

Article

Rupture, Repair, and Relational Presence: A Qualitative Study of Therapists' Perspectives on the Therapeutic Alliance

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Abstract

The therapeutic alliance is widely recognized as a central mechanism of change in psychotherapy; however, much existing research risks reifying it as a measurable and static construct, obscuring its fluid, co-constructed nature and the ways it is shaped by power, identity, and social context. This study aimed to explore how psychotherapists understand, construct, and enact the therapeutic alliance in their everyday practice, with particular attention to diversity, anxiety, rupture, and the reciprocal impact of the therapeutic relationship on the therapist. Using a qualitative design, semi-structured interviews were conducted with 14 psychotherapists primarily working in private practice, and the data were analyzed using reflexive thematic analysis. Six interrelated themes were identified: moving from technique to relational presence; diversity as relational negotiation; anxiety as a co-created relational process; rupture as inevitable and generative; therapist transformation through the therapeutic relationship; and navigating professional role and human authenticity. The findings suggest that effective therapeutic work relies less on rigid adherence to technique and more on reflexivity, emotional attunement, and a willingness to engage with discomfort, difference, and relational rupture. The study highlights the need for psychotherapy training to prioritize relational, ethical, and reflexive capacities alongside technical skills, and contributes a more process-oriented understanding of the therapeutic alliance from therapists' lived perspectives.

Keywords: therapeutic alliance; reflexive practice; rupture; diversity; psychotherapy; qualitative research

1. Introduction

The therapeutic relationship, often conceptualized as the therapeutic or working alliance, is widely regarded as a central mechanism of change in psychotherapy rather than a peripheral contextual factor [1]. While definitions vary across theoretical orientations, the alliance is generally understood as a collaborative and affectively charged bond between therapist and client, encompassing agreement on goals, tasks, and the interpersonal quality of their engagement [1]. A substantial body of research has positioned the quality of this alliance as one of the most robust predictors of therapeutic outcomes across modalities and settings, often surpassing the predictive power of specific techniques or theoretical models [1,2]. This suggests that what occurs relationally between therapist and client may be as consequential, if not more so, than the formal methods employed in treatment.

Early and influential reviews, such as that of Ackerman and Hilsenroth [3], have emphasized a particular set of desirable qualities in therapists, including warmth, curiosity,



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openness, and trustworthiness as foundational to alliance formation. More recent scholarship has extended this work by highlighting how a securely established therapeutic relationship functions as both a relational container and an ethical holding environment in which clients can safely explore distressing material [4]. However, while these studies underscore the importance of relational safety, they often conceptualize therapist qualities as relatively stable traits rather than as dynamic, context-dependent practices that are negotiated within specific therapeutic encounters.

1.1. Diversity and Power in the Therapeutic Relationship

Growing attention has been paid to the role of diversity within the therapeutic relationship, particularly in relation to sociocultural identities and structural positioning. Contemporary research increasingly recognizes that clients enter therapy not as abstract individuals but as socially located subjects whose identities, histories, and cultural backgrounds—including race, ethnicity, gender, sexuality, and class—shape their experiences of care [5]. Despite this, there remains a persistent gap between diversity training and clinical practice. Studies indicate that many therapists, although formally educated about cultural sensitivity, do not consistently integrate discussions of identity, difference, or power into their therapeutic work [6]. This disconnect raises critical questions about whether existing models of training adequately prepare practitioners to engage with diversity in meaningful rather than tokenistic ways.

This issue is further complicated by the demographic composition of the psychotherapy workforce in many Western contexts, where therapists are disproportionately white and middle-class, while client populations are increasingly diverse. Such asymmetries in social positioning can generate unexamined biases and implicit assumptions that shape the therapeutic encounter, often in subtle ways [6,7]. When therapists avoid or minimize discussions of difference, this may reflect discomfort, fear of causing offence, or an implicit belief that therapy should be ‘value-neutral’. Yet, this ostensibly neutral stance can paradoxically reproduce dominant cultural norms and marginalize clients whose experiences do not align with them.

Failure to acknowledge clients’ identities and lived realities can have significant relational and ethical implications. Pettyjohn et al. [5] argue that when therapists overlook or downplay issues of identity, they risk creating a relational barrier that undermines trust and mutual understanding. Rather than facilitating an objective stance, such avoidance may obscure the therapist’s own positionality and biases, increasing the likelihood of misattunement or microaggressions within therapy. Empirical evidence suggests that when clients perceive their identities as unrecognized or invalidated, their sense of psychological safety diminishes, which can weaken the alliance, heighten anxiety, and in some cases lead to premature termination of therapy [5,8].

1.2. Multicultural Perspectives, Empathy, and the Ethical-Relational Responsibilities of Therapists

Beyond recognizing diversity as a contextual factor, a growing body of multicultural psychotherapy scholarship emphasizes that the effectiveness of the therapeutic alliance is closely tied to therapists’ capacity to engage with clients’ racial, cultural, and social realities [9,10]. Rather than treating cultural competence as a technical add-on to practice, this literature highlights the importance of therapists undertaking ongoing reflexive work to understand their own sociocultural positioning and its influence on the therapeutic relationship. From this perspective, building a strong working alliance with racial and ethnic minority clients requires intentional efforts to demonstrate respect, curiosity, and cultural humility, as well as a willingness to adapt relational practices in response to clients’ lived experiences.

Importantly, recent research challenges the assumption that empathy is a fixed personal trait, instead conceptualizing it as a skill that can be developed through targeted training, particularly within multicultural counselling education. Studies examining Emotion-Focused Multicultural Training suggest that structured experiential learning can enhance therapists' empathic attunement, self-awareness, and ability to engage sensitively with cultural differences [11]. This finding has significant implications for clinical practice, as it positions empathic responsiveness not as an innate quality but as a professional capacity that can be cultivated, refined, and critically examined.

At the same time, the literature underscores that expressions of empathy are culturally mediated and may be interpreted differently across social and cultural contexts [12]. What is perceived as warmth, care, or appropriate emotional responsiveness in one cultural setting may be experienced as intrusive, unfamiliar, or even uncomfortable in another. This reinforces the need for therapists to move beyond universalized models of empathy and instead adopt a more flexible, context-sensitive approach to relational engagement.

Client perspectives further complicate this picture, particularly for individuals from marginalized communities who may enter therapy with pre-existing mistrust shaped by prior experiences of discrimination, cultural invalidation, or institutional harm [13]. Research indicates that racial and ethnic minority clients frequently report feeling misunderstood, dismissed, or misinterpreted by mental health professionals, which can heighten vigilance and reduce willingness to engage openly in therapy [14]. In this context, the therapist's capacity to convey genuine, culturally attuned empathy becomes pivotal: when it aligns with clients' lived realities, it can reduce resistance, foster psychological safety, and strengthen engagement in the therapeutic process. Conversely, misattuned or culturally incongruent empathic responses may inadvertently reinforce feelings of alienation, reproduce existing power imbalances, and ultimately undermine the alliance.

Scholars therefore increasingly argue that engaging with issues of diversity should not be an optional add-on to psychotherapy but an ethical and professional responsibility embedded within everyday clinical practice. This requires more than generic cultural awareness training; rather, it demands that practitioners critically examine how power, identity, and social positioning shape the therapeutic encounter [6]. When therapists demonstrate a genuine willingness to engage with difference—rather than merely acknowledging it in abstract terms—there is evidence that this can strengthen trust, deepen relational attunement, and enhance clients' overall experience of therapy [5]. However, such outcomes depend on therapists moving beyond performative or superficial forms of cultural sensitivity towards more reflexive and relationally grounded practices.

