Doctoral thesis title

How do gay men experience ruptures in the relationship with their therapist? An interpretative phenomenological study.

by

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Abstract

Rationale: There is a higher prevalence of mental health problems for gay men, who experience higher rates of depression, substance misuse problems and suicide. Gay men use therapy at higher rates than the general population, but are also more likely to report unsatisfactory experiences in therapy – otherwise known as ruptures. There is a lack of research not only on the client perspective of ruptures but also within specific minority groups such as gay men, and therefore it remains unknown how they experience ruptures in therapy. This study aims to offer insights into this area to deepen understanding and produce new knowledge about whether the experience of ruptures in the therapeutic relationship is different for gay men and, if so, how.

Methodology: Interpretative phenomenological analysis was used to explore seven gay men's experiences of ruptures/difficulties in the relationship with their therapists. Data was gathered using semi-structured face-to-face interviews.

Findings: The analysis yielded three master themes: 1) The origins of the rupture: therapist as invalidating threat to gay identity and self, 2) Rupture as process of struggling to defend gay identity and the self, and 3) Negotiating reparation and/or closure of the rupture. The key finding was that participants attributed the cause of the rupture to therapist homophobia and/or lack of therapist understanding on gay issues, which presented additional barriers to the therapeutic process, and meant that participants edited out aspects of their gay identity in therapy. The study also found that rupture overlaps with the difficulties commonly experienced as part of the therapeutic process, making it difficult to define rupture. The researcher links the findings to minority stress theory, and suggests that an over-emphasis on the transferential relationship in therapy, and rigidity in therapeutic approach, can impede the collaborative process that is more likely to lead to reparation with this client group, especially when they are at an early stage in their gay identity development. The findings indicate that participants' rupture experiences are compounded by both projections of their internalised fears of homophobia onto their therapist *and* a lack of therapist understanding of the therapeutic needs of gay men. The limitations of the study are discussed, and the implications for practice, research and training are discussed in light of the findings.

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I would like to offer a tribute to Jeremy Safran, who died in 2018, for his seminal work on rupture-repair in psychotherapy.

Reflexive Statement

Any researcher's values, beliefs and experiences will shape the nature of the enquiry, and be shaped by the research process, and therefore a reflexive process is required to improve the validity of any findings (Willig, 2008). Therefore I offer a personal and epistemological reflexive account regarding my role and influence on my study.

I am a white, British, cisgender, gay man. I do not have a disability, I am spiritual in some ways but not aligned to any religion, and I am in my late-40s, with a professional socio-economic status in the role of trainee counselling psychologist. Aspects of my identity would have had an impact on the study, in terms of how the participants experienced me, and also how my identity shaped the research. I shared a white British, gay, cisgender, male identity with six out of seven of the participants, and if for example I had a different identity, I may have recruited participants in ways that might have facilitated a more diverse sample, especially in terms of race/ethnicity and cultural background. Because I shared a white British gay male identity with six participants, they might have assumed they were more like me, while I may have subconsciously assumed at times that I was more like them, more than we actually were, which could have led to aspects of difference (such as age, disability or socio-economic status for example) not being noticed or deemed as important as sexual identity. Indeed, because I was studying a specific group (gay men), it is likely there was more of a focus towards aspects of that identity, increasing the likelihood of important intersections of identity in individual cases (eg, race/ethnicity, class/socio-economic status, age) being described as “divergences” rather than positioned centrally within the findings.

This research is very personal as it links to my experiences in therapy and my sense of being-in-the-world as a gay man. The fact I shared the participants' “gay” and “male” identity, and also their experience (ruptures in therapy), influenced how I chose the phenomenon under investigation, as it was associated with my personal interest in it. I initially chose the broad topic of LGBT+ therapy experiences as it links with my work in and passion for LGBTQ (lesbian, gay, bisexual, transgender and queer) mental health, as well as my personal values associated with equal rights, inclusion, and social justice. My research topic became focused on one group, gay men, in part because the methodology required a homogeneous sample, and also because I had a personal interest in this group, which was influenced by the fact I share that identity. I was motivated to better understand ruptures and therapy on a personal and professional level, as well as from a research/theoretical perspective.

I held initial assumptions that the quality of the therapeutic relationship for gay male clients might

be restricted by heterocentric bias and the legacy of the pathologisation of homosexuality. I partly based these assumptions on my experiences in personal therapy, but also life experiences. Because growing up gay has been a challenge for me, I have an assumption that it has been an issue for other gay men too which was likely to become reflected in the therapeutic relationship (TR) for participants.

Because of shared aspects of my experience and identity influencing the topic, research questions and selected group, and my assumption that sexual minority identity and difficulties in the TR are most likely linked in some way, this influenced the Information Sheet and recruitment flyer/poster which asked "are you a gay man?" and for information about their "experiences of difficulties in the relationship with their therapist". This inclusion criteria could be seen as leading, and suggestive that the identity and difficulties in the TR are linked, and which may have led participants to assume that they had to talk about gay issues as associated with the difficulties in the relationship, while possibly putting off any participants whose identity was not associated with the difficulty. Indeed, one participant said his identity was not linked to the difficulty in the TR and he made specific reference to it, asking me if that was OK, as though he was checking whether he had conducted the interview correctly. This bias in the poster/flyer and Information Sheet impacted on the sample and thus influenced the data and the findings, perhaps making it more likely for participants to link their sexual identity to difficulties in the TR. However, the study aims to explore whether sexual minority identity is associated with the rupture experience, while the research question asks to what extent minority identity is associated with difficulties in the TR, so it would have been difficult to avoid this bias in the recruitment materials, given the scope of this study, and ethical considerations regarding transparency.

Meanwhile, my role as a trainee counselling psychologist is likely to have influenced participants in terms of the subconscious power dynamics at interview and potential social facilitation bias. This could have influenced participants, with them possibly being compliant around their perceptions of a research agenda, and this may also have made them more likely to associate the rupture with their sexual identity.

While I was starting to explore my research topic, I was in psychoanalytic therapy with an "LGBT-affirmative" practitioner. I chose a gay male therapist for the first time because I thought it would improve the quality of the therapeutic relationship (TR) because he would have a shared understanding of the issues for gay men. He did, and it was helpful. I experienced what I call "being reached", that is, my therapist meeting parts of myself when I was at my worst. However, I still experienced difficulties and challenges in the relationship that saw me become silenced, or withdraw emotionally. Sometimes it was very subtle, but the therapist noticed and welcomed what I

will call “mini ruptures”. In fact, I needed a relationship that could welcome and withstand tensions, help me explore and work through them. It was challenging yet also helpful and insightful.

This made me reassess the TR; I had assumed the ideal TR should be conflict-free. At the same time, I was training to be a therapist, and experienced myself as being perhaps too agreeable at times – on reflection, I think I was driven by a need to avoid potential tensions and challenging clients. How useful was this for the client I wondered?

Following on from this I changed to a new therapist for 2.5 years, a heterosexual man who was a body psychotherapist, and who combined humanistic, Jungian and Embodied-Relational Therapy. This therapist had an active blog and Twitter feed; in one of his Tweets, he denounced the criminalisation of homosexuality in India and advocated for the right of people there to have gay sex. This independent act of activism/social justice meant I knew he was an ally to my gay identity, I felt I could trust him and it reduced barriers between us. Despite some difficult bumps in the therapeutic relationship, I did not experience any ruptures; on reflection, I think this was because I experienced such a good bond with him. These experiences made me wonder what constitutes a rupture, how it relates to the therapeutic relationship, and also the differences between clients and therapists in how they define and perceive ruptures.

This study might be associated with my concerns about the “ruptures” I have experienced in the interpersonal and social realms of my life that feel linked with my life-long sense of being different and later identifying as gay, and this personal contextual background had an influence on my decision to chose this topic, as well as on the research decision to choose this group. I questioned whether research into this topic had fully captured the complexity and depth of the issues with regards to gay men, and I am aware my research interest in this topic originates from a personal and social motivation to improve understanding and wellbeing.

I entered counselling/therapy at various points in my life, and while most of the experiences were helpful, some of them could have been *more* helpful, while one counsellor was negative towards my sexuality by suggesting a good heterosexual marriage would help me. While I did not always present in therapy with problems about my sexual minority identity, the fact I grew up gay in a heterosexist society means being gay *is* an issue for me, and I believe for other people who identify as gay. Not because it is a problem in itself, but because of the minority stress (subtle prejudice, discrimination and exclusion, and expectations of such) that is embedded throughout society's discourses, social institutions and structures. Thus, my reflective/reflexive process has shifted back and forth between my sense of self and society. I think the nature of my enquiry extends beyond

myself and has a wider usefulness.

I'm aware that I'm constructing a narrative embedded with assumptions. I can only attempt to minimise bias by aiming to be aware of and transparent about them. I'm aware that my research is influenced by the way I experienced a lack of inclusion, hiding myself, and feeling silenced. This background has impacted on this research project with it perhaps functioning as the opposite of the above; it aims for inclusion, having a voice and being seen, and also being useful.

I am aware that strong and unquestioned assumptions can distort research, and I have aimed to engage in a reflexive process that considers how my assumptions, beliefs and values have shaped my interpretation of existing research and the data produced by this study. I have aimed to look at the field with as much objectivity and reflexivity as I can, and I have purposefully engaged with research and theory that I felt critical towards.

I hold beliefs that favour socio-cultural and interpersonal, rather than intra-psychic, explanations for ruptures with sexual minority clients. While there was evidence of this in the data of this study, my assumptions, beliefs and values might have led me towards noticing and valuing these aspects in the data, rather than other aspects of the data that might have been deemed more important by a researcher with a different identity/background, and this had an influence on the findings in this study as discussed below.

Because of my shared experience and identity, I identified strongly at times with the participants' accounts, which I think impacted on the study by creating in me a desire to do the participants' accounts justice, and at times making it difficult for me to let go of aspects of their accounts, perhaps trying to include and explain too much information.

Reflecting on the study, I experienced a level of anxiety at different stages of the process. The impact of this anxiety on the study meant I may have been overly thorough in the analysis at times, contributing to strongly interpretative and conceptual findings. Meanwhile, after the analysis, I experienced writers' block, a form of performance anxiety. This may have impacted on the study by me overcompensating by being overly comprehensive, which meant I may have attempted to include too much contextual information in the findings, as well as being very interpretative and conceptual in places.

These processes in me impacted on the study by leading to me needing to present initial summaries of each theme in the findings in an effort to include all the lifeworld and contextual information that seemed very important to me, as well as a strong interpretative researcher narrative before

participants' extracts. Because of my need to convey understanding of the issues as I saw them (influenced by my values, beliefs and assumptions), and my anxiety about doing a good job of it, this impacted on the study by making my narrative/interpretative voice at times more present than the participants' voices.

I used the term “the researcher” to refer to myself throughout the study, in part to keep in mind my role, and also to help create some distance between my experiences of ruptures as a gay man in therapy, and those of the participants' experiences.

Reflecting during the study, I am aware that referring to myself as “the researcher” reflects my fear of researcher bias invalidating the study. This fear of LGBT+ researcher bias may stem from the fact that LGBT+ psychology has historically been politicised, as well as marginalised. I was particularly inspired by Marvin Goldfried, whose paper (2001) on integrating LGBT+ issues within mainstream psychology sees him coming out as having a gay son, which I think underlines the personal nature of this topic and my hopes for more integration. It was difficult at times to navigate the tensions of being positioned inbetween “counselling psychology researcher” and “a person with a shared identity/experience as the participants”. My fear of researcher bias impacted on the study by motivating me, sometimes outside of my conscious awareness, to take a more thorough, more sceptical/questioning, and more interpretative approach to the analysis, findings and discussion. I think this process in me impacted on the study by making the analysis and findings very interpretative. Indeed, my interpretative findings were also influenced by my own shared identity and my experiences in long term therapy and of ruptures as a client, my identity as a trainee counselling psychologist, and my understandings of aspects of psychological and psychotherapeutic theories. All of these factors have had an influence on the findings and the discussion.

Epistemological and ontological position

I hold a critical realist epistemological position that aligns with phenomenological philosophy, which proposes that knowledge is subjective and that there are multiple truths about reality depending on the social, cultural, political and historical context in which that knowledge is produced. Phenomenology posits that the individual is always embedded in a context and interprets reality (phenomena) through the filter of consciousness which results in a unique experiencing of the self and the world (Smith et al., 2009).

In terms of ontology, phenomenology argues that reality can only be known through individual subjective experiencing, and could therefore be seen as relativist. However, phenomenological

philosopher Martin Heidegger's ontological position has been described as a "minimal hermeneutic realist" (Dreyfus, as cited in Larkin, Watts & Clifton, 2006). This is explained by the following quote: *"What is real is not dependent on us, but the exact meaning and nature of reality is."* This means that the objects in the world, such as a rose for example, can only be known as such through the meanings that are attributed to it individually and collectively.

I have needed to reflect on my essentialist beliefs (Clarke, Ellis, Peel & Riggs, 2010, p. 26) about my sexuality, the idea that my sexual orientation was biologically determined, and also my reservations about Freud's theory of homosexuality (1963) which I have interpreted as suggesting that homosexuality represents an arrest of development in early childhood. Indeed, research and the literature suggests sexual orientation is a complex biopsychosocial process. I do still hold essentialist beliefs but, reflecting on this over the past few years, I wonder if this is in part a defensive/politicised stance that functioned to protect me from pathologising and negative attitudes from others, society as well as from myself, and which may have restricted my understandings of sexuality.

Introduction

There is a lack of research on the unique therapy experiences of sexual minority individuals (Bieschke et al., 2007; Pachankis et al., 2004), especially in relation to the therapeutic relationship (Muran, 2007). This is surprising considering research has found that sexual minority clients use therapy at rates higher than the general population (Bieschke et al., 2007; Cochran et al., 2003; Liddle, 1996). Meanwhile, gay men, as well as lesbian and bisexual clients (LGB), have been found more likely to report unsatisfactory experiences in therapy than heterosexual clients (Liddle, 1996).

Research suggests there is not only a higher risk of mental health problems in LGB people, but also a higher prevalence of diagnosed disorders, including anxiety, depression, suicidality and substance misuse problems (Cochran et al., 2003; Jones & Gabriel, 1999; Saewyc, 2011). For example, in the UK, gay and bisexual men are four times more likely to attempt suicide than heterosexual men, while depression, anxiety and substance-misuse issues are 1.5 times more likely in LGB people (King, Semlyen, Tai, Killaspy, Osborn, Popelyuk & Nazareth, 2008). The suicide rate in gay men is likely to be underestimated, as an unknown number of men hide their sexual identity, while registers of death and inquests do not record sexuality (King et al., 2008). In a meta-analysis by Meyer (2003a), it was found that sexual minority individuals were 2.5 times more likely to have experienced a psychiatric disorder at some point in their life compared with heterosexuals, and

were twice as likely to have a current mental health problem.

These health disparities are caused by minority stress (Meyer, 2003ab), the acute and chronic stress that originates from the pervasive social oppression of stigmatised identities such as sexual minorities. In his paper, Meyer proposes that sexual minority groups such as gay men experience three unique intrapsychic stressors: stigma-based rejection sensitivity, internalised heterosexism, and sexual orientation concealment.

Hatzenbuehler (2009) proposes that sexual minority group-specific variables are mediated by universal psychological processes, low self-esteem for example, which fosters a higher vulnerability to and incidence of physical and mental health problems. Because sexual minority people experience unique stressors, this justifies research focused specifically on specific sexual minorities such as gay men. Research in the US has used the stigma-related stress concept, and adapted CBT to sexual minority clients; for example, the randomised controlled trial by Pachankis, Hatzenbuehler, Rendina, Safren & Parsons (2015).

Despite Meyer's and Hatzenbuehler's minority stress theories, many sexual minority clients have received the message from therapists that their symptoms of anxiety and depression are linked to the pathology of their homosexuality, and not by "the pathology of society's homophobia" (Eubanks-Carter, Burckell & Goldfried, 2005, p. 8).

The legacy of the pathologisation of homosexuality (it was removed from the DSM3 as a sociopathic personality disturbance in 1973), heterosexist bias and lack of knowledge about sexual minority issues was evidenced by Garnets, Hancock, Cochran, Goodchilds & Peplau (1991), in which 2,500 psychologists were surveyed about competency issues in therapy with lesbian and gay clients. Some 58% of respondents reported incidents of overt and subtle heterosexist bias which was central to their or other professionals' formulations and treatment plans for sexual minority clients. Meanwhile, Bartlett, Smith & King (2009) found 1 in 6 therapists had engaged in therapeutic activity aimed at changing their clients' sexual orientation.

Concerns arising from Garnets et al.'s and Bartlett et al.'s papers paved the way for the APA (2000, 2011) and the BPS (2012) to publish competency guidelines for psychologists on working with sexual minority clients. In January 2015, a Memorandum of Understanding was signed by 14 health profession bodies, including the BPS, which stated that treatment designed to change a client's sexuality was unethical practice, causes harm and should be avoided.

These guidelines and regulations above align with counselling psychology's concern for social

justice, and “high standards of anti-discriminatory practice appropriate to the pluralistic nature of society today”. The BPS's Division of Counselling Psychology's Professional Practice Guidelines (2006) outlines practitioners’ responsibilities and obligations to self and society, recommending that counselling psychologists make themselves knowledgeable about the diverse life experiences of the clients they work with.

Sexual minority clients have reported improved experiences in therapy (Jones, Botsko & Gorman, 2003; Liddle, 1999), perhaps because of improvements in training, progressive law and social attitudes (BPS, 2012). However, Bieschke et al. (2007) suggest improvements in therapy experiences may also reflect sexual minority clients actively seeking out therapy that they perceive more likely to offer positive experiences, for example by finding a practitioner who matches their sexual orientation (Jones et al., 2003; Jones & Gabriel, 1999; Liddle, 1996). Other research has found that sexual minority clients check for therapist competence by prescreening potential therapists for bias and awareness (Burckell & Goldfried, 2006; Liddle, 1997; Moran, 1992; Stracuzzi, Fuertes & Mohr, 2011).

Meanwhile, research on therapist attitudes suggests a significant minority of well-intentioned therapists hold overt and subtle heterosexist biases (Bartlett, Smith & King, 2001; Kilgore, Sideman, Amin, Baca & Bohanske, 2005; Phillips, Bartlett & King, 2001; Smith, Shin & Officer, 2012). Grove (2009) found that trainees' reported lower levels of awareness of sexual minority issues in the second the year of their course compared with the first year, perhaps because they became more aware of what they did not know as the course progressed. Heterosexist bias and lack of awareness/knowledge of sexual minority issues can impede the relationship between sexual minority client and therapist in subtle ways (Eubanks-Carter et al., 2005; Pachankis et al., 2004).

Other scholars suggest therapist's with non-homophobic attitudes can still diminish the TR with gay male clients because they feel uncomfortable talking about certain issues and therefore inadvertently inhibit, discourage and divert clients from exploring issues that were important to them (Hayes & Gelso, 1993), while therapists with low negative attitudes, but also with low positive attitudes, may lack positive regard with gay male and lesbian clients and thus subtly diminish the quality of the TR (Jones, 2000). LGB-affirmative therapy has emerged over the past few decades as counter-response to therapist bias (Balsam, Martell, & Safren, 2006; Davies, 1996; Ritter & Terndrup, 2002) and multi-cultural competencies (Israel, Ketz, Detrie, Burke & Shulman, 2003).

Many of the issues discussed thus far describe negative therapy experiences, relationship breakdowns and tensions that are characteristic of ruptures. The repair of ruptures have been linked

with positive therapeutic outcomes (Horvath et al., 2011) and as a mechanism of change (Safran et al., 2011) and thus present opportunities for growth. To investigate further, this study aims to explore the meaning of the ruptures from the perspective of a specific group within the LGBT+ umbrella, gay male clients, to deepen understanding, and provide new knowledge for the potential benefit of this minority client group and others too. Counselling psychology is well-placed to undertake this study because it a pluralistic discipline positioned between applied practice grounded in the therapy relationship, and scientific research concerned with phenomenology and the subjective/intersubjective experiences of individuals (BPS, 2006).

There has been a wealth of research investigating the therapeutic relationship and ruptures, but no research specifically exploring the experience of ruptures in the therapeutic relationship with sexual minority clients. However, there have been papers investigating experiences in therapy for sexual minority clients generally, which frequently refer to events that are characteristic of ruptures (see page 16 for a definition of rupture). Therefore, I will review the literature on the therapeutic relationship and ruptures, and look at how this relates to research on therapy experiences for sexual minority clients, and gay male clients in particular.

Reflexive Critical Literature Review

The therapeutic relationship

Gelso & Carter (1985, 1994) proposed a transtheoretical definition of the therapeutic relationship as: “the feelings and attitudes that therapist and client have toward one another, and the manner in which these are expressed.” The authors suggest all counselling and psychotherapy relationships consist of three components: the working alliance, a transference configuration, and the real relationship, and these three components vary in importance depending on the therapeutic modality used.

The working alliance concept has evolved from Freudian psychoanalysis, and was generalised as a pan-theoretical construct by Bordin (1979) who suggested it is composed of three interdependent elements: goals, tasks and personal bond. The strength of the alliance depends on the quality of the relational bond between the dyad and the degree of agreement about the tasks and goals of therapy.

The transference configuration is a dynamic concept that includes transference (clients' feelings towards the therapist based on conscious or unconscious relational patterns from the past) and countertransference (therapists' feelings towards the client).

The real relationship refers to the non-transferential interactions between client and therapist in the here and now, and is characterised by the qualities of congruence and authenticity (Gelso & Hayes, 1998). The terms “therapeutic relationship” and “alliance” are used interchangeably throughout the literature. This study understands the alliance (working and therapeutic) as being an important aspect of the broader TR concept.

Relevance and importance of the therapeutic relationship

In research identifying the factors that contribute to therapeutic outcome, Asay & Lambert (1999) found that common factors including the TR account for 30% of the variance, with extratherapeutic effects accounting for 40% of variance, expectancy and placebo effects 15%, and specific therapeutic techniques 15%. Norcross & Lambert's (2011) synthesis of research shows the TR accounts for about 20% of the total outcome variance.

Research findings have consistently confirmed that therapy is effective (Lambert, 2013). With the aim of finding out how, Castonguay & Beutler's paper (2006) on the principles of therapeutic change identified participant factors (therapist and client characteristics), relational factors, and technique factors (methods used) as broad categories in which to organise factors (mediators and moderators) that influence and contribute to outcome. The relational common factors identified included: 1) the working alliance, including goal consensus and collaboration, 2) generic relational skills based on the core conditions (empathy, positive regard, and congruence), and 3) relational therapy skills that are linked to outcome, namely a) use of real-time feedback, b) repairing alliance ruptures, c) managing countertransference, d) self-disclosure, and e) relational interpretations.

Safran & Muran (2006) suggest the increasing interest and research about the TR reflects a paradigm shift towards relational therapy, as the main therapeutic orientations adapt to evidence-based findings that increasingly confirm the alliance and relational factors as the most efficacious aspects of the therapeutic process. For example, Horvath et al. (2011) reported an effect size of 0.275 between alliance and outcome based on a meta-analysis of 190 outcome research reports.

The alliance has become a hot topic with researchers seeking to identify how strong alliances are established and maintained, and how termination of therapy or breakdowns in the alliance can be avoided. Some of this research (Horvath et al., 2011) has concluded that fluctuations in alliance strength are more predictive of positive outcome than alliances that are linear or stable – so long as the fluctuating alliances do not end low or deteriorating.

Gelso (2014) notes that research into the alliance over the course of therapy overlaps with rupture-repair research. Indeed, Bordin (1979) suggested that therapy was not therapeutic without tensions in the relationship, and said tears and repairs should be expected. Examples of this have been evidenced in various studies, which have found that high-low-high rupture-repair alliance patterns over the course of therapy are associated with better outcomes (Kivlighan & Shaughnessy, 2000; Lansford, 1986; Stiles, Glick, Osatuke, Hardy, Shapiro, Agnew-Davies & Barkham, 2004). Meanwhile, Binder & Strupp (1997) found that negative interpersonal process was linked to negative outcome, while Norcross (2010) has summarised therapist characteristics linked to poor outcome (confrontations, negative therapist process, rigidity to tasks and an inflexible model of therapy among others).

Furthermore, research by Safran and colleagues (2011) has identified the rupture-repair process as a mechanism of change in therapy, however these opportunities for client growth are easily missed. Regan & Hill (1992) previously found this is partly due to therapist factors (they found experienced therapists identified just 17% of covert client processes), while Rennie (1994) found clients tend to hide their negative feelings to protect the therapist and the relationship - therefore alliance fluctuations can be so subtle they are not identified. More recent research has found that therapists' assumptions about client satisfaction tend to be inaccurate, and client perceptions of alliance strength better predicts positive outcome (Norcross, 2010).

Fluctuations in the TR and sensitivity to tensions within it are arguably of central interest to therapists from all modalities, not only to maintain strong alliances, but also to help the dyad use any rupture event as an opportunity for change and growth (Safran & Kraus, 2015; Tufekcioglu & Muran, 2016) and increase the likelihood of positive outcome (Horvath et al., 2011). The literature reviewed so far has underlined the importance and maintenance of the TR, and has highlighted that ruptures are important and prevalent yet often subtle and enigmatic events in the therapeutic process that have multiple causes, and are at risk of being unnoticed by therapists. Therefore it seems relevant to review the literature on therapeutic ruptures, and therapy experiences from the client's perspective.

Ruptures

Ruptures have been defined as, “Episodes of tension or breakdown in the collaborative relationship between patient and therapist” (Safran & Muran, 2006) and “a deterioration in the quality of relatedness between patient and therapist” (Safran, Muran & Proskurov, 2009, pp. 210). Ruptures vary in intensity, from subtle ruptures that may remain outside of conscious awareness of the client or therapist, to explicit interpersonal confrontations that lead to direct confrontation and early

termination of therapy (Safran et al., 2009).

Rupture is the most commonly used word in the literature to describe tensions in the alliance, especially in evidence-based research. However, there is a lack of consensus about how to refer to tensions in the relationship between client and therapist. Examples include: transference–countertransference enactments (Safran et al., 2006); empathic failure (Kohut, 1984); weakenings and repairs (Lansford, 1986); impasse (Elkind, 1992); rupture (Safran, 1993); misunderstanding event (Rhodes, Hill, Thompson & Elliott, 1994); strain (Bordin, 1994; Castonguay, Goldfried, Wiser, Raue & Hayes, 1996); negative process (Binder & Strupp, 1997); angry (Dalenberg, 2004); disjunction (Frankel, 2006); resistance (Aspland, Llewelyn, Hardy, Barkham & Stiles, 2008); and emotional struggles (Haskayne, Larkin & Hirschfeld, 2014).

The three dominant forces of psychology, cognitive-behavioural, psychoanalytic and humanistic, have historically conceptualised the TR and ruptures in diverging ways according to their theoretical underpinnings. It is worth noting that adherence to a monogenic approach could in itself lead to a therapeutic rupture if the model is not suited to the client's needs (Norcross, 2010). However, the bulk of rupture research has been conducted using specific models of therapy, so it is useful to offer a brief summary of how the three main therapeutic traditions conceptualise the TR and ruptures.

Theoretical perspectives of ruptures

The TR in cognitive-behavioural therapy (CBT) is a collaborative alliance based on Bordin's tasks, goals and bond. CBT generally assumes that treatment interventions lead to therapeutic change, not necessarily the TR, but those interventions have a stronger chance of success if the alliance is strong. Gilbert & Leahy (2009) acknowledge that CBT may have undervalued the importance of the TR and have aimed to address this imbalance with their book. CBT has increasingly embraced relational therapy, especially with clients diagnosed with a personality disorder (Safran & Kraus, 2015). Contemporary CBT has borrowed psychoanalytic concepts such as resistance (non-compliance) and countertransference (Leahy, 2001), and now recommends approaching ruptures as relational phenomena in which therapist metacommunication and mindful awareness can promote therapeutic gain (Katzow & Safran, 2007). Meanwhile, CBT also considers how attachment styles and internal schemas of therapist and client can contribute to ruptures, and authors recommend the development interpersonal responsiveness and skills such as immediacy (Gilbert & Leahy, 2009; Wills, 2015).

