the texts, but which became apparent in the way in which participants used emotional and crises interpretative repertoires to construct rupture as both 'inter and intrapersonal crisis'. The consequences and implications of these discursive manoeuvrings and the subsequent subjectivities made available are discussed below.

5.3.1. Rupture as 'interpersonal crisis' - Practitioner as responsible but not to blame

Within the interpretative repertoire of interpersonal crisis, participants accomplished the mitigation of personal accountability through the construction of rupture as a 'medical crisis' or contagion. This positioned both themselves and their clients as victim-patient and therefore not to blame for their bodies being overwhelmed by the 'germs' that come from an external space (Lupton, 2012). Objectifying rupture as an external, physical force constituted a rhetorical move that positioned it as a public health matter, potentially allowing for a shifting of responsibility for its management back to the wider social and institutional structures which handle matters of public health (Billig, 2009).

It was also reminiscent of the sociological discourses of the sick role originally theorised by Parsons (1951, 2001) where becoming ill and recovering is constructed as out of the patient's control. While this offers a socially endorsed position for patients, a tension arose here for participants since a 'sick' therapist is not a position a health care professional can easily assume without also being positioned as an

"impotent individual at the mercy of overpowering situational constructs" (McNamee, 1992, p.186). I argue that to manage such tensions military repertoires were also deployed by participants, consistent with other qualitative studies' findings where 'rupture' was constructed similarly as on-going disagreement (Hill et al., 1996) and emotional interpersonal struggle (Haskayne et al., 2014). The military repertories in this study though enabled participants to resist being positioned as helpless and passive, whilst also permitting them a position from which they could avoid being held entirely accountable for rupture as 'interpersonal crisis'. Indeed, 'crisis' emphasises the unexpected nature of an event that cannot be anticipated, inferring an absence of intention that mitigates against personal accountability (Whittle & Muller, 2016). After all one is hard pressed to attribute blame for making a professional mistake to a dutiful soldier/therapist who works in the difficult conditions of the therapeutic trenches. Instead military repertoires shifted blame into the interpersonal space since they allowed participants to position themselves as 'in it together' with their clients, rather than blaming of their client. As observed by Haskayne et al. (2014), this distinguishes modern relational psychodynamic constructions of rupture as 'interpersonal struggle', for which client and therapist are attributed joint responsibility, from those of Freud (1914), who constructs rupture as 'resistance' and locates it entirely within the client "as the weapon with which they defend themselves against the process of treatment" (p.151).

Such positions of shared responsibility also prove useful in negotiating issues of power. For example, military repertoires allowed participants access to the position of caring, dutiful expert. Such an expert is arguably accorded agency to act in the face of crisis for the greater good of the client without being accused of oppression. This avoids or at least reshapes the position of all powerful expert made available within a medical discourse who can thrust diagnosis and treatment upon clients without discussion. Thus, within military repertoires participants could access ways of being that allowed for competence, caring and equality, consistent with values promoted in counselling psychology discourse.

5.3.2. Practitioner as 'sinner' - blamed and forgiven

An alternative way one participant negotiated issues of accountability was to confess to having done something wrong. Foucault (1978, p.62) observed that "one does not confess without the presence of a higher authority" who requires that confession (in this case potentially the regulating bodies of counselling psychology

practice). Such bodies are perceived as capable of absolving, punishing and reconciling mistakes to produce change which "redeems and purifies the individual and relieves them of their wrongs" (Foucault, 1978, p.63). Within a nursing context Taylor (2003) has argued that as part of this confessional structure the reflective practitioner model acts as a form of disciplinary practice; through reflective practice the therapist can confess their sins, be absolved and then be reinstated to the position of healing professional. In this study one participant, Mark, sought to keep a moral sense of good self intact by deploying a Christian discourse which enabled forgiveness through self-reflection or as he put it, "soul searching".

This recalls how notions of sinning, health and illness interconnect in medical at risk discourses (Lupton, 1993). Similarly, in this study the moral and medical discourses offered up by the expert texts intersected and attributed responsibility to participants for their (moral) health, the health of the alliance and that of client; to deviate from this position incurred penalties and risked positioning them as neglectful practitioners and/or sinners. This removed them from a useful role in the therapeutic alliance in the same way perhaps that Lupton (1993) has argued that ignoring lifestyle warnings within public health discourses removes individuals from useful and morally defensible positions within society. In such a way the expert texts might be conceived of as a public health warning or a preaching from the pulpit, disseminated by a regulating, ethical, institutional body which serves to define what constitutes risk (or sin) and those at risk. They become the hegemonic conceptual tools that function to maintain the power structure of society by "appealing to reader's emotions, fears, anxieties and guilt, whilst simultaneously offering a way of regaining access to the institutional fold . . . " (Lupton, 1993, p. 38). Arguably by drawing on a Christian discourse to position himself as a sinner, Mark can access a position from which to confess and seek forgiveness from such bodies who in turn can be in no doubt of his reinforced commitment to the discipline's ideologies and ways of practice (e.g. working to resolve or repair rupture in the alliance), as endorsed by their hegemonic discourses. All professions, including counselling psychology, require fidelity from and faith in their subjects if they are to achieve professional sustainability. Thus 'rupture' can be positioned as a potential path to therapeutic growth and restoration. At a clinical level though this could be potentially limiting since it requires ways of being and practising which conform with how the regulating, ethical, institutional body define risk or sin (or in this case 'rupture'), potentially curtailing flexibility of practice for fear of doing something wrong*.*

5.3.3. Practitioner as 'emotional being' – managed accountability

Participants also constructed rupture as 'intrapersonal crisis', deploying emotional repertoires to locate it within the therapist as a moment of fear or anxiety. This could be interpreted as a discursive product of questions that asked for feelings and thus called for such internalised constructions. It could also be interpreted in relation to Siddqui's (2012) findings where 'rupture' was aligned with a non-verbal, embodied felt sense (Gendlin, 2003) or 'urrgh' moment that signalled a crisis in the therapists' therapeutic process. In this study, rupture as 'intrapersonal crisis' served to distance participants from their professional discourse and positions of expertise, and momentarily repositioned them as emotional, fallible human beings. This mirrored the positioning of 'rupture' in the wider psychotherapeutic discourse as an emotionally painful event (Haskayne et al., 2014) that can lead to feelings of vulnerability and increased levels of therapist anxiety (Binder et al., 2008). Rupture has also been connected with feelings of incompetency within the therapist (Thériault et al., 2009) and an internal collapse in the therapist's strategies (Safran et al., 2000), both of which might be explained discursively in this study by the distancing of the participants from their positions of expertise.

Discourses of professionalism generally appeal to the rational and exclude the emotional - for example, within a medical discourse an emotional surgeon might not be considered professional. However, access to human, emotional subjectivity is expected in a discourse of counselling psychology professionalism. This became a fertile ground for ideological tensions, as participants sought to reconcile professional and emotional ways of being. It also led to a state of tension as to which emotions participants were entitled to access. Fear and frustration allowed access to human ways of being in relation to 'rupture', but were irreconcilable with warmth and empathy, which are set up as the normative emotional ways of being within wider counselling discourses. Ussher (2003) argued that when ways of being do not conform to the 'regime of knowledge' in which individuals are placed, it can lead to self-blame and a lack of coherent identity or subjectivity. This is because individuals cannot live up to the internalised, idealised expectations of subjectivities that social discourses demand; by deploying a crisis repertoire, participants in this study potentially found a discursive means of reconciling their individual emotional ways of being in relation to 'rupture' with professional ways of being sanctioned by cultural discourses. This is because such a repertoire permits the destabilisation of

social norms, serving to position fear and frustration as legitimate reactions at a time of crisis.

Conversely, a negative consequence of deploying crisis repertoires was that they risked positioning therapists' negative reactions as happening only in moments of crisis. This contradicts Strupp's (1980) research that suggests ". . .that any therapist . . .cannot remain immune from negative (angry) reactions. . . (and that) . . . negative responses to difficult patients are far more common than has been generally accepted" (p.953-4). Thus 'negative', non-therapeutic emotions potentially remain marginalised, instead of being co-opted into wider institutional discourses that might allow for a more public investigation of their effects on the therapist, relationship and practice. This offers tentative support for Milton's (2016) observations that there is an over-focus on the positive aspects of the therapeutic relationship that can limit our thinking as counselling psychologists.

Consistent with Coutinho et al.'s (2011) qualitative study, participants did report that one of their strong negative internal reactions in relation to 'rupture' was guilt. I argue that in this study, guilt served to reconcile participants' individual emotional ways of being with professional subjectivities made available within therapeutic repertoires and the discipline's institutionalised discourses. Guilt permitted practitioners an expression of accountability within emotional and moral repertoires that showed remorse but also care, whilst also reinstating them to a place of expertise within a professional discourse from which they could exercise their professional responsibility to repair 'rupture'. Guilt offered a discursive site where fractured subjectivities could be reconciled both in terms of the individual and the institutional, as well as in emotional and technical ways of being. The discursive work performed by guilt for the participants in this study thus potentially contributes to a better understanding of how practitioners attempt to negotiate their emotional ways of being in the clinical room with wider cultural and therapeutic notions of what is considered to be a helpful, or unhelpful emotional therapeutic stance.

5.4. What then of endings?

So what then of rupture as 'ending'? Within both the text and the participants' analysis, rupture as 'ending' was the elephant in the room, a marginalised discourse that lingered below the surface of the texts. It was striking how few participants and texts constructed rupture as an 'end' to the alliance, preferring instead to construct it as a 'potential ending'; a breakdown (which could be repaired); a mistake (which

could be rectified); a sin (which could be forgiven). Rupture as permanent 'ending' was confined to fictionalised horror repertoires that served to both marginalise and ring fence it. Any perversion of therapeutic norms (e.g. the therapist as 'monster' who abused their power and failed to show care) was thus positioned only as the stuff of nightmares, an existential threat situated outside of the normative therapeutic discourse.

One potential way of understanding the marginalisation of rupture as 'ending' is to consider how it was constructed in ways synonymous with a loss or death. Different writers agree that there is a denial of death in Western culture (Foote & Frank 1999; Walsh & McGoldrick, 2004), and norms or boundaries are set as to how bereaved people are allowed to feel and behave, as well as to what the duration of the mourning should be. Foote and Frank (1999, p.170) call this "policing" the grief, an example of which is the bereavement discourse made popular by Kübler-Ross. Here, mourning moves through certain stages (denial, anger, bargaining, depression and acceptance) until the point is reached where the death is accepted and the grief is resolved. Klass (1999, p. 56) is critical of this bereavement discourse and against a stage theory of grief that can be demonstrated as true using any "scholarly tools" available. Similarly, in this study it might be argued that 'rupture' has been policed and constructed within technical repertoires as having stages of repair that set the norms and boundaries of how 'rupture' is to be handled. However, these scholarly tools have also been challenged by otherness discourses and crisis repertoires that position 'rupture' as a more complex construct that resists such therapeutic strategising.

Neimeyer and Levitt (2001) have argued that from a constructivist perspective death can function to undercut the human tendency to organise experience in narrative form by troubling our ability to fit transition in life into a meaningful plot structure. Arguably a meaningful plot structure in a therapeutic discourse is that therapy runs its course and does not end in client dropout. Rupture as 'ending' effectively undermines this narrative, taking up a similar discursive position to death in that it offers up a position of termination from which nothing more can be done, effectively annihilating the discourse of rupture-repair. It belongs to a discourse of failure where the therapist can only be positioned as incapable of resurrecting the alliance and having lost everything. Since texts and individual professionals are ultimately invested in the continuation of the profession, it is perhaps unsurprising that discourses which might threaten that sustainability are marginalised. This recalls

how within the wider psychotherapeutic discourse, therapist mistakes, regrets or failures which might lead to dropout or ending are part of a discourse which is often denied expression (Spellman & Harper, 1996), and can be written out of our case studies since as professionals: "we prune, from our experience, those events that do not fit with the dominant evolving stories that we and others have about ourselves" (Davy, 2010, p.63). The negative implications of this are evident - if counselling psychologists cannot talk about rupture as 'ending' amongst themselves, how do they do so effectively with clients?

This raises questions as to how rupture as 'ending' might be recruited back in the therapeutic experience so that it can be talked about with clients. In clinical terms research is underway in the UK to investigate how client feedback forms presented at the end of every session may encourage better client/therapist dialogue and understanding of 'rupture' (Laraway, 2015). We might also direct our gaze towards to existing social practices that have been constructed to allow for the managing of endings. For example, prenuptials have become a legitimised social practice made available within a modern breakup discourse as a way of managing an ending of a marriage. Similarly, Kitzinger and Wilkinson's (2015) advance decisions template has allowed for discussion around how we end life. Although planning one's death or ending a relationship remains difficult to talk about, such social practices allow for a means of vocalising the unspeakable, enabling that which is positioned as both undesirable and threatening to be talked into being.

5.5. 'Rupture in the therapeutic alliance' – both breaking up and breaking through?

In summary, what has emerged from this discursive study of 'rupture in the therapeutic alliance' is a sense of the construct as a discursive object whose power lies in its disruption and continuation of discursive boundaries. It resides in and resists binaries since it can be constructed *both* as a physical 'illness' external to the alliance, *and* it can be recruited back into the alliance as a 'relational process' co-constructed in the intersubjective space between a therapist and client and a therapist and self. It is thus potentially both knowable and unknowable, illness and relational, breakdown and breakthrough, ending and growth. This allows for a 'both/and' rather than 'either/or' perspective which "embraces a pluralistic outlook and bodes well for (counselling psychology's) ongoing development as a discipline" (Milton, Craven & Coyle, 2010, p.69). (In a parallel process it could be argued that

this piece of academic work aspires to a 'both/and' positioning in that it is simultaneously part of the psychological institution as a mandatory act of my qualifications and is also critical of the institution and its realist assumptions).