In this context, empathy cannot be understood simply as an individual therapist trait but as a relational process that involves listening, validation, and a willingness to learn from clients about their lived realities. When therapists adopt a collaborative stance—positioning clients as experts of their own experiences—this can mitigate historical and structural mistrust and contribute to a more secure therapeutic alliance. Nevertheless, the literature rarely specifies how therapists enact such collaboration in practice, leaving an important gap between theoretical ideals and lived clinical realities.

1.3. Therapeutic Ruptures and Repair in the Working Alliance

Alongside diversity, ruptures in the therapeutic alliance have received growing empirical and theoretical attention. Ruptures are typically conceptualized as moments of tension, misalignment, or breakdown in the collaborative relationship between therapist and client [15]. Rather than being treated as clinical failures, contemporary scholarship increasingly frames ruptures as an inevitable and potentially meaningful aspect of therapeutic work. These ruptures can range from subtle interpersonal misunderstandings

to more pronounced relational fractures that challenge the stability of the alliance [16]. Common antecedents include miscommunications, divergent expectations about therapy, or discrepancies in how therapist and client interpret each other's intentions.

A consistent theme within this literature is the importance of recognizing and addressing ruptures through a process of repair that involves both therapist and client [17]. When ruptures are ignored, mishandled, or prematurely minimized, they can erode trust, intensify client withdrawal, and in some cases contribute to early termination of therapy, with negative implications for both parties [15]. Despite this consensus, much of the existing research remains limited in its ability to capture how rupture and repair unfold in real therapeutic encounters, particularly from therapists' lived perspectives.

Although there is a growing body of literature on therapeutic alliance, ruptures, and relationship-building in psychotherapy, much of this research remains predominantly client-centered or dyadic, often treating therapists' skills as stable, generalized, or taken-for-granted constructs rather than as situated, reflexive, and context-dependent practices (see Table 1). As a result, there is limited understanding of how therapists themselves conceptualize and actively mobilize their theoretical frameworks, relational skills, and professional subjectivities in real-time when navigating complexities such as cultural diversity, power dynamics, and alliance ruptures. Existing studies tend to measure alliance outcomes rather than critically examining the processes through which therapists negotiate, adapt, or potentially struggle with their own therapeutic ideals in practice.

Table 1. Conceptual overview of key literature informing the study.

Conceptual Domain	Key Ideas in the Literature	Implications for Therapeutic Alliance
Therapeutic alliance as a mechanism of change	Alliance conceptualized as collaborative bond involving agreement on goals, tasks, and emotional connection between therapist and client. Research consistently identifies alliance quality as a strong predictor of therapeutic outcomes across modalities.	Relational processes between therapist and client are central to therapeutic effectiveness, sometimes exceeding the impact of specific techniques.
Therapist relational qualities	Warmth, openness, curiosity, and trustworthiness facilitate alliance formation. More recent work highlights the therapeutic relationship as a relational container enabling safe exploration of distress.	Alliance-building depends not only on therapist traits but also on relational practices enacted within specific therapeutic encounters.
Diversity and sociocultural identity	Clients enter therapy with socially situated identities shaped by race, gender, sexuality, class, and culture. Therapists may struggle to integrate discussions of identity and power despite training.	Avoiding discussions of difference can weaken trust, reproduce dominant norms, and undermine alliance formation.
Multicultural competence and empathy	Empathy increasingly conceptualized as a skill that can be developed through training. However, empathic expressions are culturally mediated and may be interpreted differently across contexts.	Therapists must engage reflexively with cultural differences and adapt relational practices to clients' lived realities.
Ruptures and repair in the alliance	Ruptures represent moments of tension or misalignment within therapy. When recognized and addressed through repair, they can strengthen the therapeutic relationship.	Therapists' capacity to recognize, navigate, and repair ruptures is critical for sustaining a strong alliance.
Gap in existing literature	Research often focuses on client outcomes or dyadic measures of alliance rather than therapists' lived perspectives and relational decision-making in practice.	Greater understanding is needed of how therapists themselves conceptualize and enact alliance-building in real clinical contexts.

To address this gap, this study aimed to explore how psychotherapists understand, construct, and enact the therapeutic alliance in their everyday practice, with particular attention to diversity, anxiety, rupture, and the reciprocal impact of the therapeutic relationship on the therapist. Rather than assuming that therapeutic skills are uniformly effective or transferable across contexts, the study critically examines how therapists interpret, enact, and sometimes rework their therapeutic frameworks in response to relational challenges. The following research questions were explored: (1) How do therapists understand and construct the therapeutic alliance in their everyday practice? (2) How do therapists navigate issues of diversity within the therapeutic relationship? (3) How do therapists experience and work with anxiety and rupture in the therapeutic alliance? (4) How do therapists perceive the impact of the therapeutic relationship on themselves, both personally and professionally?

2. Materials and Methods

2.1. Design and Epistemological Positioning

This study employed a qualitative research design to explore how psychotherapists understand, construct, and enact the therapeutic alliance in their everyday practice, with particular attention to diversity, anxiety, rupture, and the reciprocal impact of the therapeutic relationship on the therapist. Given the study's focus on lived experience, meaning-making, and relational processes, a qualitative approach was deemed most appropriate, as it allows for in-depth exploration of participants' perspectives rather than measurement of predefined variables [18].

The study was informed by a relational and interpretivist epistemological stance, which assumes that therapeutic practices and meanings are co-constructed within social and interpersonal contexts rather than existing as objective, fixed entities [19]. This positioning aligns with contemporary scholarship in counselling and psychotherapy research that emphasizes reflexivity, subjectivity, and the negotiated nature of therapeutic practice [20]. Consistent with this epistemological stance, the aim of the study was not to test hypotheses or produce generalizable claims about the frequency or inevitability of phenomena such as rupture or therapist anxiety. Rather, the analysis sought to explore how therapists interpret and make sense of these relational experiences within the context of their professional practice.

2.2. Participants

A total of 14 therapists participated in the study (see Table 2). Inclusion criteria were (a) Formal training in psychotherapy or counselling psychology, (b) At least one year of post-qualification clinical experience, (c) Current engagement in private practice (part-time or full-time), (d) Registration with a recognized professional body (e.g., BACP, UKCP, or BPS), (e) Age between 25 and 65 years.

Participants were recruited using a combination of snowball and purposive sampling. Initial recruitment involved contacting psychology and counselling lecturers, who circulated study information to therapists in their professional networks. Additionally, private practice therapy organizations were approached and, following institutional consent, disseminated the study invitation to their affiliated practitioners.

All participants self-identified as White and from predominantly middle-class socioeconomic backgrounds. While this limits the transferability of the findings to more diverse populations, the study prioritized depth of analysis over demographic representativeness, consistent with qualitative research principles.

Table 2. Participants’ Characteristics.