In humanistic/experiential therapies, the TR is not “merely the crucible in which the therapeutic

work is held and made safe; rather, the relationship *is* the therapy" (Cooper. O'Hara, Schmid & Bohart, 2013, p. 11), and the TR is characterised by egalitarianism and an authentic therapeutic presence (real relationship) based on the core conditions (empathy, congruence and acceptance). Rogers (1961) updated the traditional psychoanalytic concept of the alliance to the core conditions, notably empathetic understanding, and saw interpersonal ruptures as arising from incongruence between one's self-concept and organismic (true) self. "The whole task of psychotherapy is the task of dealing with a failure in communication" (Rogers, 1961, p. 330) with oneself, and as a result, with others. The TR facilitates the client's own healing process, also known as the self-actualisation process. Ruptures in humanistic therapies are usually experienced as being here-and-now experiences, and can happen as a result of client incongruence, or from a therapist who is experiencing blocks to empathy, or positive regard. In the experiential approach, therapists aim to intensify clients' emotive states, and this can lead to ruptures in the alliance according to Elliott, Watson, Goldman & Greenberg (2004).

In dynamic-oriented therapies, the therapeutic frame provides a holding environment described as containment in which the relationship and any ruptures within it are explored (Spurling, 2009). Freud suggested unconscious drives and unresolved conflicts will manifest in the transference (Milton, Polmear & Fabricius, 2011), leading to tensions which are to be expected. In psychoanalytic theory, the client uses resistance to protect their ego from painful feelings via psychic defences. This process can be frightening and painful for the client, and ruptures commonly occur as clients attempt to maintain their defences (Lemma, 2003). Negative client transference and therapist interpretations can lead to ruptures, as can countertransference resulting from unresolved conflicts in the therapist (Jacobs, 2010). Object relations and attachment theorists such as Melanie Klein, Donald Winnicott and John Bowlby believed the relationship with the therapist echoes early attachment experiences of fluctuating attunement with primary caregivers. The quality of the TR and accompanying ruptures has been linked to client attachment styles, and unhelpful relational patterns with the therapist based on past attachments are acted out in the TR in the form of re-enactments (Lemma, 2003).

Traditional one-person psychoanalysis assumed ruptures are a manifestation of the client's transference and therefore originate from intrapsychic disturbances and pathology. This has been criticised by relational and intersubjective theory (Aron, 1996; Benjamin, 1990; Mitchell, 1988; Safran & Muran, 2000) which updated the traditional psychoanalytic and object relations approaches by proposing a two-person, co-constructed alliance, with any ruptures arising in the intersubjective space between client and therapist. In this way, therapist and client are seen as having a mutual influence on their relationship and the way in which each one experiences the other. Safran et al. (2000) suggest one of the main tasks of therapy is for clients to develop the

ability to negotiate the needs of self and others in the TR, and that negotiation of ruptures in the alliance is the key to therapeutic change. Meanwhile, Ellman (2007) integrates Freudian theory with self-psychology and object relations in an updated analytic theory which suggests analytic treatment goes through transference cycles, with each rupture-repair process deepening trust and love in the dyad. Frankel (2006) conceptualises ruptures as disjunctions with the aim to extend ruptures beyond negative transference so that analysts can work more cooperatively with the client to resolve them. Based on client work, Frankel defines disjunctions as moments in therapy when there is a restricted capacity for the dyad to work therapeutically together. He identifies disjunctions as intrapsychic (dissociation, splitting and repression/projection), and external (misattunements, disagreements, mismatch, environmental) and points out that sensitivity to ruptures can maximise therapeutic progress.

Research on ruptures

Safran, Crocker, McMain & Murray (1990) pioneered empirical research into ruptures after they adopted Bordin's concept of the alliance, and developed a rupture-repair task-analysis method (Safran et al., 1996). Safran & Muran (2000) suggested there were two main types of rupture: withdrawal ruptures (clients disengaging with the therapist or the tasks of therapy, or withdrawing emotionally) and confrontation ruptures (overt expressions of anger or dissatisfaction at the therapist or the therapy).

Research suggests understandings of what constitutes a rupture varies depending on who is reporting them, with clients reporting far fewer than therapists (Coutinho, Ribeiro, Fernandes, Sousa, & Safran, 2014; Eames & Ruth, 2000), while ruptures are generally under-reported by therapists and clients (Sommerfeld, Orbach, Zim & Mikulincer, 2008).

Rhodes et al. (1994) explored clients' experiences of misunderstanding events in (mostly) dynamic therapy. They found that misunderstanding events (ruptures) resulted in positive experiences as well as negative ones. The researchers found that ruptures were resolved when the relationship was good, and the client and therapist were able to talk through the misunderstanding, while clients with a poor relationship, and whose therapist was unaware of the misunderstanding, dropped out of therapy. The authors suggest that learning how to talk about misunderstandings could be one of the most valuable experiences clients have in therapy; they represent a pivotal point in therapy that provide an opportunity for growth. The authors used a method based on Strauss & Corbin's (1990) grounded theory that imposes an external structure onto the data, so it remains unknown to what extent the data is representative of the findings. The study's limitations also include risk of bias (there is no mention of epistemology), data gathering and participant recall (time since event,

questionnaires and absence of interviewer prompts resulted in a lack of data), and using trainees as therapists (additional factor contributing to the rupture).

Coutinho, Ribeiro, Hill & Safran (2011) used consensual qualitative research (CQR) to explore the experiences of withdrawal and confrontation rupture events in therapy for eight client-therapist dyads, with all of the clients being diagnosed with a personality disorder. Observers used the Rupture Resolution Rating System to code for rupture markers and resolution, however resolutions were not covered in analysis because none of the ruptures were resolved. Five judges were involved in the analysis stage to construct the findings. In this study, both therapists and clients were left confused and ambivalent, while the confrontation events left both parties with intense negative feelings. The authors found that most ruptures occurred when clients felt unprepared for a therapeutic intervention, and they also echoed a previous rupture event. The therapists in the study were all trainees using CBT, the sessions were filmed, and only the first 15 sessions were studied – all these factors may have contributed to the ruptures but this is not addressed in the paper. Client results yielded no typical data in several sections but there is no reflection as to why – clients may have experienced the interviewers as being on the same side as the therapists (they would presumably have been informed about the judges) and therefore the power imbalance may have restricted their talk. CQR is a hybrid qualitative method (phenomenology, GT and comprehensive process analysis) with a constructivist epistemology and post-positivist elements (PD diagnoses, measures, judges); using methods with conflicted epistemologies undermines the validity of the findings.

Qualitative research from the therapist's perspective has revealed the extent of the negative impact ruptures on these practitioners. Coming from a counselling psychology perspective, Rajput (2013) used a grounded theory (GT) synthesis technique from a constructivist-interpretivist methodology to investigate how cognitive analytical therapists experienced ruptures in the alliance when working with clients who had been given a diagnosis of borderline personality disorder. Rajput found therapists experience profound discomfort working with ruptures, and argues that awareness and training about ruptures is important to equip and support all therapists in their practice.

Rajput's findings about the impact on therapists echoes research findings by Leinonen (2010), who looked at clinical psychologists' experiences of ruptures within an NHS context using Charmaz's constructionist version of GT. All the participants' constructions of rupture included “a breakdown in the collaborative process”, but beyond this, constructions were varied, with participants expressing uncertainty about defining and identifying ruptures in practice. Leinonen suggests this was because ruptures were comprised of many variables (severity, time, therapist/client factors, resolution, awareness) which made it hard for participants to define the phenomenon. The findings

showed a possibility for positive ruptures, that ruptures were associated with therapists' feelings of failure, and an NHS context that gave a mixed messages of support versus pressure to avoid ruptures. Leinonen concluded rupture is a technical psychological term to be avoided and suggests future research about psychologists and ruptures should refer to ruptures as clients do: “when things go wrong with a psychologist”, and she argues for a more open recognition of ruptures within an NHS context. A phenomenological methodology may have been a more effective way for Leinonen to explore the experiences of her participants, and the results read like a systematic categorisation of themes rather than an explanatory theory. GT was used to take account of the “complexity of the contextual processes” and to avoid individualistic accounts, but IPA views the participant as a person-in-context, and individual analyses are synthesised at the end of the process, which weakens Leinonen's case for GT rather than IPA.

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The problem of definition was also an interesting feature of Haskayne et al.'s (2014) study which used interpretative phenomenological analysis (IPA) to explore the rupture-repair experience for dyads in long-term psychodynamic therapy. The scholars found that Safran's definition of alliance ruptures did not fully convey the experiences for clients and therapists. These researchers found that ruptures were experienced by clients as an ongoing emotional struggle associated with the notion of resistance. The psychodynamic therapeutic process (use of silence, interpretation, not receiving feedback) seemed to jeopardise collaboration and created ongoing ruptures that needed working through. The authors found that the survival of this struggle over time (assisted by containment, mirroring for example) seemed to function as a mechanism of change, helping the client towards intimacy, greater emotional expression and insight. This study attempted to convey the rupture from two different perspectives, therapists and clients, which makes the sample less than homogeneous; it may be that these groups experience ruptures in such different ways as to make the findings incompatible when grouped together.

The literature reveals that ruptures are painful negative experiences, but can also yield positive experiences and outcomes too. It is interesting to note that the studies using dynamic therapy seemed more likely to report positive experiences and resolutions. The studies also begin to highlight the importance of other factors, such as context, modality and at what point in therapy the rupture occurred for example.

It would be interesting to see if sexual identity has a moderating effect on ruptures and the quality of the TR. There have not been any research papers published specifically on gay men's experiences of ruptures in the TR, however, studies on the experiences of sexual minorities in therapy have described difficulties and tensions in the TR which could be tentatively inferred as rupture events. Therefore I will focus on a review of research on experiences in therapy for sexual

minority clients.

Research investigating therapy experiences for sexual minority clients

Interpreting the research into LGBT client's experiences in therapy, and their perceptions of therapists, Bieschke et al. (2007) concluded that LGBT clients are sensitive to subtle forms of bias in therapy and their involvement in and motivation for therapy is guided by their perceptions of the depth and quality of the therapist's affirmative stance. Sexual minority clients are most sensitive to: heterosexist language, low levels of therapist awareness about sexual minority issues, and therapists who are avoidant of certain topics relating to sexuality.

Three studies (Dorland & Fischer, 2001; Liddle, 1996; Mair & Izzard, 2001) generally found that clients experienced either unhelpful practices (eg, therapists attributing the presenting problem to sexuality), or a TR in which they felt limited and restricted in the extent to which they felt comfortable disclosing or discussing issues around their sexuality, or sexual experiences and practices. Clients were more likely to disclose personal information and come out if the therapist's language was free from heterosexist bias (gay friendly). Evans & Barker (2010) explored LGB client experiences of coming out in therapy, or therapist disclosure of their sexuality status (heterosexual and homosexual) using questionnaires and Braun & Clarke's method of thematic analysis. While the findings show evidence of positive experiences, there are also many references to uncomfortable and difficult interactions in which clients report feeling deeply misunderstood - these read like rupture events, although they are not reported as such.

Two surveys using content analysis found evidence of unhelpful aspects of therapy for sexual minority clients, but it is unknown whether clients would view these as rupture events. Malley & Tasker (2007) asked 365 gay men and lesbians in the UK what they found helpful and unhelpful in therapy. They used a questionnaire with four open questions. Respondents produced less data about what was unhelpful rather than helpful, with 5% saying the therapist was “negative about my sexuality” and 3% saying the therapist “had a lack of understanding about sexual identity issues”. The findings offer some support for the predictions that sexual identity specific issues are very important as well as generalised concerns about therapy, but only for 5% of the respondents, a small minority. This study gives no indication of time since therapy, which may have affected participants' ability to recall experiences in detail, and also some of the questionnaires were filled out at celebration events (eg, Pride) so respondents may have been somewhat distracted.

Using semi-structured interviews, Israel, Gorcheva, Burnes & Walther (2008) asked 42 LGBT people about helpful and unhelpful experiences in therapy and found client, therapist and service-

level factors affected clients' experiences of therapy. The most frequent unhelpful situation (36%) was described as experiencing the therapist as cold, disrespectful, distant, disengaged or uncaring, while 36% also said the interventions were ineffective, for example, excessive use of silence, using "why" questions and so on. Meanwhile, 31% of clients described unhelpful situations as the therapist imposing value judgements on them, negative bias regarding their sexuality, and invalidating client's experience of progress. For most of the respondents (65%), the unhelpful situations resulted in "negative impact on the relationship with the counsellor" (which could be inferred as rupture events), while 45% said they resulted in early termination of therapy, and 43% reported in a diminished quality of life. While Israel et al.'s paper conveys the nature of ruptures in terms of unhelpful experiences in therapy, and their consequences, the findings are restricted to the limits of their content analysis, which measured themes' existence but not their frequency.

Shelton & Delgado-Romero's (2011) phenomenological analysis, which used focus groups to elicit LGBQ clients' therapy experiences, supports the existence of seven sexual orientation microaggressions. An example of a sexual orientation microaggression is when a therapist avoids or minimises sexuality by using words such "lifestyle" or "choice". Negative client feelings included confused, rejected, invisible, powerless, uncomfortable, or pressured to comply, while there were also changes reported in their attitudes and a reduction in help-seeking behaviours. The study found the therapy clients experiencing feelings of invalidation, being unaffirmed, frustrated and angry when their sexual orientation and issues relating to sexuality were dismissed, avoided, overrepresented in treatment or pathologised. These microaggressions led to a negative impact on the therapeutic process, the authors conclude. The concept of microaggressions can be interpreted as rupture events because they have affected the client's feelings or attitudes towards the therapist. Most participants described having strong therapeutic alliances in the study, and the researchers conclude that, because of this, it made it very difficult for them to challenge the microaggression in therapy. While this notion of strong alliance sounds like a contradiction in terms, considering clients felt unable to voice their feelings, it highlights how understandings of a good TR vary between modality and between client or therapist. There are pros and cons to using focus groups; a supportive peer group can enrich data by facilitating a communal and validatory space that promotes talk, however group dynamics can also contribute to social facilitation bias.

Kelley's (2015) mixed methods paper investigating the therapy relationship with LG clients underlines the importance of therapy practices and the TR in LG clients' perceptions of their therapists. Kelley surveyed 55 LG participants who had been in therapy, and measured four variables (working alliance, real relationship, therapist practices, and counsellor rating) analysed with hierarchical multiple regression, along with one open question which provided data for qualitative analysis (a modified version of consensual qualitative research). Some 21% of

respondents found their therapists were dismissive or viewed their sexuality as a problem, while clients reported 25% of therapists as lacking knowledge about LG issues. Also, 30% of respondents said they preferred a therapist with the same sexual orientation as them, which means the majority (70%) did not mind seeing a heterosexual therapist. Interestingly, the real relationship was found to predict an additional 8% of variance in clients' positive feelings towards their therapists.

Finally, US clinical psychologist Goettsche (2016) conducted a qualitative IPA study exploring the therapeutic experiences of seven LGB individuals mostly with cross-orientation dyads (heterosexual therapist, LGB client) but also with dyads with matching sexual orientations. The author found some of the client experiences resulted in therapist-induced prejudicial ruptures that were not discussed nor resolved, and which resulted in termination of therapy. These experiences tended to be organised in a theme titled, “navigating heterosexism”. Examples of incidents include one client who felt the impact of being gay was minimised, while another client said their therapist conveyed the message that the client's sexuality was a phase, and that heterosexual relationships were preferable. The author discusses ruptures within many of these experiences, how therapists expressed judgements or lack of knowledge, and Goettsche suggests competent care is likely to be contingent on an understanding and acknowledgement of the influence of heterosexism on the lives of sexual minorities.

Many of the studies mentioned thus far have problems with sampling because they collapse diverse sexual minorities into one group (eg, LGB), and therefore it is unclear how representative the findings are for specific groups, such as gay men in particular. This is especially relevant to Goettsche's study that uses IPA, a methodology that benefits from a homogeneous sample to explore convergence and divergence between cases. Some of the studies may have biased samples by using friendship networks, or finding participants through established networks; this may have resulted in white, educated, “out” participants being over-represented in the samples. Data can be limited in qualitative studies that rely on questionnaire data; the data in Kelley's and Malley et al.'s studies both lack quantity and depth because there is no interviewer to prompt and probe. There are also problems with how researchers use concepts such as the “alliance” (there are many tools, each measuring the construct slightly differently) (Horvath et al., 2011), and “sexual identity” which is increasingly being experienced as a fluid construct that is subject to change (Bieschke et al., 2007; Clarke et al., 2010).

In summary, the literature about the experiences of therapy for sexual minority clients suggests the presence of rupture events, and these experiences have been reported and described, but not explored in-depth. Ruptures are to be expected in therapy (Bordin, 1979), so it comes as no surprise to find evidence of them. The literature reviewed on sexual minority clients' therapy experiences

raises further questions such as how did the clients make sense of the ruptures, and how did the ruptures impact on the TR and their therapy?

Conclusion, Research Aims and Research Questions

A wealth of research over the past 60 years has consistently found the TR to be the best predictor of successful treatment (Norcross, 2010), while negative outcomes are associated with negative interpersonal processes (Safran et al., 2000, 2011). The importance of establishing and maintaining a strong TR is a significant factor in determining clients' successful experience in psychotherapy (Bordin, 1979; Gelso & Carter, 1985, 1994).

Rupture events provide opportunities for therapeutic change and growth (Safran et al., 2000, 2011; Haskayne et al., 2014; Tufekcioglu et al., 2016), but it remains unclear to what extent therapists are making effective use of this process in relation to sexual minority identity clients, because there has not been any research investigating how client sexual identity moderates the therapy-outcome process.

Research into experiences in therapy has tended to focus on therapists' perspectives and experiences in therapy (Manthei, 2005). This is surprising considering therapist assumptions about client satisfaction tend to be inaccurate (Regan et al., 1992), while clients' perceptions of alliance strength are the best predictor of outcome (Norcross, 2010). This supports a case for a study that investigates the client's perspective and experiences.

The rupture research that has focused on clients' experiences has tended to use participants with a diagnosis, usually a personality disorder (PD). However, in a meta analysis of rupture research, Eubanks, Muran & Safran (2018) found that client PD was not a moderating factor in the rupture experience, and highlighted the need for the research community to explore the effect of minority identity differences on clients' rupture experiences.

Indeed, Goldfried & Pachankis (2007) suggest that more research is needed to study the processes of therapy in the TR with LBG clients, as therapists have been left without literature to refer to in this area.

Meanwhile, Safran & Muran (2006) have called for more research to investigate how relational factors affect the change process, while those authors, as well as Coutinho et al. (2009) and Haskayne et al. (2014) recommend more qualitative research to explore how client/therapist

identity characteristics relate to change in the rupture-repair process.

With this in mind, I have used interpretative phenomenological analysis (IPA) to study clients' experiences of ruptures in the TR, and specifically to explore the rupture experience from people with a minority sexual/gender identity. LGBTQ+ identities are very diverse (heterogeneous) and an IPA study with a robust validity requires a homogeneous sample; these factors guided the researcher in identifying a specific sexual minority group for the study. Various LGBTQ+ groups could have been chosen for the study (lesbian, bisexual men or women, trans men or women, queer and non-binary identities for example), but gay men were chosen for various reasons.

The researcher had a strong personal interest in studying this group, in part due to a shared identity and experience of the phenomenon in question, which it was hoped would offer a unique understanding and interpretation of the lived experience of this group. This influenced the decision to select this group (see reflexivity section, page 6).

The gay male identity holds differences from other groups in the LGBTQ+ umbrella, such as its unique historical discourse in the literature, which pathologised it, and which was influenced by a discriminatory legal background, for example, the decriminalisation of male homosexual sex in the UK in 1967, and the age of consent (it was lowered from 21 to 18 in 1994, and equalised in 2000). Gay men are also an identity group which both holds privilege (cisgender male) and which is a stigmatised minority (gay). While there is a higher prevalence of suicidal distress in LGBTQ+ communities generally, gay men represent a high-risk minority sub-group in terms of completed suicide. In 2018, three quarters of people in the UK who completed suicide were male, and the proportion of these people who identify as gay is unknown in part because sexual minority identity is not recorded in coroners' reports, which means the proportion of suicides who are gay men could well be under-reported. This study also aimed to build on existing research, which has established that gay men experience higher rates of unsatisfactory experiences in therapy, and higher drop-out rates than cisgender heterosexual people. This research background has been reviewed to provide a rationale for this study.

Despite there being a lack of research into other sexual and gender minority identities, the researcher reasoned that does not necessarily invalidate the need or the decision to chose gay men as a research group. The researcher also reasoned that participants from this group might be more likely to come forward partly because it is a larger group within the LGBTQ+ umbrella, increasing the sample pool. The researcher reasoned and assumed that participants from this group might be more likely to participate due to aspects of perceived shared identity with the researcher in terms of gender and sexual identity reducing perceived barriers; this assumption was influenced by research

on clients' matching preferences (Jones et al., 2003). These factors were thought to mitigate risks associated with potential difficulties in recruiting participants. This summary aims to provide reasons and a rationale for focusing this study on participants with a gay male identity.

Relevance to counselling psychology, novelty and contribution

One of the defining aspects of counselling psychology is to "understand the therapeutic relationship and alliance as conceptualised by each psychotherapeutic model" (HCPC, 2015). The TR is of central importance to counselling psychology, which places relational humanistic values at the heart of its practice, alongside research and interpersonal processes that promote wellbeing and personal growth (BPS, 2006). Counselling psychology is well-positioned to research this topic because it is a pluralistic scientist-practitioner discipline that welcomes and can hold conflicting perspectives, and is grounded in therapeutic practice which is concerned with the subjective/intersubjective experience of individuals in context.

This study is suitably aligned with counselling psychology values, which draws upon philosophical principles based in phenomenology that are concerned with respect and empathy for the subjectivity and the validity of first-person accounts. In its brief history, counselling psychology has been at the forefront of developments in difference and diversity, with social justice at its core.

Some of the defining aspects of counselling psychology are its standards to recognise discrimination and anti-discriminatory practice – it is hoped this study will help raise awareness and deepen understanding of minority stress issues and the often unsaid subtle ruptures which impede the quality of human relatedness between therapist and client.

There is evidence that rupture events are common in therapy, and possibly more so for oppressed minority groups such as gay men, however we do not know how this client group makes sense of rupture events. This study would be the first to explore this enigmatic phenomenon in-depth with this client group, thus offering a unique contribution.

Rupture events are often very subtle, below mindful awareness, and therefore an interpretative phenomenological method such as IPA would be useful to extend analysis beyond the descriptive level. This client group could provide an opportunity to explore rupture events in unique ways and it is hoped the findings will offer new understandings that can help counselling psychologists and allied professionals facilitate repairs, wellbeing and growth. This leads me to my research question:

Research questions

How do gay male clients make sense of ruptures in the therapeutic relationship?
To what extent, if at all, are therapeutic ruptures associated with a client's sense of difference as a gay man?

Methodology and Procedures

Research design and rationale

This study uses a qualitative approach to investigate experiences of difficulties (ruptures) in the therapeutic relationship from the perspective of clients who identify as gay men. The reasons why a qualitative approach was chosen, namely interpretative phenomenological analysis, is discussed below.

Qualitative and quantitative methodologies

Research adopts different methods depending on the nature of the enquiry, and these methods can be broadly categorised under quantitative and qualitative approaches. Quantitative research produces numerical data which is analysed using statistical methods. Data is generally gathered using questionnaires with scales so that the participant responses can yield numbers. Quantitative research is grounded in positivism and empiricism, which holds a realist epistemology and ontology, and aims to test for causal links or associations between different variables. Because quantitative research is grounded in the scientific method, replications of that study should in theory produce the same results.

Qualitative research uses language and verbal communication, and converts this into text which is then analysed and/or interpreted via various methods to produce findings. Qualitative research aims to produce knowledge about how people construct meaning and how they experience particular phenomena in the social world, and therefore tends to be focused on subjective experience and construction of meaning through language. This means qualitative research tends to be grounded in relativist epistemology, which means there are a multitude of knowledges, however some qualitative research such as grounded theory is positivist or post-positivist. The research question and the aims of the research influences which methods will be used, and which methodology the research will be positioned in. Reflexivity is an important concept in qualitative research; when research is grounded in relativist or critical realist epistemology, it means that the researcher's

involvement in the research has an influence on the findings, and therefore a transparent reflection on the researcher's impact on the study and their process is essential for validity.

This study's research question aims to explore how people experience a particular phenomenon, ruptures in the therapeutic relationship, and therefore this favoured a qualitative methodology, one which which offers exploration and interpretation of the phenomenon (ruptures) within a context. Interpretative Phenomenological Analysis (IPA) was considered to be the most appropriate method to achieve the aims and objectives of the study.

Interpretative phenomenological analysis

IPA explores the subjective experience of individuals in relation to a phenomenon (Smith, Flowers & Larkin, (2009)) and therefore it is well-suited to investigate this study's research question and the phenomenon in question. IPA is theoretically underpinned by the philosophies of phenomenology and hermeneutics (Shinebourne, 2011), and its idiographic approach requires detailed focus on individual cases of a specific phenomenon (Willig, 2008), which matches this study's aims.

IPA has been influenced by phenomenological philosopher Martin Heidegger (1889-1976), who suggested that an individual's subjective experience can be understood as being organised around the *lifeworld*, a concept that understands the totality of a person's experience as being inextricably embedded in a context that includes their cognitions, feelings, behaviour, embodiment, temporal and spacial aspects, as well the influence of social, cultural and historical aspects, and linguistic resources (Eatough & Smith, 2008; Larkin, Watts & Clifton, 2006). The best way to understand a person's lived experience of a phenomena is to consider them as a “person-in-context” according to Smith et al. (2009).

Ontological and epistemological position

The researcher holds a critical realist epistemological position (Bhaskar, 1978) that aligns with phenomenological philosophy, which proposes that knowledge is subjective and that there are multiple truths about reality depending on the social, cultural, political and historical context in which that knowledge is produced. Phenomenology posits that the individual is always embedded in a context and interprets reality (phenomena) through the filter of consciousness which results in a unique experiencing of the self and the world (Smith et al., 2009).

In terms of ontology, IPA can also be positioned as critical realist. IPA acknowledges that there is a

reality of things, but that each person interprets the world through the filter of their consciousness, and thus each person's version of reality comes into existence by their experience of being-in-the-world. IPA assumes that direct access to the phenomena that come into being for each person can never be reached completely by another person. IPA has been designed to enable the researcher to come as close to those phenomena as they can through the double-hermeneutic process whereby the researcher interprets the participant's interpretation of the phenomenon in question, while engaging in a reflexive process that is open and insightful about how the researcher is shaping the research.

Alternative methods

Other methods were reviewed but not considered as appropriate for the research question, which requires an exploration of participants' cognitions. Social constructionist methods hold strong relativist epistemologies which do not attend to participants' cognitions or inner psychological world (Smith et al., 2009).

This means discursive (discourse and Foucauldian analysis), narrative and other social constructionist methods (such as constructivist versions of grounded theory) were not appropriate, because they are restricted to focusing on how participants construct aspects of psychological enquiry (eg, identity, concept, their story) through talk and language only.

Meanwhile, positivist grounded theory analysis assumes there is a scientific objective knowledge about ruptures that can be found, and is concerned with understanding processes and generating theory, rather than exploring individual experiences. Meanwhile, thematic analysis is more suited to research questions that have a practical application (Savin-Baden & Major, 2012) and lacks a methodological underpinning. Therefore neither of these approaches seemed suited to the aims of this study as well as IPA.

Other forms of phenomenological analysis are available, but IPA was selected because its interpretative focus allows for an analysis that goes beyond the descriptive level, which may offer deeper understanding and insight.

