Therapeutic Alliance and Clients' Experiences of Ruptures and Repairs in Virtual Group Therapy

Angelica Kibets

Thesis submitted to the University of Ottawa in partial fulfillment of the requirements for the

Master of Arts in Education

Faculty of Education

University of Ottawa

Abstract

Therapeutic Alliance and Clients' Experiences of Ruptures and Repairs in Virtual Group Therapy

Angelica Kibets

University of Ottawa, 2024

Advisor:

Dr. David Smith

Committee Members:

Dr. Maria Rogers

Dr. Nicola Gazzola

Therapeutic alliances often include cycles of rupture and repair. Ruptures are tension or disagreement that occur during therapy. The therapeutic alliance in group therapy operates on three levels: member-to-member, member-to-therapist, and member-to-group, and ruptures may occur at any level. The aim of the present research was to explore clients' experiences of rupture and repairs and the effect these cycles have on the alliance in virtual group therapy. 10 youth and 11 parents participating in virtual group therapy (VGT) at three community mental health and addictions agencies in Eastern Ontario were recruited and semi-structured interviews were conducted with these clients. Interviews focused on (1) their experience of participating in VGT, (2) ruptures and repairs in VGT sessions, and (3) their effects on the client and group. Data were analyzed using thematic analysis to determine overarching themes in the data. Thematic analysis suggests that unresolved ruptures were associated with poor therapeutic outcome, but repaired ruptures had a positive effect on the therapeutic alliance. Understanding how clients and therapists experience alliance ruptures in online psychotherapy has significant clinical implications for intervention strategies (i.e., weaving in conflict resolution with group therapeutic goals). These results will be helpful in training therapists to recognize and address alliance ruptures at different levels in the group, which may improve the therapeutic alliance and ultimately, client outcomes.

Keywords: Virtual group therapy; therapeutic alliance; rupture and repair; youth mental health; family mental health; videoconferencing

Acknowledgements

First and foremost, I would like to thank my thesis supervisor, Dr. David Smith, for his guidance and encouragement throughout this process. I would also like to express my gratitude to the University of Ottawa and Crossroads Children's Mental Health Centre research team, particularly Natasha McBrearty and Dr. Jessica Whitley. I could not have undertaken this journey without my defense committee members, Dr. Maria Rogers and Dr. Nicola Gazzola, who generously provided knowledge and expertise, as well as my fellow research assistant, Dimitri Dionisatos. It has been a pleasure to work with all of you. Additionally, this endeavor would not have been possible without the generous support from the Social Sciences and Humanities Research Council, who financed my research.

I also would like to thank my family and friends. To my parents, Marina and Serge Kibets, and to my dearest friends, Hannah O'Reilly and Brianna Comeau, thank you for your unwavering support and encouragement throughout this process.

Conflict of Interest Statement

I completed a clinical practicum at one of the partnered agencies in this study from Fall 2021-April 2022 at the same time as working as a research assistant on this project, which may be perceived as a conflict of interest as I was forming a trust-based relationship with clients. This was mitigated by ensuring that I did not have any contact whatsoever with any staff or clients from the partnered agency in my role as a research assistant in the context of this project.

Table of Contents

LIST OF TABLES

LIST OF SYMBOLS, ABBREVIATIONS OR NOMENCLATURE

F2F = Face-to-face

SIP = Social information processing

CMC = Computer-mediated communication

VTC = Video teleconferencing

LIST OF APPENDICES

Therapeutic Alliance and Clients' Experiences of Ruptures and Repairs in Virtual Group Therapy

The Problem of Rupture and Repairs

The quality of the therapeutic alliance plays a vital role in the effectiveness of psychotherapy (Norcross & Lambert, 2018). Bordin (1979, 1994) proposed that the working alliance consists of three components, including emotional bond between client and therapist, agreement on tasks of therapy, and agreement on goals of therapy. It has been suggested that client improvement (or lack thereof) is influenced by the therapeutic relationship as much as, if not more than, the psychological treatment method used (Norcross & Lambert, 2018). Researchers have determined that the development of the therapeutic alliance is a complex process that fluctuates over time, and is characterized by periods of rupture and repairs (Safran & Muran, 2000b), both of which can have an impact on client outcomes.

Ruptures are strains in the alliance caused by either disagreement about the tasks or goals of therapy or problems in the therapeutic bond (Safran & Muran, 2000a). Ruptures to the alliance are common, and they threaten the effectiveness of psychotherapy if they are not repaired (Marmarosh, 2021a). Ruptures are not necessarily a dramatic breakdown in the relationship as the term may imply; they can range from a minor tension that the therapist and client are only vaguely aware of, to major breakdowns in communication (Safran et al., 2011). The two types of alliance ruptures outlined by Safran and Muran (2000b) are withdrawal and confrontation. Withdrawal ruptures occur when a client reacts to challenges, misunderstandings, or disagreements in the therapeutic relationship by withdrawing from the therapist, for instance by being silent or providing limited engagement in therapy. Contrastingly, a confrontation rupture is defined by the client acting against the therapist and expressing discontent with the therapist or the treatment (Eubanks-Carter et al., 2010). It is possible for ruptures to include elements of both withdrawal and confrontation. It has been suggested that unresolved ruptures are associated with poor outcome (e.g., clients deciding to terminate therapy prematurely); however, repaired ruptures can have a positive effect on the therapeutic alliance (e.g., clients regaining trust in their clinician) (Eubanks et al., 2018). Therefore, this process can either present a problem or an opportunity for clinicians, suggesting that this is an important area to examine within therapeutic alliance research (Lo Coco et al., 2019).

The present research was conducted during the COVID-19 pandemic, when many therapists worldwide were forced to shift from traditional face-to-face treatments to teletherapy (Weinberg, 2020a). Social distancing measures imposed to curb the spread of the COVID-19 pandemic created new challenges in meeting the mental health and addictions needs of youth and families (Békés & Aafjes-van Doorn, 2020). Virtual delivery of group-based services offered a promising means of meeting these needs during a period of restricted access to social support. When people come together in a group therapy context, whether in face-to-face or in virtual group therapy, they bring with them their histories of interpersonal difficulties, trauma, loneliness, and grief (Marmarosh, 2021a). Given these complex issues, it is expected that groups will experience tension and conflicts at some point in time. Ruptures in group therapy are complex because participants not directly involved in a therapeutic rupture may be indirectly affected by it (Garceau et al., 2021). For instance, a member may lose confidence in the group as a whole through witnessing a rupture involving other group members.

Previous studies have investigated extensively the rupture and repair process in individual therapy. However, there is less research on the topic in group therapy, and its applicability to group therapy is limited, even less so to virtual group therapy. Furthermore, alliance dynamnics in the group context are more complex, since the alliance operates on three different levels—member-to-member, member-to-therapist, and member-to-group—and ruptures may occur at any level (Lo Coco et al., 2019). Finally, it is largely unknown how the therapeutic alliance and rupture/repair process unfolds in virtual group therapy – a mode of therapy that had to be employed during the COVID-19 pandemic. Given how common ruptures are in the therapeutic process, understanding the ways in which clinicians detect them, deal with them in a group, and model repairs is critical to healthy development of both the group and the individual client (Marmarosh, 2021a). It is hypothesized that resolving such conflicts can lead to greater group cohesion and facilitate positive change, as members learn to regulate their emotions, empathize with one another, work through conflict, and regain trust.

The purpose of this present research is to explore clients' experiences of forming therapeutic relationships in a virtual group therapy context, to explore how clients navigate experiences of rupture and repairs in this context, and to understand the effect these events had on them. In the present study, ruptures were defined as incidents that created tension/upset for a

client in a virtual group session, and repairs were defined as actions from the facilitator or by other group members that were aimed at addressing the tension/upset. Understanding rupture and repair in virtual groups is important given the many predictions that virtual care will outlast the COVID-19 pandemic (Khanna & Jones, 2021).

Theoretical Framework

Computer-mediated communication (CMC), such as the use of videoconferencing and text-based chat, has become increasingly popular in interactions between healthcare professionals and patients due to its convenience and availability (Grondin et al., 2019). However, CMC has been met with some skepticism in regard to its effectiveness in contexts such as psychotherapy (Sucala et al., 2013), where the quality of the therapeutic alliance contributes to clinical outcomes (Horvath et al., 2011). Walther's (1992, 2011) social information processing (SIP) theory counters this criticism, positing that with adequate time and motivation, people interacting via CMC will foster interpersonal relationships equivalent in quality to those developed in face-to-face (F2F) interactions. Walther (2011) argues that humans are social creatures that are driven towards developing connection and relationships, regardless of the medium of interaction, and that the absence of one or more cues does not mean that individuals are unable to communicate effectively in a virtual context. According to SIP theory, people will find ways to mitigate the limitations of communicating virtually. For instance, an individual's tone of voice, facial expressions, and exclamations can effectively portray emotions in videoconferencing, which would be equally salient in F2F interactions. However, certain aspects of nonverbal communication (i.e., touch, space, and genuine eye contact) are missing in CMC channels (Sumner & Ramierez, 2017).

SIP theory uses the concept of high or low bandwidth to describe the richness of verbal and non-verbal communication on the CMC channel (Sumner & Ramirez, 2017). For instance, F2F communication is considered to be the richest form of communication as it allows for the full range of verbal and nonverbal cues. However, other forms of communication, such as text chat, are considered to have a low bandwidth, as they inevitably filter out nonverbal cues. Advocates of the cues-filtered-out approach (Culnan & Markus, 1987) argue that individuals communicating on a low bandwidth channel will be limited in their ability to create interpersonal connections. However, SIP theory predicts that these connections will still develop normally, but

more time is required in order for individuals to develop a relationship (Walther, 1996, 2011). Although this process is likely to develop more quickly in F2F contexts, SIP theory recognizes that humans are able to overcome the structural limitations (i.e., reduced cues) of a CMC channel. Individuals who are given adequate time to interact, who are motivated to interact, and who anticipate that they will be interacting in the future will be able to overcome the limitations and accomplish communication that is similar to F2F settings. In sum, the theory that forms the basis of this study states that people are driven towards developing connections and relationships, and they will get there eventually. The present study aims to explore how these relational processes, – specifically the rupture and repair process in the therapeutic alliance, unfolds within a socially significant CMC context, namely virtual group therapy.

Literature Review

Teletherapy

The COVID-19 pandemic prompted several restrictions aimed at curbing the spread of the coronavirus, including physical distancing measures and orders to work from home (Wade et al., 2020). Thus, psychotherapists were forced to adapt the way they interacted with, and provided services to, clients. As a result of these new measures, teletherapy (i.e., videoconferencing) gained popularity as a viable alternative to in-person psychotherapy. Teletherapy interventions, such as text-based asynchronous email therapy and online guided self-help groups, have existed for over 20 years (Berger, 2017; Wade et al., 2020). However, at the beginning of the pandemic, many psychotherapists were new to teletherapy, had no prior experience in videoconferencing sessions, and expressed concern for how it would impact the therapeutic alliance to conduct the sessions virtually (Wade et al., 2020). Some of the issues raised by psychotherapists included navigating the distractions and potential lack of privacy in the home environment, ensuring confidentiality, as well as troubleshooting with clients who are not tech-savvy (Berger, 2017).