'Rupture' thus slips freely between medical, scientific, psychological, legal, Christian and moral discourses as well as between emotional, technical, crisis and restorative repertoires, consistent with Douglas' (2010) observations that a variety of discourses frame attempts to understand the therapeutic relationship. It also makes for interesting observations around the function of 'rupture' as borrowed from feminist ideologies. Butler (2005) encourages a mapping of the performative acts which break with norms as a site of "critical opening which places in question the givenness of the prevailing normative horizon" (p.24). In this study, the "critical openings" within participants' accounts have arguably emerged around rupture as 'inter' and 'intrapersonal crisis'. These repertoires resist or at least expand the "prevailing normative horizon" by breaking into the matrix of a hegemonic relational and medical discourses offered up by the texts. In doing so they have allowed for a mapping of participants' performative acts of 'being' in relation to 'rupture in the therapeutic alliance'.

This has enriched and even ruptured the notion of participant subjectivity since as they have negotiated the discursive junctures, fracture and gaps between discourses and attendant issues of agency and accountability, alternative ways of being have emerged (e.g. practitioner as 'sinner', 'emotional being', 'dutiful soldier'). These constitute a challenge to fixed notions of therapist as 'diagnostician' or '(idealised) relational being' made available by expert texts. This might be explained discursively as the "personal enactment of communal methods of accounting, vocabularies of motive and culturally available performances" (Wetherell & Edley, 1999, p.338). However, it is also consistent with Lo's (2004, cited in Lane & Corrie, 2007) observations that work on social discourses which underpin professional identity indicate they are never unified but consist of multiple processes – often constructed by different intersecting, antagonistic, discursive practices that make particular identification impossible (Chappell et al., 2003).

Managing fractured subjectivities was not easy for participants, but was potentially a position that as counselling psychologists they could relate to, situated as they are within a wider professional discourse which itself is positioned at a busy junction of diverse and sometimes competing ideologies, frameworks and paradigms (Blair,

2010). Counselling psychologists in general are therefore well placed to negotiate the diverse ways of being on offer in relation to 'rupture in the therapeutic alliance' since they are already required to negotiate fragmented professional identities (scientist-practitioner, reflexive-practitioner, researcher-practitioner). Such identities arguably rupture, repair themselves and rupture again in the different discursive contexts of the workplace, clinical practice and research.

5.6. Reflexivity

Without falling into "infinite regress" (Gergen & Gergen, 2000, p.1031) the ability to move between an understanding of how much the research was shaped by me, and how much I was changed by the research was difficult to grasp fluently. I was guided in my reflections by Gough (2003) who argues that qualitative researchers interested in engaging reflexivity must attend to the analysis of the phenomenon under investigation, their discourse, and the research process itself.

5.6.1. Researching and authoring the piece – 'rupture' under investigation

Revisiting my first experience of 'rupture' as described in the study's preface, I am struck as to how my construction of it as a 'disappearance' and my supervisor's as a 'therapeutic act' situated us in very different discourses of loss and professionalism. From the outset it positioned 'rupture' as a site of legitimate interest for a discursive, interpretative gaze and I believe that adopting any other approach would have been to neglect the shifting nature of 'rupture' that my discussion with my supervisor hinted at. A discursive approach has allowed me to occupy a very different space from Skinner's legacy of objective psychological science, a perspective from which arguably 'rupture' has already been extensively studied. In avoiding the realist question, 'What defines rupture?' in favour of 'How do counselling psychologists construct 'rupture'?', I have been able to look for answers in a different space within the confines of the texts and participants I consulted, their relationship with me and my relationship with the material. This has enabled me to deconstruct taken for granted assumptions, and contribute to a more complex understanding of this phenomenon (Kogan & Brown, 1998). Conducting a discourse analysis has also served a therapeutic use by shifting my subjectivities, and I hope the participants', through reflexivity as a form of conscious raising; exploring how we may have been constrained (or liberated) by certain discourses (Willig, 1999b).

The discursive process has also encouraged me to evaluate where I stand with regard to the real, the critical and the socially constructed, and how I navigate these discursive arenas. Whilst I accept that my identity can be shaped by language, I also identify with an interiority. Spong (2010) notes that discourse analysis requires the researcher to adopt a "subtle set of assumptions . . . which are not necessarily those we would reach intuitively as counsellors" (p.72). In other words, the psychologist's habitual orientation towards the interior psyche (e.g. in considering beliefs, attitudes, feelings etc) has to be put aside in favour of examining the action orientation of talk. Although this approach was not too hard to apply from a purely academic stance, it was more problematic when engaging with participants, who for the most part approached rupture as a real thing which could be defined, and had happened in their relationships with client. I was concerned at times that applying an interpretative lens to ways in which they managed their accountability in relation to ruptures (particularly around medical discourses and locating blame within clients) might make their words unrecognisable to them in hindsight. Willig (2012) debates the ethics of interpretation and how the representations of others can function as "interpretative violence" (Teo, 2010, p.296). An on-going concern throughout the analysis was therefore to ground interpretation strongly within the data and to evidence decisions via transparent accounting. It also prompted my decision to offer all those who desired it access to their transcripts and my discursive analytical summaries, a form of participants' validation (Lincoln & Guba, 1985). Only one participant chose to accept this offer and offered no feedback.

I also recognise that "analysis is inherently subjective because the researcher is the instrument for analysis" (Starks & Trinidad, 2007, p. 1376) - another researcher may well have drawn different conclusions. Indeed, my immersion within counselling psychology may have prevented me from identifying discourses that others may have seen more clearly. For example, it was hard to disengage from my own embeddedness in a cultural and professional discourse that views a healthy, caring alliance as almost unquestionably 'good'. However, it is hoped that the reflexive elements of this research have contributed to an understanding that although I entered the research process with certain questions in mind, and having a particularly critical stand towards the research topic, discourses that had not been considered were also included in the write up. I have also endeavoured not to impose meanings on the data but allowed them to emerge and been open to alternative interpretations consistent with Yardley's (2008) principles for

demonstrating validity in qualitative research. I have phrased my interpretations as tentative suggestions rather than statements, and I think that this is where my experience as a practitioner has been useful, giving me the confidence to take this stance.

Finally, my role as a trainee counselling psychologist would have inevitably created beliefs on the part of the participants about what I was expecting from them, and may have led to them using psychological, therapeutic and clinical discourses in their conversations with me. This may have even begun at the recruitment stage since the way in which my poster read - 'Have you experienced a rupture in the therapeutic alliance?' constructed 'rupture' as an unusual event, potentially positioning it outside the normal course of therapy. This may have alienated certain participants by excluding those who felt that they had had no experience of 'rupture' or alternatively those who felt that 'rupture' would be judged as a mistake, thus limiting the number of discourses made available to me since they did not fit with an "official" viewpoint. This may have had a negative impact on validity (Yardley, 2008) and also explained the preponderance of relational discourses and technical repertoires. On reflection, it may have been better to have asked if there were those willing to take part in an open discussion of 'rupture' which has a less accusatory and more expansive and explorative tone. It may also have addressed any anxieties about revealing personal experiences, although I did my best to put participants at ease by locating the focus group and all but one of the interviews outside of the university or clinical settings.

5.6.2. Attending to 'rupture' and rhetoric

Coyle (2006) argues that it would be disingenuous of discourse analysts to demonstrate the constitutive function of other people's language use whilst making an exception for their own. Undoubtedly my history has shaped the authoring of this research in terms of the forms of writing that I have privileged (expert over lay language) and what themes and constructions in this account I may have unintentionally prioritised. Arguably it emphasises ideas that challenge readers to think about the theoretical basis of practice. I realise that when attending to my discourse, I may also have drawn on the same dominant discourses (medical and relational) I have sought to deconstruct. What has emerged is the extent to which I am a product of such hegemonic discourses, finding it difficult to consistently occupy positions that are alternative to it. For example, as argued by Le Clezio (2014), I

have found it difficult not to query "the use of a non-generalisable and emic piece of work in a world where reified scientific truths hold such sway "(p.149). She observes that even counselling psychology assumes 'as if' true diagnoses and interventions, at least when accounting to the HCPC, a multidisciplinary team and potentially even clients. In the literature, 'rupture in the therapeutic alliance' is historically also represented 'as-if' true. In comparison to the wealth of empirical studies that seek to define 'rupture', my findings offer up messy alternatives to these tidy definitions - exploring what it is not, mapping and interrogating its socio-discursive function. Even though I made a purposeful choice to avoid a realist approach, I have been surprised by the constant pull towards a positivist stance of knowing what 'rupture' is as a means of understanding what I must do when I come face to face with 'it'.

This was illustrated when interviewing participants as I was sometimes tempted to find a position within the reification of mainstream science that was about discovering the truth of a thing. It was held in mind that the effects of the researcher on the participants would play an important part in the research. Some participants saw the researcher as a fellow counselling psychologist, and some even asked for an opinion in the interview on what was being discussed. Initially this led us into co-constructions that attempted to define 'rupture', rather than appearing vague or, for the want of a better word, uncertain of what we were doing. I wonder to what extent being positioned as a researcher seeking a qualification on a post graduate doctorate coloured the interview experience, or indeed how as a third year trainee I am positioned within academic and theoretical discourses to expect there to be an answer which we can apply to clinical situations. This has caused me to reflect on how it was difficult to step out of these positions and into emotional discourses with participants, and to further explore their constructions of 'rupture'. It was as if putting on both a theoretical and therapy hat with participants was difficult to reconcile, and yet positioned as a scientist-practitioner, with a wider counselling psychology discourse, this is the identity that I aspire to.

I addressed these issues by constantly reviewing my interview stance in relation to the clients via notes at the end of the interviews, and used supervision to try and balance therapeutic ways of being with participants (curiosity, rapport, creativity) with a researcher distance, so avoiding any violation of ethical concerns caused by unsolicited therapeutic invasion (Brinkmann & Kvale, 2008). It was also important to give myself permission to ask questions, without needing necessarily to arrive at an answer. This is also what we strive to do in our practice for our clients by cultivating

our ability to tolerate uncertainty; to remain open and receptive to phenomena as they are revealed to us, and to resist the urge to reduce and categorise those phenomena (Kasket, 2012). It also maintains the post-structural respect for uncertainty (Usher & Edwards, 1994) which informs this study.

5.6.3. My position as trainee counselling psychologist

Orlans and van Scoyoc (2009) argue that an ability to tolerate uncertainty can also makes it harder to develop a professional authority. This led me to reflect further on my position as a trainee counselling psychologist within a professional counselling psychology discourse. A discussion with my supervisor alerted me to how my position as a trainee might colour my analytic perspective. For example, during the analysis I observed that the construction of rupture as a locatable object of scrutiny within a medical discourse potentially allowed for a more reassured way of being, since it offered ways of managing 'rupture'. My supervisor challenged this. As a counselling psychologist of considerable experience, she argued that expert discourses offered ways of fixing or solving issues that in her experience could not be fixed or solved. She positioned herself as far less trusting of positions of knowing made available by expert discourses. Although in my study it was never the objective to compare trainee and qualified counselling psychologists' experiences, this alerted me to how the same discourse might be used by people who are at different stages of their training or career trajectories to construct different subjectivities in relation to 'rupture'.

It also caused me to reflect on how anxiety is potentially the discursive product of constantly managing and occupying these different subjectivities for all practitioners. Certainly Rizq (2006) refers to the emotional struggle of getting to grips with a pluralistic identity as a trainee counselling psychologist, causing me to reflect during training on how I have been continually repositioned within different therapeutic models and their discourses, each offering up new subjectivities. This has driven me to consider the "exercise of power that pins (me) into place and the fault lines for the production of spaces of resistance" (Parker, 1999, p.31). For example, as a third year trainee I have invested in a pluralistic positioning within professional and training discourses which informs my practice but which is challenged when I take up a position within the NHS where a medical discourse prevails. To create a 'space of resistance' I have attempted to think " . . . more creatively about how to facilitate alternative subjectivities (for myself) and those (I) work with" (Willig et al., 2005,

p.33)[10]. This process has been facilitated by a discursive approach to 'rupture in the therapeutic alliance' since it has enabled me to appreciate better the constant rupturing and repairing of my own counselling identity, the purpose of which perhaps is to "hold rather than resolve tensions" (Orlans & van Scoyoc, 2009, p.vii).

5.6.4. Evaluating the research process – potential strengths and restraints

This final reflexive section contains a discussion of the epistemology and methodology used in the current study and considers its possible strengths and restraints.

A critical realist epistemology appealed as it seemed to reflect the same epistemological tension inherent to counselling psychology, which in a sense is a struggle between relativism and realism. Similarly, critical realism acknowledges that the knowledge we have of the world is mediated by, and constructed through language, whilst also maintaining that there is a materiality that generates phenomena (Parker, 1998). Such an approach allowed me to gain an insight into how participants use discourse in order to construct particular versions of rupture e.g. as 'crisis', but how it also positions their talk within the materiality that they have to negotiate. For example, participants had to reconcile rupture as 'inter' and 'intrapersonal crisis' with 'technical' constructs of rupture on offer via expert texts and the institutional discourses that produce them.

This consideration of the context in which certain discursive constructions of rupture were more easily enabled or disabled allowed me to address limitations of a purely relativist approach which would fail to fully theorise why people use certain constructions and not others (Burr, 2003; Willig, 2000). Sims-schouten et al. (2007) consider this contextualising of participants' talk as taking an ethical stance in the sense that "analysing participants' talk without considering their material existence does not always do justice to the participants' lived experience" (p.103). For example, considering a participant's justification for not having time to repair rupture because of limited sessions as purely rhetorical may be deemed inappropriate to a participant who is working within an IAPT service.

It is possible that in adopting a critical realist stance I may have attempted to have my epistemological cake and eat it. Acknowledging that there is a material world that construct and limits our discursive practices may have also conveniently allowed me

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[10] To this end see also my reflections on my case study on p.221 of this portfolio.

to avoid having to stray too far from the path of hegemonic discourse of which I appear to be a product, therefore legitimising my difficulties in consistently occupying positions alternative to it. It is also possible that a radical relativist stance may have allowed for more marginalised discourses around 'rupture' to emerge, unshackled by material realities.