Procedure

Research design: Because IPA is an idiographic approach, data was gathered using semi-structured interviews with seven fully consenting participants; this allowed for in-depth analysis of each case, and enough participants to produce meaningful results for doctoral-level research (Smith et al.,

2009).

Participants: The sample was selected purposefully as IPA requires a homogeneous sample; participants were required to have had experience of ruptures (difficulties or tensions) in a counselling or psychotherapy therapeutic relationship, they must have self-identified as gay men and been over 18 years old. Due to the trans-theoretical definition of the therapeutic relationship, and ruptures, participants' experiences of ruptures in therapy could come from any modality of 1:1 therapy, with a therapist with a recognised professional title who is regulated by a recognised body (eg, BACP, UKCP, BPS, BABCP). To facilitate exploration of the research question, potential participants must have been in therapy as part of a therapeutic contract that lasted more than 20 sessions. Any potential participants who did not meet this criteria were excluded. Table 1 below outlines some demographic information and relevant details about the therapy in which the ruptures occurred (pseudonyms have been used throughout).

Table 1

Participant	Paul	Fraser	Julian	Stuart	Kevin	Shawn	Matt
Age at research interview	66	54	37	64	77	28	49
Duration of therapy, frequency	3 years 3xweekly	4 years weekly	0.5 years weekly	3 years weekly	0.5 years weekly	1.5 years weekly	1 year weekly
Time elapsed since rupture (at interview date)	37 years	21 years	2 years	8 years	27 years	1 year	3.5 years
Modality of therapy*	Psycho-analysis	Phenomen-ological/ existential	Psycho-dynamic	Psycho-dynamic	Psycho-analytic	Integra-tive	Psycho-analytic
Setting	Private, fee	Private, fee	Private, fee	Private, fee	Charity, free	Private, fee	NHS, free
Ended therapy with rupture resolved	No	No	No	No	No	Yes	No

*Modality of therapy: as described by participant

Recruitment: materials included A4 and A3 posters, A6 flyers, and an E-flyer (see Appendix 1). These materials were distributed via a snowballing method – I sent them by email, post and by hand to LGBTQ (lesbian, gay, bisexual, transgender and queer) organisations and other relevant organisations and individuals, mainly in the South East, but also further afield in the UK. The E-flyer was sent to the main contact of each organisation, and this was forwarded to members by email, or added to social media platforms.

Interviews: a pilot interview was carried out in June 2017 with a fully consenting participant; this pilot procedure helped to refine the interview schedule (see Appendix 4). Some seven participants were interviewed between July 2017, with the final interview being in February 2018. Four participants had been forwarded the recruitment materials by email, one was forwarded it from Pink Therapy's Facebook page, one saw a poster at an LGBTQ organisation in East London, and one participant was given a flyer in person by a third party. Five participants were interviewed in their own homes, one in his work building, and one at London Metropolitan University. The participants were from Brighton (2), London (3), Essex (1), and Glasgow (1). After the interviews, the researcher's impressions, thoughts and feelings were logged in a reflective/reflexive journal.

Ethical considerations

The planning of this study was conducted within the British Psychological Society (BPS), Code of Ethics and Conduct (2009) and the BPS Code of Human Research Ethics (2014). Ethical approval was gained from the Departmental Ethics Committee at the Department of Psychology, the School of Social Sciences at London Metropolitan University before recruitment activity commenced (see Appendix 9).

***Informed consent*:** Individuals who contacted the researcher to say they wanted to participate were asked to consent freely and without obligation on the basis of adequate information given in the Participant Information Sheet and Participant Consent Form (Appendices 2 and 3). They were fully informed without deception. Participants were only able to take part in the study once the Consent Form had been signed and returned to the researcher, along with the completed Demographics and History of Therapy Form (Appendix 7) and the questionnaires (Appendix 8).

***Debriefing*:** Participants were informed when the interview was over and were then offered adequate time to debrief in which they were given the Participant Debrief Sheet (Appendix 5). During debriefing, participants were given further information about the study, space to discuss how they felt, and information/signposting to ongoing care if needed. None of the participants presented or reported distress after the interview.

***Withdrawal from the study*:** Participants were informed they could withdraw from the study at any time without question, and that the interview could also be stopped at any time without question or reason and the data destroyed. Adequate time was given to potential participants before they were asked if they wanted to take part. Participants were informed that it may not have been possible to withdraw from the study after April 2018 as the data may have been transcribed and integrated into the study by that point.

***Confidentiality*:** Participants were fully informed about confidentiality and how their data would managed and their ability to access it under the Data Protection Act (2012). The Participant Information Sheet and Consent Form included full information about how confidentiality would be protected and its limits according to the law. The Consent Form made participants fully aware that interviews would be audio-recorded. To guarantee anonymity, participants were assigned a code/pseudonym, and any personal information was stored separately from audio recordings and kept securely. Any paper materials containing personal information was kept in a securely locked box at the researcher's home. Recording/storage devices were encrypted. Audio recordings were stored on a computer folder that was double password-protected in line with the Data Protection Act (2012) and the (BPS, 2014). Any identifiable information about participants was anonymised in transcripts, and pseudonyms were used in any write-up or published work. Participants were fully informed that all stored data would be kept only as long as necessary (until the Doctorate has been awarded, or up to five years for the purpose of publication) and would then be destroyed.

***Protection of participants*:** A risk management plan was designed to protect and minimise any harm to the participants. The Information Sheet informed participants that the topic is sensitive and discussing it might cause them distress, and they were encouraged to think carefully before consenting.

To further minimise risks and avoid harm, this study excluded any participants scoring in the severe ranges on the Patient Health Questionnaire [PHQ-9] (Spitzer et al., 1999) and the Generalized Anxiety Disorder Scale [GAD-7] (Spitzer et al., 2006), and also any participants who scored 2 or 3 on question 9 (suicidal ideation) of the PHQ9 measure (see Appendix 8). The Information Sheet and Consent Form informed participants they needed to complete the PHQ9 and GAD7 before they could take part, they should be completed after they have signed the Consent Form, and return them to the researcher with the Consent Form. They were informed that their participation would be confirmed once these forms had been received by the researcher.

In the Consent Form, the researcher asked for participants' consent to breach confidentiality in the event of high suicidal risk (intent, plans, method, failure to agree to a safe plan), risk of harm to

others (abuse, bodily harm), and disclosure of serious criminal/terrorist activity by contacting statutory services – only people who agreed to this by signing the Consent Form could participate.

The Distress Protocol further safeguarded distress by guiding the researcher in knowing how to identify distress, and taking necessary action (Appendix 6). Potential participants who are known to the researcher, either personally or in another role, would have been excluded from taking part to eradicate any risk of coercion or conflict of interests. This ensured there was no confusion of roles and no conflicts of interest.

***Health & safety issues for the researcher*:** A risk management plan was designed as part of ethical approval to ensure the safety of the researcher when interviewing participants in their own homes.

Analysis

The researcher used the guidelines in Smith et al. (2009) for carrying out IPA. Each interview was analysed in turn, and a master theme table was constructed for each participant; this table included three master themes, each with three subthemes.

Step 1. During the analysis of each participant, a notebook was used to bracket off assumptions, and reflexive notes were logged. The researcher carefully transcribed each transcript, making initial notes of impressions following initial exposure to the audio and text.

Subsequent encounters with each case involved multiple readings of the transcript, initially adopting an empathic approach to facilitate understanding of the participant's experience. A sceptical/questioning approach to reading the transcript was also used on subsequent readings to combine possible interpretations and enrich findings. The researcher used the "find" function in Word to count frequencies and clusters of words, and noted anything that stood out or raised questions. These questions did not always have answers, but they created lines of enquiry.

Steps 2 and 3. Secondly, the transcript was coded (see appendix 11) for each participant; on the right hand column the researcher made phenomenological/descriptive, linguistic, and interpretative/conceptual comments. Thirdly, emergent themes were listed in the left hand column of the transcript.

During this process, analysis was conducted in micro-detail; the researcher noted references to objects throughout each transcript, examined similarities and comparisons between objects and concepts. Examples of such objects/concepts include references to what the researcher interpreted

as “the actual rupture experience”, “self”, “therapist”, lifeworld elements among others, as well as references to time, embodiment and space/location. The researcher also analysed the data from a broader perspective by selecting longer chunks of text and analysing them for meaning.

Step 4. Fourthly, the researcher eyeballed the emergent themes by writing emergent themes on different pieces of paper attached to a wall, and analysed them for inter-theme separation, and intra-theme separation. During this process, the researcher distilled and clustered themes, and analysed them using abstraction, subsumption, polarization, contextualization, numeration and function (Smith et al., 2009). The researcher also took each theme and analysed the transcript for further references to them. The researcher continually checked that emergent themes were linked to data in the transcripts.

Step 5. Finally, the themes were organised under a super-ordinate theme structure. During this process, salient extracts/quotes were assembled and organised under the emerging theme titles.

Steps 1 to 5 were repeated for each participant in turn to produce seven master theme tables, one for each case.

Step 6. The seven master theme tables were then analysed in a process in which the researcher looked for patterns and divergences across cases (see appendix 12), a process that continued until one master theme table (each with three subthemes) was produced to represent the findings of the study (see tables 2 and 3). Throughout this process, the hermeneutic circle was repeated multiple times to facilitate a continuing in-depth analysis; this involved the researcher repeatedly becoming immersed in the details in the data, then stepping back for a more objective and broader perspective – this was followed by reflection/reflexive time in which notes were made in a reflexive diary. Each exposure to the data changed the researcher's understanding, and therefore influenced contact with the data each time it was returned to. During the analysis process, some themes collapsed into each other and became organised under broader master theme and sub-theme titles.

Evidence from the data was checked to ensure the resulting theme table was relevant to most of the participants (see table 2) and extracts from the data across the seven cases were identified to support the master theme table and sub themes (see appendix 13).

Validity and trustworthiness

It is important that psychological research demonstrates validity so the reader can be confident that it is a credible and trustworthy piece of work, which also offers potential value to counselling

psychology as well as readers from other/allied professions, and the general public. In this section, I will attempt to show how this study's validity has been assessed, using Yardley's criteria (2008).

Within a positivist philosophical framework, quantitative psychological research can be assessed for validity, reliability, generalisability, objectivity and replicability. However, qualitative psychological research cannot be assessed under these criteria because it is underpinned by different paradigmatic assumptions and philosophical methodology. Indeed, qualitative studies are assessed for quality using criteria which align with the methodological epistemology and ontology in which they are grounded, with Yardley's (2008) criteria for assessing quality offering a good fit for IPA research (Smith et al., 2009) and providing a framework for researchers to demonstrate credible and trustworthy findings. I will briefly discuss each criterion in turn.

Sensitivity to context

This criterion assesses how well the study considers existing theory and research in the development of the topic and how well participants were able to contribute and participate considering their perspective and position.

This study offers a comprehensive literature review of the rupture phenomenon and research on therapy experiences for gay men. This not only guided the research questions but also provided a robust rationale for the study. The study also offers clarity with regards to the researcher's and the methodology's epistemological and ontological stance. Participants were interviewed in a venue of their choice so that they could feel most at ease; this was their own home in most cases, and the researcher offered an empathic interviewing style as a given, with a non-judgemental approach coupled with warm interest, open-ended questions and prompts to help participants talk about sensitive issues and clarify meaning about sensitive issues where possible. The researcher believes this facilitated participants' ability to feel comfortable in divulging what they wanted to say about a sensitive and very personal topic.

With regards to sensitivity to data, steps were taken to follow Smith et al.'s guidelines (2009). This meant honouring the subjective experiences of participants, but also moving beyond description to interpretation, while ensuring the researcher owned any claims as interpretations of the data, and acknowledging the researcher's influence and role in the analysis by using a reflexive journal. Each case was analysed in micro-detail, before a theme table was produced for that case. The researcher attempted to start each case afresh and to bracket out the previous case; this was difficult when similar themes emerged across cases; notes were made after which a conscious effort was made to bracket off previous cases. Once all the cases were analysed individually, the cases were further analysed for patterns across cases, and one master theme table was produced to represent the

findings of the study, with notes regarding convergence and divergence logged. During this process, the researcher attempted to keep existing literature out of mind during analysis, and made a note when existing literature came to mind. Participant extracts have been used in the findings as validation, and the researcher attempted to use extracts that represented as many cases possible in the findings section. Appendix 13 offers examples of participants' extracts to support the finalised master theme table.

Commitment and rigour

These criteria refer to the researcher's engagement with the topic as well as the theoretical and empirical data, and their competence in IPA. They also cover how well the researcher has achieved their aims and whether the recruitment and sample was sufficient.

The researcher has been engaged with the topic for the duration of their training (five years) and new theory and research was incorporated into the study if it was relevant or appropriate. The researcher developed competency in IPA by: rigorously following the steps in Smith et al. (2009); using research training from the researcher's counselling psychology doctoral training course; attending a one-day IPA workshop at Derby University focused on how to analyse data; drawing on resources from an IPA Yahoo online community/forum; and using supervision from the researcher's academic institution.

This study used a purposive sample of participants and the researcher analysed the data in depth and in micro-detail, with specific inclusion/exclusion criteria to achieve the aims of the study. The researcher was engaged with in-depth analysis for three months. During analysis, the researcher sent a theme table and summary for each analysed case to their academic supervisor, before analysing for patterns across all the cases. Following the analysis, a final master theme table was sent to the academic supervisor, which was then reviewed and refined under academic supervision.

The researcher was deeply immersed in an empathic engagement with the data during the analysis; this involved multiple readings and processing, as well searching for references to specific concepts or objects with the data, for example, references to time, self, rupture/difficulty in the relationship and therapist among others. The researcher also embraced contextual data that did not seem directly related to the rupture phenomenon, but which was part of participants' lifeworlds, for example, information about their identity development. During the analysis, the researcher continuously moved back and forth between cases, logging the processes of the hermeneutic circle in which the researcher's interpretations deepened meaning.

During analysis, anonymised information from the initial stages of the analysis was shared with a

peer from the researcher's training course who was also conducting IPA. This helped the researcher to gain some validity in the way the analysis was being conducted, and also to gain a different perspective on the themes there were emergent, as well as the validity of the descriptive codes compared with the interpretative themes that emerged.

Smith et al., (1996) suggest that participants' review of the findings can improve validity. On request, the researcher invited participants to see a summary of the findings and the finalised theme table. Most participants requested to see this. No participants reported dissatisfaction with the summary of the findings. All participant feedback that was received was validating of the findings.

Coherence and transparency

Coherence addresses the issue of whether the study makes sense as a whole, and the extent to which the narrative in the study offers quality. The researcher believes there is a strong rationale for the study which resulted from an in-depth literature review of the topic which led to novel and useful research questions. The researcher believes there is a degree of fit between the research questions and the methodology, while the epistemological and ontological stance underpinning IPA complements the researcher's epistemological/ontological stance in the reflexivity section. The researcher has endeavoured to present the rationale, research questions, analysis and procedures, findings, discussion and implications in a clear and coherent way.

Transparency addresses the issue of clarity about how and why the study was carried out, and how the findings were produced. Extracts from the transcripts have been presented in the findings section and in the appendices to support the emergent themes, and to allow the reader make their own assessment regarding the quality of data analysis, interpretation and presentation. The researcher believes their reflexive process offers openness and clarity regarding the researcher's influence and role in the findings that have been produced. The researcher's reflexive process has attempted to openly discuss any biases or assumptions that may have impacted on this study.

The analysis section above, as well as appendices 4, 11, 12 and 13 show evidence of how the data and analysis was conducted, and the researcher has endeavoured to provide a detailed and full description of all aspects and stages of the study, from construction of the research questions through to the analytic strategy. Meanwhile, a “paper trail” can be evidenced by the following: emails to academic supervisor, research proposal and ethical submission, pilot interview, interview schedule, audio recordings, reflexive journal, reflective notes, coded transcripts, analytical notes/lists/tables, tables of extracts from the data across cases to support the themes, feedback from academic supervisor, drafts from the write up of the thesis.

Impact and importance

The criteria impact and importance assess the study's value and usefulness to the professional community, in terms of the insights offered and the potential practical implications. Research on ruptures and their repairs are at the forefront of research in counselling psychology and related fields, in part due to research that has associated rupture-repair with good outcomes in therapy (Norcross, 2010). The researcher strongly believes that this study offers a valuable contribution to counselling psychology by exploring the rupture phenomenon from the client perspective, which is researched less than therapist perspective (Manthei, 2005), and from a high-risk sub-group which arguably experiences more ruptures in therapy, and fewer repairs. It is hoped that by exploring the subjective experiences of a small group of gay men who have experienced ruptures in therapy, the findings would shed light on and offer insights into this group's rupture experience as qualitatively different to other groups, and which may be associated with their identity as gay men. It must be noted that this study does not aim to generalise findings, as its sample is too small to accomplish this, however, it is hoped the findings can complement existing work, offer suggestions for future research and contribute to practical implications by offering insight into this group's therapeutic needs.

Findings

Overview

The analysis yielded three master themes which aim to give voice to participants' experience in a summarised and condensed format. The master themes, with exemplar excerpts, are:

> **1) The origins of the rupture: therapist as invalidating threat to gay identity and self**
> *"The first thing in my head was, 'well you're heterosexual, how can you understand me as a gay man and what I've been through?'"*
>
> **2) Rupture as process of struggling to defend gay identity and the self**
> *"I was quite challenging, testing of the relationship … the test was whether I would be able to trust him to be my therapist and whether he could accept my sexuality."*
>
> **3) Negotiating reparation and/or closure of the rupture**
> *"Being a queer boy, I couldn't be loved by this this prim, frosty, you know, frosty..."*

Table 2 below shows the recurrence of master themes across participants.

Table 2

Participants	Paul	Fraser	Julian	Stuart	Kevin	Shawn	Matt	Most participants
Master theme 1 **The origins of the rupture: therapist as invalidating threat to gay identity and self**	Yes	Yes	Yes		Yes	Yes	Yes	Yes
Master theme 2 **Rupture as process of struggling to defend gay identity and self**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Master theme 3 **Negotiating reparation and/or closure of the rupture**	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Each master theme is comprised of three sub-themes, each of which serve to elucidate and deepen the meaning of each master theme. Table 3 below provides a summary of the findings.

Table 3

1) Master theme 1.

<u>The origins of the rupture: therapist as invalidating threat to gay identity and self</u>

"The first thing in my head was, 'well you're heterosexual, how can you understand me as a gay man and what I've been through?'"

1. Perceived therapist invalidations of gay identity and self
2. Fears of therapist homophobia and lack of understanding on gay issues
3. Shame-silence: threat of shame for "being gay"

2) Master theme 2.

<u>Rupture as process of struggling to defend gay identity and the self</u>

"I was quite challenging, testing of the relationship … the test was whether I would be able to trust him to be my therapist and whether he could accept my sexuality."

1. Protest: challenge/confrontation and withdrawal/anger-silence
2. Struggle to find power and voice
3. Compliance discord: the discomfort of sitting with an unresolved rupture

3) Master theme 3.

<u>Negotiating reparation and/or closure of the rupture</u>

"Being a queer boy, I couldn't be loved by this this prim, frosty, you know, frosty ..."

1. Negotiating trust
2. Seeking repair
3. Difficulties in making sense of an unresolved rupture

The emerging three master themes are structured in way that seems to reflect rupture as a process, in which there seemed to be a beginning, a middle and an ending of the phenomenon. Each master theme and its subthemes will be discussed in detail, drawing upon extracts from participant interviews. (Additional extracts to support the themes can be found in Appendix 13.) The researcher will also offer an interpretative analysis of the participants' experiences, seeking to extend sense-making. Part of this process involved consideration of the differences and similarities between participants, the way themes overlapped with each other, contradictions within individual accounts, and analysis as to how rupture is related to other processes, such as therapeutic change and process.

3.1) <u>MASTER THEME 1.</u> The origins of the rupture: therapist as invalidating threat to gay identity and self

Master theme 1 reflects what led up to the rupture, what initially triggered it, and the effect this had on the participant. The dominant feeling in master theme 1 is anxiety. This master theme suggests that the concept of threat was integral to the experience of rupture. Subthemes of master theme 1 include 1) Perceived therapist invalidations of gay identity and self; 2) Fears of therapist homophobia and lack of understanding on gay issues; and 3) Shame-silence: threat of shame for "being gay".

3.1.1) Perceived therapist invalidations of gay identity and self

All participants reported/perceived either homophobic attitudes in the therapist, a lack of interest or value in gay themes, and a paucity of understanding of the importance of gay themes. Most participants also experienced their therapist as critical at points in therapy, which was experienced as invalidating to their sense of self. The invalidations represented rupture moments in therapy in

which participants felt there was a threat to their self or gay identity in terms of feeling misunderstood, criticised or rejected in some way. Six out of seven participants attributed invalidations around sexuality as the main cause of the rupture.

There was a divergence in the way in which participants experienced invalidations, and this divergence was focused around what the researcher terms "lack" invalidations, a perceived lack of therapist input or understanding on gay issues, and/or "transgression/microaggression" invalidations, whereby it was something the therapist said or did that was perceived as invalidating to gay identity.

The following example below sees Paul describe experiencing a lack of response from his therapist in relation to important things he was saying.

> *"To begin I think there was a lot of stuff coming out around a lot of stuff coming out about coming out, but the more deep-seated stuff around my childhood and this that and the other and the anxieties … and you know and er to a certain extent that that sort of stuff came out ... but … because there was nothing coming back* [sounding like a boy] *er I just thought this wasn't y'know really, what kind of therapy was it?"* (127-134)

Paul experiences "nothing" coming back which, in the context of him talking about coming out as gay, as well as difficulties in his childhood, gave rise to negative thoughts ("this wasn't") and doubts ("What kind of therapy was it?) in his mind. This suggests Paul was not expecting "nothing", and it sounds like this led to him feeling confused. The phrase "to begin" is a temporal reference, suggesting Paul's experience went through a process over a period of time. Because Paul had been talking about being gay in this context, the researcher wonders whether this incident may have led Paul to conclude that the difficulty in the relationship was linked to his sexual identity.

Meanwhile, the example from Fraser below shows him experience a lack of therapist value in same-sex relationships, after his therapist suggested he be friends with a man for whom he had strong romantic feelings, rather than pursue a sexual relationship.

> *"There were certain I'm sure like think there were certain differences in the way that he might have dealt with my relationship my gay relationship than if I had been in a heterosexual relationship so I think it was there was a kind of erm lack of … … interest* [sounds questioning] *really I think maybe or sort of, or value, maybe a lack of value of it the ...er sort of maybe sort of dismissed perhaps more readily than perh maybe than other kinds of relationships."* (L58-63)

Fraser perceives his therapist treating the issue differently, with less value, because it relates to a gay relationship rather than a heterosexual one, which led Fraser to feel dismissed because of his sexual identity.

Kevin's extract below illustrates how he experienced feeling invalidated due the therapist's "lack".

> *"I felt angry with her because she revealed nothing. I suppose it was maybe halfway through, something like that. And something dawned on me that here I was revealing a lot of personal information about myself and there was absolutely nothing from her, but of course there wasn't meant to be, was there?*
> ***R: So do you remember what it was you were revealing about yourself?***
> *Well, I think I did tell that I was gay and all sorts of personal stuff about….yes, about my relationships or lack of them perhaps."* (L119-130)

Kevin's use of the phrases "halfway through" and "dawned on me" suggests there was growing feeling of discomfort which may have crystallised during specific rupture moment(s). Kevin experienced "nothing" in response to his disclosure around his sexuality; coming out in therapy was an important part of the process for him as he had experienced problems accepting his own sexuality. Kevin experienced a lack of therapist response, and he seems to attribute the meaning of this to her being unsupportive and disapproving of his gay identity. This experience creates a feeling of anger in Kevin, which is not fully explained other than because she revealed nothing; the researcher suggests it might be associated with Kevin feeling rejected and a frustrated need for positive responses that would help him feel supported around his identity development.

On the flip side of the divergence in the experience of invalidation, most participants seemed to perceive invalidations as transgressions or microaggressions. For example, for most participants (Fraser, Stuart, Shawn and Matt) the invalidations also focused around something the therapist said or did, either an interpretation, a disclosure, an opinion, or a challenge that participants perceived as homophobic, hostile, unsupportive, dismissive, disapproving or showing evidence as lacking understanding of issues for gay men.

The extract below shows Matt describing the therapist's interpretation as invalidating.

> *"I was going into therapy thinking you know I'm gonna unravel these problems and they're going to stem from the fact that I'm deeply unhappy or deeply needy or you know need love* [inbreath] *need connection and then he was bringing up this new idea that in actual fact I*

> *might be full of hatred and sort of wanting to just go go round.., because he was making he was actually quite specific he was kind of making reference to you know unsafe sex and the spread of HIV."* (L555-561)

For Matt, this is a "new idea" that has been introduced by the therapist, that goes against his own formulation that his sexual behaviour stems from the fact that he needs love and connection. The therapist's interpretation seemed to paint a negative picture of him as a hateful person who is risking spreading HIV out of an unconscious need to act out his hate and rage, which reinforces negative feelings he already holds about himself. Matt later says he found this comment very difficult to take onboard, he had thoughts that it was a "very straight" (heteronormative) understanding of his issues, that a gay person would not say something like that, and it made him dislike the therapist on a personal level.

All participants talked about invalidations as moments in therapy when rupture occurred and most of them associated it with their preconceived fears. Julian's perceived invalidation consisted of his therapist seeming to dismiss an issue that was important to him, around his fear of contracting HIV due to having unprotected sex outside of his relationship with his partner, and what the consequences might entail.

In the extract below, Julian talks about why he thinks the "block" happened, which prevented him from continuing therapy or getting what he needed.

> *"My preconceived ideas of feeling as though I wasn't gonna be understood, yeah, and <u>then</u>* [emphasis] *having those confir, like having those very re er the there's er real confirmation of that* [feelings] *even though I could accept that perhaps I'd internalised that a bit."* (L594-597)

Julian emphasises the temporal marker "then", which the researcher suggests may reference a moment of invalidation (rupture) which confirmed Julian's preconceived fears that he would not be understood. The researcher interprets the invalidation as very subtle, and Julian acknowledges that it is interlinked with his own internalised fears and expectations of invalidation from others and self. This seems to make it hard for Julian to trust the facts of his own experience as being "real" and "confirmed", with many of his words being unfinished and tentative. Julian's use of the word "accept" in the last sentence may represent him seeming to take some responsibility for the misunderstanding, adding an ambiguity and uncertainty to his experiencing.

Shawn was different in that he cited ethnic/cultural/religious background, class and gender as important in his experiences of invalidation. However, he was able to talk through his perceptions of invalidation with his therapist, and they resolved the difficulties in their relationship and came to a good understanding and respect with regards to the differences between them. However, for all of the other participants, whose ruptures were not resolved, the invalidations became unspoken bones of contention in the relationship and seemed to remain in the back of the participants' minds, ready to re-emerge with further rupture moments.

3.1.2) Fears of therapist homophobia and lack of understanding on gay issues

This subtheme conveys how participants held preconceived fears of therapist homophobia and lack of understanding on gay issues, as well as fears of therapist disapproval for being gay, or talking about it. These perceptions are summarised as "fears". This subtheme also aims to highlight participants' hypervigilance to interpersonal threat associated with these fears. All participants held these fears and scanned their therapists for signs of disapproval.

Participants' talked about their fears as additional barriers which were associated with feelings of intense discomfort, anxiety and feeling threatened, with expectations of rejection, fears of breaches of confidentiality, or even fears of physical assault for Fraser in one heated moment.

Julian talked about feeling he would never be able to have a true connection with his therapist after the invalidation mentioned earlier (he could not be fully himself or open enough), while for Kevin the sense of difference was unworkable, as the following extract shows.