Code	Age Range	Nationality	Gender	Professional Role
P1	30–39	British	Male	Counselling Psychologist
P2	30–39	British	Female	Psychotherapist
P3	60–69	British	Male	Psychotherapist
P4	30–39	British	Female	Integrative Psychotherapist and Counselling Psychologist
P5	40–49	British	Female	Psychotherapist
P6	30–39	British	Female	Psychotherapist
P7	40–49	British	Female	Psychotherapist
P8	30–39	Greek	Female	Integrative Psychotherapist
P9	30–39	Greek	Female	CBT Psychotherapist
P10	30–39	Dutch	Male	Integrative Psychotherapist
P11	40–49	Greek	Male	Integrative Psychotherapist
P12	50–59	Greek	Female	Integrative Psychotherapist
P13	50–59	Greek	Female	CBT Psychotherapist
P14	40–49	Greek	Female	Integrative Psychotherapist

2.3. Procedure

Following initial recruitment, interested participants were provided with a detailed participant information sheet outlining the aims of the study, the nature of their involvement, and ethical safeguards. Eligibility screening was conducted prior to consent to ensure that all participants met the inclusion criteria. Participants then provided written informed consent electronically and gave verbal consent at the start of each interview.

All interviews were conducted online via Microsoft Teams between October 2024 and March 2025. The interviews were originally collected as part of two closely related qualitative projects conducted independently by the first and second authors, both examining psychotherapists’ experiences of the therapeutic alliance. Although initiated separately, the projects were grounded in a shared theoretical orientation and addressed substantially overlapping research questions using comparable semi-structured interview guides. For the purposes of the present study, the two datasets were combined and subjected to a secondary, integrated analysis guided by a newly articulated shared research question focusing on therapists’ relational understandings of the alliance. Prior to analysis, the interview protocols were reviewed to ensure conceptual alignment and comparability across the full dataset.

Interviews lasted between 45 and 60 min, with the average interview lasting approximately one hour. With participants’ permission, all interviews were audio recorded on a password-protected device and stored securely on an encrypted OneDrive folder, separate from consent forms to maintain confidentiality.

A semi-structured interview schedule was developed drawing on prior research on therapeutic alliance and rupture [6,21], and adapted iteratively as interviews progressed to allow for emergent topics. The interview guide covered four broad domains: (1) Professional background and training (e.g., therapeutic orientation, years of practice, client populations), (2) Therapeutic approach and decision-making (e.g., how therapists conceptualize and begin therapy), (3) Relational practices in therapy (e.g., boundary-setting, working with anxiety, handling previous negative therapy experiences), (4) Relational challenges (e.g., diversity, ruptures, confidentiality, and their impact on the alliance). Interviews were flexible, allowing participants to elaborate on experiences that they considered most relevant. Follow-up prompts were used to explore reflexivity, emotional responses, and decision-making processes in greater depth. An example of the interview protocol is provided in Table 3.

Table 3. Example of Interview Questions.

Section	Interview Questions
Therapist's background and experience	What is your job title?
	How long have you been practising as a psychotherapist/practitioner?
	What made you decide to become a psychotherapist?
	Can you tell me about the professional training you underwent?
	What client groups do you work with?
Approaches of therapists	Do you have a preferred speciality?
	What is your therapeutic approach?
	How do you determine the best course of treatment for your clients?
Approaching the therapeutic relationship	What is your approach to starting therapy?
	What do you believe are the important aspects of establishing and maintaining the therapeutic relationship?
	How do you establish and maintain boundaries with your clients?
	How do you work with clients who are anxious?
	How do you work with clients who have had negative experiences of therapy?
	Have you experienced ruptures in the therapeutic relationship?
	If yes, how have you dealt with them?
	If no, how would you approach a rupture if it occurred?
	What have you learned from your clients, and how has this impacted your professional and personal life?

After each interview, participants were sent a debrief sheet reiterating the purpose of the study and providing contact details for further questions or concerns. Interviews were transcribed verbatim by the authors. All identifying information was removed from the transcripts to ensure anonymity, and participants were assigned pseudonyms (P1–P14). Once transcription was completed and verified, audio recordings were permanently deleted.

2.4. Data Analysis

The interview dataset used in the present analysis was drawn from two closely related qualitative projects examining therapists' experiences of the therapeutic relationship. Both studies employed similar inclusion criteria, recruitment procedures, and semi-structured interview protocols. Given the methodological and thematic overlap between the projects, the datasets were combined and analyzed together to explore shared patterns in therapists' accounts. The data were analyzed using reflexive thematic analysis, following the approach outlined by Braun and Clarke [22]. This method was selected for its flexibility and suitability for examining patterns of meaning across a dataset while preserving the depth and nuance of individual accounts.

Authors were actively involved in the analytic process, which was iterative and collaborative rather than linear. The analysis began with the first two authors independently familiarizing themselves with the transcripts through repeated reading and note-taking. Initial codes were then generated separately for each transcript in order to capture significant features of the data.

Following this independent coding phase, the authors met regularly to compare codes, discuss interpretations, and refine emerging patterns. This collaborative process functioned as a form of investigator triangulation, whereby multiple researchers engaged with the dataset to enhance the credibility and depth of interpretation. Through this process of dialogue and reflexive engagement, initial codes were organized into potential themes that captured shared meanings across participants while also accounting for variations

and contradictions within the data. A modified version of the constant comparative approach was used, with each of the researchers engaging in data analysis and meaning making, comparing patterns both within and across interviews and reflecting on how these emerging interpretations related to existing literature on the therapeutic alliance. This iterative comparison supported the development of intercode reliability and robust themes.

These provisional themes were subsequently reviewed in relation to both the coded extracts and the full dataset to ensure coherence and credibility. The authors jointly refined, defined, and named the final themes, paying close attention to how each theme related to the research aims and theoretical framing of the study. A visual thematic map was developed to clarify relationships between themes and subthemes.

Throughout the analytic process, all authors maintained reflexive notes documenting their assumptions, interpretive decisions, and potential biases. This reflexive engagement was intended to enhance transparency and trustworthiness in the analysis by acknowledging how the researchers’ professional backgrounds and perspectives may have shaped their interpretations.

2.5. Ethical Considerations

Ethical approval was obtained by the College of Liberal Arts and Sciences Research Ethics Committee, University of Westminster prior to recruitment and data collection (approval number: ETH2324-0873, approval date: 18 October 2024). All participants received an information sheet detailing the aims of the study, the voluntary nature of participation, and their right to withdraw at any time without consequence.

Informed consent was obtained electronically before the interview and verbally at the beginning of each session. Confidentiality was maintained by removing all identifying information from transcripts and assigning pseudonyms to participants. Data were stored securely in encrypted digital files accessible only to the authors.

Given that some interview topics, such as diversity, ruptures, and emotional challenges in therapy, could be sensitive, a sensitivity protocol was in place. Participants were informed that they could decline to answer any question or pause the interview at any time. If signs of distress had been observed, the interview would have been stopped; however, no participant required this intervention.

3. Results

Thematic analysis of the interview data generated six interrelated themes that illuminate how therapists actively construct, negotiate, and are shaped by the therapeutic relationship in practice. The analysis foregrounds therapists’ positioning, emotional engagement, and ethical reflexivity as central to how the therapeutic relationship is enacted and sustained. Table 4 presents an overview of the six themes, which are elaborated in the subsequent sections with analytic interpretation and illustrative extracts.

Table 4. Overview of Themes.

Theme	Core focus
Moving from technique to relational presence	How therapists move beyond technical skills to create safety through their relational stance, presence, and responsiveness.
Diversity as relational negotiation	How difference is co-constructed, discussed, and navigated within the therapeutic relationship rather than treated as a checklist of competencies.
Anxiety as a co-created relational process	How therapist and client jointly shape and work through anxiety within the evolving therapeutic relationship.

Table 4. Cont.