Despite the reluctance and skepticism around teletherapy, several studies have shown that it can be as effective as face-to-face psychotherapy for several mental health problems, such as anxiety and stress (Barak et al., 2008). Wade et al. (2020) conducted a literature review and discovered extensive evidence in support of tele-mental health services for children, youth, and parents in individual counselling. In particular, studies have found that it is effective for children

and youth with depression, anxiety, and ADHD as well as for parents of children with mental health difficulties (e.g., Comer et al., 2017; Donovan & March, 2014; Sibley et al, 2017; Vigerland, 2016), with clients reporting acceptable (Sibley et al., 2017) to high (Comer et al., 2017) therapeutic alliances in virtual therapy. Clients appreciate the option to do teletherapy due to its convenience, as it reduces barriers to accessing services such as arranging transportation and travel time (Vigerland et al., 2016). Teletherapy services also have the potential to reach more people, such as clients in rural areas who would not be able to access in-person services due to geographical limitations (Wade et al., 2020).

Parents have reported the helpfulness of receiving coaching and feedback on their parenting skills in the home in real-life situations through the use of teletherapy services (Wade et al., 2020). Additionally, teletherapy increases accessibility for parents who may have challenges finding childcare arrangements, which can impede their ability to attend F2F meetings. In regards to youth clients, youth may be highly familiar with using technology for communication, and teletherapy may be more youth-friendly than traditional in-person clinical services (Hanley, 2012). Gibson and Cartwright (2014) interviewed youth who participated in mobile phone text counselling and discovered that youth appreciated the sense of privacy and autonomy from being able to access services without their parents' knowledge. This finding suggests that teletherapy allows youth to access support who would otherwise not do so (Hanley, 2012). Teletherapy may offer other advantages over F2F therapy, including greater flexibility for clients and clinicians and cost savings (Payne et al., 2020). Thus, teletherapy has not only been found to be an effective tool, but it has provided several unique advantages for families that F2F therapy lacks.

Group Therapy Delivered through Telehealth

According to preliminary evidence, telehealth group treatments effectively reduce symptoms and improve functioning in people suffering from substance abuse disorders, depression, and generalized anxiety (Khatri et al., 2014; Morland et al., 2014). McMillan et al. (2020) conducted a study evaluating an ACT-based virtual group for parents (n = 26) of children with severe cerebral palsy. The researchers found that 62% of participants agreed that they formed a positive relationship with the facilitator, whereas 56% agreed that they felt connected with other group members. This finding suggests that parents participating in virtual groups are able to form therapeutic relationships both with group facilitators and with other group members.

However, the findings in this study are limited by the small sample size. Gentry et al. (2019) conducted a systematic review of 40 studies on group-based video teleconference (VTC) services, and found that tele-mental health group treatment was feasible and well-received by participants. However, it is unclear whether group-based telehealth intervention is sufficiently equivalent to in-person treatment on factors such as therapeutic alliance and group cohesion. Studies that directly compared group process outcomes showed some minor differences between groups, with small decreases in therapeutic alliance and group cohesion in the VTC group versus F2F delivery (Batastini & Morgan, 2016; Frueh et al., 2007; Morland et al., 2010). These differences in group process indicators, however, did not appear to result in different treatment outcomes between the VTC and F2F groups (Gentry et al., 2019).

Out of all the teletherapy interventions, videoconferencing therapy is the one that most closely resembles traditional F2F therapy, as this technology allows participants to see and hear each other in real time (Berger, 2017). Video-based, synchronous group therapy has the potential to increase client access to highly needed mental health services and allow group members to find commonality while also reducing isolation (Gentry et al., 2019). Research has demonstrated that, similar to F2F groups, virtual group development involves group members getting to know one another, establishing group norms, providing mutual support, and challenging one another to grow (Lopez et al., 2020). It has been suggested that clients may feel more comfortable disclosing personal information in a virtual context than F2F, as they may experience the virtual environment as less threatening (Cipolletta et al., 2018). For instance, participants have described the sense of freedom to express themselves openly in virtual therapy without judgment from the therapist or other participants, termed the disinhibiting effects of the medium (Cook & Doyle, 2002). Clients who prefer video-based therapy often cite feeling less scrutinized and less self-conscious (Simpson et al., 2021), which may be important for addressing shame-related issues (e.g., abuse, parenting issues, substance use disorders).

Research Findings on the Therapeutic Alliance and Rupture and Repair Process

It has been demonstrated that therapists and clients sometimes have different perspectives of their alliance, and that therapists should expect that their own views of the therapeutic alliance are not necessarily shared by their clients (Bachelor, 2013). For instance, in their meta-analysis of 53 studies, Tryon et al. (2007) found that therapists significantly underestimate their patients'

alliance ratings and often feel that therapeutic alliance is worse than the clients do. Additionally, Chapman et al. (2012) found that group leaders do not accurately perceive the therapeutic relationships that group members have in their groups, and that group leader ratings of alliance only correlated with group members' ratings toward the end of group treatment. Clients tend to rate the alliance highly, and it is expected that clients' view of the alliance will diverge from, but be more positive than, the views of the therapist (Tryon et al., 2007).

As a process variable, it has been found that the therapeutic alliance is often characterized by a pattern of early high scores, followed by a period of lower scores, and then returning to high scores (Golden & Robbins, 1990). Previous studies using statistical methods to evaluate patterns in the alliance and client outcome generally suggest that a positive linear increase and quadratic high-low-high patterns of strength in the alliance are related to good outcome (Coutinho et al., 2014). That is, therapists may be able to confront or question dysfunctional interpersonal patterns, emotions, or cognitions within the context of a trustworthy and safe relationship if a strong alliance is formed early and maintained or grows throughout therapy (Tasca et al., 2016).

Although there is ample research on the therapeutic alliance as a predictor of engagement and outcome in adult psychotherapy, there is limited research on therapeutic alliance in youth psychotherapy (Hawley & Garland, 2008). This is an important area of investigation, as there may be unique aspects of these perspectives to the therapeutic alliance. For instance, the decision to access services may have been made by the parent or caregiver, and the youth may oppose coming to therapy. This can pose a challenge for the therapist in reaching agreement on the tasks and goals for treatment, regarded as key components of the therapeutic alliance, as the youth is not present on their own volition (O'Keeffe et al., 2020). Previous studies have found that poor therapeutic alliance, as reported by the youth, is an important predictor of treatment dropout (de Haan et al., 2013).

Although preliminary evidence suggests that the therapeutic relationship with youth is important in treatment retention and symptom reduction, we know little about how the alliance with youth develops or changes over time (Zack et al., 2007). Youth are developing in many domains, including emotional, social, and biological development, all of which are likely to play a role in alliance formation. This is likely to affect their capacity for insight and awareness of the subtleties of the bond formed with therapists. Kazdin et al. (2006) discovered that both the

quality of the child–therapist and the parent–therapist alliance predicted therapeutic changes in children referred for oppositional, aggressive, and antisocial behavior. The findings to date suggest that although therapeutic alliance is important for both parent–therapist and youth–therapist, they may be driven by different factors and associated with different outcomes (Hawley & Garland, 2008). In cases where parent-therapist alliance is poor, youth-therapist alliance may be quite positive, and vice versa.

The importance of the rupture-repair cycle is demonstrated in Eubanks et al.'s (2018) meta-analysis of 11 studies investigating the relationship between rupture and repair episodes and treatment outcomes. The researchers discovered a moderate link between rupture resolution and a positive client outcome, suggesting that clients may have better outcomes if clinicians are proactive in detecting and repairing alliance ruptures during treatment. The rupture in the alliance may be repaired when the client and therapist work collaboratively to repair it (Lingiardi & Colli, 2015). In order to repair a rupture, psychotherapists can acknowledge their own responsibility in the interaction, explore the rupture with clients, and tie the rupture to an interpersonal pattern in the clients' lives (Eubanks et al., 2018). Safran and Muran (2000b) suggest that psychotherapists convey an empathetic stance and validate the client by exploring their experience of the rupture in order to gain a better sense of understanding. It is likely that participating in repairs acts as a transformative experience in which clients disconfirm engrained expectations of interactions and come to see themselves as resilient for being able to resolve them (Garceau et al., 2021).

Following Bordin's (1979) conceptualization of the working alliance, Safran et al. (2011) proposed that ruptures in the alliance consist of (1) disagreements about the tasks of therapy, (2) disagreement about the treatment goals, or (3) strains in the client-therapist bond. Some clients may "move away" from the rupture through subtle disconnections from their internal experience, becoming less engaged in the interaction, or making overly compliant or submissive statements to the therapist (*withdrawal* rupture markers; Eubanks et al., 2015). Other clients may voice criticism or dismissal towards either the therapist or the treatment (*confrontation* rupture markers; Eubanks et al., 2015). Withdrawal ruptures occur in most or all therapy sessions, whereas confrontation ruptures occur less frequently (Lingiardi & Colli, 2015). According to Safran and Muran (2000b), the successful resolution of an alliance rupture is defined as returning to the level of alliance prior to the rupture.

Therapeutic Alliance in F2F and Virtual Group Therapy

In a group therapy setting, there are more people to learn from, identify with, disclose to, and form significant therapeutic relationships with. The alliance in group therapy can be distinguished from other relational factors related to group processes and outcomes, such as cohesion and engagement (Tasca et al., 2016). Concepts such as group cohesion refer to the quality of the relationship within the group as a whole, or the quality of the relationship between the therapist and the rest of the group, whereas the therapeutic alliance typically refers to the bond and agreement between a client and therapist in a group. In a group therapy context, clients are simultaneously engaged with other clients in the group, with the group therapist (or co-therapists), and with the group as an entity with its own norms and dynamics (Lo Coco et al., 2019). Clients can feel a strong positive connection with the therapist, but a negative or neutral connection with some other group members or vice versa. In contrast, a client may feel a positive bond with the group itself, by feeling helped or supported in the group, but feel a week bond with the facilitator, if the client perceives their interventions are ineffective (Lo Coco et al., 2019). In a healthy therapeutic alliance, the client feels safe enough to share personal information, to accept new information, and even to disagree with and confront the group therapist (Rutan, 2021).

Norton and Kazantzis (2016) found that the client's therapeutic alliance with the group facilitators, as well as group cohesion, both significantly predicted session-to-session changes in anxiety. However, while therapeutic alliance with the group leader was a significant predictor of changes in anxiety across all sessions, cohesion among group members was only a significant predictor of anxiety change in later group sessions (i.e., at sessions 8 and 10). This finding suggests that while the client's relationship with a group leader is important throughout the group, relationships with the group members develop over time. Alldredge et al. (2021) conducted a meta-analytic review of the alliance-outcome relationship in group therapy. Their search included 29 studies involving over 3,600 group therapy clients and the researchers found that member-to-leader alliance was reliably associated with, and predictive of, group therapy outcome (r = .17, d = .34). Due to this modest link, the researchers suggest that clinicians pay attention to each member's therapeutic alliance and actively attempt to develop and maintain alliance, as well as repair ruptures as they occur.

Given the importance of the therapeutic alliance in F2F therapies, it is also necessary to consider how it plays a role in a virtual group therapy context. According to Weinberg (2020a), there is no reason to doubt that therapeutic alliance can develop in virtual therapy as long as the therapist and client agree on goals and tasks and feel a sense of connection and mutual respect. Nonetheless, the literature is mixed regarding group therapy processes in virtual group therapy (Payne et al., 2020). Compared with in-person groups, virtual groups may feel artificial, involve privacy concerns, and feel disconnecting from others as members are sitting alone in their own rooms (Kozlowski & Holmes, 2014). However, some studies have discovered contrary findings. For instance, McGill et al. (2017) evaluated a virtual group designed to improve quality of life and decrease stress for adolescents and young adults following cancer treatment. Throughout the intervention, participants (n = 39) rated the member-to-therapist alliance as high. They also rated the member-to-group alliance at a comparable level to published ratings from studies evaluating in-person interventions with young people and adults. Additionally, facilitator ratings of participant openness, mutual trust, and motivation increased significantly from the first to last session, indicating that therapeutic relationships formed in virtual groups can improve over time.