> *"I felt there was a divergence, I felt she's very different from me. Yeah, I think about when I told her I didn't believe in God and…. Yes, because she reminded me of my auntie whom I was very fond. I sort of warmed to her because of her appearance, I think. And then of course as I got to know her as a person, I thought, well, I felt there was a definite barrier, a chasm, a gorge, I'm standing on one side of the gorge, she's on the other and probably no bridge."* (L603-608)

The extract above clearly shows that his feelings changed towards his therapist after he perceived her as being different from him, a difference that created a barrier which meant they could not become close. Kevin describes their psychological distance as them standing either side of a chasm, a metaphor that emphasises their distance but is also suggestive of danger in getting coming together, especially since there is no bridge. Kevin's use of the word "bridge" suggests there was some hope that they could have bridged the difference.

In the extract below, Kevin explains what caused the chasm between him and his therapist.

> *"Well, I felt she wasn't taking my side or even acknowledging. If she'd sort of said, 'Well, yes, I think the Church is at fault there by not accepting gay people or at least telling them that they shouldn't behave this way,' I would've felt much better and I think the relationship would've developed."* (L626-629)

Kevin explains that because his therapist offered no words of affirmation towards the Church's stance and values towards homosexuality, or even seeing it as an issue, he came to the conclusion that she was not an ally to his gay identity, and assumed she was allied to the values of the Church, which Kevin experienced as homophobic. The researcher interprets Kevin experiencing his therapist as homophobic by default, because of his perception of her being allied with the Church.

Like Kevin, for most participants, the barriers represented the differences between them and their therapist's heterosexual identity. Four participants knew their therapists were heterosexual either before therapy began or during the first few sessions, while the other three were convinced their's were heterosexual too, and this difference in each dyad seemed to provide the fuel for participants' fears. In most cases, the barriers and sense of difference was irreconcilable, resulting in a mismatch and therapy ending with an unresolved rupture, either by the participant and in one case by the therapist.

For most participants, the barriers were very difficult to breach, despite them taking risks during moments in therapy, when they would would talk about being gay. All participants relied on micro-details to interpret threat, which then confirmed their preconceived fears, especially when therapist invalidations were experienced. All participants were hypervigilant to therapists' subtle movements, facial expressions, tone of voice, or the words they used, while symbols such as the crucifix were interpreted to confirm homophobic attitudes in the therapist through association with "homophobic" institutions and assumed attitudes. According to most participants' accounts, at heart, they perceived their therapists as not being a real ally to the gay part of themselves, with most being perceived as an adversary, while for Kevin and Matt it was like sitting with a homophobic enemy. Indeed, this sense of mistrust seemed very pervasive in the minds of participants.

Paul expresses his preconceived fears in the following extract.

> *"Therapists you know are trained to sit there and no matter what they* [the clients] *tell you*

you mustn't be shocked, but at the same time you got the feeling that they [therapists] *are privately in their own world gonna be judgemental."* (L680-683)

Paul's words above see him expand his fears of negative judgement to therapists in general, who he thinks will secretly judge him while appearing not to do so. For Paul, there is a "private" therapist world that is different to the non-judgemental public persona – the extract suggests he believes he will never know what therapists really think about homosexuality. The excerpt above also reveals that Paul experiences an inner process of thoughts and feelings associated with his fears, and his attitudes to therapists, that he normally would keep to himself, especially when in therapy.

Fraser struggled with his perception of what he initially termed his therapist's "homophobia". Prior to the extract below, Fraser was reflecting on the fact that he may have been more likely to believe his therapist was homophobic because the rupture was unresolved.

"My fantasy, I don't know whether it's true or not, is to do with is to do with his er homophobia that's my kind of that's what my link was my kind of default kind of … he can't deal with me being gay .. on that occasion." (L139-143)

Fraser uses the language of therapy, such as "fantasy", to talk about his perceptions of therapist homophobia, which seems to reflect the fact that he was training to be a therapist, and his therapy was part of the training requirements. Fraser experiences it to be true that his therapist is homophobic, but he does not know for sure. Interestingly, Fraser then suggests that his formulation of therapist homophobia is like a "default" position, and in this way, the researcher wonders whether he might be attributing the difficulty in the relationship to therapist homophobia, when he is also aware that a fuller reason might be more complex.

The extract below illustrates Shawn's sense of hypervigilance having roots in his background.

"Because I experienced the first the racism in the world growing up and then the homophobia through High School, and then homophobia from my own family and then racism and homophobia from within the gay community, the LGBT community, all those things led, it leaves you feeling isolated and marginalised everywhere that you've looked to feel you belong so even when you go to someone to get help with that then I think you you start, it's a bit like a cat that's been cornered and even if you go to help it it will sit there really hesitant and really ready to strike if anybody's judging it." (L163-170)

Shawn differed from other participants, with his hypervigilance to threat intersecting with other

identity differences. Shawn came from a Muslim British/Pakistani background and his family had cut contact with him for being gay. Shawn uses the metaphor of a traumatised cat to convey his sense of hypervigilance, with the threat being psychological: judgement and rejection. The cat seems very defensive and in a state of high alert, but it has nowhere else to turn to but must engage with a helper now. In the metaphor, the cat misinterprets the helpful intentions of the other, the therapist, however this also shows that Shawn is aware of his hypervigilance and how helpful intentions of the therapist might be misinterpreted as judgement. In moments of feeling judged, the cat will strike – this could be interpreted within the context of rupture, with attack as defence. Shawn conveys a sense of existential isolation that seems profound to the researcher; he does not belong anywhere and now he is assessing whether therapy is a place where he can belong, or whether he will feel marginalised and rejected once again.

3.1.3) Shame-silence: threat of shame for "being gay"

This subtheme aims to show how the threat of shame for being gay meant that participants' found it difficult to talk about issues associated with their gay identity. Following the invalidations mentioned earlier, most participants decided not to divulge further information associated with being gay; they effectively edited out their gay identity in therapy. The researcher has named this process shame-silence.

For example, Matt talked about his fears his therapist found him disgusting, after which Matt's talk around these issues "dwindled off" as he made a conscious decision to focus on other themes in therapy that were not associated with sex or his gay identity.

> *"I led it in that direction and then more or less the sexual stuff was just dwindling off."* (L252-253)

Matt's phrase "more or less" suggests he continued to refer to sex at times, or made attempts to talk about it, but perhaps felt discouraged.

Meanwhile, Fraser talked about "tailoring" what he disclosed about gay issues, while Julian said he was "almost omitting" his sexuality from therapy.

Most participants questioned to what extent the shame-silence could be attributed to perceptions of therapists' negative judgement and disapproval, or towards what the researcher interprets as their own internalised shame. Paul seems to capture this dilemma in the following extract. Prior to the extract, Paul talks about coming out age 27, when "being gay" for him meant having his first

sexual relationship with a man.

> *"So much of the problems that I felt you know that that occurred during my childhood and this that and the other ... erm* [pause] *... were leading up to my you know my sexuality and you know and the de development coming out as being a gay as being gay in a time when it wasn't ... you know I* [mumbles] *I was in a vacuum basically ... I didn't know there were any other gay people sort of er* [mumbles] *er and to be sort of given <u>this</u>* [emphasis, the therapist] *... it was almost like being th you know therapy with a nun and you're saying well I want you to have a look at my cock .. it's like it's not right it's it's er* [mumbles] *I couldn't relax with her."* (L303-317)

Paul presents his predicament as a mismatch between two very different people, his choice of therapist feels out of his control; by describing the therapist dismissively as "this", he distances himself from the therapist as a human being, like she is an unwanted object. His account described himself in the early stages of his gay identity development formation, but he is matched with a "nun", a virgin, like Paul has been. Paul's metaphor illustrates his sense of embarrassing discomfort by bringing forth an image of needing to ask the nun to look at his "cock"; the image is inappropriately exposing for him, as well as for the therapist, and fills him with anxiety. Paul is linking problems in his childhood background to his sexuality, leading to the vacuum, nothingness, where he feels isolated and has not been able to talk, and now he is faced with a religious figure who is disapproving of him and perpetuates this silence. Paul is aware of shameful feelings originating from his own Catholic background and difficulties growing up as a stigmatised minority, but he is also perceiving his therapist as being disapproving; it seems both of these factors make it very difficult for him to talk about sex and relationships.

Like Paul, most participants felt uncomfortable and unsure about whether it was appropriate to talk about sex in therapy, despite feeling like they needed to. Stuart's extract below describes how he experienced talking about sex.

> *"She said she didn't want to discuss sexual things... erm and then once I did want to raise it because I just did I just thought I I needed to at least get a a view of something erm and she did address it but I could see she was in not not at all erm comfortable, physically comfortable doing that but I pressed on cause I thought well I've paid for this erm if you really don't want to well then then say something like 'I do not I don't think we should discuss this' then, put it straight cause it's very straightforward like like that but that didn't come so we did discuss it, but I didn't do it again because I realised that she didn't want to talk about these things, but it's more my inference judging by the body language."* (L239-

249)

The extract suggests Stuart's sexual identity went into hiding. There is a contradiction in what Stuart is saying: on the one hand he says the therapist said she didn't want to talk about sex, but on the other hand he says he "realised" she did not want to by "inference". Stuart is hypervigilant to his therapist's reactions; he notices she shifts in her chair when he wants to talk about sexual things, which he interprets as her being uncomfortable and disapproving of sex talk. The researcher suggests that Stuart's interpretation of his therapists non-verbal communication brought into his reality that she did not want to talk about sex, almost like she had said so in words.

There is a sense of rebellion in Stuart's extract, and he uses money as his claim to power and right to talk about something that is important to him. However, the situation seems to have been very uncomfortable, and the researcher suggests that way he says "I didn't do it again" is suggestive of a shame-silencing process. The researcher interprets Stuart's account of his gay identity not being affirmed, which may have been experienced by Stuart as invalidating, but also potentially as something that reinforced his own sense of shame, which led to him editing out gay parts himself and disabling any challenge to the perceived invalidation.

For most participants, shame-silence seemed to involve a conscious decision not to divulge further information about their sexuality despite wanting and needing to. Julian's extract below shows what was going on for him after he felt his therapist wasn't understanding him regarding the issues around his sexuality.

> *"Like you've got one one road and another road, and one's more open where I can.. where I because of that dismissal very early on and feeling like there's a lack of understanding .. I wasn't exploring that open side too much."*
> ***R: yeah the side you wanted to***
> *"The side I wanted you to yeah .. or match them up entirely erm yeah* [sounding decisive] *it's like just I felt like it was all, even though it was long sessions that I had over those weeks, it was all peripheral stuff which was slightly kind of getting into the* [inaudible] *a little bit, but then almost omitting my sex sexuality out of the equation … hmm."* (L535-544)

Julian uses a metaphor of two different paths to convey what happened for him in therapy; he wanted to take the more open path, where he could explore his issues around his sexuality, but he felt unable to in part because of the early invalidation/rupture. The path he finds himself on contains "peripheral stuff" – content that is not central to Julian's concerns and needs. The different

paths paint a picture in which Julian is walking alongside his therapist and needs to make a decision about which path to take – he has a sense of agency but, in the process, sex and sexuality becomes "almost omitted" from therapy. It is interesting how Julian uses the word "almost", which suggests he continued to make attempts to be more open. The phrase "out of the equation" is also of interest; in the researcher's mind it evokes a situation in which something is missing, which means the equation does not add up, or is worth less, and brings to mind figures or even financial transactions that are not adding up. Interestingly, Julian ended therapy because he no longer wanted to pay for therapy any more.

3.2) MASTER THEME 2. Rupture as process of struggling to defend gay identity and the self

This master theme aims to show how the rupture happened, the in-the-moment processes and features of rupture, how it played out, including the interpersonal and intrapsychic dynamics that were at work. The researcher interprets the dominant feeling in master theme 2 as anger. Subthemes in master theme 2 include: 1) Protest: challenge/confrontation and withdrawal/anger-silence; 2) Struggle to find voice/power; 3) Compliance discord: the discomfort of sitting with an unresolved rupture.

3.2.1) Protest: challenge/confrontation and withdrawal/anger-silence

The subtheme Protest aims to show how participants reacted to the invalidations, and highlight the interpersonal and intrapsychic behaviour and psychological processes that were associated with the rupture.

There was a divergence in how participants experienced Protest. All participants experienced protest as emotional withdrawal at points, while most of them also experienced their sense of psychological protest as some kind of verbalised challenge or confrontation, which was often very subtle. The emotion most commonly associated with Protest was anger; most participants talked about this emotion during their interviews (anger, resentment, frustration, rancour, begrudging), with most of them able to feel angry in retrospect, but it remained unclear how they experienced anger during rupture moments in therapy.

Most participants seemed to experience withdrawal as silence, and an unwillingness to talk, confusion, blanking out, disconnection, for example by looking out the window, as well as cognitions and feelings about the therapist, therapy and the relationship that were private, negative, oppositional and disagreeing. Matt seemed to experience withdrawal in his body, describing a

“sinking” feeling, that possibly represented him wanting to disappear. The subtlety of participants' withdrawal made the researcher question whether it could have been noticeable to the therapist.

In the following extract, Paul talks about how he reacted in-the-moment when he was divulging information to his therapist and then became aware she was not saying anything in response to him.

> *“It was just me talking … and y'know 'I dunno my week's been alright I felt a bit ..'* [mimics himself mumbling] *are all right yep ok* [exhales, sigh] *... stud, I mean I could tell you more about the pattern, y'know the stains on her ceiling than I could … er and y'know I can remember everything about her flat … and the way she looked, but I couldn't tell you anything that she ever said to me, I can't remember, I can't remember one thing she ever said to me and I er … and I I feel that I wasted, I, there is a, there is a certain amount of resentment there because I feel like I wasted so many years .. especially since I've had therapy later, since then, which was more effective, that what the fuck, I wasted all that time and all that money, and I felt, I feel quite angry about that therapy.”* (L233-247)

Paul is describing a scene of him talking and then his talk stopping and the dyad becoming silent, with him staring at patterns on the ceiling. The researcher suggests Paul is feeling invalidated and withdraws in anger by stopping talking and emotionally disconnecting from his therapist by looking the patterns of the stains on the ceiling. Paul was lying down on a couch, so the ceiling would have been his view, but the researcher suggests that Paul may have been dissociating, such is the scene of him spending possibly long periods of time studying the patterns of ceiling stains, and thus distancing him from his feelings and interpersonal dynamics. The researcher interprets the word “stain” as having negative connotations, possibly of something being spoiled, possibly the therapy. The thing that might be spoiled could be the blank canvas of the ceiling, which in psychoanalysis may represent Paul's negative feelings for his therapist that he can not express, which may be symbolised by the stains. Paul references other time periods after therapy ended and his “now” in-interview sense-making contains feelings of anger and resentment as he looks back on an experience of which he could not make sense of at the time. Paul's use of “I felt, I feel” sees him correct himself, and is suggestive of different sense-making at different times, or of time passing amplifying his anger.

On the flip side of this divergence in the Protest subtheme, most participants showed some signs of outward verbal protest and, although this varied between them, it was frequently very subtle. Saying that, Stuart was different, in that his outburst in therapy *“I think this is a load of crap”* (L22) seemed to represent him baiting his therapist for a reaction, it seemed to be his way of

expressing the hurt of feeling criticised, as well as his frustration about the therapist's failure to address his complaints, and help him talk through his concerns about lack of progress in therapy.

The following extract shows how Kevin used shock value to express himself.

> *"In some ways, I quite enjoyed being – trying to shock her a bit and telling her I went to these clubs and there were darkrooms and all that sort of thing* [chuckles]. *So I thought I bet – I wonder if she's heard that before. But again, there was no reaction, she just accepted what I was saying and sat there you know with an impassive face* [laughs]. *So there was this anger that she wasn't – I couldn't communicate really."* (L130-136)

Kevin talks about trying to shock his therapist by talking about aspects of gay life she may have found distasteful, which the researcher interprets as functioning to force out any therapist disapproval that was kept hidden; the shock value may also function to express Kevin's anger, to get a reaction from her "impassive face" and thus reveal her real attitudes to homosexuality via facial expression or body language. Kevin's laugh seems incongruent in relation to what he is describing, and the researcher suggests it may serve to cover up his feelings of anger and hurt that he has not been able to express or communicate. Kevin does not finish the last sentence after "she wasn't" – he was not able to verbalise with the researcher what it was about her that made him angry. The researcher wonders whether the missing words are she wasn't "agreeable".

Most participants' protest was very subtle and seemed to represent their anger leaking out in more socially acceptable ways. In the extract below, Fraser explains how he reacted to his therapist.

> *"I can't really remember but, I'm sure it was it would have been … maybe slightly kind of barbed comments or kind of spiky, spiky from me erm spikiness er … dismissal perhaps of what he was saying or kind of, those kind of tactics* [smiles] *yeah mmm.."*
> ***R: So when did you become aware you were doing them, doing those...***
> *"I wasn't at the time, but perhaps when he stood up, perhaps when he you know wanted to walk out that's when I realised that I had been .. so I wasn't I wasn't a conscious thing I don't think."* (L580-588)

Fraser uses the language of a battle to describe his protest, words such as "barbed", "tactics" and "spikiness" are suggestive of a battle, with words perhaps substituting the weapons. Fraser seems to have expressed his subconscious anger in a passive- aggressive way, an anger that saw him seeking to test the therapist, and also to devalue him by being oppositional and dismissive.

Fraser seemed reticent to talk about his “tactics”, and the researcher suggests that Fraser may feel ashamed of his passive-aggressive behaviour perhaps, for not communicating in a direct assertive way. This serves to show how difficult it was for participants to express their anger and how it might reflect on negative aspects of themselves they would rather ignore.

3.2.2) Struggle to find power and voice

Participants' rupture experiences seemed to amplify the power imbalance between therapist and client; all participants struggled with feelings of powerlessness and difficulties in talking about their dissatisfactions to their therapist, who they saw as a powerful and authoritative other.

Participants' sense of stake in the rupture process, or how they found power, seemed to focus around the only means at their disposal; voice/silence, attendance/time, money, protest and compliance.

The extract from Julian below seems to capture these themes associated with struggle to find power and voice. Prior to the extract, the researcher had asked Julian how his experience of being invalidated by the therapist (“the early dismissal”) had affected him.

> *“I'd hate to say ju judged but I don't I don't know necessarily know whether that was that's that's right? ... it it I suppose at the time in that room I felt slightly powerless... it just felt yeah, erm and of course in the back of my mind is thinking well you know is she is she really going to understand, could I say this now this so I so was slightly disempowered erm ... but I also think that I definitely kind of put her in a kind of .. esteem of like she's a therapist so sh* [laughs] *she should know erm ... erm she'd got a desk there, she probably sitting where you are now but on one single chair erm a wooden chair with a cushion on it, so actually thinking about it she was slightly higher up than me.”* (L270-286)

For Julian, the feeling of being powerless can be seen as being part of the rupture experience, as it is associated with the rupture trigger (the invalidation) and this then seems to amplify difficulties related to the power imbalance. Julian's use of the present tense (“is thinking” and “is she”) suggests he is reliving the experience in the research interview, and this makes him consciously aware, possibly for the first time, that he was seated lower than her so, in effect, his powerlessness was also embodied. Julian expresses a sense of conflict in two realms; firstly, holding the therapist in both high esteem but also doubting her credentials in her ability to understand him, and secondly, doubting his own perceptions of the therapist as being judgemental. This ambivalence seems to have fed into Julian's hesitancy about voicing his concerns (“could I say this now”). Julian's use of

the words “slightly powerless” suggests he does have a sense of power, possibly in deciding what not to talk about and how much longer to keep paying her. These conflicts seem to contribute to Julian's sense of powerlessness in relation to her and his difficulties in expressing his dissatisfaction in a direct way.

Like Julian, most participants looked up to their therapists as someone in a role which carried high status, and who held authority over them like a parent, older relative, or statutory figure like a social worker. For all participants during the rupture, the power imbalance meant that at some point the authority of the therapist felt punitive.

Stuart's extract follows the researcher asking him why he went back to his therapist after he had decided to leave.

> *“I remember speaking on the phone and saying “well well let’s can’t I say say goodbye on the phone” .. and she said “no we need to say goodbye..” because I because this had happened the year before when it was when I'd tried to finish it and then it’s “we need to say goodbye” and I went back and then I carried on and I think that there was the idea that that me saying it was over was like the child saying “I’m not going to do it”, we ignore it and then I’ll come back erm, and this time I wasn’t going to. She obviously didn’t think that I was serious or something I I can ass.. I don’t know because I don’t know her view.”* (L513-521)

Stuart likens himself to a child whose behaviour is being ignored. His use of the plural pronoun in “we ignore it” seems significant; the researcher interprets this as meaning both the therapist and the adult part of Stuart ignored it. In this way, Stuart could be seen as identifying two parts of himself, an adult and a child, both of whom are in relationship with the therapist. The child could be seen as less powerful, however it seems to be to adult part that keeps yielding to the therapist's influence and returning to therapy, so it could be seen that Stuart's adult part lacks the power to end the relationship and go against his therapist's wishes. All participants talked about the therapist holding influence over them which made it difficult to end therapy.

All participants also struggled to trust the validity of their own feelings and concerns regarding the rupture, which diminished their capacity to communicate their concerns and impeded their negotiation of efforts towards resolving the difficulty.

In the extract below Matt tells the researcher what he would like to have said, but he did not feel he was in a position where he could verbalise his thoughts.

> *"Sometimes when he said something I just thought 'oh you really don't get it, you you just don't get it, and it's because you don't understand how we are, how we are as a community you don't understand, you're so different from me you don't understand, it's almost like as if I was black and trying to talk about racism to somebody who was white and who really couldn't get it, just couldn't get it."* (L512-516)

In a way, Matt was expressing his voice in the research interview, so for him it may have functioned as his way of saying what he needed to. It is interesting to note that Matt uses a plural pronoun to position himself as part of a community that Matt has perceived his therapist as lacking an understanding of. Matt entered into subsequent therapy with an LGBT organisation which seems to have given him a more affirmative and empowering experience, which may help to explain why he made sense of his rupture experience as heteronormative ("straight") in the research interview; thus new experiences after the therapy have enabled him to find his voice and express what he felt unhappy about.

3.2.3) Compliance discord: the discomfort of sitting with an unresolved rupture

This subtheme attempts to convey the tension and difficulty resulting from holding two contradictory elements together; agreeing to continue in therapy in which a rupture has not been resolved. All participants grappled with experiences of feeling stuck, thwarted and ambivalent, with most of them wanting to leave therapy but finding it very difficult to extract themselves from the therapeutic agreement and relationship. Compliance discord was associated with feelings of frustration, anxiety and confusion.

All participants' experienced compliance discord but there were variations in how they experienced its duration, with some lasting a couple of months, and others a couple of years.

All participants in open-ended contracts stayed in therapy longer than they anticipated despite the rupture experience. In the extract below, Julian explains how he decided to end his therapy after session three following an invalidating experience, but he ended up staying for about 22 sessions.

> *"It wasn't ever gonna go that that far in the end so I realised that very early on despite staying* [laughs] *erm … and that kind of baffles me a little bit also .. but there were obviously was there were reasons that I just I just carried on erm as I say it was that kind of like third or fourth sessions where I didn't wanna go but then it was making myself go and then it just I just kept going."* (L701-706)

In the extract above, Julian offers contradictory information about his experiencing regarding how long he would stay in therapy; at one point he seems clear he wants end after session four, while he also says "there were reasons" that he "just carried on" – the use of the word "just" twice mitigates Julian's sense of control over ending. This has left him feeling "baffled", which the researcher suggests may indicate that it was ambivalence that kept him in therapy; despite not feeling able to talk about gay issues, perhaps he found value in other aspects of the relationship which he found difficult to leave. Julian had to stay for at least 10 sessions to meet the requirements of a course he was doing, but by which time a relationship had developed. The researcher suggests that being involved in a therapeutic relationship made it more difficult for participants to leave, even when there has been a rupture, due to mixed feelings towards the therapist, therapy and its ending. Julian paid a fee for his therapy which may have hastened his departure as he reported that the "costs" outweighed the benefits elsewhere in his research interview.

The researcher was interested in the reasons why participants stayed in long-term therapeutic relationships that were described as so intolerable and dissatisfying. Most participants seemed to stay in the hope of progress and reconciliation, either of self or the rupture. Paul and Matt stayed because they said they needed help desperately, they held beliefs the therapy would benefit them if they continued, and they also felt they had nowhere else to get help; Stuart said he had wanted to leave therapy two years before it ended but seemed to stay due to therapist influence; Kevin wanted to stay but the therapist "terminated" his therapy; and Shawn resolved the ruptures and therapy was ongoing at interview. Julian and Fraser needed to stay partly for therapy hours as part of a course they were on, and the researcher suggests this influenced their decisions to stay in therapy.

Compliance discord seemed to involve a moment in therapy when a participant made an internal decision that signified a turning point. For Fraser, this moment came about after his therapist challenged him with an angry confrontation and threatened to end therapy if he did not work with him (comply). In the following extract, Fraser explains how he experienced his therapist's confrontation.

> *"His reaction was a shock because I wasn't … you know at the time I didn't agree* [emphasis] *that I was seducing him that I was trying to seduce him I didn't agree with this interpretation, erm but rather than kind of erm there being any dialogue around it I think c it shut me up it kind of stopped that that I that part of you know what was happening it stopped it cos his his wanting to kind of to walk to walk out walk out of the room, it didn't it wasn't kind of material that could've, that he used he didn't use it you know it was like kind of rejected I suppose... so I felt rejected perhaps, which goes with the attempt at seduction*

doesn't it? So erm … so perhaps that rejection wasn't really explored I think er with him." (L225-239)

Fraser said he needed to make sure the therapy continued as he needed to complete it as part of his training and he also did not want a bad ending to make him look bad. The researcher suggests that this extract provides other reasons for Fraser's compliance; for example, perhaps he wanted to avoid feeling rejected, or show he was not seductive, and to have an opportunity to repair the damage done. Fraser initially thought the therapist meant he was being sexually seductive, which played into his fears of homophobia, but on reflection, he owned his seductiveness as a need to be liked by his therapist, but the incident left him feeling he had done something wrong. It seems that Fraser is concerned by feeling rejected by the therapist, and he does not want him to walk out as this would be very difficult for him to make sense of. Fraser makes a decision to stay in therapy but remains dissatisfied.

After deciding not to challenge their therapists, participants seemed to put the disagreement to one side and focused on other issues. Here, Matt describes the turning point heralding his decision to change what he brought to therapy.

"I felt I kind of gave up on him in that respect in thinking well you will never understand what it's been like so I can't really see the point, I can see the point that it could help in other ways, and erm so I started to focus on talking about childhood issues that weren't related to being gay." (247-251)

In this extract Matt has made a decision that his therapist was unable to help him with his particular needs regarding his problems around sex and his sexuality, and he gives up on the therapist in relation to this. However, Matt can "see the point" in the therapist being useful in other ways, so he makes a conscious decision to talk about childhood issues that are not related to being gay. Matt was unhappy with how he experienced his therapist, but continued with it for various reasons, one being that it had been prescribed by his GP so he saw it "like medicine". In this way, Matt is being compliant but remained dissatisfied which is reflected in his retrospective feelings of resentment and grievance elsewhere in his research interview. The researcher suggests that even though it may seem as though ruptures have been resolved, hidden processes such as compliance discord indicate otherwise.

Indeed, during compliance discord, the unresolved rupture seemed to be present in the back of participants' minds. This seemed to add sensitivity to the relationship, in which rupture moments

seemed more likely to re-occur, typically dissatisfactions regarding what therapy was, how it should be done, and what participants wanted to get out of it.

3.3) MASTER THEME 3. Negotiating reparation and/or closure of the rupture

This master theme is associated with the consequences and implications of the rupture, most of which remained unresolved. Master theme 3 attempts to highlight why the rupture happened, and how the participants' attempted to make sense of it. A common feeling associated with master theme 3 was confusion, a sense of resentment/grudge as well as injustice. This master theme attempts to convey participants' need for closure of the unresolved rupture experience, that is, their attempts to move from ambivalence and uncertainty towards resolution and certainty, so that they could either continue therapy without feeling a grievance, or to have ended therapy on good terms so they were not left with unresolved feelings, regrets, or unfinished business. All participants seemed to want closure. Subthemes in master theme 3 include: 1) Negotiating trust, 2) Seeking repair, and 3) Difficulties in making sense of an unresolved rupture.