Theme	Core focus
Rupture as inevitable and generative	How relational ruptures are understood as normal, meaningful, and potentially growth-producing moments in therapy.
Therapists' transformation through the therapeutic relationship	How engagement with clients impacts therapists personally and professionally, shaping their worldview and practice.
Navigating professional role and human authenticity	How therapists negotiate boundaries, vulnerability, and authenticity while maintaining ethical and professional positioning.

3.1. Moving from Technique to Relational Presence

When participants were asked what was needed to build a therapeutic relationship, they consistently referred to core counselling qualities such as warmth, openness, empathy, and non-judgment. However, these qualities were not framed simply as technical skills but as relational stances through which therapists actively constructed a sense of safety and trust within the therapeutic space:

"...openness, discussions, being a human being. As therapists, you need to create that safe, open, warm, non-judgmental environment which is very important." (P6)

Participants emphasized that these qualities were not merely performed but embodied, suggesting that alliance-building is less about the application of discrete techniques and more about how therapists position themselves relationally with clients. The use of humor, for example, was described not as a clinical tool per se but as a way of reducing hierarchical distance and signaling the therapist's humanity. When used appropriately, humor was seen as helping clients feel more at ease, thereby facilitating openness and rapport.

Participant 7 highlighted the importance of *"meeting the client where they are,"* indicating that therapists must remain flexible and responsive rather than rigidly adhering to a predetermined professional stance:

"I think at the core of it is being able to be available to your client, and being able to kind of meet them, where they are. . . being able to know that they're being heard or being listened to." (P7)

This account illustrates that therapists continuously attune their presence to the client's emotional state and relational needs. Instead of relying solely on professional authority, participants described the importance of relating to clients as fellow human beings, suggesting that authenticity and relational engagement are central to alliance-building. This challenges more traditional, expert-driven models of therapy by foregrounding the therapist's relational presence as a dynamic, co-constructed process.

3.2. Diversity as Relational Negotiation

Participants described working with highly diverse client populations, often across multiple axes of difference including race, ethnicity, religion, sexuality, nationality, gender, and class. One participant reflected:

"I see quite a diverse range of people. . . it's different there. Different demographics of residents, people from different backgrounds and different presenting issues, reasons for coming to therapy, really." (P1)

Diversity was therefore not framed as an occasional challenge but as an ordinary feature of contemporary therapeutic practice. However, participants' accounts suggest that diversity is not simply *"present"* in the room—it must be actively recognized, named, and negotiated. Rather than conceptualizing cultural competence as a static body of

knowledge, therapists described diversity as relationally co-constructed and emotionally charged. Engaging with difference often involved uncertainty, self-questioning, and the risk of getting things wrong. As one participant articulated:

"I think it's about speaking to the difference, even if it is going to be clumsy. . . it is better for it to be clumsy but yet brought into the room so it feels like it can be discussed." (P4)

Here, "clumsiness" is reframed as ethically preferable to silence. Avoidance was implicitly positioned as collusion with invisibility. Naming difference—even imperfectly—functioned as a gesture of recognition, signaling to clients that aspects of identity such as race, gender, or sexuality were legitimate therapeutic material.

Even seemingly mundane moments—such as mispronouncing a client's name—were experienced as ethically significant:

"I have a voicemail and it's said quickly. . . I don't know how their name might be spelt. . . I might have misheard it. . . I'm always sort of conscious about the spelling and the way I'm saying it. . . I'm trying." (P5)

This illustrates how micro-interactions can carry symbolic weight. The therapist's concern signals awareness that small errors may reproduce marginalization. The repeated emphasis on "trying" suggests that effort itself becomes a moral stance—an enactment of care in the face of inevitable imperfection.

For some participants, aspects of their own identity functioned as relational bridges. One therapist reflected:

"Me being a gay man helps. . . even though I am a white middle class man, this is my diversity. . . I encourage my clients, what does race have to do with your circumstances, or ethnicity or gender. . .?" (P3)

Personal marginalization was described as enabling greater sensitivity to structural difference. However, identity was not presented as sufficient expertise; rather, it functioned as a point of entry for dialogue. Encouraging clients to reflect on how race, gender, or sexuality shaped their circumstances positioned diversity as something collaboratively explored rather than diagnostically assigned.

Similarly, a therapist working outside their country of origin described leveraging shared experiences of non-belonging:

"I know what it is like not being from here. . . maybe I don't know what it is like where they're from but I know what it's like not being from here. . . I will bring up race. . . to say it is ok to talk about this." (P5)

Here, partial commonality becomes a relational resource. The therapist does not claim full understanding but instead foregrounds shared positionality as a starting point for dialogue. Importantly, diversity is described as "always present in at least some way," suggesting that difference is not episodic but constitutive of therapeutic interaction.

Across accounts, diversity emerged not as a checklist of competencies but as an ongoing relational negotiation shaped by power, reflexivity, and emotional labor. Therapists described oscillating between confidence and uncertainty, privilege and vulnerability, knowledge and not-knowing. Engaging difference required tolerating discomfort, resisting assumptions, and explicitly legitimizing conversations about race, gender, sexuality, and cultural identity. P6 emphasized curiosity as a relational stance rather than a technical skill. Curiosity was described as an ongoing, open-ended process of learning about the client's lived experience, rather than the application of predefined cultural knowledge. This positions diversity as something that emerges within the relational encounter, shaped by dialogue rather than pre-existing therapist assumptions:

"Be curious about their own world, their own culture, about anything in their own life." (P6)

Overall, this theme suggests that working with diversity involves continuous reflexivity, negotiation, and relational sensitivity, rather than the implementation of standardized competencies.

3.3. Anxiety as a Co-Created Relational Process

Participants consistently recognized that many clients enter therapy with anxiety, hesitation, or ambivalence. However, rather than conceptualizing anxiety as residing solely within the client, therapists described it as emerging within the relational space—shaped by power, expectation, and mutual uncertainty. Several participants emphasized the importance of attuning to clients' early-session anxiety through careful pacing and containment. One therapist described being particularly mindful of silence:

"I would be really mindful of not leaving extended silences. . . As that therapeutic relationship started to build, I think you could start to speak to that anxiety. . . 'You seem a little bit more anxious today. . . I wonder what that is about?'" (P4)

Here, anxiety is approached developmentally. Initially, the therapist modulates the relational environment—reducing silence, offering structure—before gradually inviting explicit exploration of anxiety once safety has been established. This suggests that managing anxiety is not a fixed intervention but an evolving relational calibration.

At the same time, therapists reflected on their own embodied and emotional responses within these encounters. Anxiety was not described as unidirectional. One participant stated explicitly:

"So, um, I'm anxious too. . . Two people in a room should, both should be anxious. . . Clients are anxious. . . I'm in a position of power." (P1)

This account foregrounds the asymmetry inherent in therapy. The therapist recognizes the structural power they hold—the ability to diagnose, interpret, or potentially misstep—and positions their own anxiety as ethically appropriate rather than professionally problematic. Anxiety here signals awareness of responsibility. Rather than striving for complete neutrality or composure, the therapist suggests that some degree of mutual anxiety may be relationally authentic.

Other participants described somatic and cognitive manifestations of this internal vigilance:

"Sometimes I can feel a knot in my stomach in those early sessions. . . wanting to make sure I don't say the wrong thing." (P10)

"I notice I become more careful. . . almost monitoring myself, making sure I'm not moving too quickly." (P9)

These accounts indicate active self-regulation in response to perceived client vulnerability. Therapists described slowing down, softening tone, and monitoring pacing. Anxiety, therefore, circulates between participants rather than belonging to one party. It becomes a shared atmosphere that shapes interactional choices.