In addition, a critical realist stance has been critiqued for having no systematic method of distinguishing between the discursive and non-discursive, and so the constructing of factors as one and not the other comes down to individual choice, a choice driven by the researcher's political standpoint (Sims-schouten et al., 2007). This study acknowledged the power of institutions (e.g. the ability of regulating bodies of professional practice and universities to control access to resources) as extra discursive. Although this was supported by the analysis, it is perhaps worth reflecting on the extent to which my political standpoint (a third year trainee who is sensitised to the role of universities and training around 'rupture in the therapeutic alliance') may have informed my analysis of extra discursive elements in the text. I did attempt to address this critique by identifying extra discursive elements (e.g. specific institutions) in the literature review to generate a systematic approach to examining potential extra-discursive factors (Sims-schouten et al., 2007).

A final criticism of a critical realism approach is that the extra-discursive can in fact be analysed from a relativist perspective; it can be conceptualised as a discursive accomplishment (Edwards et al., 1995). From this perspective, material practices can always be reduced to discursive practices. However, this study does not challenge the utility of examining the action orientation of participants' talk. In fact, the methodology employed in this study actively embraces the local interactional context of discourse as well as wider institutional context by combining aspects of critical discursive, Foucauldian and discursive approaches.

Combining analytic procedures was ambitious, and although I aspired to a good enough analysis, at times it was hard to maintain a shifting view from micro to macro perspectives. However, by paying attention to and attempting to reconcile both a micro and macro perspective of agency, I believe that a fuller account of how participants held and managed different subjectivities (made available to them by often conflicting discourses) came to light, offering an alternative to experiential– phenomenological theory. For example, by assuming a performative focus on language the analysis allowed the examination of how blame is negotiated and

avoided developing a cognitivist argument regarding the meanings and views that participants held (Stancombe & White, 2005). It has also considered how therapy is embedded in a wider system of discourses relating to values, morality and ideology, and functions to reproduce them. One of this study's strengths has been to meet Georgaca's (2012) recommendations for an effective analysis by taking into account the interactional and wider socio-cultural constitution of practitioners' subjectivities and of counselling psychology as a process and institution.

5.7. Further research

Some of the conclusions presented in this research indicate gaps and possibilities for future research on 'rupture in the therapeutic alliance' that this work could not address. This is partly because positioning myself as a discursive researcher I did not have access to them. Georgaca (2012) has criticised discourse analysis for its neglect of individual histories and this study was not able to fully extend its reach into 'rupture' as an experienced phenomena. In his study of spirituality Coyle (2008, p.62) observed that an emphasis towards an "unknowable, non-concrete, indefinable or uncertain" quality to spirituality stressed a dimension that eluded being captured in language. Such limitations may also apply to this research since the critical realist perspective only hinted at the consequences of an embodied 'rupture' (Sims-schouten et al., 2007) in this data. I have reflected on whether 'rupture' is literally too embodied, too visceral to be satisfactorily accounted for with a purely discursive focus, and whether the 'urggh' moment referred to by Siddiqui (2012) which is potentially constructed in this study as 'intrapersonal crisis' could therefore provide fertile ground for alternative qualitative research. At this point a combined psycho social approach such as that espoused by Hollway and Jefferson (2000) may allow for a way of thinking tentatively about what may be taking place intra-psychically and intersubjectively for participants in relation to 'rupture', (perhaps as a unconscious communication) and for a greater consideration of the relationship between the personal and social. This may also prove a particularly fruitful methodological approach when considering 'rupture(s) in the alliance(s)' within group settings.

Also beyond the reach of this study was how clients construct meaning around 'rupture in the therapeutic alliance'. A similar combined macro/micro discourse analysis of how clients talk 'rupture' into being and how wider cultural and social discourses come into play would provide an interesting follow-up study, especially in

light of how the practitioners ways of being in this study were potentially limited by social discourses and the normative values they uphold. To include transcripts of actual therapy sessions and thus instances of 'rupture' in action for analysis might also enrich the data set. Alternatively, applying a different methodology such as grounded theory (e.g. Charmaz, 2006), or interpretative phenomenological analysis (e.g. Smith & Osborn, 2015), may yield rich data to further explore how UK counselling psychologists and their clients experience rupture in the therapeutic alliance. This would complement the findings of Haskayne et al.'s (2014) study of clients alongside clinical psychologists; to date it remains alone in exploring rupture in the alliance in this way in the UK.

5.8. What can this research practically contribute?

Consistent with Yardley (2008)'s principles for demonstrating validity in qualitative research, consideration needs to be given to the impact and importance of the research in practical or theoretical and socio-cultural terms. What has emerged from the application of a critical realist approach to the study of 'rupture in the therapeutic alliance' is a sense of the construct as a discursive object whose power lies in its slipperiness. It moves between illness/otherness and relational process, from outside the alliance into the alliance and vice versa; it facilitates the constant mutation in subjectivities of those positioned in relation to it. It recalls the discursive ruptures of history that Foucault (1972) argues do not constitute absolute change but a reconfiguration of its elements, where, although there are new rules of a discursive formation redefining the boundaries and nature of knowledge and truth, there are significant continuities as well.

This reconfiguring of elements, boundaries and knowledge has helpful implications for counselling psychology as it enables a position from which practitioners can enact a process of breaking with, resisting and reconciling hegemonic ways of practising. This may serve the profession well as increasingly counselling psychologists are employed by the NHS where reconciling and resisting medical discourse becomes part of day to day practice. Indeed, part of this process may begin with our language, as this discursive study of 'rupture in the therapeutic alliance' has illustrated. For example, rupture's construction as a technical construct or part of the 'professional lingo' raises questions as to how as counselling psychologists we might deploy non expert words conceptualising emotional distress and move away from the professional having a monopoly of explanation (Harper,

2002). As in this study, seeing our own theories, model and conceptualisations of 'rupture in the therapeutic alliance' as discourse rather than truth promotes a healthy scepticism and critical awareness (Spong, 2010), opening up the floor to practical ways in which we might address these issues in training by tracking how we deploy powerful words like 'rupture'.

However, this presupposes that 'rupture' is also openly talked about amongst practitioners. Given that participants in this study constructed it as not talked about or remembered within training discourses, this raises questions as to the extent in which 'rupture' (as opposed to rupture-repair) is discussed amongst professionals. One might for example be encouraged that the BPS is running a workshop on rupture in the therapeutic alliance this year (2016), except that the focus again falls on the repair. 'Rupture' as the moment before repair is perhaps the moment that is not talked about within our training institutions, and a potential strength of this study is to foreground this as a fertile discursive terrain for future tutorials, lectures and discussion forums, where the emphasis falls on how our talk positions us in relation to 'rupture' rather than prescriptive ways of handling 'it'.

Another practical application of this research might be to consider an explicit discussion of rupture in the therapeutic alliance as part of the assessment process with clients. Granted, certain therapeutic models which offer agreements (setting out goals of therapy (CBT, DBT) perhaps lend themselves to this more readily than psychodynamic models, although meta-communication around 'rupture' when it happens is advocated by Safran et al.'s (2011) relational psychoanalytical approach. However, open discussion may serve to normalise 'rupture' as part of the therapeutic process for clients, particularly in relation to issues of responsibility and accountability. As already observed within couple's therapy talk, couples can enter into blame account sequences (Buttny, 1993) where individuals work up discursive positions from which to either attribute responsibility for problems in the relations or to defend themselves against being held accountable. A greater understanding and appreciation of these discursive manoeuvrings when negotiating 'rupture' may be helpful when with clients, supervisors/supervisees or even colleagues. Such discussions could be extended beyond the individual client and practitioner and incorporated into reviews within a multidisciplinary team granting others (such as social workers and occupational therapists) the discursive space to consider alternative discourses around 'rupture'.

I have argued that discourses which construct the negative, what can go wrong or what might be constituted as mistake, to include 'rupture', are potentially subjugated by discourses of professionalism or success which are tied to the 'healthy' alliance within counselling psychology. In such a way the discipline's use of idealised relational discourses in this study recall Hemsley's (2013) repertoires of 'counselling psychology as saviour of the people' and may function to cement the discipline's dominant position as an influential advocate of the 'healthy' relational experience. I am suggesting that these discourses need to be interrogated further. Only then can we acknowledge that objects like 'rupture' need not be positioned as troubling or pathologised 'other'. Group supervision within dialectical behavioural therapy tertiary care embeds 'rupture' as a normative process within therapeutic discourse, but risks positioning it as such only within a certain presentation of clients (e.g. those with personality disorders). Opening up research to include a broader spectrum of clients' experiences of rupture may offer ways of integrating this normalisation into the wider therapeutic discourse. (To this end a discourse analysis of client feedback forms may prove interesting). This lends greater agency to all parties to counteract discourses of success promoted by outcome measures.

Counselling psychology, the institution within which this piece of work is located, is well positioned to consider individual and social experience in pluralistic theoretical terms. This may provide a means of opening up social discourse around therapy rather than remaining within an existing social framework that is discursively bound by society's prescriptions for what is expected of therapy, and how a therapist and client must behave. Indeed, it is counselling psychologists' capacity to deconstruct language and feelings and bear anxiety that positions us as effective mediators for a discursively thicker debate on 'rupture' within the therapy room. To paraphrase Kasket (2012), I have attempted here to foreground 'rupture' by using dialogical and reflexive practice to play with and critique essentialist truths around the relational. This work thus acknowledges my ongoing commitment as a counselling psychologist to open myself up to the endless possibilities of the therapeutic relationship, and to create a space in which I can continue to develop my understanding of another's experience of both being in the world and being with another. In cultivating a better understanding of 'rupture in the therapeutic alliance' I hope to have increased my ability to bear the inevitably painful, messy aspects of the human condition, and create an opportunity to slip between the cultural and therapeutic boundaries that determine the possibilities of who and how we can be.

'[T]he more open I am to all the subtleties of my experiencing, the more likely I am to discover new knowledge. This means a tolerance for ambiguity and contradiction, a resistance to the need for closure, the valuing of unbridled curiosity. It means soaking up experience like a sponge, so that it is taken in all its complexity . . . ' (Rogers, Kirschenbaum & Henderson, 1996, p.269)

B6. Appendices

Appendix B1- list of texts for analysis

Table B1: List of texts analysed.

	Text Title and type
Academic journals	1. Richards, C. (2011). Alliance ruptures: Etiology and resolution *Counselling Psychology Review*, *26*(3), 56-62. (A1) 2. Falender, C. A., Shafranske, E. P., & Ofek, A. (2014). Competent clinical supervision: Emerging effective practices. *Counselling Psychology Quarterly*, *27*(4), 393-408. (A2) 3. Oxford Psychology Training (2014), *'Working through Ruptures and Impasses'*, as advertised in *The Psychologist.* (A3)
Reference books	4. Woolfe, R., Dryden, W., & Strawbridge, S. (Eds.). (2003). *Handbook of Counselling Psychology.* (3rd.ed.). London: Sage.(H1) 5. Feltham, C., & Horton, I. (2006). The SAGE Handbook of Counselling and Psychotherapy. *The SAGE Handbook of Counselling and Psychotherapy.* London: Sage.(H2) 6. Palmer, S., & Bor, R. (Eds.). (2008). *The practitioner's handbook: a guide for counsellors, psychotherapists and counselling psychologists.* London: Sage.(H3)
Ethical content	7. Cooper, M., O'Hara, M., Schmid, P. F., & Bohart, A. (Eds.). (2013). *The handbook of person-centred psychotherapy and counselling.* London: Palgrave Macmillan. (E1) 8. Tribe, R., & Morrissey, J. (Eds.). (2005, 2015). *Handbook of professional and ethical practice for psychologists, counsellors and psychotherapists.* London: Routledge. (E2)
Website forum	9. University of Sheffield Centre for Psychological Services Research (2015) *Supporting Safe Therapy.* 29 June 2014 from http://www.supportingsafetherapy.org (W1)

Appendix B2a - Letter of Invitation to Interview

CITY UNIVERSITY LONDON

How do Counselling Psychologists use Language to construct Meaning around Ruptures in the Therapeutic Alliance?

Supervisor: Professor Carla Willig

Invitation to Interview

I am a student on City University's Professional Doctorate in Counselling Psychology (DPsych). I am currently embarking on a research project and am fascinated by language and particularly how counselling psychologists talk about impasses, breakdowns or client withdrawals (temporary or permanent) in the therapeutic alliance, otherwise referred to as ruptures. I want to attempt to understand the 'discourses' available to counselling psychologists when discussing these 'ruptures' , how these discourses are constructed, and how they may be influenced by wider, psychological, cultural and social discourses.

I believe such a project has the ability to expand counselling psychologists' critical awareness as to the powerful impact of language on the development of clinical concepts and influence how we talk about them in supervision, in training and with our clients.

To this end I would be very grateful if you would consider participating in a 60 minute interview which would be arranged at a time and a place convenient to you. If you would like to take part, I would appreciate if you would indicate your interest by replying to the e-mail below.

 For further information about the study, please read the information sheet attached and if you have any other questions, please do not hesitate to contact me on ███████████████████████ or ████████████

Thank you for taking the time to read this letter.

Yours sincerely,

Emma Jessop

Counselling psychologist in training

Appendix 2b- Flyer

CITY UNIVERSITY LONDON

Department of Psychology

Ruptures in Therapy

Calling Trainee Counselling Psychologists

- **What do you understand by the term rupture in the therapeutic alliance?**
- **How might you talk about ruptures in supervision or with clients?**
- **How might you discuss resolving them?**

I am looking for **TRAINEE COUNSELLING PSYCHOLOGISTS** to take part in a **FOCUS GROUP** lasting **1- 2** hours in London.