Some studies have found that virtual groups can replicate in-person group processes such as bonding and cohesiveness (Banbury et al., 2018), while others have found that participants in anger management and DBT groups feel less connected (Lopez et al., 2020), and have a lower alliance with the group facilitator than those in F2F groups (Greene et al., 2010). However, it is worth noting that the Greene et al. (2010) study was conducted with veterans with posttraumatic stress disorder and anger problems, which is a population that often has difficulty establishing trust with service providers. Therefore, the generalizability of these findings is limited by the specific population studied. Furthermore, exploration of the teleconferencing platform features may offer some ways to overcome the barriers in communication in virtual groups in order to create community and build relationships among group members. For instance, participants in the Lopez et al. (2020) study felt that breakout rooms were helpful in encouraging client interactions. Participants reported in their qualitative statements that using breakout rooms allowed them more time to interact with each other and made a difference in how they felt about the group as a whole after the breakout room feature was introduced in the virtual group. Overall, research findings suggest that it is possible for interpersonal processes, such as therapeutic alliance to develop in virtual groups; however, virtual group facilitators may need to implement additional measures

and time to support this (Payne et al., 2020), which is consistent with Walther's (1992, 2011) SIP theory's framework.

It has been suggested that the same factors that are required for fostering a therapeutic alliance in-person, such as empathy and support, are also required in virtual therapy (Cook & Doyle, 2002). However, virtual therapy expands the environment from beyond the sharing of a physical space of being in an office to include the client's environment, the therapist's environment, and the computer screen (Cipolletta et al., 2018). Weinberg (2020b) claims that the ability to include more sociological and cultural diversity in virtual groups improves universality and existential factors, which can be beneficial therapeutically. Nonetheless, many clinicians had little previous experience or training in virtual therapy prior to the COVID-19 pandemic. Given this context, it is likely that concerns about therapeutic alliance in virtual therapy may have been increased by the fact that switching to teleconferencing occurred rapidly, at a time when social distancing was mandated and therapeutic separation was not occurring by choice, and when isolation may be prolonged as a result of the ongoing COVID-19 pandemic (Simpson et al., 2021). In summary, it is unclear whether therapeutic alliance will replicate in the virtual group space. There are theoretical and empirical indicators on both sides of the argument, and research is clearly needed to understand this vital aspect of the group therapy experience. Berger (2017) noted that alliance ruptures may either be more or less common in virtual psychotherapy, and called for more research in this area.

Rupture/Repair in F2F and Virtual Group Therapy

Ruptures in group therapy can range from subtle tensions between members, such as a member interrupting another member, to microaggressions, such as a group leader saying racist/sexist comments that can impact the safety of the group (Marmarosh, 2021a). Ruptures are inevitable in group therapy, and it has been found that ruptures occur most commonly between group members, rather than between group members and the therapist (Garceau et al., 2021). Ruptures that may occur as the result of the group leader include ruptures related to a group leader's insensitivity to cultural diversity, equity, and inclusion, forgetting important information relevant to members, timing of interventions, countertransference, and poor boundary maintenance (Rutan, 2021). Sometimes group members express their dissatisfaction, hurt, or frustration directly by challenging the leader or members (Yalom & Leszcz, 2020). The therapist

can then respond by suggesting a different task, clarifying a misunderstanding, or empathizing with the client's frustration (Miller-Bottome et al., 2018). However, many clients find it is too difficult to share their experience of the rupture, and they may choose to avoid expressing their feelings (Rutan, 2021). Clients may exhibit avoidance behaviours such as missing sessions, arriving late, checking emails during a virtual group session, or dropping out of therapy. These behaviors are considered to be rupture markers, as they often indicate to the therapist that a rupture has occurred without the client having to say anything (Eubanks et al., 2019; Safran & Muran, 2000a).

Identifying alliance ruptures and implementing interventions to resolve them is crucial, and there are initial guidelines regarding how to approach this issue in virtual psychotherapy (Dolev-Amit et al., 2021). To compensate for the lack of a therapeutic setting (i.e., a calm and comfortable room and the therapist's reassuring physical presence), Dolev-Amit et al. (2021) suggest that the therapist must be more active than usual in teletherapy, taking command of the session and exhibiting greater interest in the client(s). The researchers propose a four-step model for dealing with withdrawal ruptures in teletherapy, and although they demonstrate the proposed techniques with a clinical illustration, their sample size is a case study consisting of one client. Therefore, it is unclear the degree to which their model would extend to virtual group therapy. Garceau et al. (2021) conducted a case study in which the researchers coded rupture and repairs in group therapy using the Rupture Resolution Rating System (3RS; Eubanks et al., 2015). The researchers suggest that the target of resolution strategies in groups (e.g., therapist-to-group) needs to match the target of the rupture behavior (e.g., member-to-group) in order for the repair to be successful.

Unresolved ruptures may harm clients by causing them to feel confused, abandoned, helpless, criticized by the therapist [or other group members], in addition to feelings of desperation, anger, and anguish (Coutinho et al., 2011). Weinberg (2020b) claims that virtual groups may be more prone to ruptures than in-person groups due to logistical reasons: Internet connections drop, computers crash, and cameras freeze. For instance, some people might feel hurt or abandoned if the therapist disconnects due to Internet connectivity issues, or some people might feel rejected because they are not accepted back into the virtual meeting. These are additional challenges and dynamics that are a part of facilitating virtual group therapy. Weinberg

stated that addressing these moments in the here-and-now can become a part of the group therapy process. The researcher advises therapists to address anything that happens virtually as something that has a dynamic meaning and to explore its impact.

Rutan (2021) posited that repair of a therapeutic alliance rupture in group therapy involves a four-step process in which: (a) The group therapist recognizes that a rupture has occurred; (b) When the therapist determines that they have caused the rupture, to accept ownership for having caused the rupture; (c) Understanding, along with the group, what behaviors have led to or caused the rupture; and (d) The therapist being transparent about their own contribution to the rupture, and the member or group considering their contribution as well. The final step is allowing and encouraging the full expression of the members' responses and feelings, which is a crucial component of resolving the rupture (Rutan, 2021). Based on their experience researching rupture and repairs, Eubanks et al. (2018) posit that clients who are motivated for treatment and/or feel that they have a strong bond with their therapist are best suited to contribute to repairs. In addition, a strong alliance may allow therapists to address ruptures in the context of a trusting and safe relationship (Tasca et al., 2016). Overall, a strong alliance suggests that clients will likely to be more committed to tolerate the often uncomfortable and challenging process of participating in repairing a rupture (Eubanks et al., 2018).

Group factors such as group cohesion (sense of belonging in a group; Johnson et al., 2005) and group climate (a therapy group’s working atmospehere; Arrow et al., 2021) are likely to influence the rupture and repair process (Marmarosh, 2021b). If the group is cohesive and the climate is safe, it is more likely that ruptures will be discussed, explored, and resolved. If the group climate is tense and there is little cohesion, members are less likely to share their honest reactions in the group, and ruptures will go undetected while still impacting the group. Burlingame et al. (2011) conducted a meta-analysis examining the relationship between cohesion and treatment outcome in 40 studies. The researchers found that cohesion requires sufficient member interaction and time to build, and is strongest when a group lasts more than 12 sessions. This finding suggests that cohesion and the rupture and repair process likely plays out differently in short-term vs. longer term groups.

In addition to the climate, the stage of group development is another factor that influences the rupture and repair process. In a newly formed group, members are more concerned about

safety and are cautious (Yalom & Leszcz, 2020). Ruptures that occur at this stage are likely to be related to group rules, issues of authority, and struggles to understand the group process (Marmarosh, 2021b). If members have dealt with conflict and tolerated ruptures, the group may become more cohesive over time. Members of such a group may feel free to express themselves and challenge one another. However, ruptures that go unresolved are likely to limit the group's growth and foster an atmosphere that is unsafe for genuine disclosures or conflict (Marmarosh, 2021b). Lorentzen et al. (2004) conducted an observational study of long-term analytic group psychotherapy and discovered a significant linear growth of the alliance across the first two years. The researchers concluded that the steady increase of the alliance throughout therapy may be seen as a deepening of the relationships, which only seems to take place in long-term therapies. In sum, it is likely that the therapeutic alliance and rupture/repair process may be represented differently in long-term groups that are cohesive than in time-limited groups.

The Current Study

The therapeutic alliance has been considered an important aspect of therapy; however, minimal research is available regarding clients' experiences of what happens when that bond is ruptured in virtual group therapy. There is little research on the process of virtual psychotherapy, and studies of the therapeutic alliance in this modality have lagged behind studies of efficacy and effectiveness of traditional in-person clinical interventions (Kortz, 2017). Past research has relied on observer-based methods, such as analyzing transcripts of counselling interactions, in order to assess ruptures and repairs (Colli & Lingiardi, 2009). However, observers are not participants in the therapeutic relationship; they may misinterpret how a client feels in a rupture, miss that a rupture has occurred, or rate events as ruptures that clients do not perceive to be ruptures (Eubanks et al., 2018). In fact, the views of clients receiving these services have been underrepresented in the existing literature (Dunn, 2012), and there are few data in the literature that capture this critical perspective. This study will attempt to address this gap by speaking directly to clients about their rupture/repair experiences in a virtual group therapy experience.

There is a clear gap in the research and a need for further investigation into the therapeutic processes in virtual group therapy. I explored this theme in the current study through a detailed qualitative exploration of clients' experiences of virtual group therapy, where counselling took place synchronously through a videoconferencing platform such as Zoom. This

study takes a different approach to examining the therapeutic alliance that does not implicate the same limitations as quantitative approaches. For instance, surveys may miss vital contextual information such as why a rupture occurred. Furthermore, self-report surveys which aim to measure ruptures and repairs (e.g., the Group Questionnaire; Krogel et al., 2013) are limited by client bias (Coutinho et al., 2014). Clients may be unwilling to reveal their dissatisfaction to their therapist, and when they fill out a post-session self-report measure, they may omit the rupture in order to protect the therapist and therapeutic relationship. This limitation will be mitigated in this study, as clients will be speaking to the researcher about the rupture, rather than directly to the therapist, thus allowing clients to speak without the fear of upsetting their therapist.

Gentry et al. (2019) call for more research on group dynamics in a virtual therapy format, as these are unique elements that have not been adequately examined in the existing literature on tele-mental health. It is largely unknown the impact of ruptures and repairs on clients in group therapy (Garceau et al., 2021), and particularly in virtual group therapy. There is substantial evidence in the individual therapy literature and modest research in the group therapy literature which suggests that therapists have poor accuracy in predicting clients' perception of the therapeutic alliance (Chapman et al., 2012; Tryon et al., 2007). Thus, in order to understand clients' perspectives on the therapeutic alliance in virtual psychotherapy, it is necessary to speak with clients directly about their experiences and invite them to reflect these experiences through open-ended interview questions, which is the approach used in this study.

Research Questions

Emerging research has begun to highlight the effectiveness of tele-mental health services to address a variety of mental health concerns (Barak et al., 2008; Wade et al., 2020). However, research on the therapeutic alliance is limited with regards to virtual group therapy, particularly in groups for youth and parents. We aim to address this gap in the literature by employing a qualitative methods design to explore youth and parent clients' experiences of the therapeutic alliance and rupture/repair in virtual group therapy. Based on the literature review, the following research questions will be addressed in this study:

(1) What are clients' experiences of forming therapeutic relationships involving themselves and their group facilitator, themselves and other group members, and themselves with the group as a whole in virtual group therapy?