3.3.1) Negotiating trust

The theme Negotiating Trust attempts to convey participants' efforts to assess and evaluate their feelings of trust and mistrust following the rupture event(s), that is, the degree to which they felt they were in a safe place that was beneficial and worthwhile for their needs and what they wanted to get out of therapy.

All participants' sense of mistrust tended to be confirmed and strengthened following invalidations, lack of progress or thwarted attempts at gaining trust. All participants talked about feeling ambivalent towards therapy and the therapist. Paul's extract below shows how he expressed his ambivalence.

> *"I think I did er … mention it every now and again you know sort of er you know 'what's going on?' and er* [therapist's voice] *'well you know there are I feel there are things that we haven't touched on yet but …'* [mumbles] *and it was almost like this thing at the end of the rainbow."* (L592-596)

In the extract above, Paul's questioning of the therapy represents him beginning to express his doubts about therapy, while him asking "what's going on?" could be interpreted as him expressing

his mistrust, and seeking some dialogue and reassurance from the therapist to help restore his trust. Paul mimics his therapist; her response may have imparted her confidence and belief in what they were doing and how they were going to do it (the tasks and goals of therapy), which at the time may have alleviated Paul's mistrust enough to enable him to continue. Paul uses the rainbow metaphor to illustrate this, a symbol made of mixed elements of sunshine as well as rain, with distant hope in the form of a pot of gold, a prize which is attractive but unattainable. The rainbow metaphor suggests that at the time Paul may have been comforted by the therapist's words, however his ambivalence returned "every now and then", which suggests his trust in the process wore thin over a long time period.

For many participants, the establishment of trust seemed to overlap with the therapeutic process. For Fraser, his testing of trust seemed to be embedded in the rupture experience, as the following extract serves to illustrate.

> *"I think it's quite a physical thing actually yes with him* [the therapist] *... standing up and ... ... sort of changing like this changing something .. er but not not acting on anything well not acting on my fantasy of what what he might do in terms of physical hitting or you know that so maybe that's that's what broke it* [fear of homophobia] *that's what you know allowed me trust him maybe I don't know."* (L455-459)

In the extract above, Fraser describes how he makes sense of a rupture incident in which his therapist stood up mid-session in frustration after being provoked by Fraser. It seems that in the moment, Fraser's experience is embodied, as he describes it as a "physical thing", a threat of being hit by the therapist. However, the "physical hitting" does not happen, which is different to what Fraser expects according to his "fantasy". It seems that Fraser is making sense in retrospect, that he was able to gain a sense of enough trust by pushing the therapist to the limit, and seeing whether it would end in physical assault of some sort, or rejection. The fact that it did not gave Fraser a sense of going through a barrier of sorts and gaining a sense of trust. The researcher suggests that the confrontational rupture facilitated a new emotional experience, enabling Fraser to feel a level of acceptance by another man despite pushing him [the therapist] to the limit.

Prior to the extract below, Julian had talked about how difficulties growing up gay made it difficult for him to trust people.

> *"A lot of my issues were brought to the t the table I I was thinking that that that that she would kind of ...* [different tone] *I f I suppose I feel like it's like sh she should've been on my*

side but and it, although she was motherly, it was kind of like it it didn't feel like ... I'd got an ally on my side so it t goes back to that creating a block for me." (L185-190)

Julian describes having expectations about how his therapist should be when he brought his important issues to the table, issues he had been unable to talk about when he was younger and coming to terms with his sexuality. Julian's bringing issues to the table could be seen as him looking for trust. Julian seems to link this feeling of being let down when he was younger to the therapist, he was expecting her to be an ally to him, but he did not feel she was on his side, which strengthened his existing feeling of mistrust (block), and led him to leaving therapy after five months. The researcher suggests the "motherly" nature of his therapist may have created a maternal transference, possibly recreating a situation from the past in which he was not able to talk to his mother about being gay for fear of disapproval, or support from her on gay identity issues.

Most participants talked about their therapist reminding them of relationships in their past; Matt's therapist reminded him of a bully from school, Fraser talked about a paternal transference, and others were reminded of aunties or mothers. All these relationships carried with them a threat of disapproval, rejection and hostile attitudes to their gay identity.

3.3.2) Seeking repair

In this subtheme, the researcher suggests that participants sought repair to the rupture so they could end ambiguity, and move towards a sense of closure in the relationship, either by ending with clarity and on good terms, or continuing therapy in agreement.

Participants' need for repair seemed to be associated with their wanting acceptance from their therapists, and what the researcher understands on a deeper level as their longing for their therapists to connect with the wounded parts of themselves. Participants' accounts indicate they all at some point wanted to have a discussion with the therapist about the difficulty in the relationship, but most of them found it very difficult to voice their concerns or they experienced therapist silence, anger/criticism or lack of follow-up/interest from their therapists, which discouraged them and thwarted dialogue around the difficulty.

Stuart's case illustrates how he wanted to talk about the difficulties, and how he experiences his therapist as seeming to use her power to block dialogue around it. Stuart had been questioning the lack of progress in his therapy and, when his therapist said "you just come here and dump" in response, he experienced her as critical and attacking. The extract below shows how Stuart responded.

> *"I think I took it to heart what she said as though I think that's one of, I think that's one of my problems I take things to heart and I would've hoped that somehow we could have discussed this and then so I wouldn't take things to heart .. but that sort of stuff never raised never was raised, because if you you she was you she said you don't we we don't you don't come along with shopping list and, so I didn't, I followed the rules as it were and I think looking back I was silly following the rules."* (L534-541)

In this extract, it is clear that Stuart had wanted to have discussions with his therapist about difficulties in their relationship. Stuart says "somehow" there must have been a way, but he continually felt blocked as "that sort of stuff" (talking about the relationship) was permanently off the agenda – Stuart uses the qualifier "never" to emphasise this. Stuart therefore describes what sounds like an oppressive arena in which it seemed impossible for him to resolve the difficulties. Stuart described one of his problems as difficulties in asserting himself when he felt undermined, which was now happening in the relationship with his therapist, like a re-enactment. The lack of dialogue seems to have affected Stuart as he attributes the difficulty to a problem within himself, and he also describes himself as "silly", blaming himself for tolerating the situation. In this way, the researcher suggests that repair could be seen on more then one level; as repair to the relationship, but also repair to self.

In the extract below, Paul describes his need for love and acceptance.

> *"I wanted to be loved. I've always wanted to be loved because I I lacked that all my life, and so I was desperate to be to be loved and … and the being me I didn't feel you know being you know being a queer boy couldn't be loved by this you know prim sort of frosty you know frosty* [mumbles] *yeah she was quite cool never giving any ... never giving any clue as to who she was you know, I mean she was just this block the ice maiden sort of er and you didn't understand .. y you where she was coming from apart from these little symbols* [crucifix]*."* (L687-694)

For Paul, difficulties with his sexuality were additional to difficulties in his childhood, and these experiences seemed to conflate within the rupture phenomenon and his need for repair with the therapist. In the extract, Paul seems to be merging experiences of emotional deprivation and being unloved as a child, with being unloved in the therapeutic relationship, and he seems to attribute this to him "being a queer boy". The way Paul says "the being me" seems to suggest an existential way of describing how it felt for him in therapy. Paul describes himself as a boy in this extract, a young vulnerable person who is in relation to a freezing "block". Paul constructs the therapist as an "ice

maiden", a fairy tale-like metaphor which serves to emphasise the futility of his need for warmth in relation to a fantasy figure who is frozen, unmoving. Paul uses the word queer in this context in a derogatory way, which historically was an offensive word for gay people before it was reclaimed. Paul seems to be saying that he wanted a warm and real relationship with the therapist – he wanted to know who his psychoanalyst was. The researcher tentatively suggests an interpretation of the therapeutic relationship as a re-enactment of the relationship with his mother, which was also cold and lacked input, but which also kept him stuck and paying her bills, much like he did with his therapist; in this way, the researcher suggests that Paul could be seen as seeking repair by wanting a different ending to his relational wounds in a therapeutic relationship which was played out in the rupture.

Most participants talked about wanting more from their therapists, and also being thwarted in what they wanted to explore. The rupture caused them to feel angry and frustrated, primarily because of the invalidations to their sexual identity mentioned earlier. In the extract below, Fraser talks about his anger at his therapist and his need for love that he finds difficult to say.

> ***R: So the being angry was threatening but it was also more intimate, is that what you were saying?***
> *Er a defence against intimacy. Yeah so yeah so you know not allo yeah not, covering up other other kind of stuff er ...*
> ***R: … You're going to have to tell what stuff***
> [both laugh] *I knew you were going to ask that, well I guess like…* [long pause] *... m love, loving in the in the kind of therapeutic relationship, that it didn't feel particularly loving er over four years."* (L539-548)

Despite the rupture, it seems clear from the extract that Fraser wanted to feel a sense of being loved in the therapeutic relationship. The word "love" seemed difficult for Fraser to verbalise, as though it is a taboo. Fraser is suggesting that his anger was covering up his need for love, and therefore in this way, the researcher suggests rupture could be seen as being linked with a thwarted and suppressed need for repair. Fraser's case could also be interpreted as a re-enactment of a thwarted wish for paternal love, of rupture functioning as defence against vulnerability and intimacy which is threatening to Fraser.

Fraser began his interview with attributing the rupture and his anger to therapist homophobia, but during the research interview, he came to realise that the reason he was angry was more complex and touched on issues that were difficult to name. Fraser's four-year therapy formed part of the

requirements for his training to be a therapist, which may explain why his language contains "psychodynamic" language.

3.3.3) Difficulties in making sense of an unresolved rupture

Ending therapy without resolution seemed to leave something unprocessed in participants' psyches, something negative and unresolved that stayed in the back of most of their minds over many years. The lack of closure seemed to manifest as grievance for most participants.

The lack of closure meant participants remained uncertain why certain things happened. For example, Matt describes his difficulty with making sense of why his therapist told him in session three that he was heterosexual. The therapist's self-disclosure followed Matt's disclosure about feeling out of control with his casual sex behaviour the previous session.

> *"It make me feel awful because I felt that he might perceive me as some kind of mad perverted predator that was going to jump on him, you know, which is totally ridiculous, but you know I mean he was younger than me he was as I say very slight of build and I I started to think 'well why did he say that? does he think I'm going to pounce on him or something just because I go cruising.'"* (L207-212)

The reader can see how the therapist's disclosure made Matt very anxious about how he might be perceived by the therapist. Matt was left wondering why the therapist had disclosed his sexuality, something Matt will never know the answer to as the issue was not discussed further and they will never meet again. The researcher suggests that attributing the rupture to therapist homophobia seemed to be facilitative for Matt in coping with the discomfort in this rupture experience.

The following extract shows how Kevin made sense of the difficulty in the relationship with his therapist.

> *"Well that was her training, wasn't it? So she practised that form of therapy where you're a blank screen, project anything you like onto. So I suppose the fact that I'd thrown the baby out with the bathwater was quite a thing for her because normally she wouldn't have said anything. She'd just listen to me and just sat there and smiled and nodded her head. So the fact that she actually said, 'I think you're throwing the baby out with the bath water' was quite something, she actually did react, didn't she?"* (L671-677)

Kevin had rejected the church due it's anti-gay stance. When Kevin told his therapist this, she made a comment that he had thrown the baby out with the bathwater, meaning he had discarded something of value. At the time, this meant Kevin perceived his therapist as being a churchgoer, which meant she must be aligned with the church's anti-gay values. Thus she was constructed as an anti-gay adversary to him. In the extract above, the way Kevin points out the therapist has moved away from her training method is suggestive to him, in retrospect, of confirming a therapist transgression; offering her opinion on these matters revealed her stance and alignment with an institution commonly perceived as homophobic. For Kevin, his updated sense-making confirmed his initial formulation that his therapist was indeed a Christian, which for him gave rise to strong beliefs that she would have been disapproving of him as a sexual being.

Kevin's extract shows how he was able to update his sense-making years after the rupture, which validated and gave certainty to his sense-making. Kevin's subsequent counselling training experience seems to have helped him realise his therapist was using psychoanalytic methods, which may have helped explain why there was a lack of response from her, but it also seemed to lead him to reappraise a comment she made that was loaded with meaning for him at the time.

There seemed to be updates in all participants' sense-making during the interview with the researcher, despite long periods of time between the rupture experience and research interview. Participants' attitudes towards the therapist tended to become more positive and warmer as the research interview progressed, perhaps because they were able to process their feelings, something they had previously not been able to do.

Indeed, according to their accounts, participants' sense-making seemed to evolve over time, becoming more coherent and also more complex as they made temporal references to different ways they understood the rupture.

For example, Fraser describes how he made/makes sense of the difficulty in the extract below.

> *"Well I think after talking about it it feels slightly different about it actually. But I think I've always since felt it was erm … there was like a kind of erm damaging for therapy that it was homophobic, but now talking about it I think probably that's was just a kind of side issue, really it was kind of more about sort of trust really yeah so, er well I I think I talked about in terms of it feeling that I had behaved wrongly or that he wasn't didn't like this part of me."* (L670-681)

Fraser's extract suggests a rapid evolution in his sense-making during interview with the researcher. Fraser's sense-making seems to be located in three temporal frames. Shortly after the initial rupture, there is a sense of self-blame in Fraser's sense-making, as though he did something wrong. This seems to have led him to perceiving the therapist as homophobic because he "didn't like this [gay] part of me". However, during the research interview, Fraser has come to a new understanding that the rupture was more about trust, rather than just about homophobia. The researcher interprets this updated sense-making as arising from subsequent life-experience interacting with at-the-time memories to create new meaning. For Fraser, the perceived homophobia is still an important issue, but by the end of the research interview, it did not hold as much importance as it did before.

Indeed, subsequent positive life experiences seemed to interact with participants' at-the-time memories and their later sense-making, leading to new in-interview processing and sense-making about why and how the rupture happened.

Discussion

In this section, the findings are discussed in relation to the extant literature. In light of the findings, the researcher will discuss the implications for counselling psychology practice, research and training, before discussing the limitations of the study, and ending with a concluding summary.

Overview

One of the research questions asked to what extent rupture was associated with participants' identity as a gay man. According to their accounts, the findings suggest participants' rupture experiences were strongly associated with their identity as gay men, with six of seven participants attributing the rupture and its cause to a perceived therapist invalidation around their gay identity.

The themes that emerged in this study in part reflect the findings from research that found that gay clients felt invalidated, judged and dismissed by their therapists around their sexual identity, and experienced their therapist as lacking an understanding of gay issues which led to feelings of discomfort and dropping out (Evans & Barker, 2010; Garnets et al., 1991; Israel et al., 2008; Kelley, 2015. The concept of sexual orientation microaggressions described by Shelton & Delgado-Romero (2011) can be seen as being represented in the subtle invalidating experiences described by participants in this study. The findings is this study also concur with previous research which found that gay men restricted talking about themes or issues associated with their gay identity when they felt invalidated by their therapist (Dorland & Fischer, 2001; Liddle, 1996; Mair & Izzard, 2001).

While most participants said the rupture was caused by therapists' lack of understanding and response on gay issues, which they perceived as indicative of some form of underlying heterosexism/homophobia, there was also some uncertainty from participants regarding their own perceptions as being based in reality, or whether they were projecting their fears onto their therapists (projected internalised heterosexism). The researcher suggests the answer might be a combination of both factors, to varying degrees, with the rupture experience being triggered by and compounded by both therapists' invalidations/lack of understanding on gay issues *and* participants' projected internalised heterosexism.

Therefore the findings from this study suggest a more complicated picture than simply participants' reports of therapist homophobia, especially for those participants whose therapeutic relationships lasted longer; for these participants, difficulties around vulnerability, trust and emotional intimacy existed alongside their fears of homophobia mentioned above. The therapists may indeed have had gaps in knowledge around awareness of issues for gay men and differences in gay male culture, especially about what participants needed from therapy, however, it is also possible that participants may have partly attributed therapist homophobia as the cause of the rupture as a defence against becoming more vulnerable and intimate with them, the heterosexual other. Neither explanation fully answers the question of what is happening, so it would seem there is a complex mix of factors and variables at play in the rupture phenomenon experienced by the gay men in this study.

Despite this complexity, six of seven participants strongly felt that their therapist lacked an understanding of issues important to gay men. To address these concerns, and facilitate understanding, the researcher will attempt to address the question: what is it the therapists did not understand?

Discussion and theoretical insights

Participants' concerns with therapists' lack of understanding on gay issues: what is it they are suggesting their therapists did not understand?

Master theme 1 (The origins of the rupture: therapist as invalidating threat to gay identity and self) identifies the trigger for the rupture experience as being caused by therapists' invalidations around gay identity. Either participants felt dismissed on gay issues, they perceived the therapist as lacking interest or value on gay issues that were important to them, or they perceived therapist' as holding

holding negative and judgemental attitudes towards their gay identity, which meant participants self-censored and edited out aspects of themselves linked to their gay identity.

The researcher suggests the subthemes in master theme 1 map neatly onto Meyer's minority stress theory (2003a), with the therapists' heterosexual identity accentuating a difference between them that seems to have created additional barriers to be overcome for participants that therapists may not be fully aware of. This in turn is likely to have an influence on each dyad's intersubjectivity/co-constructed relationship, which may have exacerbated the difficulty/rupture. The researcher suggests the therapy context could be seen as a microcosm of participants' social world, which they have learned is unsafe and threatening to their identity and sense of self. According to Meyers' theory, the hostile social world in which gay men develop leads to gay-specific intrapsychic processes that function to protect them, namely internalised heterosexism (homophobia), rejection sensitivity and identity concealment.

Internalised homophobia and rejection sensitivity could be seen as being re-enacted in the therapeutic situation in the subthemes invalidations and fears of therapist homophobia/lack of understanding on gay issues; this might partly explain participants' hypervigilance to interpersonal threat and their perceptions of therapist homophobia, whereby they might be projecting their fears onto their therapists, and interpreting a lack of therapist response or interest as hostile and confirming their fears, strengthening a sense of barrier and mistrust. Indeed, most participants did acknowledge that some of their fearful perceptions of the therapist originated from within themselves, as Julian says, he was unsure whether the therapist was negative towards his gay identity, or “whether I'd internalised it, I don't know”, while Fraser updated his perception of therapist homophobia as being a side issue, rather than the main cause of the difficulty in the relationship. Meanwhile, the sub-theme shame-silence: threat of shame could be linked to Meyers' identity concealment concept, as participants showed strong evidence of editing out aspects of their gay identity and sexuality in therapy due to fears of therapist disapproval and judgement (shame).

The findings in master theme 1 chime strongly with the research findings discussed earlier, in which therapists with non-homophobic/heterosexist attitudes can diminish the TR with gay male clients by subtly discouraging them from discussing gay issues that are important to them (Hayes & Gelso, 1993), or damage the TR with gay men in subtle ways with low positive attitudes alongside low negative attitudes towards gay identity (Jones, 2000), in other words, the therapists were neutral. This study strongly confirms these findings and would suggest that these situations were integral to the perceived therapist invalidations which constituted the rupture phenomenon for the participants. These findings also suggest that the gay men in this study needed high positive attitudes towards their gay identity that would have supported them in talking about issues that

were important to them, around sex, gay relationships as well as coming out, despite their ambivalence about doing so.

All participants in this study talked about difficulties with self-acceptance and coming to terms with their sexuality, primarily because they grew up in an environment that was unsafe and invalidating towards them from early childhood. The researcher suggests this may make it feel difficult to talk about sex and gay issues; indeed, many participants felt conflicted about talking about gay issues and sex. Most participants in this study at the time the rupture occurred described being at an early stage in their gay identity development, for example, they had not come out to family and friends. Paul for example reported being a virgin at 27 and began to explore his sexuality around the time he went into therapy. Cass (1979) and Fassinger (1997) theorised gay identity development as a process LGB people progress through, as they move from denial and self-disgust through to self-acceptance and integration of their gay identity into their lives. The researcher suggests that therapy could be seen as part of the identity development process for the gay men who were interviewed. For most participants, their therapy was at times not experienced as supportive of their gay identity, which may have generalised the therapy experience as unsatisfactory for them and thus increased the likelihood of and sensitivity to perceptions of rupture experiences.

In their paper Enhancing Therapeutic Effectiveness With Lesbian Gay and Bisexual Clients (2005), Eubanks-Carter et al. point out that some heterosexual therapists, in a well-intentioned effort to treat everyone the same, fail to acknowledge difference with regards to sexual minority individuals, including the unique challenges faced by them. They suggest therapists should not ignore these unique challenges, and to not be afraid to ask about the difficulties and differences for fear of being prejudiced or lacking knowledge. Moreover, Eubanks-Carter et al. suggest therapists may also be unaware of the influence that their heterosexual identity has on their case formulations with gay men, and may turn to literature that is negatively biased and pathologising towards them. The scholars suggest that if therapist's want to enhance the chances of effective psychotherapy with gay men, they will need to understand the oppressive forces that gay clients have faced, and also the norms that develop in the gay community that might seem very different to the heterosexual mainstream. The scholars suggest therapists need to learn about the following issues that affect gay men: rejection, discrimination, harassment, internalised homophobia, the challenges of the coming out process, and also the benefits of being gay.

The researcher suggests an understanding of the cultural/historical/political context is also vital for a fuller understanding of gay issues, for example: the age of consent for gay men in particular (it was lowered from 21 to 18 in 1994, and equalised in 2000); the effects of Clause 28 on a

generation between 1988 and 2003; and gay conversion therapy that was advocated by seminal theorists such as Albert Ellis (1956) and Melanie Klein (1950), and continues to be practised today despite being deemed unethical by the UK's regulatory therapy organisations (Memorandum of understanding on conversion therapy in the UK, 2015).

Perez et al. (2000) suggest that some forms of long-term traditional psychoanalytic psychotherapy, for example classical psychoanalysis, may not be helpful for gay clients who are at the early stages of the coming out process, partly because it tends to emphasise the importance of intrapsychic processes "to the exclusion of contextual and environmental considerations" (pp118) while the focus on pathology and personality reorganisation "can be seen as insensitive to the real effects of oppression on development and functioning" (pp. 118).

Indeed, most participants' accounts in this study suggested a warmer, more two-person/relational approach was needed, a therapist who could convey an interest in and value for the importance of gay issues. Most participants in this study were in long-term traditional psychodynamic/psychoanalytic therapy, or psychoanalysis. Most participants were also at early stages of their identity development, and therefore it could be suggested that their identity development needs were not met, and this looks likely to have played a major part in the rupture experience in their experience of "lack"; typically minimal, neutral responses from their therapists.

How the findings relate to existing rupture research

This study asked participants about difficulties in the relationship with their therapists, and the resulting data has been extrapolated to the rupture phenomenon. The phrase "difficulty/rupture" will be used to refer to this phenomenon in this section.

The findings in this study support parts of Safran & Muran's (2000) definition of rupture in terms of confrontation and withdrawal, and a breakdown in the collaborative relationship. There were also differences; Safran et al.'s definition included compliance as part of the withdrawal rupture process, but the researcher in this study, however, interpreted participants' compliance as separate from their withdrawal rupture. In this study, "compliance discord" described a process, often lasting years, in which participants put their grievance around gay issues to one side, focused on other issues in therapy, and attempted to find value in the therapy/therapist for other areas of their lives, despite feeling uncomfortable about the unresolved rupture(s). The researcher suggests this may represent a re-enactment process, whereby the gay men have been used to being invalidated and rejected throughout their lifecourse, have experienced challenges in navigating "being gay" in the world and what this might mean, and have possibly felt ashamed to assert their gay identity

at times, and therefore have learned to defer and accommodate in what might have been experienced as an invalidating heteronormative environment.

This study concurs with Haskayne et al.'s findings (2014), that Safran's definition of the rupture phenomenon does not fully convey the way participants' experienced difficulty/rupture in this study. In this study, participants also experienced a sense of emotional struggle as in Haskayne's study. Meanwhile, participants in this study also experienced a process of negotiating and bargaining for trust, reparation and closure, both of the relationship and in their sense-making. Participants wanted to be reached, for example Julian and Shawn wondered if they would ever find a therapeutic space in which they could reveal their deepest darkest secrets. However, most participants described being in therapy that was not relational, but rather described therapy that would typically emphasise the importance of the transferential one-person relationship (typical in classical psychoanalytic therapy) rather than two-person collaboration drawing upon elements of the real relationship.

Echoing the findings in the study by Coutinho et al. (2011), participant's in this study who withdrew were left confused and ambivalent – however the researcher suggests ambivalence had a multi-purpose function in this study, to express dissatisfaction, to attempt to find voice and power, as well as part of the negotiation of trust, reparation and closure. This study also concurs with Coutinho et al.'s findings that ruptures echo a previous rupture event (invalidation) that has not been resolved; the researcher suggests that lack of resolution is therefore more likely to lead to further ruptures, or a protracted rupture experience.

This study concurs with Leinonen (2010) that rupture is a multifaceted phenomenon that is influenced by a multitude of different variables, including severity, time, therapist/client factors, resolution, awareness. For example, in this study, the researcher noticed that the personality of the participant seemed to have an influence on the likelihood of withdrawal or confrontation ruptures, with participants who presented a more introverted personality more inclined to withdrawal ruptures and deference.

This study agrees with the findings in Haskayne et al.'s study (2014) as well as Rhodes et al. (1994), in that client experiences of difficulty/rupture are different to therapists' experiences of rupture. Participants' accounts in this study suggest that they found it difficult to make sense of what was happening during in-the-moment experiences of rupture following invalidations. Meanwhile, participants tended to disregard difficulty/rupture if the bond was good and they achieved repair, as was the case with Shawn who resolved the rupture with his therapist, whereas the perceptions of participants with unresolved ruptures were strongly influenced towards

generalised dissatisfaction and negative bias when recalling the therapeutic experience, with positive aspects of the therapy shifting to the background.

Overlaps between ruptures and the therapeutic process in long-term psychotherapy

According to participants' accounts, there was a noticeable overlap between the difficulty/rupture and the therapeutic process in long-term psychotherapy that typically involves fluctuations in the TR (difficulties) as the client becomes more trusting and vulnerable. The issue about what constitutes a rupture remains a slippery topic in the literature (Safran & Muran, 2006; Leinonen, 2010). Indeed, rupture seems to be a phenomenon that is embedded in the therapeutic relationship and process, which makes it difficult to identify, arguable more so when the main therapeutic task involves a process that is challenging, painful and difficult. The researcher, integrating his own experience in personal therapy, wonders whether client perceptions of a strong therapeutic relationship mitigates perceptions of ruptures, with tensions being overlooked as necessary challenges as part of the therapeutic process, while such tensions are more likely to be perceived as ruptures in therapeutic relationships that are perceived as weak or poor, as Rhodes et al. found (1994).

Eubanks-Carter, Muran & Safran (2015) suggest that ruptures can include incredibly subtle interpersonal processes that go unnoticed by therapist, and also the client, who may not be consciously aware of the interpersonal processes in the moment. This was the case with this study, with participants' accounts suggesting that in-the-moment rupture experiences were confusing and ambiguous; only with some distance were they able to make some sense of it. Moreover, we can only speculate, but it is likely that the therapists had no idea that their client felt aggrieved by the initial invalidations.

Indeed, participants in this study were more likely to see difficulty/rupture experiences as part of the to-and-fro of the therapeutic relationship, which inevitably involved more disagreement, defensiveness and difficulty as the dyad became closer and more intimate. Participants is this study tended to only see difficulty/rupture as a distinct phenomenon when a disagreement was not resolved by the end of therapy; therefore the client perspective of what constitutes a difficulty/rupture in this study seems qualitatively different compared with the definitions in the literature (Safran et al., 1993, 2006). This might be because the more subtle aspects of the difficulty/rupture events were below participants' conscious awareness, or participants simply viewed the phenomenon as an inevitable part of the therapeutic process, rather than a distinct phenomenon separate to it. These findings concur with the research that suggests that clients report ruptures less than therapists (Coutinho, Ribeiro, Fernandes, Sousa, & Safran, 2014; Eames & Ruth,

2000). The discussion above offer suggestions as to why.