For more information about this study, or to take part, please contact:

Emma Jessop, Counselling Psychology Department
Email: ████████████████████

Supervisor, Professor Carla Willig: ████████████████

This study has been reviewed by, and received ethics clearance through the Psychology Department Research Ethics Committee, City University London. Ethics approval number PSYCH(P/L) 14/15 33 If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on 020 7040 3040 or via email:

████████████████████

Appendix B3 Letter to DCoP editorial team for newsletter

Editorial copy to DCoP newsletter

Ruptures in the Therapeutic Alliance - What do counselling psychologists understand by this term? How might you talk about ruptures in supervision, in training or with clients? As a third year counselling psychologist in training at City university, my doctoral thesis explores how we use language to construct meaning around ruptures in the therapeutic alliance. I am looking for **qualified counselling psychologists to take part in semi-structured interviews and trainee counselling psychologists to take part in a focus group**. Further information can be found at http://www.bps.org.uk/networks-and-communities/discussions/division-counselling-psychology/general-discussion OR please contact me on ███████████████. Thank you.

Appendix B4 -Study Information Sheet

CITY UNIVERSITY LONDON

Title of study: *Linguistic Subcultures: Counselling Psychologists' Constructions of Ruptures in the Therapeutic Alliance*

Emma Jessop

Email: ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮

What is the purpose of the study?

As a counselling psychologist or trainee have you ever reached an impasse, experienced a client's withdrawal or a breakdown in communication between yourself and the client? Such events can be described as ruptures in the therapeutic alliance. How might you then talk about these ruptures in supervision or with clients? What language would you use to describe them? How might you discuss resolving them?

This study in interested in how qualified counselling psychologists and those in training talk about ruptures in the therapeutic alliance and how these ways of talking may be influenced by wider psychological, cultural and social discourses. This potentially informs therapeutic practice by exploring how language impacts practitioners' understanding of their own and the client's experiences of therapy. It also creates the potential for framing or talking about rupture in the alliance in different ways within training institutions, clinical practice, and supervision. The study forms part of a thesis for the Professional Doctorate in Counselling Psychology at City University and will run for the next eighteen months with a proposed completion date in October 2015.

Why have I been invited?

I am recruiting qualified counselling psychologists for semi-structured interviews and trainee psychologists to take part in a focus group in order to gather data for this study. I have chosen a mix of trainees and qualified counselling psychologists as I am also interested in the way rupture in the alliance might be discussed in training institutes and how it might be talked about differently (or similarly) depending on experience. Since data will be analysed using discourse analysis techniques; I would like to emphasise that I am interested in how you choose to talk about ruptures in the therapeutic alliance rather than how you handled it within a therapeutic session.

Do I have to take part?

Participation in the project is voluntary and you can withdraw at any stage without having to explain your reasons or being penalised or disadvantaged in any way. You are free to stop the interview or participation in the interview at any time if you feel uncomfortable or intruded upon. Please be aware

that you can decline to answer any questions that you do not feel comfortable with. You can also request a copy of your transcript or summary of research findings at any time after the interview has taken place. It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will happen if I take part?

If you wish to take part, you will then be asked to attend a 60 minute interview. Details of these are outlined below.

- *TIME: You will be required to give **one interview** lasting approximately 60 minutes, at a time most convenient to you.*
- *LOCATION: A location most convenient and comfortable to you can be chosen. I can make arrangements to come to you or organise a room at a central and neutral location such as City University. Should you request that I come to you, then this will be arranged in accordance with researcher safety provisions.*
- *INTERVIEW: The interview will comprise of questions designed to explore the concept of ruptures in the therapeutic alliance. Although I would be interested in hearing your personal experiences, the study itself is focusing on the language that you use to describe this experience. An opening question might be: - 'Perhaps we could start by considering the term 'rupture in the therapeutic alliance' and what you understand this to mean?'*
- *RECORDING: The interview will be a one off session and will be audio taped. All recordings will be kept under lock and key and will be accessed only by the researcher.*
- *DATA ANALYSIS After the interview is recorded, it will be transcribed. During this process any identifying and personal details will be changed to ensure your identity remains anonymous. Discourse analysis techniques will be used to analyse data which pays particular attention to language and how it is used to convey meaning. It is important to make you aware that quotes will be used in the final analysis but that all personal and identifying details will be removed so that those reading the analysis will not be able to identify you. Materials such as tapes and recordings are destroyed at the end of the study.*
- *CONSENT You will be asked to sign a consent form, once you are satisfied that you have understood the study and its rationale.*

What are the possible disadvantages and risks of taking part?

It is possible that during the course of the interview that some emotional upset may be experienced. The researcher is aware that the topic of rupture in the therapeutic alliance might call to mind moments in therapy that were painful or concerning to you. It may also be the first time that you are recalling these moments and this could lead to concerns that you will be judged on their practice.

To this end, you will be asked to observe the anonymity and confidentiality of any clients discussed and advised to look after yourself and others in what you choose to disclose and to maintain safety at all times. At all stages you are reminded that participation is voluntary and you can withdraw consent at any time in the process.

What are the possible benefits of taking part?

Rupture in the therapeutic alliance has been established as an important part of the therapeutic process and participating in this project provides you with a unique opportunity to contribute to a greater understanding as to how we construct meaning around it. Indirectly you will also be contributing to an important and current debate as to the powerful impact of language on the development of clinical concepts such as ruptures in the therapeutic alliance and how we talk about them in supervision, in training and with our clients. It is hoped that this research will also stimulate debate in training institutions as to the language we use to teach these clinical concepts and its potential impact on the therapeutic experience.

What will happen when the research study stops?

The projected completion date of the project is October 2016. All records including audio and video recordings, transcripts and notes will be destroyed when the study is complete. They will be wiped from hard drives, backups and paper documentation will be shredded. If the project is stopped prior to this date all personal details, participant data and recordings will be destroyed immediately.

Will my taking part in the study be kept confidential?

All information disclosed by you will be treated as private and confidential. Access to raw data will be restricted to the researcher and research supervisor. All recordings/transcripts will be encrypted, stored securely and notebooks will be kept in a locked drawer to which the researcher only has access. Confidentiality will only be broken in the following circumstances: should the researcher feel there is a risk of serious harm either to you or others or where the researcher is legally compelled to do so. In terms of anonymity this research aims to comply with BPS ethical guidelines, and all participants will be consenting adults whose anonymity will be guaranteed. As such all names and identifying information will be changed to preserve confidentiality and you will be given a participant ID.

Only the researcher will have access to the participants' recruitment details and these will be kept in locked drawers at the university and not disclosed to anyone. Any future use of personal information will only be with the participant's signed consent. There will be no sharing of data with other universities or researchers.

What will happen to the results of the research study?

The findings of the study will be written up for a Doctorate in Counselling Psychology but may also be disseminated more widely through journal publications and academic conferences. Future publications may include the BPS journal and the Counselling Psychology Quarterly Review. It is important to make you aware that in both the report and the future publications, some direct quotes from your interviews may be used. However all personal details will be changed and so it will not be possible for readers to identify you. If you would like a copy of either your interview transcript or a summary of research findings, once the study has been completed, you can contact me directly at any point thereafter and I will ensure that you receive it by post. My contact details can be found at the end of this document.

What will happen if I don't want to carry on with the study?

You remain free to withdraw at any point by notifying me, either in person or using the contact details below. Should this situation arise, all contributions made in the interview will be erased from the recordings and transcripts, although others' surrounding comments will remain intact. Withdrawn participants' data will not be analysed and will not be published. Surrounding data from other participants, including responses to withdrawn participants' comments, will be analysed and may be published as part of the results.

Ethical approval

This study has been approved by City University London Psychology Department Research Ethics Committee.

What if there is a problem?

If you would like to complain about any aspect of the study, City University London has established a complaints procedure via the Secretary to the University's Senate Research Ethics Committee. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is **Linguistic Subcultures: Counselling Psychologists' Constructions of Ruptures in the Therapeutic Alliance.**

Further information and contact details

Researcher Emma Jessop ████████████████████ *Supervisor Professor Carla Willig*

Thank you for taking the time to read this information sheet.

Appendix B5 Interview Consent Form

![City University London logo]

Title of Study: **Linguistic Subcultures: Counselling Psychologists' Constructions of Rupture in the Therapeutic Alliance** Ethics approval number: *[*PSYCH(P/L) 14/15 33 *]*

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • being interviewed by the researcher • allowing the interview to be recorded (audio).	
2.	This information will be held and processed for the following purpose(s): • As part of a study which considers how counselling psychologists talk about and give meaning to ruptures in the therapeutic alliance. • This study makes up part of the researcher's thesis which is submitted as part of City University's Professional Doctorate in counselling psychology. • The data will be analysed (using discourse analysis) as part of this study and will be quoted within it, although identities will be protected by the use of a pseudonym. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. I understand that the tape will be kept in secure conditions and that no other person other than the researcher will have access to the original recording. I understand that quotes may be used in the report and any resulting publications but that no information that could lead to my being identified will be included in any report or publication resulting from this research.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

_____   _____   _____

Name of Researcher   Signature   Date

_____   _____   _____

Name of Participant   Signature   Date

Appendix B6 Interview schedule

Interview Schedule and Questions

- Greeting and introduction of the topic including what is being investigated and why participants have been selected.
- Issues of confidentiality and anonymity restated.
- Signing of consent forms.

Warm up

- Could you tell me a little about yourself in terms of how long you have been qualified and how you work with clients?

Opening Question

- What does the term 'rupture in the therapeutic alliance' mean to you as a counselling psychologist?
- How have you employed the term in your professional capacity? (supervisor/lecturer/clinician)
- How do you think your practice experiences have shaped your views of rupture?
- How do you think personal therapy /supervision has shaped your view on rupture?
- How do you think training/university courses make sense of rupture?

Ask about attributes/influences of rupture

- What do you think causes rupture in the therapeutic alliance?
- What function does it serve?
- Tell me about positive experiences you've had with rupture?
- Tell me about disappointments you've had with rupture?

Ending /All things considered questions

- "Of all the things we discussed about rupture, what to you is the most important?"
- Is there anything you feel I should have asked or you would like to add?

Debriefing

- Reiteration of confidentiality policy
- Further information about the study and sources of support
- Opportunity to ask questions
- Feedback

Appendix B7- Focus group consent

CITY UNIVERSITY LONDON

Title of Study: **Linguistic Subcultures: Counselling Psychologists' Constructions of Rupture in the Therapeutic Alliance:** Ethics approval number: *[*PSYCH(P/L) 14/15 33*]*   Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve: • Taking part in a focus group discussion which will be moderated by the researcher and one other • allowing the focus group to be videotaped and recorded.	
2.	This information will be held and processed for the following purpose(s): • As part of a study which considers how counselling psychologists talk about and give meaning to ruptures in the therapeutic alliance. • This study makes up part of the researcher's thesis which is submitted as part of City University's Professional Doctorate in counselling psychology. • The data will be analysed (using discourse analysis) as part of this study and will be quoted within it, although identities will be protected by the use of a pseudonym. I understand that confidentiality cannot be guaranteed for information which I might disclose in the focus group(s)/group interviews(s) but that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. I understand that the tapes of this focus group will be kept in secure conditions and that no other person other than the researcher will have access to the original recording. I understand that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other organisation. I understand that quotes may be used in the final report and any resulting publications but that no information that could lead to my being identified will be included in any report or publication resulting from this research.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw at any stage of the project without being penalized or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose(s) set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	

Name of Researcher   Signature   Date

Name of Participant   Signature   Date

Appendix B8 Focus group agenda

Framework for group- (1) Welcome (warm, friendly and polite, introduce self and fellow researcher), (2) Overview of the topic including what is being investigated and why participants have been selected (3) Ground rules (not to speak all at once, mobiles etc, no right or wrong answers, issues of confidentiality (4) Signing of consent forms

Warm Up

- Participants asked to introduce themselves.
- Opportunity to ask questions

First question (posed to group)

Opening Questions example:

- We are here to talk about rupture in therapeutic alliance and I am very interested to hear how you make sense of rupture. The study itself is focusing on the language that you use to describe this experience. Perhaps we could start by considering the term rupture in the therapeutic alliance and what you understand this to mean?

Open-ended questions

- How do you think your training has shaped your views on ruptures in the therapeutic alliance?
- How do you think your practice experiences have shaped your views on ruptures in the therapeutic alliance?
- How did you think your own personal therapy experience have shaped your views on rupture in the therapeutic alliance?
- How has rupture been talked about by supervisors/lecturers?
- How has rupture been talked about by your peers?

Ending /All things considered questions

- "Of all the things we discussed about rupture, what to you is the most important?"
- Is there anything else you feel I should have asked or would like to add?

Debriefing

- Reiteration of confidentiality policy
- Further information about the study and sources of support
- Opportunity to ask questions
- Feedback
- Ending

(Structure taken from Krueger, 2002)

Appendix B9 Ethical approval

![City University London logo]

Psychology Research Ethics Committee

School of Social Sciences

City University London

London EC1R 0JD

25 November 2014

Dear Emma Jessop,

Reference: PSYCH(P/L) 14/15 33

Project title: Linguistic Subcultures: Counselling Psychologists' Constructions of Rupture in the Therapeutic Alliance

I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval

Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments

You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

(a) Recruit a new category of participants

(b) Change, or add to, the research method employed

(c) Collect additional types of data

(d) Change the researchers involved in the project

Adverse events

You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee (   ), in the event of any of the following:

(a) Adverse events

(b) Breaches of confidentiality

(c) Safeguarding issues relating to children and vulnerable adults

(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

Erika Suchanova	Katy Tapper Departmental Administrator	Chair
Email:	Email:	

Appendix B10 Participant debriefing form

![City University London logo]

PARTICIPANT DEBRIEFING FORM

Title of study: *Linguistic Subcultures: Counselling Psychologists' Constructions of Ruptures in the Therapeutic Alliance*

Brief Description of the Research Project:

Thank you for participating in this research project. The information you have provided will be analysed using discourse analysis techniques, which will attempt to understand the discourses available to participants when discussing ruptures in the therapeutic alliance, how these discourses are constructed, and how these discourses may be influenced by wider, psychological, cultural and social discourses.