(2) What are clients' experiences of ruptures and repairs in virtual group therapy?
(3) What similarities and differences emerge between the perspectives of youth participants and parent participants in relation to their experiences of the therapeutic alliance and of rupture and repair processes?

Methodological Framework

Source Study

The larger study from which the data were drawn for this thesis was funded by an Ontario Centre of Excellence for Child and Youth Mental Health Innovation grant. The lead research organization involved with the study is Crossroads Children's Mental Health Centre, and the source study is titled *"Using evidence to connect children, youth and families to effective in-person, virtual, or blended care."* The overarching goal of this study was to develop a deeper understanding of the experiences and perceptions of youth and families accessing virtual groups during the COVID-19 pandemic in order to inform the development of a hybrid service delivery model. As part of this study, we conducted semi-structured interviews with youth and parents participating in virtual group therapy (VGT) at community mental health agencies in Eastern Ontario.

Participating agencies were provided with recruitment documents from the research team. The agencies then disseminated the recruitment poster through social media channels, and also via email directly to their youth and adult clients who have participated in virtual groups. Interested clients then contacted the Principal Investigator (using the information provided on the recruitment documents) if they were interested in participating in the study. Prospective participants were contacted by the researcher to schedule the interview. For those who agreed to participate in the study, youth and parent/guardian participants were required to provide informed consent. Participants were given the option of completing a virtual interview on Zoom or by phone at a time convenient for them. Participants were compensated with a $25 Amazon e-gift card as a small thank you for their participation in the study. For the current MA thesis, an ethics application for secondary use of data was submitted and approved at the University of Ottawa.

The Current Study – Participants, Recruitment, and Eligibility Criteria

Participants were 21 clients—10 youth (12-25 years of age) and 11 parents—from community mental health and addictions centres located in Ottawa, ON. Youth participants were not specifically asked to disclose their age as long as they met the inclusion criteria of being at least 12 years old at the time of the interview. The rationale for this cut-off was that in Ontario children aged 12 and over are deemed capable of providing on their own consent to receive mental health and addictions services in a community setting; therefore, clients should be able to consent to sharing their experiences of having received such services in a research context. The maximum age to be considered a youth was determined by the participating agencies' cutoffs (for instance; one of the participating agencies' youth programs serves youth ages 18-25). Participants were recruited over a period of six months in collaboration with the partnered agencies. We approached a number of agencies, and in the end we had participants from three community mental health agencies – a children's mental health agency, an addictions treatment agency, and a youth mental health agency. Clients 12 years old and over and parents/guardians who have participated in a virtual group service at a community mental health agency were invited to participate in individual interviews. For the purposes of this study, there were no restrictions on the specific issues or topics treated within the groups. In order to be eligible for participation in this study, clients had to have participated in a group virtual service at one of the partner agencies in the 12 months prior to the research interview. The interviews were conducted in English or French; therefore, participants must have been able to understand and communicate verbally in one of these languages.

Participants were recruited through quota sampling. Our intention was to recruit a representative sample of clients who have received virtual group services, and we had the time and resources to recruit a maximum of 30 interview participants. The review of the literature suggests that therapeutic alliance experiences vary by age. Therefore, we decided on two subgroups: youth and parents. To this end, we planned to recruit a minimum of 5 participants within the youth segment of our sample and a minimum of 5 parent clients within the sample. This number of interview participants would generate substantial content for thematic analysis, thereby limiting the possibility that relevant themes might be overlooked. The participants were selected on a first come/first served basis (which was indicated in our consent forms), and this

applied until we reached the quota of up to a maximum of 15 in each participant group. Recruitment ended in June 2022 with 21, rather than 30, participants, due to time limits for the research project imposed by the funder.

Development of Interview Protocol

The semi-structured interview protocol (see Appendix F) consists of 14 open-ended questions organized in five sections that were designed to elicit in-depth information about participants' experiences in virtual group-based psychotherapy. Only the interview data that were directly relevant to research questions (i.e., sections 4 and 5) were analyzed for this thesis project. In the first section, participants are asked to provide contextual information on the virtual group services they received (i.e., the name of the agency that offered the group, the purpose and duration of the group). The second section includes questions about logistical and technical processes related to participating in group (i.e., registration process to get into the group, challenges with accessing the virtual group). The third section asks participants about their experience of being a client (i.e., the experience of staying focused in the group and participating in group discussions). The fourth section of the interview includes questions on the therapeutic alliance regarding agreement on goals, tasks, and the participant's experience of bonds with the group facilitator and other group members. Finally, the fifth section is focused on the phenomena central to this thesis, the participant's experience of ruptures and repairs in the virtual group sessions.

The questions were developed in collaboration with the members of research committee overseeing the funded project from which the study data were drawn, in conjunction with key concepts identified within the literature review. The questions on therapeutic alliance were based on Bordin's (1979, 1994) three components of working alliance. The draft of the protocol was first created in consultation with a Masters-level counselling psychology student working as a Research Assistant on this project, as well as with a Ph.D.-level counselling psychology faculty member, who had extensive experience conducting psychotherapy and qualitative research studies. The protocol was then revised by three subject area experts on the research team with experience conducting psychotherapy research. Finally, the protocol was then pilot tested on two participants who had some virtual group experience to draw from. Feedback about the protocol

was sought from these participants, and no modifications were made to the protocol based on their feedback.

Procedure

Participants completed an individual, semi-structured interview with a research assistant. The interviews took place over Zoom and were audio recorded. One interview was conducted for each participant, lasting 30-40 minutes. The interviews were conducted by two research assistants who were Masters-level students studying counselling psychology at the time of data collection (one of whom is the author of the present study). Each research assistant conducted approximately half of the 21 interviews. Some of the questions asked include, "Did you ever feel tension or feel upset, even a little bit, in a group session? What happened in the group that made you feel this way?" If participants were unable to identify a rupture initially, the interviewer probed for more by letting them know that they are interested in hearing about even minor instances of tension or upset. If participants identified a rupture, the interviewer asked questions about repairs such as "Were the incidents that created the tension/upset addressed by the facilitator or by the group members?" If the participant was unable to identify a rupture after being probed, the interviewer skipped the questions regarding repairs and continued with the rest of the interview.

Data Analyses

The data were analyzed using thematic analysis to determine overarching themes in the data (Braun & Clarke, 2006). Thematic analysis is a theoretically flexible approach which entails reading a body of information and identifying, analyzing, and recording emergent themes. This method involves six stages; however, these stages are not linear, and one can move between phases as needed (Braun & Clarke, 2006). Initially, all interviews were transcribed verbatim by the student researchers. Then the researchers began the six stages, which involve familiarization with the data, coding (i.e., creating a short phrase that captures what is important in bits of data), generating themes, reviewing themes, defining and naming themes, and writing the results section.

To begin the thematic analysis, it was essential that the researchers familiarized themselves with the data by actively reading the transcriptions several times to search for

meanings and patterns (Braun & Clarke, 2006). Once fully familiar with the content, researchers produced a preliminary list of ideas emerging from the data. Specifically, this step required that we generate initial codes as we began to organize the data into meaningful groups (Braun & Clarke, 2006; Terry & Hayfield, 2021). In this first level of analysis, we completed an initial coding using "mind maps" to identify patterns in the data (Braun & Clarke, 2006). A mind map is a radial diagram of words or concepts arranged in relation to a central concept, branching into subtopics that can better analyze, understand, synthesize, search for, and generate new ideas (Eppler, 2006). Mind maps are an effective way to identify recurring themes and a way to visually represent and communicate qualitative data (Burgess-Allen & Owen-Smith, 2010; Kotob et al., 2016). Next, we engaged with the data on a deeper level by assigning codes or short phrases to capture the meaningful content in the data, keeping in mind the research questions. In this phase, some of the key suggestions to consider are to: (a) code for as many potential themes as possible, (b) code inclusively (i.e., preserve some of the context of each data extracts), and (c) data extracts can be coded into as many different themes as they fit into (Braun & Clarke, 2006). *Semantic codes* capture or summarize a point that has been made by the participant, whereas *latent codes* capture what is beneath the surface in the data, and require in-depth interpretation on the part of the researcher (Terry & Hayfield, 2021).

After coding all the data, the next phase involved clustering and combining codes to create initial themes, and combining the appropriate coded data extracts within the identified themes. Codes were clustered according to similarity and overlap with other codes. Next, these prototype themes were reviewed to ensure that they are producing a meaningful theme, rather than just a domain summary. Prototype themes were reviewed and refined at two levels: the coded data and the overall data set. Firstly, the generated themes were reviewed to ensure a coherent pattern exists, that is, whether the data extracts fit within the distinct themes, or if the themes themselves need to be revised (i.e., *internal homogeneity;* Patton, 1990). Secondly, the themes were examined to ensure that they work within the whole data set, that is, the themes should "accurately reflect the meanings evident in the data set as a whole" (i.e*., external thematic heterogeneity;* Patton, 1990, p. 21). In the final phase, we produced thematic definitions which capture each theme's key ideas. We then produced the written report, which involved selecting compelling quotes from participant interviews that illustrated each theme, as well as connecting the themes to the literature review and research questions (Braun & Clarke, 2006).

Trustworthiness

Trustworthiness of the findings was ensured through the use of an audit trail. An audit trail was maintained via thorough documentation of (1) the researcher's theoretical and reflective thoughts throughout the analyses, and (2) potential codes and themes as they emerged and developed. As I did the analysis, I did in a way that enabled me to retrace the steps that took me from the interview data all the way through to generating themes. I completed an initial coding using "mind maps" to identify patterns in the data. Mind maps were used to create initial themes, which were then reported and described as larger themes. My thesis supervisor, Dr. Smith, audited the analytic process. I met with my thesis supervisor, Dr. David Smith, presented themes to him, and he asked me to trace it backwards to the initial themes and mind maps to assess the integrity of each theme. We then made revisions in the wording to accurately capture the themes. This audit process was repeated multiple times throughout the analysis.

Operational Definition of Ruptures

Safran and Muran (2000a) define ruptures as strains in the alliance caused by either disagreement about the tasks or goals of therapy or problems in the therapeutic bond. In this study, I used difficult feelings, as reported by clients, as markers for identifying ruptures in the interview data. Therapeutic ruptures were defined as painful emotional experiences in therapy which resulted due to conflicts in the therapeutic relationship. Ruptures were associated with difficult feelings, such as feeling annoyed, awkward/uncomfortable, tense, dismissed, confused, angry, disappointed, self-conscious, and incompetent. Participants also reported hesitancy in engaging in the group following a rupture due to discomfort or fear of being attacked. For instance, the following statement indicated to me that a rupture had occurred: *"It made me feel uncomfortable… so that really threw me off… And that made me feel like I didn't want to share as much."* (Youth 5) Another participant mentioned the emotional difficulty caused by witnessing a rupture, and the feelings that arose in her at the time, which also signified to me that a rupture had occurred:

One time these two people kind of got into an argument about something. It was about vaccines. So that was kind of awkward. I just honestly, like, stayed quiet. I didn't really want to get between it. I was just kind of like, okay, this is awkward. And I turned my camera off. It just

made me have anxiety; it did give me a lot of anxiety. Here are these two people fighting, and we should just go back to sharing. So that was kind of weird. (Youth 1)

Results

The thematic analysis of the data yielded the following five themes related to therapeutic alliance, and five themes related to rupture and repair that reflect the key experiences of the participants.