The findings in this study suggest that participants also experienced processes of negotiation in the therapeutic relationship, in which they seemed to be attempting to bargain for reparation and/or closure, causing tension and frustration as their attempts were thwarted by therapists who were described as not responding to their concerns, doubts or dissatisfaction. In this way, it seems participants wanted to talk about the difficulty/rupture (wanting collaboration) but the therapists seemed to not be responsive to their needs for reparation.

The findings in this study seem to contradict the “misunderstanding events” study by Rhodes et al. (1994), which looked at experiences of rupture from both sides of the dyad. Rhodes et al. found that clients with a poor relationship, and whose therapist was unaware of the misunderstanding, dropped out of therapy. In this study, most participants (5 out of 7) remained in therapy despite the rupture being unresolved and despite reporting difficulties in the relationship with the therapist and dissatisfaction with therapy.

Goettsche's (2016) study on LGB people's experiences in therapy found that participants were tasked with navigating heterosexism; this involved participants negotiating therapist-induced prejudicial rupture events that were not discussed nor resolved, and which resulted in termination of therapy. The word “negotiation” infers that participants perceived the therapeutic relationship as a co-constructed relationship with both parties contributing to the rupture. This reflects the finding in this study's master theme 3 (Negotiating reparation and closure of the rupture), with participants bargaining for trust and seeking a collaborative approach for reparation.

The difference with this study is that the participants remained in therapy in the long term, despite early ruptures associated with gay identity invalidations. Therefore this study could be seen as extending the research mentioned above by exploring what happened after the rupture trigger, and how participants experienced it. The word “navigating” suggests an ongoing and active process of remaining hypervigilant to and defending against therapist heterosexism/heteronormativity, as well as difference, while also seeking reparation and closure, which may in part help to explain participants' ongoing feelings of tension, ambivalence and frustration.

Interestingly, in this study, if therapy was relatively brief (between 20-25 sessions), then participants were much more likely to attribute the rupture to therapist lack/invalidations around gay identity. For those participants who remained in therapy, the picture became more complex, and they were more likely to feel doubtful about attributing the cause of the rupture to

“homophobia”. Instead, the difficulty/rupture also became about trust/mistrust, acceptance/love, negotiating notions of difference, and fears/feelings of rejection – possibly as a re-enactment echoing ruptures in previous interpersonal relationships that may have been associated by feelings of being different in early childhood and disruptions in their identity development.

The researcher tentatively wonders whether participants were searching for reparation, and wanting their therapists to connect with the most painful parts of themselves despite the barriers. Ellman's (2007) paper about transference cycles, resistance and analytic love seemed to echo what was happening for Paul, Fraser, Stuart, Shawn and Matt, albeit in varying degrees – they all wanted to feel loved, and also to be able to have and express positive feelings towards their therapists. Most of them were also in analytic therapy, which works towards dismantling clients' defences by working through resistance via the transferential relationship.

This need for love/acceptance and reparation also seems to be reflected in master theme 3's subthemes negotiating trust, and seeking repair, two subthemes in which participants may subconsciously be seeking a corrective emotional therapeutic relationship, possibly giving them an alternative outcome to the rejection/emotional neglect they experienced when they were growing up as children, and later, the rejection and isolation they felt as they experienced the oppression towards their sexuality and suppression of their identity development. Indeed, in Safran et al.'s (1996, 2011) rupture-resolution process, the final stage of the reparative process involves the therapist helping the client to identify the underlying wish/need. In confrontation ruptures, this involves making contact with underlying feelings of vulnerability and a wish to be nurtured. Meanwhile, in withdrawal ruptures, this involves bringing into the open client fears of vulnerability/rejection and a wish for self-assertion, as well bringing into the open these client's fears of their own subconscious aggression and potential therapist retaliation if they assert themselves in therapy.

Concerns with the quality of the bond, rather than tasks & goals

For participants in this study, the bond between client and therapist seemed to be the most important factor; if the bond was poor, then the rupture experience was more salient, but if the bond was good, then difficulties in the relationships did not seem so important and seemed to fade from memory, as Rhodes et al. also found (1994). For example, Shawn initially experienced difficulties in the relationship before resolving them with his therapist, after which the difficulties/rupture seemed to become less important.

Participants were mostly concerned with the poor bond they had with their therapists (lack of

empathy for example) compared with their concerns over the tasks and goals of therapy. Most of them reported being in long-term traditional dynamic/analytic psychotherapy, in which the transferential relationship would have been prominent. However, what most participants seemed to want was more of the real relationship (Gelso & Hayes, 1998), and a collaborative partnership in which they could relate to their therapists even if it was heated at times. In this study, for example, Fraser was shocked and scared by his therapist's confrontational outburst, in which the therapist got out of his chair and threatened to end the therapy – however for Fraser, on reflection, this event was real and authentic, and it created a change in his therapeutic relationship whereby he felt more able to trust his therapist.

The researcher suggests that the ruptures may have been exacerbated by an over-emphasis on the transferential relationship; for example, traditional psychoanalytic theories that advocate one-person therapy typically views frustrations and dissatisfactions as reflecting client transference to be interpreted, rather than legitimate client concerns that require a collaborative approach. Contemporary relational therapy, for example as outlined by Safran & Kraus (2014), and integrated approaches from modalities including psychodynamic, typically emphasise intersubjectivity (Benjamin, 1990; Mitchell, 1998) and collaborative elements of the real relationship (Safran & Muran, 2011), for example, therapist congruence/disclosure to metacommunicate the therapist's perspective in therapy about the difficulty in the relationship. Indeed, modern psychoanalytic thinking in psychotherapy suggests that therapy is an experience in which client and therapist have a mutual influence on each other, in a relational matrix (Mitchell, 1998). This way of thinking would view the therapist as having a contribution to the rupture; however in this study, most participant's described trying to negotiate with a non-collaborative partner, which frustrated them and left them feeling powerless.

This discussion has raised various issues and concerns on working therapeutically with gay men who are experiencing difficulty in the therapeutic relationship. These concerns will be addressed in the next section.

Implications for counselling psychology practice, training and research

Implications for counselling psychology practice

Understanding gay men's experiences of ruptures in therapy offers a unique opportunity to understand what will be helpful in not only resolving ruptures, but also in deepening trust in the dyad and developing emotional intimacy with gay male clients. This study found that when it

comes to gay male clients, one of therapists' immediate tasks is to break through their barriers of mistrust around identity differences, something that may not be easy to achieve. One way of approaching this issue is to invite clients to explore the differences between them and the therapist, to open up a discussion about this to bring into the open any fears they may have. It may be also be very useful for therapists, if they haven't already done so, to explore ways of sensitively working with shame with this client group if it feels appropriate. The researcher suggests that an understanding of the historical context is important (equality laws, age of consent etc), as well as the impact and disruption this could have had on the lifespan development of sexual minority people. The researcher suggests another way of approaching this is reflective practice; for example, for practitioners to reflect on how their sexual identity might be influencing their clinical formulations of gay male clients, and how this might influence intersubjectivity. There are differences between gay men and their heterosexual peers, just as there are differences between everyone; however the group of men in this study saw their identity as presenting extra differences that felt important to them, and which gave rise to specific needs. The researcher believes it is helpful to learn about these differences and to validate this diversity, while remaining sensitive to gay client's subconscious needs to either maximise or minimise their sense of difference.

This study shows that clients find it very challenging to talk about difficulties in the relationship with their therapist, perhaps due to deference or concerns with looking after their therapist (Rennie, 1994), or due to difficulties with shame which, by its very nature, is silencing. From the research, it also appears that most therapists also find it very difficult to broach ruptures with clients (Regan et al., 1992), while a need to support therapists in this area has been highlighted by qualitative counselling psychology research (Rajput, 2013). Therefore, it would seem useful to offer counselling psychologists and other therapists resources and support with this so they can assist their clients, but, as research has found, this is not always easy when settings such as the NHS encourage avoidance of ruptures (Lenionen, 2015). This study supports a seachange in approach towards ruptures that would encourage their exploration in therapy. In their paper *Repairing Alliance Ruptures*, Safran & Muran (2011) offer an evidence-based step-by-step guide on how to do this effectively by drawing upon approaches from relational therapy and meta-communication in collaboration with the client.

When therapists feel challenged by ruptures, they have been found to manage their anxieties around it by becoming more reliant on their therapeutic modality, or by adhering more rigidly to treatment methods (Norcross, 2010). In this study, most participants were frustrated by the classical one-person analytic approach, and may have benefited from more flexible approaches, strategies or techniques. This researcher recommends that a flexible, integrative or pluralistic approach is effective at working through therapeutic ruptures. The pluralistic approach in particular (Cooper,

2011) emerged from counselling psychology, and bases it's framework on what works in therapy based on research, and includes an approach to rupture-repair that is transtheoretical.

Implications for counselling psychology training

This study suggests that there may be a lack of therapist understanding on issues that were important for the gay men who were interviewed, which suggests there may be training needs around awareness of these issues, especially for therapist's who intend to work with gay men in medium or long-term psychotherapy and which is relational. Indeed, the researcher would assume that in any long-term therapy, an assessment of the client's sense of sexual identity, sense of difference/sameness, organismic valuing process, or libidinal energy will feature in the work at some point. The researcher suggests that, if it is not already in place, that training institutions include an assessed module on difference and diversity, which would require trainees to reflect on differences between them and their clients, and how this might influence their therapeutic practice, as well as offer opportunities for practitioners and trainees to attend workshops or reflective practice sessions around LGBT+ issues. It would be helpful for trainees to be aware of the historical context and the impact this has had on sexual minority people. As well as offering teaching on traditional theories of sexuality, it may also be helpful to include knowledge from different, more contemporary approaches and scholars, such as queer theory and intersectionality theory for example, which would give non-LGBTQ+ therapists an understanding of alternative experiences of the world from a minority perspective and the norms in those sub-cultures that are different from the non-LGBTQ+ mainstream. This may help to broaden knowledge, and broaden epistemological understandings for example by viewing traditional theories from a critical/poststructural perspective and how the historical, social and political context might influence and produces different knowledge. The researcher also suggests that it would be beneficial to gain knowledge of some of the norms within aspects of this sub-group's culture, which is different to the heterosexual mainstream, for example, the different ways of having relationship (polyamory, open relationships, cruising etc), the sexual categories gay men commonly use (for example, bears, twinks, jocks), the increase in anal sex without condoms due to the use of PrEP, the increasing use of online “hookup” apps, porn as a useful resource to model positive representations of gay male sexuality, and the chemsex phenomenon among others.

Implications for counselling psychology research

As Rhodes et al. (1994) point out, it makes sense to explore client experiences of rupture, because they are the ones who feel misunderstood, and therapists frequently are not aware there has been a misunderstanding. Despite this, the client perspective is not researched as much as the therapist's,

and the researcher would suggest that it is under-represented to the detriment of the counselling psychology field. This researcher believes that if counselling psychologists want to understand more about ruptures then we need to ask clients more, or even better, dyads, how they experience it. However, the researcher suggests one of the problems with exploring the client view of ruptures is mistrust of the researchers, who they may see as being aligned or allied to the counselling psychology academic community, and therefore biased, which inevitably will influence the findings. Insider research may present an alternative approach that could yield richer data from the client perspective.

This study shows that identity differences have a big impact on how clients experience ruptures, so it would be useful to extend this kind of exploratory research with other client groups with intersecting minority identities which include both minority sexuality, gender and ethnic/cultural background. While similar themes around invalidations and trust may well occur occur, such research might elicit nuances and specific information about the ruptures between different groups which might be useful.

This study suggests that rupture is broader than the alliance concept (task, goals and bond), in that the transferential configuration, and the real relationship seem to influence the phenomenon. This study as well as others (Haskayne et al., 2014) has found that rupture includes emotional struggle that is not included in Safran & Muran's original definition of rupture. This may be because Safran et al.'s research has until recently concerned itself with the alliance concept, rather than the broader concept of the therapeutic relationship, which also includes transference-countertransference, the real relationship, intersubjectivity, and the relational matrix. Future quantitative research on ruptures may come to new findings if the broader definition of the TR is used.

In this study, rupture emerged as a process, albeit with many variables influencing the phenomenon. The researcher suggests a grounded theory study could be useful to identify rupture as a universal process applicable across modalities, cultures and settings.

Limitations of the study

This study used IPA to explore the subjective experiences of seven participants. A small sample size was purposefully used so that an in-depth analysis could be undertaken to explore each participant's lived experience. It would not have been possible to conduct such a detailed analysis with a larger sample size that could offer validity and reliability in the findings and conclusions, due to the time constraints that such an analysis would involve. Therefore, due to the small sample

size, it is not possible to draw substantive conclusions from this study.

Participant's recall of the rupture experience may have presented discrepancies which may have influenced the findings. Firstly, time elapsed since the rupture may have made it more difficult for participants to recall the rupture experience. Despite the memories seeming to retain strong impressions in their minds, there were considerable amounts of time that had elapsed in which to recall an event in detail, which means some information may be missing from participants accounts. Secondly, there were differences between participants in the time elapsed since the rupture occurred, with the three participants above talking about an experience more than 20 years ago, while Julian, Shawn and Matt's rupture experience occurred within the past few years. This difference in time-elapsed between participants may have compromised recall, and also the homogeneity of the sample. Despite this, the researcher was surprised by the strength of participants' recall, with specific things being remembered and therapists being quoted. Therefore with regards to *commitment and rigour*, the study may have benefitted from having a wider pool of potential participants, due to the variation between participants in the time elapsed since the rupture experience.

With regards to *impact and importance*, the fact that several participant's rupture experiences happened more than 20 years ago could be seen as weakening the relevance of the findings, as rather old news perhaps, and any future research may be achieve greater impact and importance if these experiences were more recent. Despite this, most of the participants' experiences happened within the past eight years, and their emergent themes resonated strongly with the experiences from participants that were more dated. Also, the researcher was surprised by the level of detail and emotion that was recalled by the participants whose experiences had happened in the 1990s, suggesting that the psychological impact of the rupture at the time is also very influential in relation to participant recall. Indeed, strong emotional experiences make for more enduring memories. There was a concern from the researcher that subsequent life experience might contaminate or pollute participants' sense-making of the actual experiencing of the rupture phenomenon at the time it happened, however the researcher believes subsequent experience interacted with the original experience or trigger, and enriched it by acknowledging that temporal factors influence meaning-making with regards to any phenomenon. This research captured participants' experiences on a particular day, and the findings produced may have been different if they had been interviewed on a different day.

There were differences between participants' duration in therapy, which may have influenced their rupture experiences, and may have compromised the homogeneity of the group. For example, Kevin and Julian's duration of therapy was just over 20 sessions, while all the other participants

were in therapy for one year or more, with Fraser being in therapy for four years; indeed, there were differences between these two groups of participants, with those in longer therapy tending to offer richer data, presumably because there was more intimacy in the therapeutic relationship. The findings may have been more reliable if all participants had been in long term therapy (more than one year). The inclusion criteria asked participants to have been in therapy for more than 20 sessions, an arbitrary number of sessions, but one in which it was felt a therapeutic relationship would have formed. It is unknown whether 20 sessions offered enough duration of therapy to extrapolate reliable data.

This study included participants who had been in different types of therapy which may have influenced the findings. Indeed, the accounts from those participants who described being in traditional dynamic therapy did seem to differ from those who described being in integrative therapy which was more relational in its focus. This transtheoretical approach may have made the sample more heterogeneous and compromised the findings. Most participants, however, were in a dynamic oriented therapy.

The data may have been influenced by participants' perception of the researcher as a gay man. I endeavoured to conduct the study in an impartial and neutral way, in a spirit of warm interest, however Kevin assumed I was a gay man because of my interest in the subject, while Shawn Googled me and would have discovered I worked in LGBTQ mental health. Other participants most likely assumed I was a gay man due to my interest in the subject. The way I wrote the recruitment materials and the way I presented during interviews may have given the impression that I was a gay man, which would have had an influence on the participants. I wonder whether these factors may have made participants assume I knew what they meant when they were describing their experiences, which may have restricted how they explained things to me; conversely, it may have made them open up more.

Few studies are devoted to client experience of rupture, so this study provided an invaluable perspective on the phenomenon. However, participants seemed to have an agenda of wanting to educate what they may have seen as a heteronormative system which emphasises doubts around therapist credentials, as perhaps so did the researcher (see reflexivity section) which may have influenced the findings and conclusions drawn. Participants' interviews may have been influenced by a politicised agenda, and this may have impeded their talk about the rupture phenomenon in question. The researcher has experiences from both client and therapist perspective and, with commitment and rigour in mind, attempted to maintain an impartial position. Despite this being difficult at times, the researcher has made every effort to balance any bias with rigorous bracketing and reflexive processes.

Participants were asked about “difficulties in the relationship with their therapist” and they were not directly asked about how they experienced “rupture”, however, references to “rupture” were made in the flyer/poster and the Information Sheet. The researcher made a decision to ask about “difficulties” because the term “rupture” is a technical word used by the therapeutic community, and may have lacked meaning for participants. However, this means the data that was yielded about “difficulty” is being used to draw conclusions about the term “rupture”, and it remains unknown to what extent the two terms are related or interchangeable. The raises the question as to why or for what purpose the therapeutic community uses technical terminology that is lost on clients, and on therapists too according to some research (Leinonen, 2010).

With regards to *sensitivity to context*, the researcher's shared identity and experience (gay man who has experienced therapeutic rupture as a client) was both a strength and a weakness in the study. A strength, because it facilitated a unique understanding of the experience within the social-cultural-political context of being gay in the UK. A weakness, because the researcher may have been at risk of over-empathising and becoming over-involved with each participant's experience, and imposing the researcher's meaning-making onto participant's; steps were taken to minimise this, including using a reflexive diary, and purposefully adopting a more distanced, sceptical/questioning approach during some of the analytical readings.

The *commitment and rigour* of this study is supported by the fact that most participants validated the researcher's findings in a participant review process, however one participant (Shawn) said that cultural differences were also very important for them in their rupture experience, and this divergence was mentioned in the findings. For the sake of the *coherence* of the study, the researcher focused on gay identity as central to the rupture experience because it applied to the majority of participants. This might be because the sample did not represent the diversity of the general population (six out of seven participants were white British), and a more purposive sample may have addressed this.

Concluding remarks

In answer to the research question, the rupture experience of the gay men in this study was associated with their gay identity. In terms of how they experienced it, most participants (Paul, Julian, Stuart, Kevin, and Matt) came to the conclusion at the end of the interview that a contributing causal factor of the rupture was a mismatch between them and therapist's model of therapy, along with difficulties navigating the sense of difference between them and their

heterosexual therapist. These factors exacerbated their needs for a different kind of support which may have helped them to perceive a warmer, more collaborative active approach, or one that supported their identity development at a sensitive stage in their life course, or one that was more conducive to talking through the difficulty in the relationship. Participants were only able to come to these conclusion following subsequent life experiences which included more satisfying therapy elsewhere that was used to compare and make sense of the original rupture. The research interview seemed to act as a therapeutic intervention which helped participants to process the experience, and the interview helped them to further make sense of the original experience in more balanced and measured ways. Most participants seemed to want a strong relationship with their therapist, but before that could happen, they needed to know their therapist was an ally to their gay identity and sexuality, something that was very difficult to confirm, even when they were offered reassurance by the therapist. The difficulty/rupture experience was essentially about trust for the gay men in this study and navigating difference between them and their therapist.

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Appendices

1. Recruitment poster/flyer
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<u>Appendix 1</u>: Recruitment poster/flyer

Appendix 2: Participant Information Sheet

Participant Information Sheet
Title of research: Exploring the experiences of ruptures in the therapeutic relationship for clients who identify as gay men: An interpretative phenomenological study.

Participant Information Sheet

From: **Researcher: Phil Brooke; Tel: 07940 583083; Email: prb0069@my.londonmet.ac.uk**

To whom it may concern,

My name is Phil Brooke and I am doing research as part of a Doctorate in Counselling Psychology at London Metropolitan University. My study will look at how gay men have experienced tensions, difficulties, misunderstandings and/or breakdowns (ruptures) in the relationship with their counsellor/psychotherapist. These ruptures could be subtle which you kept to yourself, or more obvious ones. I'm writing to you in the hope that you will be interested in this study and be willing to take part as a participant, which would mean you sharing your experiences with me in a face-to-face interview.

For this study I am looking for gay men:

- Who have experienced any tensions, difficulties, misunderstandings and/or breakdowns (ruptures) in their relationship with their counsellor or psychotherapist
- Whose counselling/psychotherapy lasted for more than 20 sessions
- Who are over 18

Purpose of the study
Very little is known about the topic in relation to minority groups such as gay men. My hope is that by carrying out this research we will be able to gain a better understanding of ruptures in the therapeutic relationship from the perspective of gay male clients, and any new understandings may assist the profession in providing help and services that better support and reach the needs of gay men.

Participation
Taking part in the study is entirely voluntary. If you do decide to take part, first I ask you to read

and sign the Consent Form (enclosed) - this form ensures you understand the procedure, that you are aware of your rights as a participant and also to confirm your agreement.

Once the Consent Form is signed, I ask you to complete the questionnaire (enclosed) called the PHQ9 and GAD7. You can return the Consent Form and questionnaire in the self-addressed envelope, or by email. Once you return the Consent Form and questionnaire, I will be able to confirm your participation in the study and will make contact with you to arrange a place to meet.

Participation would mean taking part in an interview with me that would last approximately 1 hour, with another 30mins for introductions and debriefing. Interviews will be voice recorded, and data from your interview will be used for the study. You will also be asked for some demographical information.

If you choose to take part, you are free to withdraw without question. Withdrawing would mean anything you have said during our conversation will not be used in the study, and any recordings or information about you will be deleted. If you decide to withdraw, it is best to let me know as soon as possible - it may not be possible to withdraw from the research after April 2018 as the data may have already been processed into the study. During the interview you do not have to answer any questions you are not comfortable with and, if at any time you feel distressed, it will be OK to stop or pause the interview at any time, without consequence or need for explanation. The interviews will take place at London Metropolitan University or an alternative arranged location that offers you confidentiality. Although no financial incentives can be offered, travelling costs to the interview will be reimbursed and refreshments offered.

Confidentiality

Interviews will be voice recorded and all information that is collected about you during the course of the research will be kept strictly confidential. Following the guidelines of the British Psychological Society's ethical principles for conducting research with human Participants (2009, 2014) your confidentiality and anonymity will be respected. This includes storing your data securely and safely, with personal information and audio recordings kept separately, and anonymising any personal information in any published work with a code/pseudonym. Your name or any identifying information will be removed from the data, and will not be mentioned in the study. The Consent Form will be kept separately from the voice recording, and will only be kept so I can show my supervisor/assessor that proper consent has been obtained. Audio recordings will be stored on devices that are encrypted, and in a computer folder that is double password-protected in line with the Data Protection Act (2012) and the British Psychological Society. Consent forms containing personal information will be stored physically in a locked secure safe box in my home.

The completed study may end up published in an academic journal; successful publication would mean I may need to keep all the data for a certain length of time. This could be around five years, depending on the journal. If the study is not planned for publication, all recordings will be erased once the project is completed and the Doctorate has been awarded. My supervisor or the external examiner may request access to the raw data to check it is correct and proper.

The study may use your direct quotes, so please let me know during or after the interview if there if there is anything you would rather I didn't use as a direct quote, and I will ensure those quotes are not used.

Please note there are limits to confidentiality where I consider there is a significantly high risk of harm to yourself or others, the disclosure of serious criminal activity (such as abuse or bodily harm to others) or a threat to national security. This would mean notifying statutory services.

This study has been approved by the Research Ethics Review Panel at London Metropolitan University and will be conducted in accordance with the ethical guidelines provided by the British Psychological Society (2009, 2014).

Risks

Before you decide to participate it is important that you understand the interview will involve us discussing emotive and very personal issues and therefore may evoke some distressing and difficult feelings for you. It is important you feel comfortable sharing such personal information with me, so please take your time in deciding whether or not you wish to take part. You will have the opportunity to discuss with me any feelings evoked after the interview. I will give you a Debrief Sheet which includes information about the purpose/aims of the study and additional sources of support. I will discuss this with you to ensure you have access to any additional support you might need or want.

How you can hear about the findings

If you take part in the study, you can request a copy of the final study when it is finished, or a summary of the findings. You can make this request by emailing the researcher Phil Brooke at prb0069@my.londonmet.ac.uk.

Making a complaint

If at any point you would like to make a complaint, then you can do this by contacting my Supervisor Dr Catherine Athanasiandou-Lewis on 020 7133 2669 or email at

c.athanasiadoulewis@londonmet.ac.uk. My supervisor can also answer questions you would rather not ask me.

Thank you so much for your time and interest. If you have any further questions, or you would like to take part in this study, then please contact me. I look forward to hearing from you.

Researcher: Phil Brooke; Tel: 07940 583083; Email: prb0069@my.londonmet.ac.uk

Yours sincerely,

Phil Brooke, Trainee Counselling Psychologist

Appendix 3: Participant Informed Consent Form

Participant Informed Consent Form
Title of research: Exploring the experiences of ruptures in the therapeutic relationship for clients who identify as gay men: An interpretative phenomenological study.
Researcher: Phil Brooke, trainee counselling psychologist at London Metropolitan University

Consent Form

This Consent Form is designed to make sure you are happy with the information you have received about this research. It aims to ensure you are aware of your rights as a participant, that you are fully aware of what to expect and also to confirm that you would like to take part in the study.

Description of procedure: In this study, you will be asked a series of questions about your experiences as client of psychotherapy/counselling of ruptures (difficulties/tensions/misunderstandings/breakdowns) in the relationship between you and your counsellor/psychotherapist. The interview will be audio-recorded. Please tick the boxes below, and sign the form below, to indicate your agreement to each statement.

- I understand I need to complete the questionnaire (PHQ9/GAD7) and return it with this Consent Form before I can take part in the study.
- I have read and understand the participant information sheet dated for the above study. I have had the opportunity to ask questions and I am satisfied with the information given in response.

- I understand the procedures to be used and agree to take part in the study.
- I understand I am free to withdraw at any time without question. I understand that if I wish to withdraw I will need to do so before the data is processed **(around April 2018)**
- I understand that my participation in this study is anonymous. My name will not be used in connection with the results in any way, a code/pseudonym will be used on the digital voice recording and all information that may otherwise identify me will be changed prior to transcription. There are limits to confidentiality however; confidentiality may be breached if there is a risk of harm to myself or others, or if I disclose taking part in serious illegal activity.
- I understand that the results of the study will be accessible to others when completed and that excerpts from my interview (minus identifying information) may be used in the writing up or publication of the study.
- I understand that I may find this interview upsetting and that it may evoke difficult and distressing feelings for me. I will be offered support and the opportunity to discuss these feelings after the interview. The researcher will also give information on further support available if required.
- I understand that I have the right to obtain information about the findings of the study and details of how to obtain this information will be given to me in the Participant Debrief at the end of the interview.
- I understand that the data will be erased as soon as possible, either once the study has been assessed, or 5 years after publication.

Signature of participant	Printed name	Date
….....	.....	.....
Signature of researcher	Printed name	Date
….....	.....	.....

Appendix 4: Interview schedule

Title of research: Exploring the experiences of ruptures in the therapeutic relationship for clients who identify as gay men: An interpretative phenomenological study.

Welcome and introductions

House rules (time boundaries, mobiles, toilets, needing a break, exits etc)
Check understanding of information sheet
Informed consent

1) What can you tell me about the difficulty in the relationship with your therapist? Or therapists?
    Can you describe what happened in the difficulty in the relationship with the therapist?
    Can you give me an outline of the difficulty we're going to be talking about?
2) How did it happen? Was there a trigger? What was it about? What caused it?
3) How did it affect you? Affect the therapy?
4) What was it like to experience it? (memories, thoughts, images, smells, feelings, sensations)
5) How did you make sense of it? Why did it happen? What did it mean to you?
6) Anything remain unsaid? If so, can you tell me more?
7) Is there anything else you feel is important I've not asked that you would like to add?
8) Is there anything you'd like to say to the therapeutic professional community?
9) Are there any quotes you would rather I didn't use?