If you would like to be informed about the outcome of this research, please let me know so a summary report can be prepared for you.

You remain free to withdraw at any point by notifying me, either in person or using the contact details below, stating the Participant ID Number given at the top of this form. Should this situation arise, all contributions made to the focus group discussion/interview will be erased from the recordings and transcripts, although others' surrounding comments will remain intact. Withdrawn participants' data will not be analysed and will not be published. Surrounding data from other participants, including responses to withdrawn participants' comments, will be analysed and may be published as part of the results.

If your participation in this research has evoked concerns or queries about any aspect of your participation, please do not hesitate to raise them with me. Should you wish to you can arrange a meeting with me where your concerns can be discussed in confidence and assistance will be provided to find you further support as necessary. To find a Counselling Psychologist or therapist go to the BPS website (www.bps.org.uk) and click on "Find a Psychologist", or visit the British Association for Counselling and Psychotherapy website (www.bacp.co.uk) and click on "Find a Therapist". If you wish to contact me or my research supervisor in relation to this research, please find contact details below

Researcher: Emma Jessop. Email: ████████████████████. Tel: ████████████

Research Supervisor: Professor Carla Willig, ████████████████

City University

Appendix B11 - Transcription confidentiality agreement

CONFIDENTIALITY AGREEMENT Between Transcription City, 19 Terrapin Road, Balham, London SW17 8QN And Emma Jessop, Honey Hill, Foundry Lane, Haslemere, Surrey. GU27 2QF. The parties named above agree: 1. That all information disclosed by the client, its agents, employees and subcontractors, is entrusted to Transcription City and shall i) be maintained in confidence and held in safe custody by Transcription City from the date of this agreement. ii) not be used by Transcription City for any purpose, commercial exploitation or otherwise, other than for work for the client iii) be disseminated amongst agents, employees and sub-contractors of Transcription City only on a "need to know" basis and after notifying the recipient of the contents of this agreement and obtaining a guarantee of confidentiality from them. 2. That this Agreement shall not prevent Transcription City from disclosing information which i) is already known to him. ii) is published, or otherwise comes into the public domain without breach of this agreement. iii) is received from a third party without restraint. iv) is knowledge of a general nature, gained during the course of this work. v) if required to be kept confidential, would amount to a restraint of trade. 3. That work done by Transcription City (including but not limited to reports, spreadsheets and presentations) shall i) have copyright owned by the client. ii) be subject to the conditions of clauses one and two of this agreement. 4. To act, at all times, in good faith with regard to this agreement. Signature: Name: Date: On behalf of Transcription City Signature Name: Samantha Wood Date: 20th April 2015

Appendix B12a – Transcription notations

Table of transcription notations

Transcription notation	Example
{} brackets mark overlap between utterances	Interviewer: 60 {And you are basing that on your clinical experience or reading books?} P002 Eleanor line 61 {Yeah} I'm not a huge reader but I find that I'm quite reluctant to kind of go to any psychological literature so I'm not one of those people.
An equal sign at the end of a speaker's utterances and the start of the next utterance indicates the absence of a discernible gap	P002 Interviewer: ln 8 =Okay(1), that's interesting because I guess that kind of brings (.) me onto what, as a counselling psychologist, it means to you this term (.) rupture in the therapeutic alliance?= Eleanor: 9 =Yeah (1). 10 I guess it's something about a disconnection in the therapy.
Numbers in brackets indicate timed pauses. A full stop indicates an untimed pause, too short to measure	P001/Ian 15And I just sort of through chance really fell into a placement here doing CAT. (.)16 And at that time they were doing some training here= so I got a bit of CAT training when I started here. 17And I finished at aahh (2) at [removed for purposes of confidentiality] or I should have finished as you sort of alluded to, the sort of taught component, a good eighteen months before that= = 18 = Ok.
Round brackets indicate material that is either inaudible or there is doubt about its accuracy.	P001/Ian: ln88 Cos I guess it could happen even with… Yeah even with sort of a workplace or something I suppose. 89Thinking you know. Yeah (unclear cross talk).
Underlining indicates that words are uttered with added emphasis; words in capitals are uttered louder than the surrounding utterances	P001 line 96 The rupturing idea as I said is just is more, but again I wouldn't say that's happening all the time.
Material in square brackets is clarifying information or notes where information has been altered to protect anonymity and as such as been replaced with a description	P001:ln30 Ummm...this is my first sort of paid employment (.) [in take of breath] sort of paid employment within [name of placement changed for anonymity purposes].

Example taken from Interview P001 (Ian)

1. **:If I can set this rolling if that's okay. Ummm I should ask ....Did you have any questions before we start?**
2. R: No, no, that's fine.
3. **I: So I was just gonna ask actually if you would just give me an outline of sort of ummmm.. (.)**
4. **where you are and what, what modality you like to work and perhaps a brief outline of the work in you are doing at the moment and so on?**
5. R: {..Sure}. So I've been working here for, ahhh (.) just over two years.
6. Ummm...this is my first sort of paid employment (.) [in take of breath] sort of paid employment within [name of placement changed for anonymity purposes]
7. And I finished at aahh (.) at (removed for reasons of confidentiality) (.)or I should have finished as you sort of alluded to, the sort of taught component, a good eighteen months before that= = but I maintained one of the placements which I'd started in my third year which is also within this building but within another department, ummmm secondary care, doing CAT, cognitive analytic therapy.
8. Ummm (2) the [removed for reasons of confidentiality] structure is the first year is all humanistic theory and practice and the second year is all psychodynamic and the third year is integrative.....
9. I: { Yes}
10. R: [There is a CBT component to that which was fairly poor on our course. Not particularly well (2) developed.}
11. The teaching was..was good enough but the actual amount of hours and stuff dedicated was pretty limited=
12. = And I just sort of through chance really fell into a placement here doing CAT.
13. And at that time they were doing some training here= so I got a bit of CAT training when I started here. (1)
14. So I kind of really fell in love with CAT a little bit at that point and then continued to do it for, yeah for quite a while.
15. But it was just placement stuff. And then I realised that it's hard to get those sorts of jobs especially as a newly qualified counselling psychologist, if you wanna get a job that's gonna be sort of fairly reliable and regular, you're looking at IAPT. So then I got a position within [edited for reasons of confidentiality].
16. Yeah and generally speaking its CBT informed practice overall. (2) ummm I haven't done the high intensity CBT training.
17. Ummmm (2) and so it's kind of been a bit of a learning curve since I started piecing together my own CBT training.
18. And I mean we have had quite a few top up training days and stuff.
19. And it's very, (2) it feels quite protocol and disorder driven the sort of setting. And errr so yeah, it's the full sort of spectrum of [deep breath in] anxiety disorders and depression and err(.) .
20. and as you can imagine the more complex patients also sort of (.) slip through the net and end up here and so you've got to be kind of (.) flexible which is why I think my CAT work {certainly}
21. I: {ok}
22. R: [inaudible] is helpful as well.

Appendix 13 – Sample transcription of expert text analysis (E2)

Taken from:

Tribe, R., & Morrissey, J. (Eds.). (2005, 2015). *Handbook of professional and ethical practice for psychologists, counsellors and psychotherapists.* London: Routledge. (2015 version - p.138-139)

Complaint management strategies

Line 1 Organisations should have formal processes to manage complaints.

Line 2 A well grounded complaint offers useful feedback to adjust practice accordingly.

Line 3 It may be most useful for the therapist to avoid defensiveness, employing active listening and empathy instead.

Line 4 It may also be helpful validate the complainant's experience, however much at odds with the therapists' intention this is.

Line 5 Assess a complaint rationally and consider if there are reasonable grounds.

Line 6 Good supervision cannot be valued too highly, as a supervisor is one with whom all aspects of the process can be discussed.

Line 7 Reasonable complaints signal relational ruptures, which require redress and repair.

Line 8 Insurance indemnity cover is vital in some circumstances e.g. an accidental injury on your premises.

Line 9 However, in any event, consider all feasible outcomes and be mindful of the need to defend oneself.

Line 10 Seek and use support with appropriate confidential confines.

Line 11 In employed circumstances it is usually wise to alert managers sooner rather than later.

Line 12 Formal complaints normally follow relevant organisational policies and protocols.

Line 13 Casemore's (2001) book offers many useful perspectives on thinking about and managing complaints.

(handwritten margin notes, top): 'rupturing' · ongoing process | 'strain', 'averted', 'made useful in some way', 'moments of miscommunication', sort of 'disconnect' | (alluded to) 'averted' 'reconciled' 'drawn into a dynamic' 'repair it' | — necessary - to be worked through — grist / effort — render's 'allow for change (transformati how into cen.

(handwritten left margin): PTO mechanical NORMALISATION SANITISATION rupture as a supporter inevitable | therapist (drawn into) no choice / against will. | doubt (sort of)

(handwritten right margin): nupture | rupture as 'grist to the mill' | — rupture/miscommunic | construct as time limited 'manct' → rupture as transformat (made useful) | P 'rupture as block, focus'

63. I: [] I don't know if... I suppose I'm asking about the usefulness of the term rupture in a therapeutic event in terms of how you might communicate that to others, your supervisor or []...

64. I;   []mmmm

65. R: []Does that make sense?

66. R: It does yeah. And I suppose I think of the...I think of rupturing could perhaps happen in a way umm (1) that is kind of um (1.5) grist to the mill of therapy.   accept it ok / no 'fault'

67. So of course there's always gonna be moments of miscommunication.

68. There's always gonna be moments of getting drawn into particular acting out or relationship dynamics which (.) which(.5) might put a strain on the relationship.

69. Um (1) And could be worked with or could be made to be useful in some way. Or could be...or a (1.5) rupture in terms of the event could be averted if you like.

70. The rupturing doesn't necessarily have to lead to the disconnect I suppose.

71. And maybe that's how I view it in mind is that the rupture is once there's been a sort of disconnect and something needs to be sort of attended to and reconciled everything else needs to be sort of parked for the time being in a way.

72. So yeah I guess I see those two things as a bit like that.

73. I: Okay. That makes sense.

74. **How often do you use the term in terms of when you might go to supervision in a different context and talk about something that's happening? Would you use the term rupture? How have you talked about it in a supervision?**

(handwritten left margin): JARGON | 'rupture as theory' / happens on page | disconnect between bks & theory

(handwritten right margin): rupture not relevant in day to day (not in therapy room)

75. R: (intake of breath) Rarely, if at all I think it's a word that I think is in my mind more associated with (1) sort of reading theory about the therapeutic relationship and breakdowns in the therapeutic relationship. And attending to that and trying to sort of repair it. So in terms of actually practical day to day use in supervision I can't think of a recent time.

76. And then I'm thinking now back to clients that I would consider using that sort of technical language of there was a rupture in the relationship.

77. At the time would I have used that in therapy, in supervision rather with my supervisor? Um (1) possibly but I don't recall, it's not something that feels very present.   'mechanical'

(handwritten right margin): — relevant ('present')

(handwritten left margin): 'technical objective term' | Multivocal

(handwritten right margin): being in involved construction of felt sense disconnect

78. I wouldn't be going in there and saying, oh I've had a rupture with this client because...um (1) well why? (3) Why wouldn't I? I suppose because I'm more involved and within the situation and I suppose that makes me, that goes back to the thing about it being a more technical objective term that you might read in a book about how to manage that thing.

79. Of course when it's happening you're talking more about the intricacies and idiosyncrasies of what's happened and its management and how it might worked with or (1) used to sort of further the work in some way if possible, (.) yeah.

80. I: I wonder about the word itself being quite powerful? (2)

81. I wonder if there are, or I suppose I'm thinking about whether there are alternatives that feel...that maybe we naturally use that...you mentioned you use it...you see it very much as a technical term that informs you. B

82. ut I guess if we're seeing it as a relational thing it maybe is something that is marked in different ways and in using normal relational words. I don't know if that's to you[]...

(handwritten right margin): co-casting emotional language.

(handwritten bottom left): I/v + Interviewee negotiate stake in negotiation of personal vs therapeutic vs professi. Embraces

(handwritten bottom): constructed | rupture in book as concept | 'technical language' / objective | 'how to' (manual) | rupture constru... idiosyncrac... (present) felt' 'in moment) | involvement (in the...