Table 1

Emergent Themes

Themes related to therapeutic alliance	Themes related to rupture and repair
Sense of group as a safe space is foundational to a positive therapeutic experience in the group	Group members' disruptive behavior generates ruptures in the group process
Importance of similarity, relatability, and empathy between group members in developing bond	Ruptures that were unaddressed and kept away from the group fostered forms of disengagement in clients
Challenge of building relationships with other group members within the virtual environment	Ruptures that were addressed by facilitators promoted clients' re-engagement in group
Therapists as leaders providing safety, care, guidance, knowledge and information	Clients in the group look to the facilitators to address and repair ruptures when they occur
Facilitators engaging and enabling members to participate in the group process	Compassion and perspective-taking increased participants' tolerance for ruptures

These themes are described in detail below.

Therapeutic Alliance

Theme: Sense of group as a safe space is foundational to a positive therapeutic experience in the group

Description: Participants reported that they felt their therapeutic relationships in group were a place of comfort and security that promoted their own self-disclosures. Thus, the sense of community and belonging was a significant gain in their lives that contributed to a sense of safety in therapy. The sense of group as a safe space increased participants' hope, well-being, stability, and reduced isolation. As one participant said, *"It was very comforting, just to kind of vent and then just hear other people also vent. And you're like, hey, looks like I'm not alone in my trouble. So for that, because of that stuff, it was positive."* (Youth 2) Another participant said, *"To be with a tribe that understands and has many of the same experiences is comforting."* (Parent 4) Another participant mentioned the value of group therapy as meeting a need for social connection: *"Fulfilling the need for community, fulfilling the need for connection. These are goals within themselves, especially when you're coming out of like the drug addiction community."* (Youth 4)

Theme: Importance of similarity, relatability, and empathy between group members in developing bond

Description: Participants emphasized the importance of similarity and being able to relate to other members in developing the therapeutic bond. Seeing group members dealing with similar issues helped clients realize that their problems are not unique to them and that others experience similar emotions. *"[Group members] being accepting and just kind of being reassuring like, hey, you know, we've been through this too, and this sucks and just kind of like, showing support. I thought that was nice."* (Youth 1) This sense of universality fostered feelings of acceptance and belonging within the group, thereby facilitating the therapeutic process. Participants shared that, *"Everyone kind of had almost the same stories. So it wasn't too hard to tell my story when I had to."* (Youth 6) .... *"Everybody was reaching out, everybody was looking for answers, basically. So I felt perfectly comfortable saying what I had to say."* (Parent 10)

Groups with members who were experiencing similar conditions also learned from and guided one another. Interpersonal learning enabled members to gain new perspectives on their conditions and to learn effective coping strategies.

Right off the bat, one of my first meetings, I had said that, and you know, some of the other youths were like, hey, this is what I did. And then after the fact, when you meet again, you're like, hey, I tried that, and it worked! And then that also helped, the support with the friendships that are just amazing. (Youth 5)

Another participant described how she felt comfortable to share her experience in group because when she did, group members listened and responded with empathy:

I definitely wasn't afraid to share my experiences, and I felt like I did experience the other members paid attention, sometimes would comment or, you know, something I said would then cause a chain reaction that they agreed or that they applied the same thing to their life and, you know, worked good or bad and so that's the way that the group really worked. So, we were able to have a lot of conversations based on things that we were going through or had experienced, for good or bad. And so, it was really, you were able to just help each other and be heard by other parents that got it, that understood. (Parent 4)

Parents more directly and frequently than youth members indicated that empathy from others in the group was a positive experience.

So many people had so many stories and so many things that they could relate to how [another group member] was feeling when she was feeling so alone. Thought that she was in this all by herself. It really showed how close the group was, and how much empathy was shown and kindness. (Parent 6)

In contrast to the experiences of similarity and relatability among groups members, some participants in groups covering substance use issues mentioned that dissimilarity among group members' situations was helpful in fostering hope. Seeing group members worse off than them contributing in the group provided motivation, keeping clients committed to the therapeutic process. For instance, one parent stated: *"Some of the other parents' kids were very addicted. It made me feel better because it felt like my son was not as bad."* (Parent 8) Another participant

mentioned that seeing someone struggling with substance use in the group encouraged him to continue with his own recovery:

Honestly, [another group member acting aggressively] reminds you how much substances have effects on your brain like it's, as a hardcore substance user, seeing another one is always like an ick moment, right? Like yeah, it's never pleasant to see someone who's that far down. It reminds you that you need to stay sober. (Youth 4)

Theme: Challenge of building relationships with other group members within the virtual environment

Description: Participants spoke about how building relationships with other group members was difficult online due to aspects of the virtual environment. Issues such as time lag, poor internet connection, and lack of eye contact and body language cues were identified by participants as restricting the ease of flow of communication, which would not be experienced in an in-person context. *"Sometimes it would cut in and out. So that would be difficult, because they'd be talking, and then you'd have to kind of be like, oh, sorry, we can't hear you. And they'd be emotional. So that was kind of hard."* (Youth 1) The screen-sharing feature was also mentioned as a barrier to communication, with one participant describing how the inability to see all group members when a facilitator shared their screen limited the sense of communicating with the group. A few participants also mentioned feeling anxiety around the fact that others could be recording the sessions, which limited what they shared. For instance, one participant said, *"I still felt pretty good, but there would still be a limit as to what I would be able to say, because it could all be recorded."* (Parent 9)

Members who typically experienced social fear became more comfortable with exposure to social situations in a virtual group environment due to the aspect of anonymity. *"I thought that maybe I would do better in the virtual [group] as I've always been a little anxious. I find I do better when someone can't see me."* (Youth 6) Whereas participants who experienced social anxiety sensed the screen as protective and felt more comfortable participating in group while having their camera off, other participants felt that not seeing group members impeded their ability to form connections. As a result, facilitators encouraged group members to participate with their video turned on in order to promote group cohesion. Participants appreciated when

group members had their camera on as this felt more similar to in-person interactions. *"It was good that you felt like you were still in an in-person meeting because everyone was on camera. You could see expressions on people's faces and just have more of that human contact."* (Parent 6)

For some participants, the virtual setting and the potential for loose boundaries online made it challenging to trust that members were maintaining privacy/confidentiality.

Some of it is the reflection of the Zoom experience, you know, when you're not getting body language and eye-to-eye contact with the other individuals in a group. It didn't lend well to the confidentiality. So, I would say the format over Zoom definitely impacted the ability to feel safe at all times and comfortable. (Parent 7)

Participants felt that speaking in group on Zoom felt *"stilted"* (Parent 10), *"unnatural"* (Youth 2), *"not authentic"* (Youth 1), *"difficult to connect personally*" (Parent 7), and one participant felt that it was *"as if you were in a lecture hall with 25 or 30 people."* (Parent 10) Ultimately, the virtual group experience was described as feeling artificial. Participants described experiencing discomfort in instances when a group member shared their personal struggles without being visible on the screen. One youth noted the difficulty involved in supporting someone who presents as a blank square: *"If the person is just talking from a black screen, I don't really know what they look like, I can't really be there for them. It's really disconnecting."* (Youth 1) Parents more often than youth reported being intolerant and displeased with the quality of their therapeutic relationship with other group members in a virtual group, citing a desire to chat outside of the group in neutral spaces (i.e., getting coffee together before or after the group, which they would be able to do if they were in-person). Some participants had been part of an in-person therapy group prior to the COVID-19 pandemic, and contrasted the genuine connections they felt in an in-person group with the lack of connections they felt in the virtual group:

You did get to know people, but maybe not as much as you would have in-person. Because you didn't have that coffee break time where you, guys, let's go take a 10-minute break, go over get yourself a coffee, get yourself a water, you know, where you can sort of get more personal. And maybe things are said during that time that are outside of the boundaries of the class but still mean the most to you. (Parent 3)

Another parent echoed this sentiment:

I know that if it was in person, I would have came out with some friendships, for instance, and there would have been more conversations during break time and before and after with other parents who are going through the same thing. So that bonding, or even just being around people who have similar lived experience with the challenges that we're trying to overcome, that would have been really nice. However, you did get some of that in the virtual from people sharing the experiences. But even then it was limited on who would share, whereas in person, I think there would be a lot more of that as rapport was built up, which you couldn't do much of because it was online. (Parent 9)

However, this participant also noted that despite her preference for an in-person group, she was grateful that the virtual group was offered during the pandemic. *"The fact that it was available at all, this was still extraordinarily useful, and I would still recommend it online. I'd just prefer it in-person."* (Parent 9) While attending the group virtually would not have been this participant's first choice, virtual treatment was preferable to no treatment at all.

Theme: Therapists as leaders providing safety, care, guidance, knowledge and information

Description: Participants looked to the group leader to provide safety, care, guidance, and knowledge/information through using their communication and presentation skills. *"They were both really good at communicating whatever it is that they need to make me understand. They would use words that, you know, they would explain things in a way where I could easily absorb the information."* (Youth 2) One parent felt that: *"The two women who ran it were very good in terms of their information and being sensitive and being kind."* (Parent 10) Participants also valued when the facilitator was skilled in their field. *"Having an experienced facilitator made a big difference."* (Parent 9) Another participant spoke about how he expected the therapist to be an expert but when they weren't, he felt disappointment.

One of the people who leads the group is definitely I want to, like, I hate to say this, but too young. I think he's lacking some experience that the other person in the group has. That's life. He's only gonna get experience through leading stuff like this. But it's just funny seeing things

like, I've been using drugs for a decade. You learn what's true and what's not, and you just hear something and you're like, oh, like, sweetie, that's not true at all. (Youth 4)

Theme: Facilitators engaging and enabling members to participate in the group process

Description: To ensure clients' engagement, facilitators fostered a culture of interaction by creating an environment where clients felt comfortable speaking. Facilitators used a positive and welcoming approach to encourage participation. *"He was nice, welcoming, kept the group focused."* (Youth 1) As one participant mentioned, *"There was a lot of positive reinforcement for trying out what they were teaching during the week. And there was a lot of encouragement for participating as well."* (Parent 1)

The therapist used relational processes to encourage members, such as asking for group members' perceptions on group topics, encouraging questions and reflections, and making space for people who have difficulty participating. For instance, facilitators were understanding of members who preferred to participate via the chat function due to feeling anxious. *"They were pretty accepting of people who were too shy to turn on the camera. So they were like, it's okay if you don't want to talk but like, you can still type in the chat or something."* (Youth 3) One participant felt that *"having the facilitators just constantly having your back, checking in, you feeling important and feeling validated and valuable, right from the start is extremely beneficial."* (Youth 5)

One participant shared that he processed information in group by being quiet and listening and that for him, silence did not mean a lack of engagement:

Once they finish the presentation of like, talking about whatever they're talking about, and the slide it would go around asking questions, like, hey, [Participant name], what do you feel about this? Hey, what does that girl feel about it? And sometimes, I don't really have a comment to make. I just, I heard you, I absorbed it. And I don't really have any insightful thing to say. I just kind of want to be quiet and listen, but I also don't blame them because having to talk with nobody speaking back sometimes it's just awkward. (Youth 2)

Rupture and Repair

Theme: Group members' disruptive behavior generates ruptures in the group process

Description: Youth and parents reported feeling frustration and shock due to other members' disruptive group behaviors. Disruptiveness ranged from minor frustrations such as group members asking facilitators to repeat themselves, to overt belligerence, such as group members blaming or attempting to pick a fight with another group member. In addition, other group members' monopolizing in group led to negative emotional experiences from others in the group, feeling that they do not have the opportunity to make their points and must compete for the group facilitator's attention. This was evident in the following quote from a parent:

There was one group member who participated a lot. And she had a very, at the beginning, she participated a lot. And she had a serious problem that her child was refusing to go to school. And I felt badly. And it sounded like she also had a conflict going with the school. And at one point you could see that her hand was raised, and the facilitator did not call on her this time. So I think they explained at the beginning that we would all have to share kind of the attention of the facilitators. So yeah, well, I felt badly that she had this serious issue. And I think that, I don't know, it was something that the facilitators needed to manage is how much she could participate. (Parent 1)

Additionally, witnessing or engaging in arguments was distressing for participants. Some conflicts that appeared to be targeted towards a group member were actually displaced anger that a member felt toward the facilitator. For instance, participants spoke about feeling frustration with a group member for spending too much time sharing in group, but also frustration with the facilitator for not enforcing time limits on sharing:

[The facilitator] would kind of just let her talk, which was really annoying. So I think she just like, got used to it, that she could just go over the time. Maybe at the start, whoever was the facilitator, if it was this guy, should kind of like keep the rules in check and mindful of everything. (Youth 1)

Theme: Ruptures that were unaddressed and kept away from the group fostered forms of disengagement in clients

Description: Youth in particular shared stories of feeling themselves disengage from their therapeutic processes as a result of unresolved ruptures. Disengagement for youth typically included turning off their camera, engaging in non-therapy related websites or activities during group time, reducing how much they shared about themselves, and dropping out of the group. For instance, one participant said that experiencing a rupture made her reconsider participating in the group and ultimately resulted in her dropping out. *"It just kind of made me like, tune out, really, and not really care to go back."* (Youth 1)

Ruptures were met by discomfort and a feeling of "awkwardness," introducing distance into therapy. Whereas some participants recalled that after experiencing a rupture, they continued to attend therapy with reduced participation despite greater initial participation, others declined to go back. The various ruptures that youth experienced resulted in more cautious disclosures and disengagement from the process. For parents, disengagement due to ruptures was less prominent as a theme. One parent mentioned that ruptures were educational and did not have a big impact on her experience in the group. However, when it did occur, disengagement for parents included reducing engagement in trying the skills that were being taught, as well as questioning the facilitators' expertise.

I started to lose a bit of confidence in the method that they were teaching... I think if I lose confidence in the model, then I might reduce my engagement in trying to apply it if I think it's not really, you know, if it doesn't hold water, then how invested am I in it? (Parent 1)

Theme: Ruptures that were addressed by facilitators promoted clients' re-engagement in group

Description: Participants spoke about instances where resolved ruptures allowed them to re-engage in the therapy. One participant spoke about how she felt anxious at the thought of group safety being compromised due to younger group members entering the group who were saying triggering comments. However, when the comments were addressed by the facilitators, the participant felt relief about participating in group again.

It was extremely hard when thinking after that incident, that we wouldn't have been able to reach our goals and be able to get that support we needed all of our sessions, knowing that we wouldn't be able to have our life and health update and not be allowed to say anything about like

we used to do. But then now with these two groups and how they're going to blend with the step process that they have made, we're still going to be able to have our group the way it was and integrate youth way better in it. (Youth 5)

Another participant echoed the sentiment of relief in the following quote when a triggering group member was removed from group: *"I hadn't been to group in a few days because of that guy. And so I came back, essentially, like, [when the triggering group member was removed], it made me rejoin and have just as good a time as I was before he showed up."* (Youth 4)

When participants experienced ruptures with the facilitator or other group members, they largely kept it to themselves. Thus, participants did not always disclose to the facilitator that they experienced tension, and therapists were not always aware that a rupture had occurred. In such instances, the rupture stayed in the participant's private space and did not go beyond that. For instance, one parent described how she oftentimes felt triggered due to comparing herself to other group members. This was not voiced to the facilitators, and the participant managed her feelings by herself.

I didn't let anybody know, I'm very respectful. And I mind my own life and my own triggers. I was listening respectfully. I am goal-oriented and results-oriented, and I was there to learn. So I was managing my own triggers, and I never let a facilitator or the group know. (Parent 5)

Because of participants not always sharing their experiences of rupture, it can be difficult for facilitators to notice ruptures in the group. However, unspoken ruptures did not always lead to client disengagement. The above participant mentioned that her interest in learning psychoeducational skills was a perceived benefit that kept her coming to the group despite experiencing ruptures: *"My interest in learning about the skills that we were learning, and the material and the videos that we watched, this is what helped me stay focused. My interest in the course."* (Parent 5)

Theme: Clients in the group look to the facilitators to address and repair ruptures when they occur

Description: Participants reported that when ruptures occurred, they typically did not take any actions to repair it themselves. In most instances of rupture, it was the facilitator who took action to repair it, and this was often done by processing and discussing the rupture in the group, encouraging group members to be respectful of others' viewpoints, redirecting the focus of discussions, or by exploring the client's experience of the rupture individually and allowing clients to voice their concerns. Facilitators dealt with inappropriate behaviours of group members by interrupting them, removing them from the group, and/or speaking to them privately outside of the group. Facilitators also explained the responsibility of each group member to respect differing opinions among group members, and they created a safe space by discouraging abusive or aggressive language or behaviour.

Facilitators addressed inappropriate ruptures individually and processed how clients were feeling after a conflict. Participants spoke about how group leaders were helpful in facilitating repair interactions between group members in group. The group therapist facilitated alliance repairs by helping clients express and regulate feelings in the presence of others while in the safety of the therapeutic space. Therefore, therapists providing safety and care was essential in supporting members to endure the challenging feelings that emerged during ruptures in virtual group therapy.

They were very good at helping us speak in the moment and deciding if we were okay, in the moment, to continue. They gave us the choice, if we wanted to sign off or whatever. I think they handled it very well and gave us every opportunity to bail. We both decided we were fine. It was this other person and myself, who openly right there in the group said to each other what we had to say and got through it. (Parent 7)

Additionally, participants felt that the leader stepping in to manage ruptures provided reassurance that the individual(s) and the group would be safe and under control. "*I think it just made me reassured that if something were to happen, or if someone were to say something to me, then [the facilitator] would kind of step in."* (Youth 1)

It appears that participants believe repairing ruptures is the facilitator's responsibility, as several of them mentioned there was nothing other members could have done to intervene. When the facilitator addressed the rupture, this was typically helpful in resolving it, but the facilitator's

intervention was not always effective. For instance, one participant spoke about how when an argument erupted in group over vaccines the facilitator attempted to intervene by muting the participants, but they continued the argument in the chatbox. *"He tried to interrupt but then that's the thing over Zoom too is he like, tried to mute them. And then they just kept talking. They just kept going. The poor guy."* (Youth 1)

Finally, resolving ruptures was associated with a sense of ambivalence. Participants reported feelings of resolution and calmness as well as apprehension and nervousness that such instances would reoccur. Some instances of rupture were never repaired, which negatively impacted participants' therapeutic alliance with the group and facilitator(s). For instance, one participant spoke about how she repeatedly asked for specific material which was never covered in the course. The group facilitator responded by saying that this information was not part of the course and that they did not have this material. The participant felt disappointment as this information was crucial for her, and she felt frustrated at the facilitators, which led to her questioning the facilitator's expertise.

I felt slightly angry at the facilitators on and off throughout the course for not being able to provide that since it was so important, and so needed. But it is what it is, and you can't do anything about it. And maybe they don't have that expertise, right? (Parent 9)

The participant dealt with this rupture by providing feedback at the end of the group experience to express how important it is for facilitators to bring this information into the group for future sessions.

A youth participant described how the group facilitator effectively repaired a rupture between the participant and younger group members who were saying hurtful comments. The facilitators involved the participant who was hurt by the younger youths' comments and asked her to collaborate on how they could move forward. This resulted in the participant and facilitators working together to come up with a plan for separating younger and older youths through a *"step [group] process"* (Youth 5). Additionally, facilitators planned to provide younger youths with a few individual sessions before they join the group, in order to ensure group appropriateness and to introduce them to group rules ahead of time, thus limiting the risk of the younger youths saying triggering comments due to lack of awareness of the rules.

Theme: Compassion and perspective-taking increased participants' tolerance for ruptures

Description: Some participants reported increased tolerance of ruptures when they were able to channel compassion and understanding of others' circumstances. Compassion enabled group members to make room for people from diverse backgrounds and at different stages in their recovery journey. Additionally, compassion improved participants' ability to relate to others, understand their behaviors, and to forgive ruptures when they occurred. As a result, clients spontaneously engaged in repairing processes, which involved integrating other information, perspective-taking, and compassion towards others in the group. Although they looked to the facilitator to lead efforts to repair ruptures in the alliance, they also contributed to the repair process on their own. One participant mentioned that:

I felt angry with [another group member] a couple of times. I did. But I mean, I also know that different people are coming from different places in their lives. So I didn't call him out on it. And I didn't say anything because I just thought, you know, he's got to deal with things in his own way. But yes, I did take some of it to heart… So [by the end of the group] I was like okay, I think he might be getting it now. So I felt like I was a little more, I was far more sensitive to him at that point, because I realized, okay, it's just some people take a little longer. (Parent 2)

Compassion and perspective-taking allowed group members to see that the stress of challenging life circumstances explains why people may behave in dysregulated ways and that they need not take it personally. By broadening their perspective, group members were able to view conflict and challenges through a more sympathetic lens and better understand the people involved. They were able to endure the occasionally uncomfortable feelings triggered by difficult group interactions by remembering that no one is perfect and that we all bring our own unique life experiences. One participant described how when she felt triggered by other group members, she managed the triggers on her own through various methods, including compassion. *"You go there to learn and share, and everybody was doing their best and there is no expectation… I deal with my own feelings myself, because I have my own resources and techniques and psychotherapy."* (Parent 5)

Compassion towards facilitators was also helpful in increasing participants' tolerance of member-to-therapist ruptures. For example, one youth participant mentioned how she was

frustrated due to a facilitator's excessive attention to the client's safety, but accepted that managing risk and ensuring safety was part of the facilitator's job:

With school and everything going on feeling like I have to then what, call [the social worker], make an appointment? I have no time on my hands. But then I also have that side of me that understands that it's probably protocol. So it's like, frustration, but a little bit of understanding. (Youth 5)

Overall, by being compassionate towards other group members and facilitators, participants mitigated the impact of ruptures, which enabled therapeutic connections to grow. The majority of participants in this study felt that they belonged in the virtual group therapy they participated in because they related to other group members sharing similar stories. Additionally, most participants in this study felt that the group was beneficial and met their needs, and they would recommend the agency's services to others.

Discussion

The purposes for this study were to explore clients' experiences of forming therapeutic relationships in a virtual group therapy context, to explore how clients navigate experiences of rupture and repairs in this context, and to understand the effect these events had on them. For this objective, qualitative interview data were analyzed using thematic analysis. In this study, participants described their experiences of the benefits and challenges of forming therapeutic relationships in a virtual group therapy. It was found that the development of the therapeutic alliance in virtual group therapy was similar to F2F therapy in many ways. For instance, empathetic responses between group members and having common therapeutic goals played an important role in the development of alliance in virtual group therapy.

Qualitative results suggest that although virtual group environments involve unique challenges not encountered by clients in a F2F context, clients are able to adapt to virtual delivery and to build therapeutic relationships, especially when there is a skilled and empathetic group facilitator and when the virtual group feels like a safe space. The group facilitator is also instrumental in initiating rupture repairs through employing diverse strategies, which plays a role in whether clients disengage/drop out or continue to engage in therapy. Participants' qualitative

reports of the therapeutic alliance and rupture and repair process in the current study were consistent with previous research that demonstrated that unresolved ruptures are associated with poor outcome (e.g., clients deciding to terminate therapy prematurely); however, repaired ruptures can have a positive effect on the therapeutic alliance (e.g., clients regaining trust in their clinician) (Eubanks et al., 2018).