Importantly, some participants reflected on whether therapist anxiety might, in subtle ways, contribute to alliance-building:

"I don't necessarily communicate that anxiety directly, but I think it's got to sort of come out in some way. . . does that diffuse, does that help to build a relationship?" (P3)

This reflection introduces an interpretative tension. While therapist anxiety could potentially destabilize sessions, it may also humanize the therapist, signaling humility and investment. Anxiety, in this framing, is not necessarily something to eliminate but something to hold and metabolize within the relationship.

Similarly, client ambivalence was reframed as meaningful rather than resistant:

“If people are hesitant about therapy. . . that in itself can be explored and held. . . being mindful of where the client is on their journey.” (P6)

Thus, anxiety was conceptualized as integral to the therapeutic process—particularly at beginnings or moments of rupture. Rather than being treated as pathology or obstruction, it was understood as relational information requiring attunement.

Across accounts, anxiety emerged as co-created, shaped by structural power, personal vulnerability, and the unfolding alliance. Therapists described engaging in continuous reflexive monitoring of both client cues and their own internal states. In this sense, anxiety functioned less as a symptom to be resolved and more as a relational signal—indicating uncertainty, responsibility, and the fragile emergence of trust.

3.4. Rupture as Inevitable and Generative

Ruptures in the therapeutic alliance were consistently described as both emotionally challenging and clinically unavoidable aspects of psychotherapeutic work. Participants did not frame ruptures merely as technical problems to be managed, but as complex relational moments that evoked discomfort, vulnerability, and self-scrutiny in therapists themselves. Across interviews, therapists acknowledged that ruptures could feel personally destabilizing, particularly when they threatened their sense of professional competence or their self-concept as a *“good therapist.”* Several participants described experiencing internal tension between their professional training—which frames rupture as normal—and their emotional response, which often involved anxiety, defensiveness, or self-doubt. This highlights a critical tension in clinical practice: while ruptures are theoretically accepted as inevitable, they remain affectively uncomfortable and can feel like a personal or relational failure in the moment.

Participant 1 emphasized the importance of slowing down and jointly examining what had occurred when a rupture emerged, suggesting a move away from reactive problem-solving towards reflective sense-making:

“When a big rupture does happen. . . what has gone on in terms of literally what’s gone on in the session? And what’s around it?” (P1)

This response illustrates a reflexive, shared-responsibility approach to rupture repair, where meaning is co-constructed rather than blame being assigned to either therapist or client. Rather than viewing rupture as a unilateral mistake, P1 frames it as a relational event embedded within broader interpersonal and contextual dynamics.

Other participants spoke more explicitly about the emotional discomfort that ruptures elicited. Some therapists described feeling *“exposed,” “on edge,”* or *“thrown off balance”* when a rupture occurred, particularly if it involved perceived client dissatisfaction or withdrawal:

“I find ruptures really uncomfortable. . . I can feel myself tensing up, worrying that I’ve done something wrong, like the whole relationship is suddenly fragile. Part of me wants to smooth it over quickly, but I also know that rushing to fix it isn’t always helpful.” (P10)

Participant 4 similarly highlighted the necessity of tolerating discomfort within the therapeutic relationship:

“A good therapeutic relationship is one where you can sit with some really uncomfortable things. . . and rupture and repair.” (P4)

This framing repositions rupture not as an external disruption to therapy but as an integral component of meaningful therapeutic work. Rather than aiming to eliminate rupture, effective practice involves developing the capacity to remain engaged through relational tension, uncertainty, and conflict.

Some participants described a learning process whereby repeated exposure to ruptures positioned them as more capable of handling them. However, this did not mean that ruptures became easy; rather, therapists constructed themselves as developing greater tolerance for discomfort and ambiguity:

“Even now, when a rupture happens, I still feel that knot in my stomach. I don’t like conflict, and part of me wants to avoid it. But I’ve learned that if I can stay with it, name what’s happening, and invite the client into that conversation, something important can emerge.” (P13)

This statement underscores the paradox of rupture: it is experienced as emotionally aversive yet clinically valuable. The therapist’s willingness to acknowledge discomfort—rather than defensively masking it—can itself become a relational resource that models honesty and vulnerability for the client.

Participants also emphasized that rupture repair required humility and a willingness to question their own assumptions. Therapists described needing to balance professional authority with openness to being wrong, which could feel particularly challenging in situations where power dynamics, cultural differences, or miscommunications were at play. One therapist expressed this tension as:

“Sometimes I realize that what I thought was supportive actually landed very differently for the client. Admitting that in the moment is uncomfortable, but it’s often where the real work begins.” (P11)

From an analytic perspective, these accounts suggest that ruptures function as sites of reflexivity, compelling therapists to critically examine their relational positioning, implicit biases, and theoretical commitments. Rather than weakening the alliance, such reflective engagement can deepen trust by demonstrating accountability and respect for the client’s experience.

3.5. Therapists’ Transformation Through the Therapeutic Relationship

Participants consistently described the therapeutic relationship as having a profound and enduring impact on their own personal and professional development. Rather than viewing therapy as a unidirectional process that primarily benefits clients, therapists framed themselves as “active participants” who are continually shaped by their relational encounters. Many participants suggested that sustained engagement in therapeutic relationships fostered greater reflexivity, emotional sensitivity, and openness to complexity. Over time, working with clients appeared to challenge rigid beliefs, encourage perspectival flexibility, and deepen therapists’ awareness of their own assumptions and biases. In this sense, therapeutic work was described not only as a professional practice but also as an ongoing process of personal transformation.

Participant 4 reflected on how their practice had influenced their worldview:

“It has made me far less rigid. . . more open to seeing things from other perspectives. . . more mindful of people’s experiences and emotions.” (P4)

Therapeutic encounters were narrated as opening space for ongoing reflexivity, empathy, and ethical sensitivity, aligning with relational models of psychotherapy that view therapists as co-participants in the therapeutic process. Similarly, Participant 6 described feeling honored to engage in deeply personal therapeutic encounters:

“It is an honor to be in the same space as someone who is dealing with a lot of things. . . if I can create an example of their life, then I am happy with that.” (P6)

This highlights how therapists derive meaning, purpose, and professional identity from the relational aspects of their work, further reinforcing the idea that the therapeutic relationship is mutually transformative.

Several therapists also described how engagement with clients influenced their emotional attunement beyond the therapy room, shaping how they related to others in their personal lives. This suggests that therapeutic practice does not remain bounded within professional contexts but extends into broader patterns of relating.

Reflecting this, one therapist noted:

“Working with clients has made me more patient in my own relationships... I listen differently now, I don’t rush to judge or fix things the way I used to.” (P8)

For some participants, this transformation was not always comfortable or straightforward. A number of therapists acknowledged that being continually exposed to clients’ pain, vulnerability, and relational ruptures could be emotionally taxing, yet ultimately growth-promoting. Rather than seeing this emotional labor as a burden, they framed it as an integral part of their professional development.

One therapist captured this tension:

“Sometimes I leave sessions feeling unsettled or questioning myself, but I’ve come to see that discomfort as part of the work rather than something to avoid.” (P9)

This highlights how therapists gradually learn to tolerate uncertainty, self-doubt, and emotional discomfort, viewing these experiences as opportunities for learning rather than threats to their competence.