Prompts:
Can you tell me more?
Can you please expand on that?
Might sound like a silly question … what does xxxx mean?
Is there any more you can say about that?
I'd be really interested to hear more about that, if you've got more to say on that?
How was that different?
How did you think/feel?

Appendix 5: Participant Debrief Sheet

Exploring the experience of ruptures in the therapeutic relationship for clients who identify as gay men: An interpretative phenomenological study.

Dear Participant,

Thank you very much for taking part in this study. This is part of a Doctoral research project that I am conducting. Your time and effort are very much appreciated.

This Debrief Sheet aims to inform you about the purpose of this research and explain why I as the

researcher think it is important. This study aims to explore experiences of ruptures in the therapeutic relationship from the perspective of gay male clients. The therapeutic relationship and the repair of therapeutic ruptures, as well as positive client perceptions of therapy, have been associated with better therapeutic outcomes. It is hoped the findings will provide a better understanding of the phenomenon in question so that therapists can more effectively understand and meet the therapeutic needs of gay men in particular. The findings may also identify a need for further research with other minority groups.

If you have any questions or concerns following the completion of the study, please contact me, the researcher:
Phil Brooke
E mail: prb0069@my.londonmet.ac.uk
Phone: 07940 583083 (research contact mobile)

You can also raise any queries, concerns or complaints with my academic supervisor:
Dr Catherine Athanasiandou-Lewis
E mail: c.athanasiadoulewis@londonmet.ac.uk
Phone: 020 7133 2669

If taking part in the study has left you in need of further help or support, then please see the list of helplines and support agencies at the bottom of this Debrief Sheet.

Please be reminded that your participation in this study remains anonymous; only me (the researcher), my supervisor and the assessors will have access to the voice recording. A code/pseudonym will be used, and no identifying information about you will be transcribed from the voice recordings. You can withdraw from the study without question – please let the researcher know as soon as possible as it may not be possible to action this request from April 2018.

As mentioned before, you can request a summary of the study's findings. If you haven't already done so, please indicate your interest by emailing me at: prb0069@my.londonmet.ac.uk.

Thanks once again,

Phil Brooke
Trainee counselling psychologist

List of useful information, advice, support and counselling agencies and services

Crisis/emergency

You can contact your GP and request a referral to free NHS psychological assessment/therapy, or an emergency mental health referral.

Or call the NHS 111 24-hour helpline on 111

In an emergency, always call the police on 999. If you feel unable to keep yourself safe, you can head to your local A&E or call 111. If you have already harmed yourself and need assistance, call an ambulance on 999.

LGBT+ agencies

Metro

London-based service for LGBTQ+ people: counselling, advice & information, advocacy, mental health drop-in and crisis support.

020 8305 5009

www.metrocentreonline.org/mental-health

hello@metrocharity.org.uk

London Friend

LGBT service offering counselling, telephone advice, social support.

86 Caledonian Road, London, N1 9DN

020 7833 1674

http://londonfriend.org.uk/get-support

office@londonfriend.org.uk

LGBT+ Switchboard

Helpline, online support.

http://switchboard.lgbt/help/

chris@switchboard.lgbt

0300 330 0630

PACE

Promoting the mental health and emotional wellbeing of the LGBT community. Offers counselling, mental health advocacy and more.

34 Hartham Road, London, N7 9JL.

www.pacehealth.org.uk/index.htm

Tel: 020 7700 1323 Email: info@pacehealth.org.uk

Helplines and general mental health support

HOPElineUK (for under 35s or those concerned, Mon-Fri 10am-5pm, 7-10pm, w/ends 2-5pm) Tel 0800 068 4141, text 07786 209 697, email pat@papyrus-uk.org

Mind
Website: www.mind.org.uk Email info@mind.org.uk
Mind Infoline 0300 123 3393 and Text: 86463
(Lines are open 9am to 6pm, Monday to Friday (except for bank holidays).
Provides a confidential helpline, face-to-face counselling, advocacy, support and befriending for a broad selection of mental health difficulties.

Rethink 0300 5000 927

Samaritans
Tel: 084 5790 9090
Email :jo@samaritans.org.uk
Website: http://www.samaritans.org/
Offers a 24 hour support help-line service.

Saneline (6pm-11pm) 0845 767 8000

Supportline (opening hours vary) 01708 765 200

Counselling/psychotherapy

Counselling Directory
http://www.counselling-directory.org.uk/

British Psychological Society
Provides details regarding qualified psychologists trained in a variety of methods/approaches in UK.
St Andrews House, 48 Princess Road East, Leicester LE 1 7DR
0116 254 9568 www.bps.org.uk

The British Association of Behavioural And Cognitive Psychotherapies (BABCP)
Provides details regarding qualified cognitive behavioural therapists in the UK.
Globe Centre, PO Box 9, Accrington, BB5 2GD
01254875277 www.babcp.co.uk

British Association for Counselling And Psychotherapy (BACP)
Offers information on CBT, counselling, group therapy and psychotherapy.
BACP House, 35-37 Albert St, Rugby, Warwickshire, CV21 2SG.
0870443 5252 www.bacp.co.uk

Relate
Offers relationship counselling, children and young people's counselling, family counselling and sex therapy.
Relate, Premier House, Carolina Court, Lakeside, Doncaster, DN4 5RA
0300 100 1234 www.relate.org.uk

UK Council for Psychotherapy (UKCP)
Offers CBT, couples, family, group therapy and psychotherapy.
167-169 Great Portland Street, London WI W 5PF.
0207 326 3002
www.psychotherapy.org.uk

Appendix 6: Distress Protocol

Exploring the experience of ruptures in the therapeutic relationship for clients who identify as gay men: An interpretative phenomenological study.

Distress Protocol

Protocol to follow if participants become distressed during participation:

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in the research while discussing their experiences of psychotherapy and ruptures in the therapeutic relationship.

The researcher is a trainee counselling psychologist with extensive clinical experience monitoring and managing situations where distress occurs. It is not expected that extreme distress will occur in this research, nor that the relevant actions listed below will become necessary. This will be verified by an introductory telephone conversation with each participant, and each participant will be required to complete a PHQ9/GAD7 questionnaire. Participants scoring in the severe ranges, or who score 2 or 3 on question 9 of the PHQ9 will be excluded from the study. These steps will minimise any potential risks.

If any participant does become distressed, the following three-step protocol listed below will act as a guide to keep participants and others safe and free from harm. The protocol guides the researcher in what to look out for and what actions to take should participants become distressed.

Mild distress:

Signs to look out for:

1. Tearfulness
2. Voice becomes choked with emotion/ difficulty speaking
3. Participant becomes distracted/ restless

Action to take:

1. Ask participant if they are happy to continue
2. Offer them time to pause and compose themselves
3. Remind them they can stop at any time they wish if they become too distressed

Severe distress:

Signs to look out for:

1. Uncontrolled crying/ wailing, inability to talk coherently
2. Panic attack- e.g. hyperventilation, shaking, fear of impending heart attack
3. Intrusive thoughts of a traumatic event- e.g. flashbacks, or extreme difficulties with concentration/focus of attention

Action to take:

1. The researcher will intervene to terminate the interview
2. The debrief will begin immediately
3. Relaxation techniques will be suggested to regulate breathing/ reduce agitation

4. The researcher will recognize participants' distress, and reassure them that their experiences are normal reactions to their difficulties and that most people recover from such psychological distress
5. If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss with mental health professionals and remind participants that this is not designed as a therapeutic interaction
6. Details of counselling/therapeutic services available will be offered to participants (see Debrief Sheet, Appendix 5)

Extreme distress:

Signs to look out for:

1. Severe emotional distress such as uncontrolled crying/wailing
2. Severe agitation and possible verbal or physical aggression
3. In very extreme cases, suicidal ideation with intent (plans and/or method expressed), and possible psychotic breakdown where the participant loses touch with reality

Action to take:

1. Maintain safety of participant and researcher
2. If the researcher has concerns for the participant's or others' safety, he will inform them that he has a duty to inform any existing contacts they have with mental health services, such as a Community Psychiatric Nurse (CPN) or their GP.
3. If the researcher believes that either the participant or someone else is in immediate danger, then he will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.
4. If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency)

<u>Appendix 7</u>: Demographic & client history of therapy questionnaire

Demographics and participants' experience as a client of counselling/psychotherapy

Personal information

Name

Address:

Date of birth:

Gender: Do you, or have you ever, identified as transgender? Sexual orientation:

Ethnicity / cultural background:

Religion / belief:

Would you describe yourself as having a disability? Y / N If so, what kind of disability?

<u>Counselling/psychotherapy history</u>

Please give details of counselling/psychotherapy you have accessed in your lifetime. Please answer the questions as best you can remember. Please say if you don't know or you are unsure.
Please indicate which therapy relationship(s) you discussed in the interview.

Number 1:
When it was (start date / end date)

How many sessions / how long it lasted / please say if it's still ongoing

Profession of practitioner and regulating body, if known.
(eg, professionals: counsellor, psychotherapist, counselling psychologist. Regulating body: BACP, BABCP, UKCP, HCPC, other)

Did you talk about this one in the research interview? Y / N

Organisation? Please circle: private practice / NHS / counselling agency. / charity other.....

What kind of therapy was it? (eg, psychodynamic, humanistic, CBT, integrative etc)

What issues you initially went with

Why the counselling/therapy ended?

Repeated 9 times

Appendix 8: GAD7 & PHQ9 questionnaires

Questionnaires

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every Day
1 Feeling nervous, anxious or on edge	0	1	2	3

2	NOT being able to stop or control worrying	0	1	2	3
3	Worrying too much about different things	0	1	2	3
4	Trouble relaxing	0	1	2	3
5	Being so restless that it is hard to sit still	0	1	2	3
6	Becoming easily annoyed or irritable	0	1	2	3
7	Feeling afraid as if something awful might happen	0	1	2	3

PHQ-9

	Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every Day
1	Little interest or pleasure in doing things	0	1	2	3
2	Feeling down, depressed or hopeless	0	1	2	3
3	Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4	Feeling tired or having little energy	0	1	2	3
5	Poor appetite or overeating	0	1	2	3

6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Appendix 9: Letter of ethical approval from Research Ethics Committee

LONDON METROPOLITAN UNIVERSITY

London Metropolitan University
School of Social Sciences
Research Ethics Review Panel

I can confirm that the following project has received ethical approval by one anonymous reviewer and the Head of School of Social Sciences Ms. J. Skinner to proceed with the following research project:

Title: Exploring the experiences of ruptures in the therapeutic relationship for clients who identify as gay men: An interpretative phenomenological study.

Student: Philip Brooke

Supervisor: Dr Catherine Athanasiadou-Lewis

Ethical clearance to proceed has been granted providing that the study follows the ethical guidelines used by the School of Psychology and British Psychological Society, and incorporates any relevant changes required by the Research Ethics Review Panel. All participating organisations should provide formal consent allowing the student to collect data from their staff.

The researcher is also responsible for conducting the research in an ethically acceptable way, and should inform the ethics panel if there are any substantive changes to the project that could affect its ethical dimensions, and re-submit the proposal if it is deemed necessary.

Signed: Date: 27 March 2017

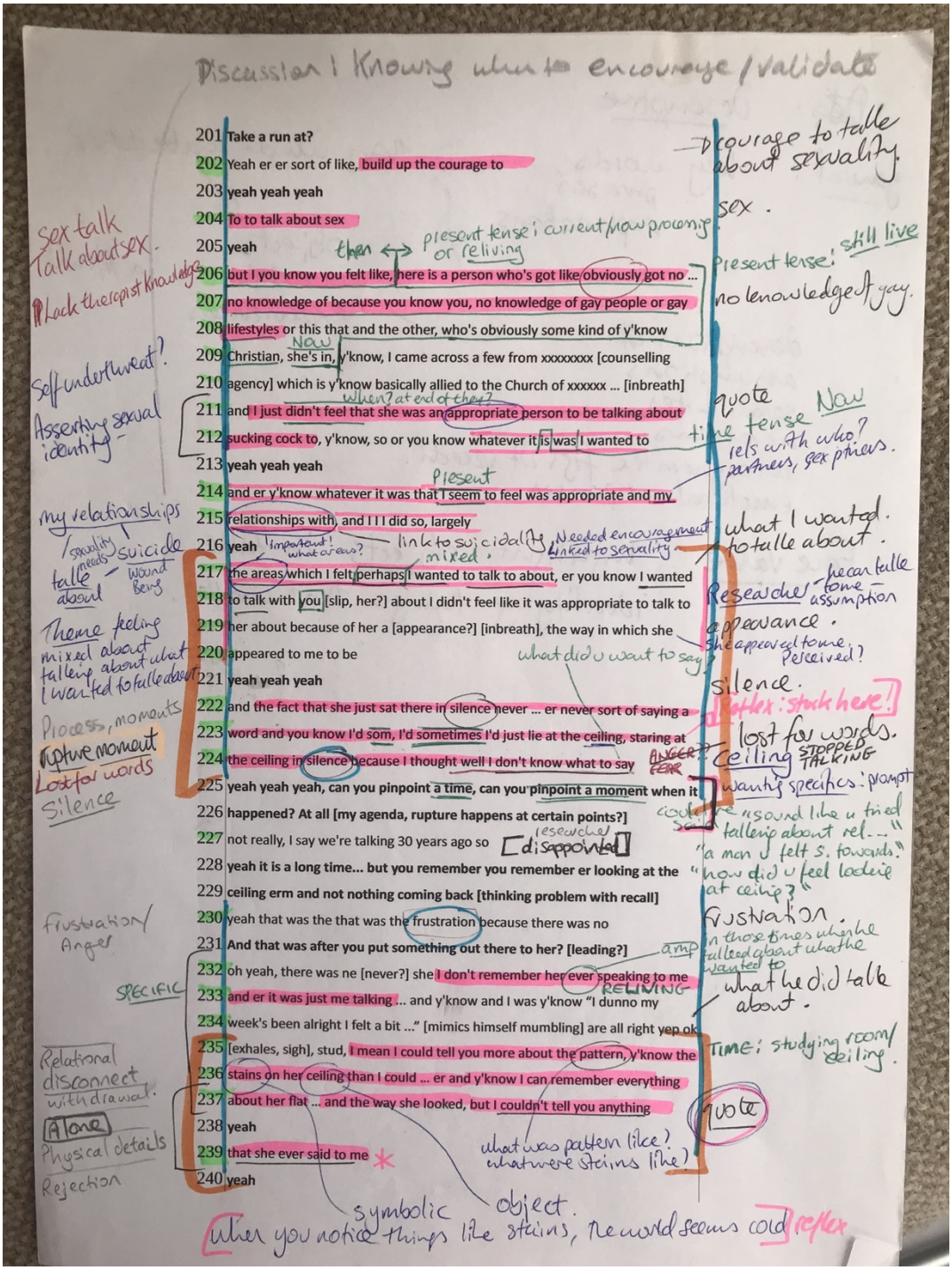
Prof Dr Chris Lange-Küttner
(Chair - Psychology Research Ethics Review Panel)

Email c.langekuettner@londonmet.ac.uk

Appendix 10: Summary of demographic information and history of therapy

Participants	P1	P2	P3	P4	P5	P6	P7
Interview date	July 2017	Sept 2017	Oct 2017	Oct 2017	Oct 2017	Dec 2017	Feb 2018
Year of birth, age at interview (mean age 54yrs)	1951,66yrs	1963,54yrs	1979,37yrs	1953,64yrs	1939,77yrs	1989,28yrs	1968,49
Age when in the therapy (mean age 41 years)	28-31	31-34	35	53-56	1) 50; 2) 56-58	27	45-46
Time since the therapy rupture (at interview date)	37 years ago	21 years ago	2 years ago	8 years ago	1) 27yrs; 2) 20yrs	1 year ago	3.5 years ago
Duration of the therapy (average approx 2 years)	3 years	4 years	5 months	3 years	1) 5 mnths 2) 2 years	18mnths ongoing	1 year
Dates of therapy with difficulty relationship	1979-1982	1994-1997	2014-2015	2006-2009	1) 1990 2) 1996-1998	2016- ongoing (interview date 23/09/17)	2014-2015
Reason for going to therapy	Sleep issues	Training requirement	Training requirement, relationship & sexuality issues, fears around HIV	"Something's wrong and clarification"	1) depression, unhappy with being gay 2) diverse issues, talked about sexuality	Sexuality, coming out to family, violent reaction of family, police involvement to keep P6 safe	"Panic attacks, unbearable anxiety and fear"
Aprrox number of sessions approx (based on 40 sessions per yr)	360 sessions	160 sessions	21 sessions	120 sessions	1) 25; 2) 100 sessions	40 sessions at interview	40 sessions
Frequency of therapy	3 times a week	once a week	once a week	once a week	both once weekly	2-3 x/per month	once weekly
Type of therapy	P1 didn't know, sounds like **psychoanalytic**	P2 says **phenomenological existential**, sounds like dynamic interpretations were offered	Psychodynamic / integrative	Psychodynamic	1) **psychoanalytic** 2) **integrative**	"Psychotherapy". Sounds like **relational integrative**	Psychodynamic
Fee	Yes	yes	yes	yes	1) no 2) yes	yes	no
Why therapy ended, or still ongoing	"frequency cost too much, lack of progress, uncomfortable talking about sexual issues"	"Finished training, moved away"	"I ended it after 21 hours"	"I thought it was going nowhere"	1) therapist finished sessions 2) therapist finished training	Ongoing	Fixed term, NHS rules
Therapist's profession & professional registration	?	?	BACP	?	? ?	BACP	Dr title
Type of organisation / private?	Via an agency, private, therapist home	Private	Private	Private	1) Charity 2) private	Private	NHS
Number of times in therapy before rupture experience in interview	0	2	0	0	1	1	2
Number of times in therapy after rupture experience in interview	5	2	0	1	1	0	1
Ethnicity	WB	WB	WB	WB	WB	British Pakistani	Jewish & Romany
Religion / belief	none	agnostic	unstated	C of E / Christian	agnostic/atheist	Wiccan	not stated
Disability	no	no	no	no	no	Yes dyslexia	yes LT health condition / HIV+
Cisgender	Yes	Yes	Yes	Yes	Yes	Yes	Yes
PHQ9	6	2	1	4	7	4	9
PHQ9 question 9	0	0	0	0	0	0	0
GAD7	10	2	0	6	6	4	10

<u>Appendix 11</u>: IPA analysis steps 1-3: sample of transcript: – Paul



Appendix 12:

IPA analysis step 6: analysing for patterns and amalgamating themes across cases

master theme	case themes – occurrence and strength	P1	P2	P3	P4	P5	P6	P7	tallies
Psy impact & implications	reanactments	3	3	3	3	3	repair	3	
	Difficulties processing / making-sense / updates	3	3	3	3	3	3	3	
	all about trust & being reached – on many levels	3	3	3	3	3	3	3	
Barriers – defence	M**Additional barriers resulting / from identity differences**	3	3	3	3	3	33	3	24
Barriers – defence	P1 M**ADDITIONAL BARRIERS Gay identity presents additional barriers**	3	3	3	2	33	3	3	23
Barriers – defence	Perceived mismatch – differences too wide	3	3	3		33	3	3	21
Barriers – defence	barriers up – closed shut down	3	3	3	3	3	3	3	21
Barriers – defence	barriers	3	3 defences	3	1	3	3	3	19
defending	unwillingness to divulge / moving onto safer ground, different paths	33	3	3	2	33	3	3	26
defending	M**In defence of & protection of the self**	3	3	3	3	3	33	3	24
defending	**M Struggling to defend self: difficulties in finding voice in hostile environme**	3	3	3	2	3	3	33	23
defending	Frustrated explorer: rejection of therapist and wanting an LGBT therapist.	33	3	3	2	3	3	3	23
defending	Withdrawal – partial, fluctuating	33	3	3	3	3	2	3	23
defending	Hiding gay self / gay self is suppressed DISAPPEARING	3	3	3	2	3	3	33	23
defending	(Barriers) Blocks & obstacles	3	3	evid	2	33	3	3	22
defending	Feeling defensive L104 L202	3	3	2	2	3	3	33	22
defending	unwillingness to disclose / divulge on gay-related issues	3	3	3	3	3	3	3	21
defending	M**Struggling to defend the "gay self" against perceived invalidation**	3	3	3	2	3	3	3	20
defending	devaluing therapist	33	2	2	3	3	2	2	20
defending	**M Struggling to protect gay self and identity**	3	3	2	1	2	3	3	17
defending	Aserting gay identity - Shock value	3		2	2	3	1	3	14
defending	**Asserting identity – explaining - educating the therapist on identity issues**	3		1		3	33		13
defending	Rejection of therapist and wanting an LGBT therapist {understanding]	33		3		33	3	33	21x
defending	**Rejection of therapist [withdrawal]**	3	3	3	3	3		33	21x
defending	**The divergence: Irreconcilable differences and opposing values: mis-match**	3	3	3	3	3	2	3	20x
defending	**Barriers**	3	3 defences	3	2	3	3	3	20x
defending	**M Struggling to protect & defend self [the shamed sexual self]**	3 ?	3	3		3	3	3	18x
defending	Fighting back – outburst – flashpoints – protest vs retreat – [challenge & withdrawal]		3		3	3	2	3	17x
defending	**M Battle zone: attempting to defend the SHAMED self**		3		3	3	2	3	14x
Defending - threat		33	3	3	2	3	1	3	21
diffs finding voice -power	Struggling to find voice: difficulties in challenging the therapist	33	3	33	33	3	3	3	30
diffs finding voice -power	Main problem: therapist unwillingness to talk it through, lack of resolution	333	3	3	33	33		2	29
diffs finding voice -power	Struggling to challenge therapist and find voice	33	3		33	33	3	3	27
diffs finding voice -power	**Difficulties voicing anger, finding voice**	3	3	3	33	3	3	3	24
diffs finding voice -power		3	3	33	2	3	3	3	23
diffs finding voice -power	Difficulties in finding voice [SHAME]	3	3	3	3	3	3	3	21
diffs finding voice -power	**Difficulties in finding voice**	3	3	3	3	3	3	3	21
identity development	other themes – lifeworld contextual	3	3	33	1	3	33	33	28
Invalididation	Lack of therapist response, deprivation of words and non-verbal cues	33	2	33	33	33	2	33	34x
Invalididation	dismissed	333	33	33	3	33	33	33	42
Invalididation	microinvalidation on sexuality – heteronermativity [excluded]	33	33	33	3	3	33	33	36
Invalididation	lack of therapist understanding of minority experience	33	33	33	3	3	33	33	36
Invalididation	Perception of lack of therapist understanding about "being gay" 206	3	33	3		33	33	33	30
Invalididation	Bothered about **lack of therapist interest/response**in gay related themes (invalidations)	33	3	3	3	33	2	33	29
Invalididation	**Microinvalidations**	33	3	3	2	3	33	33	29
Invalididation	Invalidated self - lack of therapist response	33	3	3	3	33	1	33	28
Invalididation		33	3	3	2	33	3	3	26
Invalididation	M**FeelingInvalidated – therapist not on-side**	3	3	3	3	33	3	3	24
Invalididation	Lack of therapist value/interest in gay-related themes: initial trigger	33	3	3	3	3	1	3	22
Invalididation	**P2 M Invalidation of identity**	3	3	3	3	3	3	3	21
Invalididation	**Need for validation / relationship: looking for an ally**	3	3	3	2	3	3	3	20
Invalididation	M**Difficulties "being gay" with an invalidating & powerful other**	3	3	2	3	3	2	3	19
Invalididation	**Lack of therapist understanding on gay issues**	3	3	2	1	3	3	3	18
Invalididation	**Lack of validation / therapist response when talking about being gay**	3	3	2	3	3		3	17
Invalididation	"felt let down rejected after coming out "I've told you worlds about me"	3		33		3		3	15
Invalididation	Rejected sexual self	2	33	3	33	3		3	23x
Invalididation	**M Anger at therapist failure to support/validate developing gay identity [blindspot]**	3	33	33	2	3		3	23x
Invalididation	**The nothing: Lack of therapist response or interest in gay relationships and sexuality**	33	33	3	2	3		3	23x
Invalididation	therapist blindspot on gay issues (sense making now) [also therapist lack]		3	3	1	33		33	22x
Invalididation	Therapist blindspot/gay issues (sense making now) id dev / same as 'lack'	3	3	3		33		33	21x
Invalididation	**Rejection:Gay self as unacceptable**	33	3	3	2	3		3	20x
Invalididation	Rejection gay identiy – feeling rejected	3	3	3	3	3		3	18x
Invalididation	**M Invalidation of the self**	3			3	3	3	3	18x
Invalididation	**Frustrated need for validation / an ally**	3	3	3		3	3	3	18x
Invalididation	Need for validation unmet	3		3		3		33	15x
power	Power – therapist influence	33	3	3	33	33	2	33	32
Power	power imbalance -*"there seemed a lack of balance – that's what annoyed me"*	3	3	3	33	3	2	33	26