The discussion of findings is organized according to the research questions that have guided this study.

(1) What are clients' experiences of forming therapeutic relationships involving themselves and their group facilitator, themselves and other group members, and themselves with the group as a whole in virtual group therapy?

In group-based therapy, developing a strong therapeutic alliance involves fostering an agreement on goals and tasks of therapy as well as an emotional bond across all three levels of relationships in the group: member-to-therapist, member-to-member, and member-to-group (Lo Coco et al., 2019). Participants spoke about how they were able to achieve agreement on goals and tasks easily, with the exception of one participant who experienced repeated alliance ruptures due to group psychoeducational content not reflecting what the participant was hoping to learn about. Many participants felt that the third factor of therapeutic alliance, therapeutic bond, was also achieved, particularly with the group facilitator(s). The qualitative results indicated that to build strong alliances with their virtual group facilitators, participants relied on foundational relational factors required to build a therapeutic alliance (Cook & Doyle, 2002) including kindness, caring, support, encouragement, understanding, and compassion.

Some participants, in particular parents, reported feeling connected with the group facilitators, but less connected to other group members in their virtual group. This is in alignment with McMillan et al.'s (2020) findings; these researchers found that some participants in a virtual group for parents of children with cerebral palsy had more ease building relationships with the group facilitator than with group members. Participants in the present study viewed facilitators as leaders who provided empathetic feedback, care, safety, and knowledge, who guided the group process and encouraged supportive interactions. The emergence of these themes suggests that participants developed a strong member-to-therapist alliance. In order to ensure participants'

comfort and safety in virtual group therapy, facilitators prioritized confidentiality, which is more difficult to enforce in a virtual group format as facilitators do not have control over participants' environments. Clients are participating from their homes, potentially sharing a space with other people who are not participants in the virtual group and may overhear the participant or other group members. In addition to standard confidentiality practices, clients were encouraged to turn on their cameras and wear headphones to protect the privacy of other group members. Facilitators explained in group that members could be compromising the privacy of other participants if they were not mindful about the environment in which they were participating in the group. Some participants reported that when the facilitator shared their screen on Zoom, their connection with the facilitator and other group members was diminished because they could not see the facial expressions of other group members and the facilitators as easily. While screensharing of pictures, videos, or mindfulness activities can provide an opportunity to enhance learning in virtual group therapy (Lopez et al., 2020), it was found in this study that using this feature can also impede therapeutic connection among the group members.

Contrasting with the strong member-to-therapist alliances participants developed, participants felt that it was more challenging to build member-to-member alliance in a virtual group. Participants cited the lack of eye contact and body language cues as a barrier to communication, which affected their ability to build therapeutic alliance with other group members. Participants mentioned the challenges of building a therapeutic relationship with group members who participated in sessions with their video turned off. This aligns with Walther's (1992, 2011) SIP theory, as it demonstates an absence of visual cues and introduces a barrier between participants in the virtual environment. Participants felt it was challenging to share sensitive information with someone who presents as a blank screen and to support an individual who was sharing their experiences without being visible. Additionally, it introduced suspicion and anxiety around whether these participants were maintaining confidentiality. On the other hand, participants who experienced shyness reported feeling more comfortable participating with their camera turned off or via the chat function. This is consistent with past research stating that participating without being seen reduces barriers to treatment for clients who are self-conscious due to social anxiety or stigma-related concerns (Simpson et al., 2021). Nonetheless, present findings highlight both the potential discomfort involved in speaking about personal challenges without being able to see group members, and the increased openness expressed by clients who

feel comfort in participating with their camera turned off. Therefore, while virtual groups offer some advantages to socially anxious clients, they may come at a cost of undermining the member-to-member alliances developing across the group.

Walther's (1992, 2011) SIP theory states that with adequate time and motivation, people interacting via CMC will foster interpersonal relationships equivalent in quality to those developed in face-to-face (F2F) interactions. The findings in the current study provide mixed support for this theory, with some participants expressing difficulty in building member-to-member alliance as a result of the virtual platform even with adequate time and motivation. It is worth noting that some participants in this study who cited difficulties with forming group therapeutic connections reported that they dropped out of the group after a few sessions, whereas participants who were able to form therapeutic connections reported that they had attended at least 8-16 group sessions. This finding suggests that therapeutic alliance in group therapy may be slower to develop than in F2F therapy. This is consistent with Walther's (1992, 2011) SIP theory's framework, which states that connections can be developed online, although this process unfolds more slowly. This is also consistent with Burlingame et al.'s (2011) findings that group cohesion requires sufficient member interaction and time to build, and is strongest when a group lasts more than 12 sessions. Therefore, it is possible that these participants did not allow adequate time to build strong therapeutic alliances, and if these participants continued with the group therapy experience, they may have developed deeper connections later on. Thus, it is possible that barriers in virtual groups get in the way of developing alliances with members; or, in these groups, clients did not have adequate time to develop the alliance.

Although barriers to fluid communication via the virtual platform (i.e., lag and connection cutting out) created some disruption in the flow of the conversation, it was typically not enough of an issue to distract from the overall conversation or to cause significant frustration among the members. Nonetheless, the results might suggest that it is more difficult to build a strong member-to-member therapeutic alliance in virtual group therapy and that there are additional factors to consider when using the virtual platform. In the present study, the theme of the challenge of building relationships with other group members within the virtual environment could reflect difficulties in forming therapeutic relationships online, despite a systematic review by Banbury et al. (2018) finding bonding and cohesiveness to be similar for virtual and F2F

groups. However, is is plausible that the context of the COVID-19 pandemic has exacerbated some of the difficulties described by participants in forming therapeutic relationships in virtual groups. For instance, the general lack of in-person connection available during this time period may have been a challenge that heightened clients' desire for face-to-face contact that they would have experienced in an in-person group. Pietrabissa and Simpson (2020) state that loneliness is an increasingly recognized public health issue which is associated with feelings of disconnection from others. The researchers suggest that the onset of COVID-19 and enforced social distancing measures are likely to have exacerbated what is already a prevalent issue in our society.

Because there are not the typical social cues, participants felt that it became more difficult to know when to start or stop speaking when using the online platform, which introduced awkwardness and discomfort. Nonetheless, participants in this study described the benefits they experienced from connecting with and receiving empathetic feedback from others in similar circumstances. Many participants valued engaging with others facing similar challenges, which is significant given the social isolation that many people faced during the COVID-19 pandemic. Many participants reported that as a result of being in the group, they learned skills to be able to better manage their own internal experiences and help their loved ones to manage theirs. It appears that although the member-to-member therapeutic alliance may not be as strong in virtual groups, virtual groups are still perceived by clients to be beneficial, acceptable, and effective for meeting their mental health needs. Although participants experienced challenges with developing member-to-member alliances, the theme of the importance of similarity, relatability, and empathy between group members in developing bond was an exception to this trend of clients experiencing difficulty with member-to-member alliances. Therefore, it is clear that virtual group therapy allows for the same or comparable benefits of mutual support that is observed in traditional F2F group therapy settings.

The literature on member-to-group alliance suggests that some groups are more effective than others. In some groups, the members feel a substantial benefit from the group experience as a result of the specific group they are participating in (Kivlighan et al., 2015). However, in other groups, the specific group a member belongs to can be, but is not necessarily related to, the member’s outcome. Kivlighan et al. (2015) refer to these between-group differences as the “group effect.” Group effects indicate that a group-as-a-whole phenomena is occurring and that

group members share a common experience, which can include a group sense of the group's climate, cohesion, and alliance. Participants who feel a strong alliance to the group as a whole may feel that group members are dedicated to helping them overcome their difficulties and that group members accept and respect them (Kivlighan et al., 2015). In the present study, all participants felt that they belonged in the group and that the group was a safe space, which suggests they were able to develop a strong member-to-group alliance. Participants' reported levels of engagement in the group indicates that virtual groups are a feasible intervention for youth and parents, who may have barriers to accessing in-person services.

Past research has shown that small decreases in group process indicators such as therapeutic alliance did not appear to result in different treatment outcomes between VTC and F2F groups (Gentry et al., 2019). Therefore, participants' experiences of limited bond with other group members may not reflect a hindrance to treatment efficacy. It is possible that a strong member-to-therapist and member-to-group alliance was sufficient for clients to generate therapeutic gains and a positive experience in the group. However, the focus of this study was on therapeutic alliance and rupture and repair, and changes in mental health symptoms were not evaluated.

(2) What are clients' experiences of ruptures and repairs in virtual group therapy?

Safran and Muran (2000a) define ruptures as strains in the alliance consisting of disagreement about the tasks or goals of therapy or problems in the therapeutic bond. Repair, on the other hand, is defined as the resolution of an alliance rupture (Eubanks et al., 2018). Qualitative results of this study suggest that while virtual group environments involve unique challenges in forming therapeutic relationships and in detecting and resolving therapeutic ruptures, clients are nonetheless able to form therapeutic relationships virtually, and ruptures are fairly common throughout this process. Most participants reported experiencing a rupture, although not all of them did. Participants' stories revealed that ruptures were associated with difficult feelings, such as feeling annoyed, awkward, tense, dismissed, confused, angry, disappointed, and self-conscious.

Consistent with past research (Garceau et al., 2021), participants' reported ruptures occurred most commonly between group members, rather than between group members and the

therapist. Participants described how group members' disruptive behavior generated ruptures in the group process, and clients' reactions to ruptures had the immediate effect of generating disengagement in therapy. In the present study, clients who experienced a therapeutic rupture and subsequent repair tended to also descibe the member-to-therapist alliance in positive terms. Rupture resolution was initiated when the client was willing to discuss the rupture and when the therapist facilitated to accept the rupture and discuss the repair. Clients who experienced an unresolved rupture tended to also describe the member-to-therapist alliance as weaker. Clients who experienced unresolved ruptures spoke about their unwillingness to discuss the rupture, a lack of agreement about therapeutic goals, and disengaging from therapy before ruptures could be discussed and repaired. The thematic results will be addressed in more detail in the following paragraphs.

Throughout participants' narratives, there were many descriptions about negative emotional experiences in the virtual group which varied in intensity and which indicated that a rupture had occurred. Ruptures reported by participants were typically small instances of tension or upset experienced during the session, and most of them were withdrawal ruptures. These were often one-time instances, but sometimes, these ruptures would repeat across several sessions, deteriorating the participant's confidence in the group. Some examples of one-time ruptures reported by participants included witnessing group members argue, one participant not receiving individual guidance about appropriate services for their circumstances, and participants being dissatisfied that facilitators were not fully comfortable with slides they were using to present. Examples of repeated ruptures included other participants taking up too much time to speak, facilitators not covering topics requested by participants, and participants feeling triggered by other group members.

In order to cope with negative emotions that resulted from the therapy, participants developed different ways to protect themselves emotionally. Some participants described that they would address ruptures by sharing their experience of the rupture with their therapist, while others used their personal coping skills and chose not to share their experience of the rupture, or disengaged/dropped out from the therapy. Participants did not always share their experience of the rupture with their therapist. Perhaps it felt safer for them to cope with their emotions themselves than to share them with their therapist. This aligns with previous research which

found that participants may avoid expressing their dissatisfaction or negative experiences of therapy to their therapist (Rutan, 2021), perhaps due to fear of upsetting their therapist or other group members involved in the rupture. Some clients in the present study believed it was inappropriate or difficult to share their experience of a rupture, and felt that processing ruptures was not the focus of the psychoeducational group they were participating in.