5

Appendix 14b sample stage 2 analysis texts and interviews

Discursive constructe	Line	D.C object man therapeutic term	Discourse?
→ term therapeutic I' rupture / usefulness	63		technical / Jargon therapeutic / profess
- rupture could be grist to the mill of therapy	66	rupture as opportunity - has product	- mechanical - health discourse - recovery restorative
- of course always moments of miscommunicat	67	- rupture as 'normal' event - symptoms	- normalisat - medical
- always' drawn into acting out / relationship dynamics	68	-	therapeutic - relational relationships
- strain on relationship	68	- object needs tending or worsen	- mechanical - relational - medical
- could be worked with made useful could be averted (drama or emergency averted)	69	rupture as opportunity	- cntrd discourse therapeutic - research
- rupture doesn't have to end in disconnect	70	rupture as 'bad ending separation severy	- relational divorce blame
- How I new it in my mind sort of discent needs to be attended to + + reconcile / everythg part	71	rupture as emergency to be avoided - immediate attn sort of / brought back from edge of disconnect	- control managment discourses - psychological - personalised disorders - medical
I term rupture	74	- know about	- therapeutic professnl technical
associated with read nery therapul + breakdn	75	know about theory	- jargon technical mechanic
- attendg to t repairs		"	
- technical language there was a rupture	76	"	- scientific mechanical
- but I don't recall technical objective term	77 78	Missing	- Theoretical academic
- when it's happing intricacies / idosyncras worked into / pick up/ powerful term / relational / norm	79 ___ 81	- felt state / interal - personal exp opportunity	- self discourses opportunity - emotional discourses nanads,

176

Appendix 15 - Questions to aide analysis of Interviews and focus group date

Table B3- aide to analysis

	Questions to ask of text during analysis	
FDA How is rupture being constructed through language? (as informed by Vingoe, 2008 and Willig, 2008, 2013)	**DP** Why am I reading the passage this way? What features of the text produce this reading?	**CDP** What is the local organisation of talk, as well as the organisation of the broad, social and culturally resonant Interpretative resources the participants draw upon? (Edley & Wetherell, 2001).
Discursive constructions How is the object rupture constructed through language? What type of object is being constructed?	How is this being achieved? e.g. Rhetorical devices How does it vary across different discursive contexts? What are the consequences of this deployment?	
Discourses What discourses are drawn upon? What is their relationship to wider social discourses? How do these wider discourse shape possibilities for subjectivity? How do they constrain or limit what can be said and by whom? Implication for power	**Interpretative repertoires** Identify the metaphors, tropes, figures of speech in the text and how they might construct the object /subject differently? How do speakers use them differently and to what end? How do IR's construct alert naive and contradictory version of events?	**Interpretative repertoires** What IR's are available to the participants? What repertoires does the speaker negotiate, resist or take up? What ideological dilemmas arise because of contradictory version of events?
Action orientation What do the constructions of rupture achieve? What is gained from deploying them her? What are their functions? What is the author doing here?	Action orientation What are the discursive contexts within in which accounts of rupture are produced and what are the consequences for participants in a conversation? (consider also position of interviewer) How do they orientate towards the requirements of the discursive context? How can this lead to varied accounts of the same object? What is achieved by taking up or resisting a certain subject positions in terms of what participants can achieve within the interaction at hand?	What are the different constructions of rupture made available by the IR's? What function do this IR's have? Whose interests do these particular constructions of rupture serve? What is achieved
Subject positions What subject positions are made available to counselling psychologist through the accounts of rupture?	**Subject positions** What variability in subject positions is achieved through the participants' situational talk?	**Subject positions** What ways of being were made available to counselling psychologists within the IR's identified? What ways of being were denied?

177

		What are the implications for counselling psychologist subjectivity?
Practice What possibilities for action are mapped out by the constructions of rupture? What can be said and done form the subject positions indentified?	How does counselling psychologist construct rupture through talk? What do they do with discursive devices and to what effect?	What possibilities for action do the IR's identified create/ deny? What did they say about counselling psychologist can do or have done to them?
	Roy-Chowdhury (2006) Why is this being said at this moment within the context of other things that have been said in my meeting with these people today? What is the aim of saying this and what is the speaker hoping to achieve by speaking in this way? How does this utterance position the speaker in relation to other participants and how does it position me in relation to her? What is the purpose of constituting these positions at this moment in the conversation?	Which discourses that are to be found in social relations within this time and place are being expressed through the speaker's speech? **How do they position the speaker?** Are there discourses that are being drawn upon which are marginalized within this culture and this context, but which are important to the speaker in constituting her individual subjectivity? What do the ways in which discourses are being evoked say about the individual and her history, and what does the individual's history say about the ways in which discourses are being evoked? What conflicts, intersubjective and intrasubjective, are being alluded to? What competing discourses sustain these conflicts? In making these remarks, what response is being elicited and invited by others? What are the interpretive repertoires open to me in designing a response and what, in its turn, would be the consequences of making each possible response? If I choose to give a dispreferred response, how will this be managed and negotiated and trouble sources repaired?

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Section D: Theoretical Paper

(Formatted for submission to Counselling Psychology Review according to the Journal's instructions to authors, see Appendix D.1.)

Discursive Reflections on 'Rupture in the Therapeutic Alliance': A Question of Professionalism (and fractured subjectivities) for UK Counselling Psychologists?

D.1. Abstract

Content and focus: Professionalism within counselling psychology can reside in discourses of success. These are dominant in places of employment via a dialogue of positive outcomes, and in the discipline's training and regulating institutions in constructions of the 'healthy' therapeutic alliance as normative and desirable. This paper discusses 'rupture in the therapeutic alliance', and how it troubles notions of professionalism and attendant discourses of success. It is informed by discursive, qualitative research carried out by the author into constructions of 'rupture' within UK counselling psychology's expert texts, and in the talk of chartered and trainee UK counselling psychologists. One of the principle tensions to emerge in the analysis was an attempt by practitioners to avoid fixed notions of professional subjectivities (e.g. therapist as 'diagnostician', 'relational being') as made available by expert texts in relation to 'rupture'. These were renegotiated by practitioners in the therapeutic dyad, where rupture was constructed as 'inter' and 'intrapersonal crisis'. Negotiating issues of accountability in relation to rupture as 'crisis' resulted in fractured professional subjectivities.

Conclusions: Fractured professional subjectivities provide enriched ways of being with the client (e.g. practitioner as 'dutiful soldier' or 'emotional human being') that potentially enhances creativity in clinical practice. However, they also entail risk as they challenge dominant discourses of success which position good counselling psychologists as guardians of a 'healthy' alliance. This can lead to professional anxieties. It is argued that counselling psychologists are well placed to manage this risk, embedded as they are within a pluralistic framework which affords them the capacity as professionals to facilitate alternative subjectivities. Expanding what it means to be a professional beyond binaried discourse of *either* 'good' *or* 'bad' contributes to practitioners' understanding of the alliance, and the ongoing development of counselling psychology as a discipline.

D.2. Introduction

The therapeutic relationship between client and therapist has been the cornerstone of psychological theory since the 1900's when Freud (1912, p.13) called it the "vehicle for success in psychoanalysis". Over time empirical research has evolved the mechanisms of the relationship to reveal the working alliance. This constitutes a collaborative stance between the patient and therapist fostered by three interrelated processes: agreement on therapeutic goals; agreement on therapeutic tasks, and the quality of the relational bond between the patient and therapist (Bordin, 1979). Evidence suggests that when healthy the therapeutic alliance is a robust predictor of positive outcome across clients, treatments and identified problems; this is supported by several meta-analyses (Horvath & Bedi, 2002; Horvath, Del Re, Flückiger, & Symonds, 2011). Within the discipline of counselling psychology a positive alliance is not just attributed scientific value, but also positioned as an object of ethical importance. The *Division of Counselling Psychology: Professional Practice Guidelines* (BPS, 2006, p.1) grounds the profession "in the primacy of the counselling or psychotherapeutic relationship", and its quality is policed by regulating professional bodies. Institutions such as the British Psychological Society (BPS) and its *Code of Ethics and Conduct* (BPS, 2009) thus encourage practitioners to "be mindful of the importance of fostering and maintaining good professional relationships with clients and others as a primary element of good practice" (p.10).

While this paper does not seek to contest the therapeutic value of a 'healthy' therapeutic alliance, it does encourage the reader to regard it with a post-structuralist, discursive gaze. Post-structuralism is a philosophy in which language is not taken to be representative of the structure of things, but as constitutive and dynamic in itself (Spedding & Milton, 2013). Consequently, it can expose diverse discourses relating to terms or practices whose everyday meaning is often taken for granted. In drawing the reader's gaze to the language of health and success that constructs the therapeutic alliance (e.g. "vehicle of success"), I argue that a 'healthy' alliance risks becoming a taken for granted truth within counselling psychology. This is because the provision of such an alliance can be positioned as normative

and desirable within a counselling psychology discourse, and therefore becomes closely linked to issues of professionalism. Thus a 'healthy' therapeutic relationship can serve as a dominant discourse that overshadows or subjugates alternative discourses, as reflected on by Milton (2016) in the most recent edition of the profession's handbook:

> The over-focus on the positive means that there is often a misconception that therapeutic relationships are nice, always valuable and important, exclusively characterised by respect and warmth. On the contrary they can also include or even be dominated by other feelings too - boredom, resentment, disgust, rage and disappointment, hate and the like. (p.186*)*

I seek to draw out one particular discourse which I posit sits in the shadow of the positive alliance - that of 'rupture in the therapeutic alliance'. Constructed as difficulty, breakdown, disruption, withdrawal and confrontation in the alliance between client and therapist, 'rupture' has the potential to trouble notions of a 'healthy' alliance. As such, 'rupture' provides a useful, critical lens through which to interrogate and reflect on such issues. To aid in this process I draw on the findings of my recently completed doctoral research[13] which explored how 'rupture in the therapeutic alliance' was constructed in UK counselling psychology expert texts[14], and in the talk of trainees and chartered counselling psychologists. I reflect specifically on one finding which suggests counselling psychologists take up fractured professional subjectivities in relation to 'rupture', the consequences of which are debated in relation to issues of professionalism and clinical practice.

D.3. Matters of Professionalism in UK Counselling Psychology

Counselling psychology attained its divisional status within the BPS as recently as 1994 when it emerged in the UK as a discipline in its own right (Corrie & Callahan, 2000). If professionalisation is the process whereby an occupation gains its characteristics (Hamilton, 1991, cited in Keogh, 1997), then several key developments in counselling psychology reflect its increasingly professionalised status. Firstly, UK counselling psychologists' requirements for qualification have now reached the level of a doctorate (BPS, 2011). Secondly, the awarding of the Royal

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[D13] The longer version can be requested.
[D14] Expert texts include UK counselling psychology handbooks, professional regulating guidelines, and academic journal texts.

Charter to the profession in 1965 functions as a symbol of state approval in attributing responsibility for the application of pure and applied psychology for the public good (BPS, 2010). This positions the profession as a moral guardian of public wellbeing. Finally, consistent with the professionalisation of therapy as outlined by Parker (2002), the introduction of state regulation for counselling psychologists via the UK Health Professions Council in 2009 further legitimised the activities of the profession.

Universities might also be regarded as producing a specific type of professional socialisation. Du Toit (1995) argues that this "is essentially an acculturation process during which the values, norms and symbols of the profession are internalised" (p. 164), thus transforming the novice or moulding the student into a good professional (Sparkes, 2002). This would suggest that to access professional or expert ways of being, individuals are most likely to adopt the discourse and values consistently upheld by their profession. I argue that in counselling psychology the internal value, potentially internalised by its practitioners above any other, is that of being able to deliver a 'healthy' therapeutic relationship.

D.4. Counselling psychology and the 'healthy' therapeutic relationship - a language of success?

Counselling psychology draws on a humanistic discourse, as propagated by Maslow (1966) and Rogers (1951), and places relational practice at its centre by engaging with the phenomenological experience and emphasising the importance of subjective and intersubjective perspectives. The therapeutic relationship thus becomes "the main vehicle through which psychological difficulties are understood and alleviated" (Jones-Nielsen & Nicholas, 2016, p.211), as well as a distinguishing feature of counselling psychology identity as a discipline (*Standards for Doctoral programmes in Counselling Psychology*, BPS, 2015). Those that can deliver such an alliance have been positioned in the literature not just as good professionals, but as "pioneers" of the "successful" therapeutic relationship (du Plock, 2006, p.22.) This offers one tentative explanation as to why, from a discursive perspective, the building of a 'healthy' therapeutic relationship with the client has become one of the most pertinent and highly valued discourses in counselling psychology (Larsson, Loewenthal & Brooks, 2012). However, I argue that in order to remain a highly valued discourse within the discipline and to continue permitting counselling psychologists to retain their status as pioneers, a healthy alliance has become

inextricably linked to a discourse of success. In this discursive context, evidence based research could be argued to deploy scientific discourses of success to legitimise claims that it is the quality and strength of the client-therapist relationship that most consistently predicts good outcomes (Cooper, 2004; Roth & Fonagy, 2005).

These discourses of success can also be observed in clinical and research settings. Rizq (2013, p.20) identifies a "language of success" that currently dominates in NHS settings (e.g. 'competence frameworks', 'best practice', 'outcomed services') and argues that such language does not leave room for discourses of distress that are consequently marginalised. This raises questions as to how counselling psychologists employed in these settings discuss 'rupture in the therapeutic alliance' if only equipped with a "language of success"– language that would seem unable to accommodate connotations of rupture as a 'breakdown' of the alliance. In addition, Spellman and Harper (1996) observe that the therapist's mistakes, regrets or failures (which might lead to rupture or client dropout) form part of a discourse which is often denied expression in academic journals. Consequently, they argue that therapists become embedded in discourses of success so that "the potential for proper diversity in accounts of therapeutic process is limited" (p.211). In turn, discourses of success call into account what it means to be a good professional. For example, if within a discourse of success only those counselling psychologists who deliver strong, healthy and robust alliances are positioned as good practitioners, are those who do not then automatically positioned as bad or neglectful practitioners?

A profession such as counselling psychology where the healthy therapeutic relationship is prioritised in its ethical practice, research and training may then have trouble in accommodating 'rupture in the therapeutic alliance' if a discourse of success prevails. Indeed, it offers a tentative explanation as to why a literature review carried out for my thesis revealed an apparent paucity of literature about 'rupture in the therapeutic alliance' within UK counselling psychology expert texts. It is neither mentioned within the *Division of Counselling Psychology Professional Practice Guidelines* (BPS, 2006) or the *Health and Care Professions Council's (HCPC) Standards for Conduct, Performance and Ethics guidelines* (HCPC, 2016). Although such regulating bodies state that practitioners should know how different therapeutic models conceptualise the alliance, it would seem this does not explicitly extend to knowing what happens when that alliance ruptures. Even a search of the theoretical and clinical literature revealed only two studies about 'rupture' specifically

authored by a UK counselling psychologist/or included within a UK published counselling psychology journal (Richards, 2011; Siddiqui, 2012). This sits in contrast with the wider psychotherapeutic literature in which there is an extensive body of research dating back over 25 years which discusses 'rupture in the therapeutic alliance'. It can be argued that counselling psychologists are able to avail themselves of such literature, potentially foregoing the need to discuss it in their own profession's academic journals. Nevertheless, that 'rupture' would appear to be missing in the discipline's expert texts, raises interesting questions. For example, if expert texts such as academic journals are argued to be ultimately invested in the continuation of a profession, and that profession is in turn invested in a discourse of success linked to 'healthy' alliances, it could be posited that rupture discourses which might threaten that sustainability are necessarily marginalised. It also begs the question: what is it in a 'therapeutic rupture' that potentially makes it so difficult to accommodate within a counselling psychology professional discourse?