Navigating moments of conflict, misunderstanding, or emotional intensity appeared to foster humility, accountability, and greater relational awareness. Over time, therapists seemed to develop a more collaborative and less defensive stance in their clinical work.

A therapist with a more conflict-avoidant style expressed this as:

“I used to shy away from tension because it made me anxious, but sitting with ruptures has taught me that conflict doesn’t mean failure—it can actually deepen understanding if I stay present.” (P10)

Another participant added:

“I’ve learned that I don’t always have to ‘smooth things over’ right away. Sometimes just acknowledging the discomfort with the client is more honest and more healing.” (P11)

Overall, this theme highlights how therapists described themselves not as static implementers of technique, but as relationally positioned actors whose professional identities are continually renegotiated within interaction.

3.6. Navigating Professional Role and Human Authenticity

Across all interviews, a pervasive and ongoing tension emerged between therapists’ professional role and their sense of human authenticity within the therapeutic relationship. Rather than presenting this as a conflict to be resolved, participants framed it as a dynamic negotiation that fundamentally shaped how they built, maintained, and repaired the therapeutic alliance. This tension manifested in therapists’ accounts of boundaries, vulnerability, emotional presence, and their positioning within the therapeutic encounter.

Participants consistently indicated that adopting an overly detached or purely “professional” stance could hinder genuine connection with clients. Instead, they described deliberately softening the traditional therapist–client hierarchy to create a more relational, person-centered encounter. One participant reflected:

“There are moments where I feel the pull to be the ‘expert in the room’, but I’ve learned that if I stay too much in that role, I lose something human with the client.” (P9)

This suggests that therapists are not simply applying techniques but actively managing their professional identity in relation to the client. The therapeutic alliance, therefore, appears to be shaped by how therapists navigate their dual identity as both clinician and human being.

The use of self-disclosure and emotional presence further illustrated this tension. Participants described carefully calibrating how much of themselves to reveal, balancing authenticity with professional boundaries:

"I don't want to be so clinical that I feel distant, but I also don't want to blur the boundaries. It's a constant balancing act." (P14)

This highlights that alliance-building is not a static application of skills but a fluid, reflexive process in which therapists continuously assess how to present themselves in ways that are both ethically responsible and relationally meaningful.

This tension was particularly evident in discussions of diversity and rupture. When addressing cultural or personal differences, therapists acknowledged the risk of appearing incompetent or insensitive. However, rather than prioritizing professional certainty, they often chose relational honesty:

"Sometimes I worry about saying the wrong thing, but staying silent feels worse. I'd rather risk being imperfect and keep the relationship open." (P10)

This suggests that therapists privilege relational connection over professional perfection, indicating that authenticity may be more therapeutically valuable than technical mastery in certain contexts. Similarly, during ruptures, participants described the difficulty of maintaining professional composure while also acknowledging their own emotional responses:

"When something goes wrong in the relationship, my instinct is to 'fix it professionally', but I've learned that I also need to show I'm affected by it as a human." (P13)

This illustrates that rupture repair involves not only technical reflection but also emotional transparency, reinforcing the idea that therapeutic effectiveness relies on the therapist's capacity to inhabit both professional and human positions.

Finally, participants' reflections on how therapy had influenced them personally further underscored this theme. Therapists described becoming more flexible, reflective, and emotionally attuned as a result of engaging authentically with clients:

"Working this way has softened me. I'm still a therapist, but I'm also more comfortable being a person in the room." (P8)

This indicates that the negotiation between professionalism and authenticity is not only enacted in sessions but also reshapes therapists' broader professional identities.

4. Discussion

This study set out to explore how psychotherapists understand, construct, and enact the therapeutic alliance in their everyday practice, with particular attention to diversity, anxiety, rupture, and the reciprocal impact of the therapeutic relationship on the therapist. Rather than treating the alliance as a static construct or an outcome variable, the findings suggest that therapists in this study experienced the alliance as a dynamic, relational, and contextually situated process that is continuously negotiated through therapist positioning, reflexivity, and emotional presence. Overall, the results offer qualitative insight into how the alliance may be actively constructed, experienced, and ethically navigated by therapists in practice, shifting the focus from whether the alliance is effective to how it is relationally enacted in real time.

4.1. From Technique to Relational Presence: Rethinking Alliance Formation

In line with Ackerman and Hilsenroth's [3] emphasis on core therapist qualities such as warmth, openness, and trustworthiness, participants identified these attributes as central to alliance-building. However, the findings move beyond trait-based models by demonstrating that these qualities are not simply owned but embodied and relationally performed within specific therapeutic encounters. Therapists did not describe alliance formation as the application of standardized interpersonal skills; rather, they portrayed it as an ongoing process of positioning themselves in ways that invited safety, collaboration, and mutual engagement. Participants' emphasis on humor, attunement, and flexibility suggests that, within this sample, therapists did not primarily frame alliance-building as the implementation of techniques but as the ongoing calibration of their relational presence in response to clients' emotional states and interpersonal signals. This reframes alliance formation in participants' accounts as less about what therapists "do to" clients and more about how they "are with" them in the therapeutic space.

This supports and extends Prusiński's [4] conceptualization of the therapeutic relationship as a holding environment, but with an important nuance: participants described safety not simply as something the therapist provides, but as something co-constructed through ongoing responsiveness to the client. Rather than positioning the therapist as the sole architect of psychological safety, participants implicitly acknowledged clients as active contributors to the relational process. This echoes relational and client-expertise perspectives in psychotherapy, which argue that clients are not passive recipients of treatment but knowledgeable agents in their own lives who shape the therapeutic process through their responses, preferences, and ways of relating [23]. From this standpoint, the therapist's role is less about intervening upon the client and more about engaging in a "meeting of minds," in which both parties collaboratively negotiate meaning, understanding, and direction in therapy. Our findings align with this view by illustrating that therapists build safety not through authority or control, but through openness, curiosity, and willingness to engage with the client's lived experience.

The findings also challenge traditional expert-driven or medicalized models of therapy, which tend to frame therapists as technical specialists who "apply" interventions to clients' difficulties. For example, highly manualized approaches such as Cognitive Behavioral Therapy (CBT) and certain protocol-driven forms of manualized psychodynamic or behavioral treatments often emphasize structured interventions, treatment plans, and technique-based change processes. While these approaches have strong empirical support, participants in the present study tended to describe alliance-building as emerging less from the application of specific techniques and more from therapists' relational presence, flexibility, and responsiveness to the client in the moment. Specifically, participants' accounts suggest a shift toward a more relational and person-centered stance, where therapists see themselves as partners rather than authoritative problem-solvers. This perspective aligns with postmodern and collaborative approaches to psychotherapy, which emphasize client expertise, transparency, and shared meaning-making rather than hierarchical therapist authority [24,25]. Rather than claiming superior insight into clients' experiences, participants appeared to adopt a more reflexive and humbler stance, recognizing that understanding must be co-created rather than imposed. This is particularly evident in their emphasis on "meeting the client where they are," which reflects a move away from predetermined professional positioning toward situational, relational responsiveness.

Furthermore, the findings correspond with research on early alliance formation, which highlights the importance of clients experiencing the therapist as both genuine and relationally engaged in the first sessions [26]. Studies of dyadic processes in early therapy suggest that when clients feel overwhelmed by fear or shame, positive relational devel-

opment depends on the therapist's capacity to create a secure interpersonal environment in which these emotions can be safely held and explored [27]. Participants of the current study similarly described safety as emerging through their presence, timing, and sensitivity rather than through structured techniques. This suggests that the "real relationship"—characterized by authenticity, person-to-person connection, and emotional attunement—may be foundational to the later development of a collaborative working alliance, rather than secondary to it.