power	Power imbalance: growing dissatisfaction with therapist power	33	3	2	3	3	3	2	22
power	power imbalance	3	3	2	2	3	3	33	22
power	**M Power struggle: difficulties in finding voice and asserting the disempowered/SHAMED self**	3	3	3	3	3	3	3	21
Power	power imbalance / struggle	3	3	2	2	2	3	3	18
Power	lack of resolution as main problem / damage to rel and lasting effects	3	3	3	33	3		3	21x
power	Problems unresolved	33	3	3	3	3		3	21x
power	Critical therapist:		3		33	33		33	21x
power	Critical therapist – against		3		33	3		33	18x
power	unresolved issues associated with sexuality invalidations	33	3	2	1	3		3	18x
power	Money: what am I getting out of it?	33		3	3	3	2		17x
power	control car		2	3	3	3	3		14x
Power / threat	**Feeling less equal / inferior**/ power imbalance 339	2	33	2		3	33	33	25x
power struggle	Disagreement: on what we are doing and how we do it	33	3	3	3	3	3	3	24
process	Updates in sense-making: it was the method, comparison with other therapy	3	3	3	1	3	2	3	18
process	**M Negotiating dissatisfaction and disillusionment**	33	3	3	3	3		1	19x
Protecting - trust	evaluation of therapist's knowledge of gay issues	3	3	3		3	33	33	24
protecting – self	**Desire for escape / withdrawal**	3	2	2	2	2	33	3	20
protecting – self	keeping self safe	3	3	3	2	3	3	3	20
protecting – self	Compliance	3	3	3	3	2	3	3	20
protecting self	compliance	3	3	evide	3	2	2	33	21
protecting self	Presenting an acceptable self	2	3	3	3	3	3	3	21
protecting self	hiding self	3	3	3	3	3	3	3	21
protecting self	compliance	3	3	2	2	2	2	3	17
psy impact	Therapy echoing and reinforcing wounds from the past [identity formation disruption – psy	3	33 bully	3	33	3	3		30
psy impact	internal conflict, 724 also mixed feelings & ambivalence	33	3	3	3	3	33	33	30
psy impact	**Internal conflict about whether to trust**	33	33	3	3	2	33	3	29
psy impact	exposing shamed self L184	3	3	33	2	33	3	33	29
psy impact	Ambivalence: questioning and doubts	33	3	33	33	2	3	2	28
psy impact	Ambivalence: in therapist, and own experience	33	3	3	33	3	3	3	27
psy impact	Identity suppression	33	3	3	2	3	3	33	26
psy impact	Ambivalence: doubting own experience them or me?	33	3	3	33	2	3	3	26
psy impact	gay self as unnaccaptable*"I was probably a disappointment"*	3	33	33	2	3	3	3	26
psy impact	Identity development issues	3	3	3	1	33	3	33	25
psy impact	Questioning doubts in therapy, the therapist	3	3	3	33	2	33	2	25
psy impact	compliance	33	3		3	2	2	33	24
psy impact	Ambivalence: stay or go?	33	3	3	3	2	33	1	24
psy impact	Frustration – feeling stuck – disagreement [power strggle / psy impact]	33	3	3	3	3	3	3	24
psy impact	anger	3	3	3	33	3	3	3	24
psy impact	shame	3	33	3	3	3	3	3	24
psy impact	Frustration 721	33	3	3	3	3	3	3	24
psy impact	Feeling not important	33	3	3	3	3	3	3	24
psy impact		3	3	3	3	2	3	33	23
psy impact	Questioning and doubts about therapy and the therapist [ambiv]	33	3	2	3	2	3	3	23
psy impact	psychological consequences: lasting effect, lack closure, bitterness, anger	33	3	3	3	3	2	3	23
psy impact	Same: lasting feelings: bitterness, rejected, humiliation, treated badly, defeat, anger	33	3	3	3	3	2	3	23
psy impact	***Shame / struggle self-acceptance**	3	33	3	1	3	3	3	22
psy impact	Ambivalence 424	3	3	3	3	3	3	3	21
psy impact	anger	3	3	3	3	3	3	3	21
psy impact	anger	3	3	3	3	3	3	3	21
psy impact	Hurt	3	2	2	33	3	2	3	21
psy impact	reinforced negative beliefs about the self / low self-esteem / lack of worth	2	3	2	2	3	3	33	21
psy impact	**M Difficult feelings**	3	3	3	3	3	3	3	21
psy impact	anger	3	3	3	3	3	3	3	21
psy impact	discomfort / uneasy	3	3	3	3	3	3	3	21
psy impact	anxiety / tension	3	3	3	3	3	3	3	21
psy impact	Feeling rejected being gay	3	3		2	3	1	33	20
psy impact	**invisible gay self**		3	3	2	3	3	3	20
psy impact	feeling judged – disgusting	3	3	3	2	3	3	3	20
psy impact	Passive anger – subconscious attacks & challenges	3	3		3	3	2	3	19
psy impact	Suppressed anger "I tried to rationalise it"	3		3	2	3	2	3	19
psy impact	anxiety / tension*"I felt tensed and I was quite glad to go at the end of that session"*	3		2	2	3	3	33	19
psy impact	**Anger as defence against hurt and shame**	3	3	2	2	3	3	3	19
psy impact	**Dissociation / withdrawal /disconnection**	3	2	2	3	3	3	3	19
psy impact	**Difficulties negotiating anger / disowned anger**	3	3	2	3	2	3	3	19
psy impact	Identity development coming out – disappearing gay self	3	3	3		3	3	3	18
psy impact	**THE PSYCHOLOGICAL IMPACT OF THE RUPTURE**	3	2	2	2	3	3	3	18
psy impact	bad self	2	3	2	2	3	3	3	18
psy impact	**Confusion & internal conflict in sense-making**	3	3	2	3	1	3	3	18
psy impact	Rejection feeling	3	3	3	3	3		3	18
psy impact	self as bad and wrong, unnacceptable, something wrong with	3	3			3	3	3	17

psy impact	Shame and self-blame for difficulty: sexual self as bad/wrong	3	3	evid		2	3	3	16
psy impact	**M psychological suffering, turmoil**	3	1	1	2	1	3	3	14
psy impact	Gay identity development	3	3	3		3	33	33	24x
psy impact	**M Negative feelings / perceptions**	33	3	3	3	3		3	21x
psy impact	discomfort / uneasy*"it wasn't a comfortable room"*	33		2	2	3	2	33	21x
psy impact	rejection in lifeworld (excluded)	33	3	3		3	3	3	21x
psy impact	Feeling excluded / no belonging	33	3	3		3	3	3	21x
psy impact	self-doubt "maybe she was right"	3	3	3	2	3		33	20x
psy impact	confusion	3	3		3		3	33	18x
psy impact	Therapy as microcosm-re-enaactment – rejection, identity concealment/hypervigilance (	3	3	3		3	2	3	17x
psy impact	Wounded self - feeling hurt by critical therapist [disinterested therapist]	3	2		33	2		3	16x
psy impact	M**Psychological consequences of unresolved rupture event**	33			2	2	2	3	15x
psy impact	Unresolved conflict: holding a grudge – grievances unaddressed	3	1	3	3	2		3	15x
psy impact – defending	**Disappearing gay self / identity suppression**	3	3	3	3	3	3	3	21
psy impact / process	Stuckness / impasse / Caught in a maze / frustration	33	3		33	2	3	3	23x
threat	difficulties talking about sexuality	33	33	33	33	33	33	33	42
threat	The taboo of gay sex and difficulties talking about sex 194	3	33	33	3	33	2	33	35
threat	Difficulties talking about sex	33	3	33	3	3	33	33	33
threat	**Difficulties opening up about intersecting identity issues**	33	3	33	3	3	33	33	33
threat	**M THERAPY AS THREAT TO GAY IDENTITY Fear of therapist as disapproving & non-accepting in**	3	33	3		33	33	33	30
threat	Hypervigilance: noticing her when talking about sex, disapproval, needing NV cues	33	2	2	33	3	3	33	28
threat	**Fears of being judged [shamed] & misunderstood on points of difference**	33	3	33	1	3	33	3	28
threat	Hypervigilance to therapist's words and non-verbal cues	33	2	3	3	3	3	3	25
threat	Mistrust: pervasive fear of therapist's lack of understanding on gay issues - preconception	33	3	3	3	3	3	3	24
threat	preconceptions / the background	2	3	3	3	3	3	3	22
threat	criticised / judged	3	3	3	3	3	3	3	21
threat	The background issues:preconceptions, lack of choice, non-LGBT	2	3	3		3	33	3	21
threat	*criticised / judged "I felt she was critical about my lack of faith"*	3	3	2	3	3	3	3	20
threat	The threat of intimacy and being known	3 evid?	3	evid		3	33	2	19
threat	hypervigilance [symbols NVC etc]	3	2	2	3	3	3	3	19
threat	hypervigilance L169 cat, L219 twitch	3	2	2	3	3	3	3	19
threat	Hypervigilance/sensitivity to therapist's possible negative attitudes about gay men	3	3	2	1	3	3	3	18
threat		3	3	3		3	3	3	18
threat	**Perception of lack of therapist knowledge and understanding regarding gay issues**	3	3	3		3	3	3	18
threat	hypervigilance "gradually reveal … gay"	3	2	1	3	3	3	3	18
Threat	interpreting symbols and clues	3	2	3	3	2	1		17
Threat	**Therapist as homophobic other, as adversary to gay self, bully**	3	3	2	1	3	2	3	17
threat	critical therapist		3	2	3	3	1	3	15
threat	therapist interpretation interpreted as homophobic [invalidation]	33	3			33		333	24x
threat	Pervasive perceptions and fears of homophobia	3	3	3		3	3	33	21x
threat	**Perception of therapist as anti-gay adversary [or clueless on gay issues/ neg attitudes]**	3	3	2		3	3	33	20x
threat	Triggering incident – homophobic cause	3	3		maybe	33		33	18x
threat	fear of rejection for being gay	3	3	3		3	3	3	18x
threat	**The something: therapist comment [or symbol] interpreted as critical, anti-gay, shaming**	33	33	3		3	2	33	26x
threat		33	3	3	3	3	3	3	24
threat	difficulties opening up – talking about emotional issues	3	3	3	3	3	3	33	24
threat	**M HYPERVIGILANCE [sensitivity] TO THERAPIST AS DISAPPROVING OTHER Friend or foe?**	3	33	3	2	3	3	3	23
threat	Managing shame: difficulties talking about sex	3	3	3	2	3	3	33	23
Threat - protecting	Suppression of talk/identity for fear of disapproval / rejection 367 /217	3	33	33	3	3	3	33	30
Threat – trust	Trust 528, in her hands L?	3	3	3	3	2	33	3	23
Threat – trust	Mistrust	3	3	3	3	3	3	3	21
Threat – trust	mistrust	3	3	3	3	3	3	3	21
Threat Fears barriers	difficulties talking about sex / gay relationships / being gay 738	33	33	33	33	33	33	33	42
threat psy impact	Exposed shamed self	3		3		2	3	3	14
threat- protecting	unwillingness to divulge – private intimate things	3	33	33	3	33	33	33	36
threat- protecting	unwillingness to disclose	33	3	33	3	33	33	33	36
threat- protecting	Withdrawal - talk/identity suppression-doubt	33	33	3	3	3	33	33	33
thrust threat	**M Struggling to trust in a risk situation / encounter**	3	33	3	3	3	33	3	27
Threat	fear of being judged	33	33	33		3	33	33	33x
threat	fear of not being understood	33	33	33		3	33	33	33x
threat	preconceived fears	3	33	33		3	33	3	27x
threat	Looking for an ally, not finding one in the therapist	33	3	3	2	33		33	26x
trust	mistrust	33	3	3	3	3	3	3	24
trust	mistrust	3	33	3	3	3	3	3	24
Trust	**M Negotiating safety and trust in a danger zone**	3	3	2		3	3	3	17
Trust / threat	Mistrust	33	33	3	33	3	3	3	30
	Diffs being gay in the therapy	3	3	3	2	33	3	3	23
	need for affirmative responses	2	3	3	3	3	3	3	20
	power imbalance / struggle	3	3	3	2	3	3	3	20

<u>Appendix 13</u>: Master theme table with supporting extracts across cases

Master theme 1: The origins of the rupture: therapist as invalidating threat to gay identity and self	Line reference
1.1 Perceived therapist invalidations of gay identity and self	
Paul: "To begin I think there was a lot of stuff coming out around a lot of stuff coming out about coming out, but the more deep-seated stuff around my childhood and this that and the other and the anxieties … and you know and er to a certain extent that that sort of stuff came out ... but … because there was nothing coming back [sounding like a child] er I just thought this wasn't y'know really, what kind of therapy was it?"	127-134
Fraser: "There were certain I'm sure like think there were certain differences in the way that he might have dealt with my relationship my gay relationship than if I had been in a heterosexual relationship so I think it was there was a kind of erm lack of ... … interest [sounds questioning] really I think maybe or sort of or value maybe a lack of value of it the ...er sort of maybe sort of dismissed perhaps more readily than perh maybe than other kinds of relationships."	58-63
Julian: "There was a huge thing going on in my life at that time .. erm .. to then kind of not not [doesn't finish] … for for that aspect of that fear .. as a gay man as well as a gay man that fear erm that I was .. holding not to be kind of embraced or kind of looked at .. properly or yeah [fades out] .. so [sounding annoyed] .. I think that was one of the main ob obstacles within that within the counselling relationship."	48-53
Stuart: "I often I felt that, there there wasn't a response to give me any cues as I say yeah cause I sort I so I suppose I needed those [NV cues] as well as well as the words."	229-233
Kevin: "The trigger was something, it was the anger really, I felt angry with her because she revealed nothing. I suppose it was maybe halfway through, something like that. And something dawned on me that here I was revealing a lot of personal information about myself [being gay] and there was absolutely nothing from her."	119-124
Shawn: "I was explaining it to her and I was, like, you know, the funny thing is that, um somebody turned around and said, 'So, you must be the lady, then, in the relationship if you got proposed to.' And I was quite hurt by that and quite upset by that. And she was, like, 'Why? You know. It doesn't matter, you know, and they were just making a rude joke." And I was, like, "That's not the point."	384-390
Matt: "You're you're therefore pro providing this interpretation that it's you know that it .. it reinforces that we are sort of quite disgusting that we're you know, that we live out disgusting kind of behaviour."	543-545

Matt: “In terms of body language there really was nothing, it was quite amazing like to be in that situation where you’re not kind of getting any feedback or response or any verbal confirmation of what you've said and things like that.”	285-289
Matt: “Yeah a bit resentful that he said it... yeah a bit resentful that he'd he'd crossed crossed a certain line or a certain sort of line of protocol.”	592-595

1.2 Fears of therapist homophobia and lack of understanding on gay issues

Paul: “With her you know little crucifix around her neck immediately marked her out as being her a specific kind of person [Christian] which I didn't feel it was appropriate to, it was like you know as I said, it was like being therapised by a nun and you know you don't talk to nun's about bum sex.”	663-667
Fraser: “There was some kind of information that I got from xxxxx about this therapist erm suggesting that he might be homophobic erm so … / Or it might not have been homophobic it might of been something macho or something something kind of about his erm ... heterosexuality I guess.”	24-26 / 37-38
Fraser: “His er homophobia that’s my kind of default kind of … Yeah yeah he can’t deal with me being gay.”	140-143
Julian: “I had counselling with a … a woman a heterosexual woman ... / it can only come to the fact that I kinda I've gone in with the preconceived idea that it's perhaps not .. I'm not gonna be understood.”	13-14 / 141-143
Kevin: R: *Researcher: What did it mean the fact that she might be religious or in the church, what did that mean?* “Well, that she would therefore be critical of me and perhaps unaccepting of me as a gay person.”	571-575
Shawn: “On her website it said that she was married, she had a husband etc etc and for me the first thing in my head was 'well you’re heterosexual, you know how can you understand me as a gay man and what I’ve been through?'”	23-27
Matt: “He started the session by saying to me in some kind of roundabout way 'Oh I just think I ought to tell you that I’m not gay', so he actually said that so [awkward tone] I so I felt that what he was saying was 'I need to tell you this .. because I feel threatened by you'... I thought why would you need to say that? you don’t say anything else about anything in the world virtually but the one thing you’ve come out and said is 'I think I should you know make sure that you're aware that I’m not gay'.”	170-178
Matt: “I felt that he wasn’t comfortable and I also felt … and it might of been my own protection but I felt a lot of the time that he would find me disgusting.”	32-34

1.3 Shame-silence: threat of shame for “being gay”

Paul: “Sex is about cocks and bums and things that I had always been in my experience considered dirty and rude ... I I needed somebody that I could feel comfortable in talking to and I didn't feel comfortable talking to her.”	368-373
Fraser: “I didn’t agree [emphasis] that I was seducing him that I was trying to seduce him I didn’t agree with this interpretation, erm but rather than kind of erm	225-228

there being any dialogue around it I think c it shut me up."

Julian: "It was all peripheral stuff which was slightly kind of getting into the [inaudible] a little bit, but then almost omitting my sex sexuality out of the equation … hmm."	542-544
Julian: "I felt like I was not progressing through a kind of a maze in a way so I was I was bringing other things to the .. to the forefront rather than kind of really discussing … *that* [sex and sexuality]."	207-210
Stuart: "She said she didn't want to discuss sexual things / I didn't do it again because I realised that she didn't want to talk about these things."	239 / 247-248
Kevin: "It was mainly because of my sexuality. I at first didn't want to tell her. I've always had a problem with it."	389-390
Kevin: "Well, it was just a reluctance to reveal—even to acknowledge even to myself sometimes that I'm gay and this is the way I am."	284-285
Shawn: "So that for me was a big for me was how can I speak to this woman who's straight, who's got a husband, about me being gay?"	39-40
Matt: "I really felt I couldn't tell him any of that [chemsex] so I kind of had to present, if I was talking about a situation, present it and just cut out a huge factor from it."	231-233
Matt: "I led it in that direction and then more or less and less the sexual stuff was just dwindling off."	252-253
Matt: "I kind of gave up on him in that respect in thinking well you will never understand what it's been like so I can't really see the point, I can see the point that it could help in other ways, and erm so I started to focus on talking about childhood issues that weren't related to being gay."	248-251

Master theme 2: Rupture as process of struggling to defend gay identity and the self

2.1 Protest: challenge/confrontation and/or withdrawal/anger-silence

Paul: "You felt like, here is a person who's got like obviously got no … no knowledge of because you know you, no knowledge of gay people or gay lifestyles or this that and the other, who's obviously some kind of y'know Christian."	206-209
Paul: "That was the frustration because there was no, there was ne [never?] she I don't remember her ever speaking to me and er it was just me talking … I couldn't tell you anything that she ever said to me I can't remember, I can't remember one thing she ever said to me."	230-233
Fraser: "Me challenging him not being engaging in the in the therapy being quite challenging and defensive probably maybe for several weeks."	148-150

Julian: “But I then I don’t know whether I was kind of then challenging her because I'd got used to her .. so there was all that going on really for me erm in terms of like challenging her.” 68-70

Stuart: “I got the impression that erm .. [tuts] we were just marking time .. and I did say at some point then “Well I think this is a load of crap.” 20-22

Kevin: “Well she must’ve realised I was angry I was so—my voice would’ve displayed that. I said, “Now look here” I said, “I’m telling you a lot about myself and I know nothing about you.” And again, no reaction, just sat there with that smile on her face, slightly nodding her head. She’s like that the whole time [laughs].” 614-618

Shawn: “They give you this look like you're a lost little child puppy and I'm just like “don't! You couldn't be ever more condescending or patronizing” or you know you know you know excuse the language take the piss out of my experience you know “I don't want your sympathy or anything, I want you to go and stop being the judgemental arse that you are in your life right now and make sure that when you have kids, or your kids at the moment, they grow up to know that being gay, bisexual, or whatever is normal.” 206-213

Matt: “[sharp inbreath] erm ... it was difficult making eye contact with him so I would often look at the floor erm and there were quite a lot of long periods periods of silence because he wasn’t speaking and I dried up erm and I would just be sort of sitting there looking at the floor.” 110-113

2.2 Struggle to find power and voice

Paul: “Perhaps I should have you know perhaps I should have spoken to her about it but then she didn't seem to inv .. you know if I if I even if I did say something she would have just sat there in silence.” 258-260

Fraser: “In retrospect I’m not sure if I could’ve expressed that at that time or even have acknowledged it [to myself].” 81-82

Julian: “I suppose at the time in that room I felt slightly powerless.” 272

Stuart: “She was making all the rules and I was er acomm accommodate accommodating to the rules which I think was re looking back I think that's round the wrong way to some extent .. erm I’m the one who’s got the I'm paying for this.” 545-548

Stuart: “I took it as being gospel this this phrase because it w was said [emphasis] to me.” 347-348

Stuart: “I think that’s one of my problems I take things to heart and I would’ve hoped that somehow we could have discussed this and then so I wouldn’t take things to heart .. but that sort of stuff never raised never was raised.” 535-538

Kevin: “[she] sat there you know with an impassive face. [laughs] So there was this anger that she wasn’t—I couldn’t communicate really.” 134-136

Shawn: “I felt like 40 per cent of my time was spent explaining things, rather than actually dealing with whatever I'm there to deal with, if that makes sense. So, like, 364-373

difference in, like, the sexualities and, like, um talking...the relationship dynamics and things, like, you know...Um, it is very different from a heterosexual relationship, from a heteronormative relationship."

Shawn: "And it was just like 'how do I talk to you about this?' and I put it bluntly exactly those words to her I said that to her 'how can I talk to you about this?'" 634-636

Matt: "I I hold tightly to this kind of like, way I should behave like be polite or be be you know so somehow it didn't feel right to like tell him what I thought of him, or what how I felt, not what I thought of him, but how I was feeling, funny but I never really did." 492-496

Matt: "There was a slight sort of like you know when you've been told off and you don't like being told off and you feel that it wasn't right that you were told off or, that yeah something not quite right about it, it wasn't done in the right way perhaps, I dunno." 616-619

Matt: "Sometimes when he said something I just thought "oh you really don't get it, you you just don't get it, and it's because you don't understand how we are, how we are as a community you don't understand, you're so different from me you don't understand it." 512-515

2.3 Compliance discord: the discomfort of sitting with an unresolved rupture

Paul: "I sort of thought that you got to go on with it so I did sort of bite the bullet and er you know and as I say I went on for about three years [in breath] and didn't and going you know three times a week, it was a lot." 269-272

Paul: "I went along with it because because there was no .. nothing else I wasn't getting help from anywhere else." 401-402

Fraser: "I you know my result was compliance so that he wouldn't walk out of the door." 127-128

Julian: "It wasn't ever gonna go that that far in the end so I realised that very early on despite staying [laughs] erm … and that kind of baffles me a little bit also ... but there were obviously was there were reasons that I just I just carried on erm as I say it was that kind of like third or fourth sessions where I didn't wanna go but then it was making myself go and then it just I just kept going so..." 701-706

Stuart: "The first year was the productive the better year the best year the erm and then the af after me saying "I think this is crap" I don't think it ever got back to being as good and then the next two years I sort of we carried on and I just I just thought well we're not getting and well as I kept saying I don't think we're getting anywhere I kept saying it time and time again." 691-696

Kevin: "It wasn't a very comfortable room, it wasn't comfortable. Well, I don't remember having any cushions or the chairs were not very well upholstered. And I can remember getting up after the 50 minutes were over being quite relieved. [laughs]." 516-520

Shawn: "I was frustrated I was frustrated because I was .. there was that feeling inside me that was telling me that she is going to help me she will help me I know she'll help me but there's also that other side of me that's it's like having the angel 721-724

and the devil on each shoulder."

Matt: "Maybe from an intelligent point of … you one would sort of say look this is really not working but I didn't, I did for a year." 128-129

Master theme 3: Negotiating reparation and/or closure of the rupture

3.1 Negotiating trust

Paul: "I'd spent all that money all that time and you know I just thought well I don't really think … that I've, you know I think that I've been done." 163-165

Paul: "I just thought this wasn't y'know really, what kind of therapy was it? Erm, it was obviously very therapeutic very therapeutic for her bank balance." 134-135

Paul: "I think I did er … mention it every now and again you know sort of er you know "what's going on?" and er [therapist's voice] "well you know there are I feel there are things that we haven't touched on yet but [mumbles]" and it was almost like this thing at the end of the rainbow, it was you know [chuckle], where is the end of the rainbow you know, well it's over the hill, it's over the next hill and you get to the top of that one and it's over the next hill and er." 592-598

Fraser: "I was probably quite erm challenging [questioning tone] testing of the of the relationship testing of and the my trust in it." 110-112

Fraser: "I guess welI guess it's the test was … whether I would be able to … trust him to be my therapist and erm … whether whether he could accept my sexuality." 119-122

Fraser: "For me it was about erm testing the safety of the space and the how trust trust issue I think erm … particularly around this kind of … you know around my sexuality and being around a straight man I think that's you know I was testing that that was the basic basis of what I was testing I think, whether I could trust him." 438-442

Julian: "I did feel as though I was going through something with with her, obviously it wasn't just me, so I felt, so we were walking along that road.. but that's it, I don't think I don't feel I could've trusted her enough to to get onto the other side of the road where I could've added the other stuff." 632-635

Stuart: "I think it was a ruse, I think it was a basic ruse." 444

Kevin: "Well, you do gradually reveal things about yourself and I revealed that I was gay. And then also I thought I'll tell her that because of the church's attitude to gay people I'd rejected it." 558-560

Shawn: "They're letting you ride out the trauma... breathe through it and then they'll help guide you back it's like when they guide you back that's when you know you can trust them." 778-781

Matt: "He might get me to talk and then I couldn't, you know he might share it or something like that you know, you aren't able to trust him." 91-93

3.2 Seeking repair/closure

Paul: “Therapists you know are trained to sit there and no matter what they tell you you mustn't be shocked but at the same time you got the feeling that they are privately in their own world gonna be judgemental and I wanted to be loved.”	680-683
Paul: “I was desperate to be to be loved and … and the being me I didn't feel you know being you know being a queer boy couldn't be loved by this you know prim sort of frosty you know frosty [mumbles].”	689-691
Paul: “I was longing to talk to somebody and be involved with somebody I wanted that involvement I wanted to feel less lonely and so to have some this invisible person behind me which I couldn't see, you know feeling I was enfor en enforced the feeling that I was on my own.”	652-655
Fraser: “Part of the therapeutic relationship [for me] erm and my relationship with my father was straight man and so erm so there would have been some sort of erotic transference or something but not consciously as I say there was nothing kind of erm … there was nothing [emphasis] you know concrete … To it was more kind of a kind of fantasy world realm really.”	203-209
Fraser: “My problem is not with him doing that [getting up and threatening to end therapy] it was about the lack of kind of … uh er [tuts] … there was kind of the effect it had on the on the on me afterwards it wasn’t kind of resolved really er if that makes sense.”	152-155
Julian: “I thought on reflection it could’ve all been pick picked up on .. and maybe I could’ve said you know I don’t feel I feel as though all this has been a bit dismissed.”	330-332
Stuart: “I dropped it [the issue of lack of progress] somehow, I should’ve pressed on, I think my my fault was that I didn’t carry on erm but there was no inducement to carry on, there was no, the conversation seemed to end pretty quickly if I if I came up with negative views of things of her or the process.”	53-57
Stuart: “I felt and again it’s one of the problems and there we are it’s still recurred so so it wasn’t sorted .. I think that's that’s why I think I went along that was one of the problems that was seen to be a problem and it wasn’t sorted that’s a good example of it, it wasn’t sorted.”	782-784
Stuart: “Periodically I would raise 'I don’t think I'm getting anywhere' and then she once said erm very near the end 'well you just come here and dump' [mimics therapist, critical voice] ….. and I sat up and I thought and I said 'well why didn’t you say this?' I per I I actually asked back 'so well well why didn’t you say something like this?' again no answer.”	70-76
Kevin: “I was probably a disappointment to her.”	63-64
Shawn: “When I walked in and it hit me then … it was just that flashback for an instant that I had. And I was just, like, my therapist when I was a kid, for me in my head, it went through the feelings of abandonment. That, like, I know that she died from cancer later. But...and that was why my therapy halted and I got lost in the system.”	481-482 / 485-489

Matt: “I was going into therapy thinking you know I’m gonna unravel these problems and they’re going to stem from the fact that I’m deeply unhappy or deeply needy or you know need love [inbreath] need connection.” 555-559

3.3 Difficulties in making sense of an unresolved rupture

Paul: “After about the first six weeks I began to sorta I began began to feel well this you know I don't see what I don't understand what's going on here.” 254-256

Fraser: “At one point that he thought I was trying to seduce him erm... so perhaps that’s what it was, it was the seductiveness and the that he couldn’t handle or didn’t like or was uncomfortable with perhaps I don’t know I don’t know if he meant sexually but erm ….. yeah there was something …….. Er no actually at the time I did I did think he meant sexually, so that he thought I yeah and now I remember being conc confused about it at the time [nervous laugh].” 172-179

Julian: “Whether I’d internalised it I don’t know.” 329

Julian: “Looking back I think I think one of the things then as I've said haven't I is that I just wonder [emphasis] whether she she didn’t want to make it the problem or whether she didn’t want to come across as not understanding.” / *Researcher: so it sounds like you’re still making sense of it now?* / … regard for me, yeah … but actually I think it in a way that was more .. damaging is too strong a word but that was more detrimental to the relationship if that if that was if I’m going to make meaning from that I don’t know.” 741-750

Stuart: “Well I I feel [voice breaks slightly] betrayed I don’t feel as if I was properly helped I went along and I said what I wanted at the time was clarity, I distinctly remember asking, I said I want from the sessions, clarity.” 153-155

Stuart: “I I actually having talked to you I think it’s been very good because I do think it’s allowed me to reassess it.” 859-860

Kevin: “I tried to rationalise it and think... Well, it’s always a bit difficult to know what you’re getting from counselling, isn’t it?” 144-145

Kevin: “It’s funny, it’s very much—it’s almost as if I can hear her voice now saying, “You’re throwing the baby out with the bath water.” I mean, I did think, I wonder if I have perhaps thrown the baby out with the bath water. [chuckles] / *Researcher: So help me understand what that means again if you’re worried that you had, what would that mean then?* / “Well, I suppose I thought maybe she’s right.” 650-656

Shawn: “I remember that frustration overtaking and I just started crying because when I get frustrated and angry I don’t get angry I just burst into tears erm and I don’t know why that is.” 745-748

Matt: “I seem to remember that it was one of those moments where it was such a such a you know full on sort of suggestion or comment that I think I just was quiet for a while and sort of taking in because [inbreath] that was often when I used to feel really uncomfortable would be when I was sort of taking something in that he had said that erm was difficult to take in as an idea you know, so … yeah silence and then really uncomfortable.” 578-583