D.5. What is in a 'therapeutic rupture'?

Definitions of 'rupture in the therapeutic alliance' within the psychotherapeutic research literature are multiple and varied. It has most recently been defined in the Encyclopaedia of Abnormal and Clinical Psychology (Muran & Safran, in press) as "a negative patient communication and a negative client therapist interaction", although alternative definitions describe it as "a tension or breakdown in the collaborative relationship between client and therapist"; "problems in the quality of relatedness", or a "deterioration in the communicative process" (Safran & Muran, 2006, p.288-9). Predominantly negative in tone, these definitions construct rupture as both an 'act' of mechanical failing (e.g. "breakdown", "tension"), and a 'process' which conveys a relationship 'problem'. These definitions have emerged as a result of extensive qualitative and quantitative research predominantly carried out by the Safranlab in New York. This lab has pioneered a range of task analysis outcome process methods (for a review see Safran, Muran & Shaker, 2014) to advance certain claims as to what 'rupture' is or what can be known about 'rupture'. From a discursive point of view this can serve to thingify 'rupture' (Tillich, 1988) in that it becomes objectified as a technical construct about which a set of 'as if' truths can be established. Through repetition they can function as therapeutic assumptions, potentially even norms around 'rupture in the alliance' (although conversely they do not always serve to normalise 'rupture'). Based on my research, I argue that such

claims have also been upheld within the UK counselling psychology expert texts, as illustrated below.

Firstly, 'rupture' is positioned in the wider literature and in UK counselling psychology texts as a critical juncture in the therapeutic process (Safran & Muran 1996). This suggests an important but also a potentially dangerous point in therapy where a line can be crossed between therapy continuing or ending. As a result of such critical positioning, this leads to a second construct of rupture in the alliance as a "negative process between client and therapist" (Ackerman & Hilsenroth, 2000, p.171) and a therefore damaging, even risky object if left unrepaired. This risky object is reinforced by research to suggest that unresolved ruptures are associated with deterioration in the alliance, and may lead to poor outcome or patient dropout (Henry, Schacht, & Strupp, 1986; Muran, Safran, Samstag, & Winston, 2005). Discursively this locates rupture in a "vocabulary of deficit" (Gergen, 1990, p. 358), where it is defined by what it lacks, rather than what it is and therefore positioned as the bad 'other' which serves to trouble the 'healthy' alliance. Conversely, a resolved or repaired rupture within the relationship is positioned as an opportunity for therapeutic gain that can foster growth and insight in both patient and therapist (Safran & Muran, 2000). This reinforces a third organising principle widely established in the wider literature and in UK counselling psychology texts that rupture not only *can,* but *must* be repaired. UK counselling psychologist Richards[15] (2011, p.56) argued that it is "incumbent on counselling psychologists to familiarise themselves with the causes and resolutions of alliance ruptures" given our therapeutic stance as relational practitioners. Her use of the word "incumbent" draws on a moral discourse to position the counselling psychologist as ethically obliged to take up this informed position in relation to 'rupture'.

Constructions of rupture-repair as 'opportunity' arguably recalls the discourses of success which Spellman and Harper (1996) observed can dominate in professional texts. In contrast, rupture as unrepaired is positioned as 'other', and thus can be overshadowed by these dominant discourses of repair and success in the professional texts. Indeed, to find suggestions of 'rupture' before repair one must turn to how rupture is constructed in the talk of practitioners, as shown below using examples from the wider psychotherapeutic literature:

[D15] Used as data for analysis in my research.

> He just clammed up in the session! For the last 15 minutes, no matter what I tried, he wouldn't answer me. And then he just fell asleep and started snoring! I can't believe how mad I am...I know I'm overreacting, but . . . (Friedlander, 2015, p.174)

> I knew she would not be back. It was an undisputed act of revenge to break off the treatment so suddenly, when I had every expectation of bringing the analysis to a happy conclusion, thus dashing all those hopes. (Freud, 1905, p.1993)

Here, rupture is constructed as therapist and client hostility, anger, frustration and fear by deploying emotional interpretative repertoires (e.g. "how mad I am", "dashing hopes"). This was mirrored in my own research where rupture was constructed as an intrapersonal 'urrgh' moment by counselling psychologists and located in repertoires of crises, as exemplified below:

> Ian 226 =I mean I suppose the only thing I wanna add is it's horrible. It feels horrible as a therapist. Much as you wanna put it into technical terminology and explain what you do. There's a, in terms of that felt sense of when a rupture occurs, it's really unpleasant. (Jessop, unpublished doctoral thesis, 2016)

Interestingly in my research, these crises repertoires were prioritised in the practitioners' accounts of 'rupture' within the client and therapist dyad in the clinical room over discourses offered up by expert texts in relation to rupture. This hints at a discrepancy in the discourses deployed externally (i.e. outside the clinical room/alliance) by expert texts and those deployed by practitioners once 'rupture' is recruited back into the alliance, and located in the intersubjective space between client and therapist. The consequences of such a disparity and its implications for issues of professionalism and clinical practice are discussed below in relation to my own research.

D.6. A Discursive Approach to 'Rupture in the Therapeutic Alliance' - Expert texts as limited voices of professionalism?

My discursive qualitative study used a synthesis of discursive approaches (Foucauldian, critical and discursive) to firstly map out how 'rupture in the therapeutic alliance' was constructed in UK counselling psychology professional texts (to include handbooks, HCPC guidelines and journal articles authored and/or

published within UK counselling psychology academic journals between 1994-2015); it also explored how UK trainee and chartered counselling psychologists then took up, resisted or renegotiated such ways of constructing 'rupture' in their own talk. This synthesised gaze attempted to move between macro post-structuralist and micro-discursive approaches to language, and so orientate my analysis towards "positions taken by the participants, whilst also maintaining an awareness of the ways in which speech constitutes and represents the negotiations of identity . . . power relations and institutional structures" (Roy-Chowdhury, 2006, p.156-157).

One of the findings most pertinent to this discussion was that UK counselling psychology texts offered up professional subjectivities which ultimately had to be renegotiated, and even resisted by individual counselling psychologists in relation to 'rupture' in the clinical space. For example, several expert texts deployed medical discourses to construct rupture as 'illness'. Most notably Richards' (2011, p.53) theoretical paper offered an "Etiology of rupture and its causes and resolutions", which from a discursive perspective afforded 'rupture' a similar status to that of a psycho-pathology or medical condition as would be found in the *Diagnostic and Statistical Manual of Mental Distress* (5th ed; DSM-5; American Psychological Association, 2013). These medical discourses made available the position of the informed, self-regulating diagnostician who can act to treat rupture as 'illness'.

However, deploying a medical discourse came at an ideological cost for counselling psychologists and arguably risked compromising their professionalism. For example, by positioning themselves as diagnosing experts who can identify 'rupture' through its symptoms, they risked losing access to the authentic, meaning-making values of the humanistic and relational discourse within which they are also positioned as counselling psychologists. They also risked locating the source of distress or 'rupture' within the client and blaming them, thus disregarding the value of understanding the social context and interpersonal relations as sources of dysfunction (Hare-Mustin & Marecek, 1997).

The expert texts did offer alternatives to this medical discourse and the diagnosing expert way of being that it made available. They constructed rupture as an 'relational process' locating it in the intersubjective space between client and therapist, and drew on a relational discourse to achieve this. This discourse made available a relational way of being, positioning practitioners as curious and makers of meaning (as opposed to expert diagnosticians) in relation to rupture. This was consistent with

humanistic philosophies of counselling psychology that "value a search for understanding rather than demanding universal truths" (Rafalin, 2010, p. 41). In addition, the relational discourses of the expert texts attributed shared responsibility for rupture to both client and therapist, and offered an alternative to medical discourse and its attempts to locate blame within the client. This reflects the similar emphasis in current relational models of rupture found in the wider literature, where it is positioned as "the function of both patient and therapist contributions with the relative contributions varying from case to case" (Safran & Muran, 1996, p.447).

However, I argue that even this position of 'relational being' was restricting in that it offered up an idealised or culturally romanticised position of the therapist as an always good and caring relational being, which "limited thinking to a positively constructed relational experience of love, care and concern" (Milton, 2016. p.185). It potentially denied access to the fallible, emotional human practitioner who might enter into a 'rupture' with a client. This raises questions as to the consequences of prioritising the positioning of therapists within cultural and professional discourses as 'good/caring', especially if practitioners internalise an overly idealised or textbook relational way of being as a professional imperative, and cannot then access alternative ways of being with the client for fear of not being 'good' enough.

It also raises broader questions as to how expert texts (as produced by the institutions that train, employ or regulate individual counselling psychologists) position individuals in relation to issues of professionalism. Davy (2010) argues that academic journals play a part in reproducing a certain kind of professional subjectivity since psychologists read such articles as apparent exemplars of what they should aspire to. Expert texts can thus promote overt and covert norms about being a proper professional (van Langenhove & Harré, 1999); making available to the reader positions from which they can act effectively as a good practitioner by observing practices of self-governance (internalising the rules). Conversely, when practitioners find themselves working with clients in ways not valued by literature, they risk experiencing themselves as unprofessional (Davy, 2010). Given that 'rupture' is constructed broadly in the literature as a negative process or as something going wrong in the alliance, then there is the potential for it to challenge notions of what makes a good professional. If discourses of success position a good professional as one who can build and maintain a healthy alliance, then a practitioner can easily experience themselves as a bad or neglectful professional for failing to maintain or repair rupture in the alliance.

Additionally, if current counselling psychology training institutions or places of employment (such as the NHS) are invested in producing professionals who can be positioned as expert *only* if they build a strong, healthy alliance then such 'expertise' can open the way for an abuse of power (Hansen, 2006). For example, counselling psychologists may not be encouraged to critically question their professional assumptions around 'rupture' within such institutions because to do so challenges their role as agents of social regulation and guardians of the healthy alliance; within their clinical practice they could seek to explain 'rupture' as the client not being ready for therapy, rather than as a problem in the relationship. 'Expertise' could also conversely function as a container for therapist anxiety in relation to rupture by arming therapists with the "certainty of therapeutic truth-claims" (Ryan, 2011, p.43). Such claims may encourage belief in the value of the healing powers of the good relationship, and thus afford protection from the doubts of both the client and themselves. Therefore, professional expertise might be considered as a defence against a position of vulnerability, and non-expertise potentially offered up by a discourse of rupture.

This raises issues of accountability and blame. In social contexts individuals are attributed responsibility for their part in relationships which breakdown and courts can apportion blame through divorce proceedings (Wharton, 2006). Similarly, in my study the profession's expert texts that arguably function as mouthpieces for counselling psychology training, research and institutional regulation, positioned practitioners as self-monitoring individuals and so shifted responsibility for 'rupture' onto them (Sneijeder & te Molder, 2005). Indeed, the Health Care Professions Council (HCPC) most recent amendments to their codes of practice emphatically reinforce individual accountability, as exemplified in the extract below:

> 8.1 You must be open and honest when something has gone wrong with the care, treatment or other services that you provide by:
>
> – informing service users or, where appropriate, their carers, that something has gone wrong;
>
> – apologising;
>
> – taking action to put matters right if possible;
>
> (*Standards of conduct, performance and ethics*, HCPC, 2016, p.8)

By using the word "you", and deploying discourses of moral responsibility, the individual practitioner is positioned as accountable for events or processes that go wrong within the clinical arena. This blaming discourse potentially arises in response to discourses of success which do not allow for nuanced positions and make available only fixed positions of *either* successful *or* failed practitioner. I argue that such positions do not permit individual practitioners the flexibility required to handle complex negotiations of accountability and responsibility which are present when 'rupture' occurs in the therapeutic alliance. Indeed, informed by my research findings, I suggest that negotiating such issues in relation to 'rupture' was only achieved by resisting the professional ways of being on offer from expert texts, and taking up fractured professional subjectivities. This is consistent with Hore's (2014) observations that professionalism is not just bestowed upon counselling psychologists by the BPS or HCPC, but also created and enacted by counselling psychologists through the creation and manipulation of certain identities**.** These are explained and reflected on below.

D.7. 'Rupture' recruited back into the alliance - repertoires of crises and fractured subjectivities

In my doctoral research counselling psychologists used repertoires of 'intra' and 'interpersonal crisis' to construct 'rupture in the therapeutic alliance'. Rupture was thus constructed as a far messier, less predictable object than that of the identifiable, treatable illness or manageable relational process offered up by expert texts. Rupture as 'crisis' also troubled professional discourses of success since it introduced risk: it *could* be successfully managed, but it *could also* spiral out of control and lead to unmanaged endings such as client dropout. If (as is currently the case within the NHS) success is measured in terms of positive outcomes, and good practitioners are those that deliver such outcomes, then rupture as 'crisis' has the potential within such an institution to be located within a discourse of failure or unprofessionalism. Here, practitioners are at risk of being positioned as bad professionals who could be held accountable for rupture as not delivering client recovery.

Similarly in my study, counselling psychologists were faced with a dilemma of trying to access professional ways of being that allowed them to identify and manage 'rupture' in order to avoid being positioned as bad practitioners who could be blamed. However, they also sought to maintain access to a therapeutic and

relational way of being which allowed them to work therapeutically with 'rupture' in the clinical space, but which arguably made them more vulnerable to the risk of being blamed. This perhaps mirrors a dilemma for all counselling psychologists who, when negotiating professional subjectivities, must seek to reconcile technical expertise and 'doing' with relational ways of 'being' with a client (Strawbridge & Woolfe, 2010).