4.2. Diversity as Relational Negotiation Rather than Technical Competence

Consistent with the critique around competence-based models of diversity [6], participants did not describe diversity as a set of skills to be mastered. Instead, they framed it as a relational negotiation characterized by curiosity, vulnerability, and willingness to tolerate discomfort. This aligns with multicultural psychotherapy literature that emphasizes cultural humility over competence and highlights the importance of therapists' reflexive engagement with their own positionality [28–30].

Importantly, participants actively resisted a "color-blind" or value-neutral stance, recognizing that avoiding conversations about difference could inadvertently reproduce dominant norms and marginalize clients [5]. Their willingness to be "clumsy but present" captures one way therapists might engage with diversity, but it is not a universal response. Different therapists may approach cultural and identity differences in varied ways, shaped by their own experiences, comfort levels, and the specific context of the therapeutic relationship. Diversity is omnipresent in therapy: both clients and therapists bring multiple intersecting identities, histories, and sociocultural positions into each encounter. The findings suggest that effectively navigating diversity may require not only ethical intention and openness but also ongoing relational skill and reflexivity, a set of capacities that may develop over time and vary across individuals.

The predominance of therapists working in private practice may have shaped these findings. As Holyoak et al. [7] note, public sector settings often impose time constraints and bureaucratic pressures that can limit opportunities for in-depth relational or cultural exploration. In contrast, the relatively open-ended nature of private practice may have allowed participants greater latitude to engage meaningfully with issues of identity, power, and difference. This contextual factor helps explain why participants in this study appeared more willing to address diversity than some previous studies have suggested.

4.3. Managing Anxiety and Rupture

The emergence of anxiety as a central theme underscores the fundamentally relational nature of therapeutic work. Therapists did not frame anxiety solely as an individual client difficulty; instead, they described it as something that unfolded within the therapeutic relationship and required ongoing relational attunement. Their accounts of adjusting silence, pacing, and timing of interventions illustrate a process-oriented approach that prioritizes containment, emotional regulation, and interpersonal safety before interpretive or exploratory work. This suggests that managing anxiety in therapy may involve not only the application of specific techniques but also how therapists position themselves emotionally and relationally in the moment.

Importantly, the findings also reveal that client anxiety was closely linked to therapists' own internal experiences. Participants frequently described feeling heightened vigilance, self-monitoring, or a "knot in the stomach" when working with anxious clients, indicating that client anxiety could evoke parallel emotional responses in therapists. This aligns with emerging research on therapists' emotional experience in practice, which suggests that early-career and even experienced therapists often deal with self-doubt, performance

anxiety, and emotional strain when faced with intense client affect or relational uncertainty [31,32]. In the current study, therapists appeared to engage in active self-regulation—modulating their presence, slowing down, and tolerating silence—to manage both the client’s anxiety and their own. This highlights that anxiety management in therapy is a co-regulatory process, requiring therapists to remain emotionally grounded while remaining empathically responsive.

Although this study did not explicitly assess attachment styles, participants’ sensitivity to anxious clients resonates with attachment-informed perspectives that emphasize attunement, responsiveness, and the creation of a secure relational base in therapy [33]. Our findings extend this literature by demonstrating how therapists actively monitor and adjust their relational stance in real time, rather than simply relying on pre-existing attachment formulations. This also connects to research on therapist vulnerability, which suggests that clinicians’ own biases, insecurities, and emotional reactions can shape therapeutic encounters, particularly in challenging or emotionally charged work [34]. The ability to reflect on and manage these internal responses appears crucial for sustaining a stable alliance with anxious clients.

Turning to ruptures, the findings are consistent with contemporary conceptualizations of rupture as a potentially important relational process in psychotherapy, rather than positioning rupture solely as a clinical failure [16]. Participants often described ruptures as critical relational moments that required reflexivity, humility, and emotional engagement. However, the current study adds a crucial dimension often underdeveloped in the literature: the lived emotional experience of rupture from the therapist’s perspective. Participants described ruptures as personally unsettling, anxiety-provoking, and destabilizing, even when they intellectually endorsed rupture as normal. This reveals a meaningful gap between theoretical acceptance of rupture and its affective impact on therapists in practice.

This finding resonates with recent work on therapist burnout and emotional strain, which indicates that intense responsibility for clients, fear of “getting it wrong,” and emotional exhaustion can heighten vulnerability during difficult relational moments [35]. In the current findings, ruptures appeared to intensify these pressures in the experiences described by participants, particularly when therapists felt their competence or relational attunement was questioned. Yet, rather than withdrawing or becoming defensive, many participants described using these moments as opportunities for reflection, suggesting a move toward greater emotional maturity and professional resilience over time.

Notably, participants adopted a shared-responsibility model of rupture repair, which contrasts with quantitative findings suggesting that some therapists may externalize blame onto clients when ruptures occur [2,17]. This suggests that a relational, reflexive stance—grounded in accountability and openness—may be particularly salient among therapists who are attentive to issues of power, diversity, and relational ethics. Our findings therefore challenge more deficit-based interpretations of rupture by positioning them as sites of ethical engagement rather than technical breakdowns.

This interpretation is supported by research indicating that ruptures often reflect underlying relational patterns, unmet needs, or interpersonal fears that can be therapeutically explored [15,36,37]. In the present study, participants’ willingness to slow down, name discomfort, and collaboratively examine what had occurred aligns with this view, suggesting that ruptures can become moments of deepened understanding rather than threats to the alliance. Moreover, when therapists remained present and responsive during rupture moments, this likely offered clients a corrective relational experience—demonstrating that conflict or tension does not inevitably lead to relational breakdown [38].

Our findings also align with evidence that unresolved ruptures are associated with alliance deterioration and premature dropout, whereas successful repair can improve

therapeutic outcomes [15,39,40]. The contribution of the current study is distinctive in illuminating how therapists subjectively experience and navigate this process. In particular, our participants' emphasis on humility, emotional transparency, and willingness to admit mistakes reflects research showing that therapist responsiveness is closely linked to clients' perceptions of attunement and alliance quality [41].

Finally, the data suggest that repeated engagement with rupture and anxiety fostered professional growth in therapists. Over time, participants described developing greater tolerance for discomfort, uncertainty, and conflict, which mirrors findings that supervision, reflection, and lived clinical experience help therapists integrate their personal and professional selves [31]. In this sense, managing anxiety and navigating rupture were not only relational tasks but also transformative processes that shaped therapists' identities and ethical practice.

4.4. The Therapist as Transformed by the Relationship

Therapists were consistently described as being shaped by their therapeutic work. Therapy was not portrayed as a unidirectional process enacted upon clients from a position of detached expertise; instead, participants described it as a mutually transformative process in which both parties may be shaped through sustained relational engagement. This aligns with existing literature indicating that therapists derive meaning, purpose, and professional identity from their relational work with clients [21,42]. More broadly, research suggests that direct experience with clients is one of the most significant contributors to therapists' professional development across theoretical orientations and career stages, often outweighing formal training alone [43,44].

Importantly, this transformation extended beyond affective development to encompass ethical and epistemic dimensions. Therapists described becoming more reflexive, less rigid in their theoretical assumptions, and more attuned to issues of power, difference, and vulnerability within the therapeutic space. Over time, their reliance on rigid theoretical frameworks appeared to soften, as empathic engagement with clients' lived realities tempered received professional knowledge. This resonates with research suggesting that therapists often develop greater humility and patience through their work, recognizing the complexity and individuality of human experience [21]. Such shifts may indicate that therapeutic practice can cultivate not only clinical sensitivity but also moral sensitivity and ethical awareness.

Crucially, this process of transformation was not always experienced as comfortable or straightforward. Therapists spoke of learning to tolerate uncertainty, self-doubt, and emotional discomfort, particularly in relation to ruptures, ethical dilemmas, and encounters with cultural or experiential difference. These accounts resonate with studies highlighting the emotional strain, vulnerability, and professional insecurity that therapists may experience, especially when working with complex or challenging clinical material [34,35]. However, rather than being framed as a deficit, such discomfort was positioned as an integral component of professional maturation, contributing to greater empathy, humility, and reflective capacity. This suggests that emotional labor is not peripheral to therapeutic practice but central to how therapists grow and develop.

Therapists also articulated the personal impact of their work, noting how engagement with clients influenced their own ways of coping, relating, and making sense of difficulties. Many described developing greater patience and humility, recognizing that psychological change often unfolds gradually and cannot be forced through technique alone. This aligns with research indicating that therapists frequently benefit personally from their work, gaining deeper appreciation for human resilience, complexity, and diversity [21]. Such learning appeared to blur the boundaries between personal and professional development,

implying that therapeutic work can reshape how therapists engage in relationships beyond the consulting room.

A persistent tension emerged between maintaining professional boundaries and being authentically human in the therapeutic encounter. Rather than being fully resolved, this tension was described as an ongoing, productive dialectic that continually shaped clinical practice. This supports the broader argument that the therapeutic alliance is not a static construct but a fluid, negotiated process shaped by power, identity, and context [45]. Ethical practice thus required continual calibration between openness and containment, presence and professionalism, engagement and restraint.

In moments of rupture or cultural uncertainty, therapists tended to prioritize relational honesty over professional perfection. This included acknowledging mistakes, naming discomfort, or admitting uncertainty when this was deemed to serve the relationship, provided it was held within clear ethical boundaries. These accounts suggest that authenticity—when situated within reflective and ethical practice—may be more therapeutically generative than strict adherence to technical roles or ideals of neutrality. Conversely, overly technocratic models of psychotherapy that privilege detachment, control, or procedural correctness [46] risk overlooking the deeply human and co-constructed nature of therapeutic change.

Overall, this analysis portrays therapists as continually being shaped by their clients and by the relational processes inherent in therapeutic work. Transformation occurred not only through formal supervision or training but through everyday, emotionally charged, and sometimes destabilizing clinical encounters. In this sense, therapy can be understood in participants' accounts as a reciprocal learning space in which therapists may develop not only as clinicians but as more reflexive, ethically attuned, and relationally responsive professionals.

4.5. Strengths, Limitations, and Implications for Future Research

A key strength of this study lies in its in-depth, qualitative exploration of therapists' lived experiences of the therapeutic relationship. By prioritizing rich, reflexive accounts rather than standardized measurements of alliance effectiveness, the study offers valuable insight into how therapists actively navigate relational processes such as safety, diversity, anxiety, and rupture in real time. This approach captures aspects of the complexity of clinical practice that may be less visible in many quantitative studies, which often reduce the therapeutic relationship to measurable variables. Additionally, the focus on therapists' perspectives addresses a relatively underexplored area in psychotherapy research, contributing to a broader understanding of the therapeutic encounter as mutually influential rather than client-centered alone. The inclusion of therapists from primarily private practice settings also provides meaningful insight into how relational work unfolds in less structured, longer-term therapeutic contexts, where there may be greater flexibility to engage with issues such as cultural difference and rupture.

Despite these strengths, the study has important limitations that must be acknowledged. A significant limitation concerns the lack of ethnic and cultural diversity among participants, as all therapists identified as belonging to the cultural group of white and Western-educated professionals. This restricts the range of perspectives represented, particularly in relation to how therapists from minority backgrounds might experience, negotiate, or respond to issues of diversity, power, and marginalization within the therapeutic relationship. It is possible that therapists with lived experience of racial or cultural marginalization may conceptualize and navigate these issues differently, and their absence represents a notable gap in the findings. Furthermore, the predominance of participants working in private practice may have shaped the results, as these therapists often have fewer time constraints and greater autonomy than those working in public mental health services.

Therapists in public settings may face institutional pressures, high caseloads, and limited session time, which could influence how they manage diversity, anxiety, and ruptures in practice [47–49]. Another limitation relates to the age range of participants (25–65 years), which may have excluded older, more experienced therapists whose perspectives could have enriched the findings, particularly regarding long-term professional development and relational growth. Finally, as with all interview-based research, the study relies on self-reported data, which may be influenced by memory biases or social desirability, meaning that participants may have presented their practice in a more reflective or ethically favorable light than their actual behavior in sessions.

In terms of implications for practice, the findings underscore the importance of psychotherapy training that goes beyond technical skill acquisition and explicitly addresses relational, emotional, and ethical dimensions of clinical work. Training programs should incorporate reflective practice, cultural humility, and rupture repair skills, enabling therapists to tolerate discomfort, engage with difference, and navigate relational tensions more effectively. Given the emotional impact of ruptures highlighted in this study, supervision and training should also provide space for therapists to process their own reactions to conflict, anxiety, and relational breakdowns [50]. Additionally, the findings suggest that training should encourage therapists to view diversity not as a checklist of competencies but as an ongoing relational and reflexive process that requires curiosity, openness, and willingness to learn from clients.

Future research should build on this study by exploring therapists' perspectives across more diverse cultural, ethnic, and professional backgrounds, including those working in public mental health settings. Comparative studies between private and public practitioners could shed light on how institutional contexts shape relational practices, particularly in relation to diversity and rupture. Further research could also incorporate client perspectives alongside therapist accounts to provide a more comprehensive understanding of how alliance, rupture, and repair are experienced by both parties. Mixed-methods studies combining qualitative interviews with observational or session-based data could help bridge the gap between self-reported experiences and actual therapeutic interactions. Additionally, longitudinal research following therapists over time could offer deeper insight into how professional identity, reflexivity, and relational sensitivity evolve throughout their careers. Finally, further qualitative research focusing specifically on therapists' emotional experiences—particularly in relation to rupture, vulnerability, and transformation—would contribute to a richer understanding of the personal impact of therapeutic work.

5. Conclusions

This study contributes to a more relational and critically informed understanding of the therapeutic alliance from therapists' perspectives. The findings suggest a contrast with static, trait-based, or purely technical conceptualizations of alliance by demonstrating that it is continuously co-constructed through therapist positioning, reflexivity, and emotional presence. Therapists in this study described their work not simply as applying skills but as inhabiting relationships, navigating power and diversity, tolerating discomfort, and allowing themselves to be shaped by their work. Ruptures emerged not as failures but as ethically and clinically significant moments that could deepen the alliance when approached with humility and openness.

By foregrounding therapists' lived experiences, particularly in relation to diversity, anxiety, and rupture, this study bridges the gap between theoretical ideals and clinical realities. It underscores the need for psychotherapy training that prioritizes reflexivity, cultural humility, emotional resilience, and relational ethics alongside technical competence. Ultimately, the findings suggest that effective therapeutic practice may involve not only

the application of techniques but also the capacity to remain present, accountable, and authentically engaged in the face of complexity, uncertainty, and relational tension.

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