I argue that the counselling psychologists in my study took up fractured professional subjectivities to manage these professional tensions between doing and being, as well as issues of accountability in relation to rupture. These alternative ways of being allowed for greater flexibility and creativity in practice, since they were positioned outside of the fixed and limiting professional subjectivities made available by the expert texts (as influenced by institutionalised discourses of success and the healthy alliance). For example, one participant potentially resisted idealised relational ways of being as offered up by the texts by deploying military repertoires to construct rupture as 'interpersonal crisis', as illustrated below:

> Mark: Umm I think (2) certainly for myself it's just about getting back
> in the trenches and trying to make right what was you know *(sighs)*
> wrong.
>
> (Jessop, unpublished doctoral thesis, 2016)

By locating himself and his client in the "trenches", Mark allowed for therapist struggle and emotion to enter the rupture discourse as potentially indicated by the sigh. However, by potentially taking up a position of the frustrated therapist at war, he risks being positioned outside of sanctioned, institutionalised, professional ways of being (the warm, caring relational being) as offered up by relational discourses in the texts; as such, he is potentially vulnerable to increased blame for having caused 'rupture'. Interestingly a military crisis repertoire simultaneously served to manage this risk by also allowing access to the position of dutiful soldier/practitioner, as exemplified below:

> Ian: So I find myself being the one, (1) ummm people kind of laugh,
> and in the team meetings, I'm the one that tends to put my hand up in
> the team meetings and say oh yeah when people are saying, <u>oh</u> I've
> got this really (1) . . . difficult [sharp uptake of breath] patient.
>
> (Jessop, unpublished doctoral thesis, 2016)

"Holding my hand up" and "getting into the trenches" recalls the actions of a volunteer for the army or a dutiful solider ready to fulfil their responsibilities. From this position Ian could mitigate against being held entirely accountable for rupture and therefore being unprofessional, since who can blame a soldier for what happens in the heat of the therapeutic trenches when following orders?

Rupture as 'intrapersonal crisis' also led to alternative subjectivities that allowed for managed accountability in relation to rupture. Counselling psychologists in the study drew on emotional repertoires to construct rupture as an internal crisis - one associated with fear or anxiety. Such repertoires served to distance participants from their professional discourse and positions of expertise, and momentarily repositioned them as fallible, emotional human beings who felt deskilled or unprofessional.

> Ian: There's a, in terms of that felt sense of when a rupture occurs, it's really unpleasant. It gets under your skin I suppose . . . 228 It's tapping into something of your . . . even if it's just your sort of therapist's ego and wanting to be the good therapist and feeling like you're failing them or what you have. 229 Like I don't know. But it's a horrible, horrible feeling.

> (Jessop, unpublished doctoral thesis, 2016)

This is mirrored in wider psychotherapeutic discourse where 'rupture' has also been connected with feelings of vulnerability and even incompetency within the therapist (Binder, Holgerson & Nielsen, 2008; Thériault, Gazzola & Richardson, 2009). While discourses of professionalism generally appeal to the rational and exclude the emotional, access to human and emotional ways of being are expected in a discourse of counselling psychology professionalism. Nevertheless, even within this discourse, it can be argued that those emotional ways of being are limited to what is professionally acceptable. For example, anger might allow access to a human way of being in relation to rupture, but it is irreconcilable with warmth and empathy, which are set up as the normative emotional ways of being within wider counselling discourses. Ussher (2003, 2004) argued that when ways of being do not conform to the regime of knowledge in which individuals are placed, it can lead to self-blame and a lack of coherent identity or subjectivity. This is because individuals cannot live up to the internalised, idealised expectations of ways of being that social discourses

demand. Arguably, crises repertoires as deployed by participants in this study again served to negotiate such tensions, since they allowed for the destabilisation of social norms, and so functioned to position practitioners' fear and anxiety as legitimate reactions at a time of crisis. I argue that these crises repertoires served as a useful discursive site where participants could reconcile their individual, human emotional ways of being in relation to 'rupture' with the professionalised therapist emotional ways of being sanctioned by social and therapeutic discourses.

Fractured subjectivities, such as practitioner as 'dutiful professional/soldier' and practitioner as 'emotional (human) being' were therefore negotiated as alternatives to practitioner as 'diagnostician', or 'relational being' as offered by the expert texts. Arguably they provided participants with greater flexibility when managing ways of being in relation to 'rupture' in the clinical space. However, they also led to greater professional anxiety (perhaps because notions of 'good' professional subjectivity are more readily drawn from discourses of success and the healthy alliance within counselling psychology). This was indicated in participants' attempts to tidy up rupture as 'crisis' in supervision by resorting to technical repertoires in this context, recalling Parker's (2002) broader observations that places of learning can cultivate the elaboration of theories which can operate as forms of (professional) defence. A tentative explanation for this professional anxiety in relation to 'rupture' may lie in the observation that by adopting fractured professional ways of being, practitioners risked positioning themselves outside of the discipline's institutional discourses and the professional subjectivities they make available. Handling issues of accountability in relation to 'rupture' thus became a risk that practitioners had to negotiate alone. Admitting accountability for their part in 'rupture' was therefore not easy for practitioners, potentially because such admissions risked positioning them simultaneously within a discourse of failed professional responsibilities. This sits in contrast with models of rupture resolution within wider psychotherapeutic discourses where therapists are actively encouraged to admit accountability, or say 'sorry' for their part in the rupture as a normal part of the process for repairing it (Safran et al., 2014). It also calls into question how we might use supervision to discuss issues of accountability and professionalism in relation to our clients. My study hints at a potential subjugation of rupture discourses, and recalls similar findings within a study by Friedlander (2015) where trainee psychotherapists were found to be reluctant to discuss 'rupture' within supervision. This raises questions of how a discourse of success might again function to subjugate those discourses that

potentially call into question the therapist's professional abilities. From a discursive point of view it also hints at the potential politicisation of supervision as a discursive site where institutional discourses wash their hands of the individual, positioning them as an individually responsible for any clinical mess such as 'rupture', which as institutions they are not prepared to be held accountable for. This would appear incongruous with supervision discourses in wider counselling discourse as a place for sharing all professional concerns.

D.8. Don't tidy up the mess – Implications for practice

In light of the observations above, making space for discourses of rupture to emerge within counselling psychology discourse would therefore seem important in order to broaden both the discipline's and individual counselling psychologist's understanding of 'rupture' and the therapeutic relationship. One way in which this might be practically achieved is by outing alternative positions to include the angry, frustrated, bored therapist which are currently overshadowed by the normative cultural discourses which position the practitioner as always 'good' and 'caring'. This may involve bringing discussions of processes like 'rupture' out from behind the closed doors of such professional forums as clinical supervision or personal therapy and introducing them into wider public and social discourses. Future discursive research might therefore consider how as professionals we construct rupture in supervision, and how this may be enhanced. Broadening such discourses to accommodate what can go wrong may also serve to encourage practitioners to accommodate rupture as mess and crisis, rather than seek to tidy it up. In turn, this could make room for new or alternative professional ways of being which are potentially edited out of a psychotherapeutic discourse if, as a system of meaning, it is used to promote "ideals" regarding "healthy or ideal selves" (Avdi & Georgaca, 2009, p.662).

It also raises questions as to how 'rupture' can be talked about with clients. Here it might be useful to direct the gaze towards existing social practices which allow for a means of vocalising the unspeakable, enabling that which can be positioned as both undesirable and threatening, like 'rupture', to be talked into being. For example, prenuptials have become a legitimised social practice made available within a modern breakup discourse as a way of managing a disagreement or even ending. In the same way a discussion about the possibility of rupture might be managed as part of our initial contract with the client. Client feedback forms presented at the end

of every session are currently being investigated, and may offer a means of opening up the dialogue around rupture (Laraway, 2015).

D.9. Summary

This discussion has raised issues as to how counselling psychologists accommodate 'rupture in the therapeutic alliance' within the broader discourses of success and healthy alliances which are argued to circulate within the profession's regulating bodies, places of employment and training institutions. Taking up fractured professional subjectivities offered counselling psychologists in my study one potential way of negotiating such discourses of success and rupture. This is consistent with observations that research on social discourses that underpin professional identity indicate they are never unified, but consist of multiple processes (Lo, 2004, cited in Lane & Corrie, 2006). Often these are constructed by different intersecting and sometimes antagonistic discursive practices (Lane & Corrie, 2006). Such fractured subjectivities allowed individuals to break into the matrix of hegemonic relational and medical discourses offered up by the texts, and challenge the fixed notions of therapist as 'diagnostician' or 'relational being' they made available. These ruptured professional subjectivities led to enriched ways of being with the client (e.g. therapist as 'dutiful solider', 'emotional human being'), which potentially enhanced creativity in the clinical practice.

Whilst negotiating fractured subjectivities was anxiety inducing for the participants, as counselling psychologists, I argue that we are well positioned to manage this; situated as we are in a counselling psychology discourse which is itself "positioned at a busy junction of diverse and sometimes competing ideologies, frameworks and paradigms" (Blair, 2010, p.20). Embedded in a postmodernist and pluralistic framework we have the capacity as a profession to facilitate alternative subjectivities, and to accommodate the constant rupturing and repairing of a counselling psychology identity, the purpose of which is perhaps to "hold rather than resolve tensions" (Orlans & van Scoyoc, 2009, p.vi). Indeed, if what it means to be a good professional can be expanded beyond binaries of 'good' and 'bad' to incorporate more fractured subjectivities, this will allow for a 'both/and' rather than 'either/or' perspective. Such a perspective arguably "embraces a pluralistic outlook and bodes well for [counselling psychology's] ongoing development as a discipline" (Milton, Craven & Coyle, 2010, p.69).

D.10. Appendix

Appendix D.1. Counselling Psychology Review Instructions for authors -
Retrieved 06/06/2016 from (http://www.bps.org.uk/publications/member-network-publications/member-publications/counselling-psychology-review)
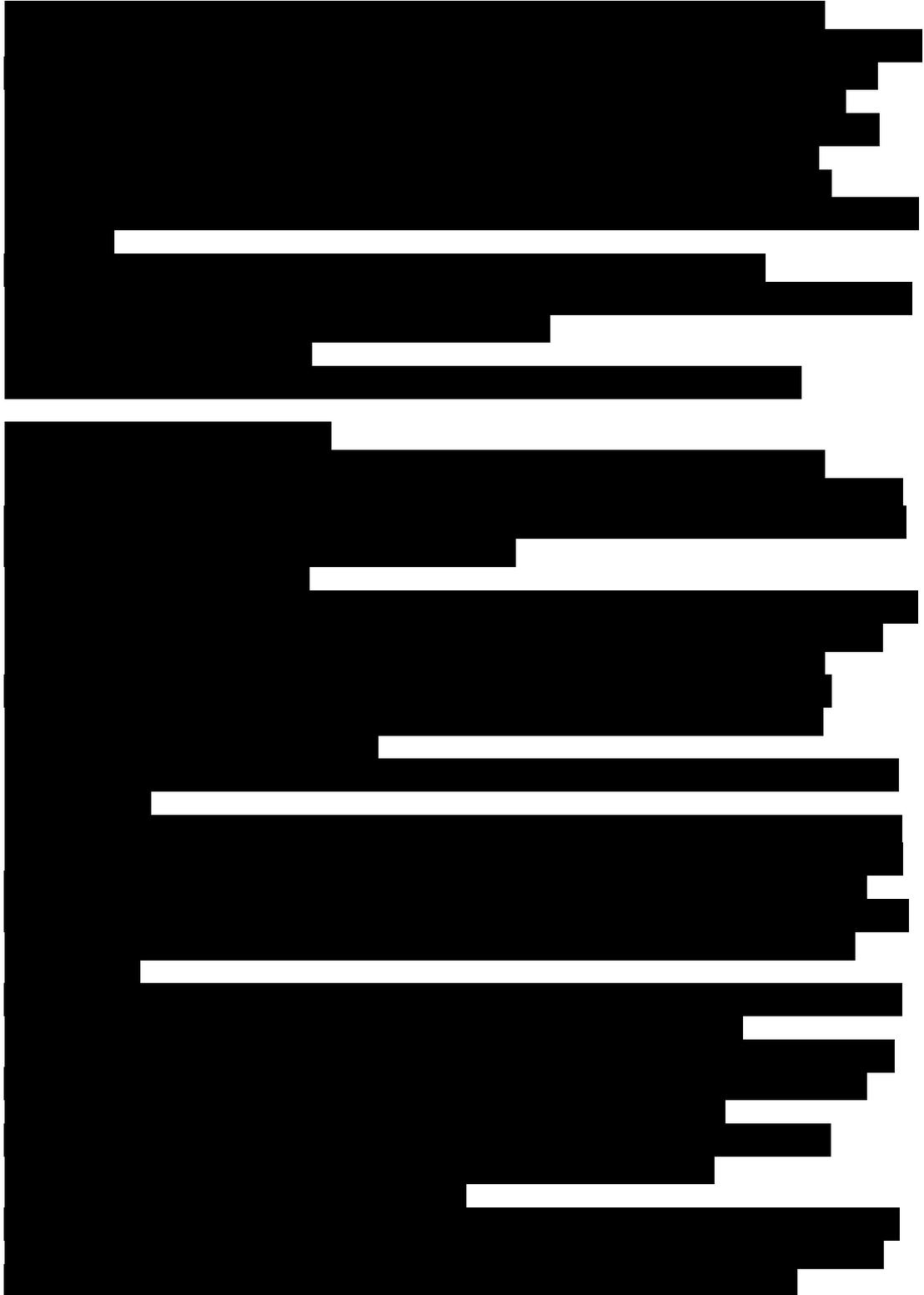
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