In previous research, alliance ruptures that were not repaired have been associated with high dropout rates (Safran et al., 2011), which is consistent with the reports of participants in the current study and aligns with the theme of ruptures that were unaddressed and kept away from the group fostered forms of disengagement in clients. Some clients in the present study also spoke about instances in which the facilitator's attemps at repair were unsuccessful. For example, one client witnessed an argument between group members that the facilitator tried to end by muting the participants. However, they continued the argument in the chatbox, which is a challenge specific to virtual group therapy that virtual group facilitators need to be prepared for. When the facilitator addressed the rupture, this was typically helpful in resolving it. However, resolving ruptures was associated with a sense of ambivalence. Participants reported feelings of resolution and calmness, although they reported apprehension and nervousness that such instances would reoccur.

Muran et al. (2009) conducted a study examining the relationship of early alliance ruptures and their resolution to process and outcome in a sample of 128 patients randomly assigned to one of three time-limited psychotherapies for personality disorders. The researchers discovered that lower rupture intensity and higher rupture resolution were found to be associated with higher ratings of the alliance and session quality. Furthermore, lower rupture intensity predicted better outcomes on interpersonal functioning measures, whereas higher rupture resolution predicted better treatment retention. In the present study, participants' stories highlight how failure to repair a rupture can lead to poorer group processes and therapeutic outcomes. Similar to previous research (Eubanks et al., 2018), participants in the current study oftentimes disengaged or dropped out of therapy when ruptures were unrepaired, and when ruptures were repaired, participants typically re-engaged in the therapy.

Regarding repaired alliance ruptures and what facilitates repairing within the group, identification of ruptures occurred when clients directly expressed their dissatisfaction or when

clients argued with another group member, in some instances becoming hostile and abusive. Safran and Muran (2000a) termed these therapeutic events "*confrontation ruptures*." Other participants discontinued treatment by logging off or choosing not to return to the virtual group, or stayed in treatment but were not fully engaged. Safran and Muran (2000a) termed these therapeutic events "*withdrawal ruptures*." Past research (Eubanks-Carter et al., 2010) has demonstrated that ruptures may have elements of both confrontation and withdrawal, which was supported by clients' narratives in the present study. For instance, when participants were involved in or witnessed a confrontation rupture, they typically disengaged or withdrew from therapy as a result, indicating confrontation and subsequent withdrawal.

Most of the participants in the study reported experiencing small instances of ruptures, the majority of which were successfully repaired when the client voiced them. Participants reported that when ruptures occurred, they typically did not take any actions to repair it themselves; they looked to the facilitator to address and repair ruptures. In most instances of rupture, it was the facilitator who took action to repair it, and this was often done by processing and discussing the rupture in the group. It appears that participants believe initiating rupture repairs is the facilitator's responsibility, as several of them mentioned there was nothing other members could have done to intervene. However, clients also contributed to the repair process themselves through channeling compassion towards facilitators and group members as well as perspective-taking, which increased participants' tolerance for ruptures. Thus, although group members are not trained to identify and repair ruptures in the group, they were nonetheless able to within the context of a skilled and empathetic group facilitator and in a group with a positive group climate.

Previous research suggests that a strong therapeutic alliance is likely to support clients in tolerating the often uncomfortable and challenging process of participating in repairing a rupture (Eubanks et al., 2018). This finding was supported in the present study, as participants who discussed that the rupture they experienced was repaired typically also felt they had a strong alliance with their facilitator(s). Participants in the present study appreciated when the facilitator was willing to listen to their frustration and make changes that were aligned with what the participant felt would be helpful. Participants described how facilitators supported repairs by providing care, containment, and empathetic responses, which allowed them to feel more comfortable to open up emotionally and to process the rupture in the virtual group or individually

with the therapist. Eubanks et al. (2018) conducted a meta-analysis of 11 studies investigating the relationship between rupture and repair episodes and treatment outcomes. The researchers discovered a moderate link between rupture resolution and a positive client outcome, suggesting that clients may have better outcomes if clinicians detect and repair ruptures during treatment. In the present study, participants' stories highlighted the importance of therapists' abilities to identify alliance ruptures, to see how the ruptures have an effect on members of the group and across sessions, and to see how repairing a rupture can increase cohesion and trust in a group.

When rupture repair was successful, some of the participants described a process that was similar to the rupture/repair process recommended in F2F therapy. This process includes empathizing with and validating the client's concerns, understanding the source of the rupture, clarifying misunderstandings, and focusing on the client's feelings (Safran & Muran, 2000b). Previous research detailing suggested approaches and strategies for facilitators to employ in repairing ruptures in group therapy also suggested that facilitators employ a four-step process of (a) Recognizing that a rupture has occurred; (b) When the therapist determines that they have caused the rupture, to accept ownership for having caused the rupture; (c) Understanding, along with the group, what behaviors have led to or caused the rupture; and (d) The therapist being transparent about their own contribution to the rupture, and the member or group considering their contribution as well (Rutan, 2021). The participants in this study similarly identified these strategies as helpful approaches in repairing ruptures. Participants also identified an additional approach which included involving clients' input regarding how to address member-to-member ruptures and how to prevent them in the future.

(3) What similarities and differences emerge between the perspectives of youth participants and parent participants in relation to their experiences of the therapeutic alliance and of rupture and repair processes?

The majority of themes were shared between youth and parents. Both youth and parents identified the painful emotions associated with experiencing ruptures at various levels in the group. Both youth and parents emphasized the importance of group as a safe space where they could connect with others going through similar struggles. Additionally, both participant groups spoke about feeling connected to the group facilitator(s), but at times struggling to connect with group members due to the virtual environment. However, youth reported that technological

disruptions were tolerable, whereas parents more often reported technological disruptions as negatively impacting the therapeutic process. Youth more commonly than parents reported disengagement and drop-out following a rupture, whereas parents reported that although ruptures were uncomfortable, they continued in therapy due to perceived benefits from the group. Contrary to findings suggesting that the therapeutic alliance may operate differently in youth and adults due to youths' cognitive developmental skills (Zack et al., 2007), the present study found that both youth and parent experiences of the therapeutic alliance and rupture and repair processes were broadly similar and few differences emerged. Both participant groups reported similar experiences in developing the therapeutic alliance and experiencing the rupture and repair process in virtual groups, which suggests that these processes are universal.

Youth cited less frustration than parents in regard to utilizing the virtual platform itself, which is not surprising given that the younger generation has grown up with technology as a part of everyday life. As such, they are likely to be adept at quickly learning how to use new technology as well as using technology for communication (Hanley, 2012). Therefore, it is possible that younger clients felt more confident in dealing with videoconferencing technology. Despite their comfort with using the platform, some youth felt that virtual groups could not replace the interpersonal connections that they have developed or would have developed in a face-to-face group setting. Finally, proportionately more parents than youth in our participant group cited empathy from other group members as an important factor in developing the therapeutic alliance. Empathy was not mentioned frequently by youth, who instead prioritized similarity of group members as being important to forming a therapeutic bond (i.e., similarity in age, hobbies, presenting issues).

This study contributes to the existing knowledge base by providing a clearer understanding of clients' experiences of virtual groups during the COVID-19 pandemic. Overall, virtual groups can be useful when meeting in person is not possible, whether due to social isolation measures or other factors. They can be an excellent option for clients living in rural areas, when transportation is unavailable, or when work or family obligations impede their ability to attend an in-person group. However, there are some disadvantages to virtual groups. Participants in this study felt it was more difficult to interpret other participants' facial expressions and body language in a virtual group. Furthermore, for some participants, the lack of

in-person contact reduced communication and member-to-member alliance, which is an important part of the group therapy process. Despite these limitations, participants did not believe that the virtual format limited members' ability to express empathy to others in the group, and most participants reported that being in the group generated positive benefits.

Implications for Practice

Since therapists cannot assume that their evaluation of the therapeutic alliance is shared by their clients (Bachelor, 2013), it is important for clinicians to monitor and attend to the quality of the therapeutic alliance, which can be achieved through asking clients to fill out alliance measures. In group therapy, alliance measures would need to measure whether individuals are forming positive alliances with the therapist as well as other group members (Quirk et al., 2013). Most ruptures to the alliance reported by participants in the present study were withdrawal ruptures, which are harder to detect in a virtual group context because group members' cameras may be turned off. Therefore, it is recommended that clinicians plan for this by being proactive in soliciting feedback from clients, for instance through asking clients to fill out standard forms such as the Group Session Rating Scale (GSRS; Duncan & Miller, 2007), a four-item visual analogue scale designed to measure group therapy alliance. The measure is administered at the end of each session and takes approximately two minutes to complete (Quirk et al., 2013). Clients are asked to respond to statements about how they felt being in group that day by placing a mark on the line closest to the statement they agree with. The items on the GSRS (Duncan & Miller, 2007) ask clients to respond the degree to which they felt/did not feel understood, respected, and accepted by the leader and the group (measure of relationship), the degree to which the client felt they had/had not worked on and discussed what they wanted to work on and discuss (measure of goals and topics), the degree to which the client felt the leader and group's approach is/is not a good fit for them (measure of approach or method), and the degree to which they felt they belonged/did not belong in the group they participated in that day (measure of overall fit).

Quirk et al. (2013) conducted a study examining the psychometric value of the GSRS. They administered the measure at the end of the first four group therapy sessions to 105 clients in group therapy covering substance use issues. The researchers found that the GSRS is a reliable measure based on Cronbach alphas (ranging from .86 to .90 over four sessions of group therapy) and test-retest coefficiants (ranging from .42 to .62 over four sessions) (*ps* <.01). They also found

that the GSRS was related to other group process measures and predicted early changes in clients' psychological distress, which provides support for concurrent and predictive validity, respectively. The researchers suggest that clinicians can use the GSRS scores as a way to generate discussions about clients' therapeutic alliance in the here-and-now. For instance, if some group members are reporting moderate alliances compared to other group members reporting high alliances, then the group facilitators can use this information to spark a discussion about what dynamics are occurring for some members to not feel as connected to the group. Additionally, discussions about low scores can be used to encourage group members to express frustrations about the group, which can increase the possibility of addressing ruptures and altering the group to better fit group members. Ultimately, the use of the GSRS can enable facilitators to better identify group members who are not benefiting from the group experience, which can prevent disengagement and drop-out (Quirk et al., 2013).

Clinicians can also use a co-facilitator model, which is a group therapy leadership structure in which two therapists are partnered to facilitate meaningful interactions among group members (Kivlighan et al., 2012). The interactions that occur within groups of three or more members are complex. As a result, it may make a big difference to have an additional facilitator when group leaders are trying to keep track of multiple interactions. Kivlighan et al. (2012) found that group members who participated in co-led groups reported greater benefit from treatment than those group members in individually led groups. In a co-facilitator model, one facilitator is tasked with presenting the material and leading discussions, while their co-facilitator monitors client well-being and may be more tuned in for when a rupture occurs. Co-facilitation increases the chances of at least one of the therapists being able to attend to the many verbal and non-verbal interactions occurring in group therapy, which can provide a more therapeutic experience for group members (Kivlighan et al., 2012). A co-facilitator in virtual group therapy can also be helpful for supporting technology issues and moderating the chatbox (Dhariwal et al., 2021). Furthermore, facilitators can encourage clients to communicate with facilitators to address ruptures in the here-and-now of the therapeutic relationship or to their experience (Weinberg, 2020b). Common examples of therapist statements to initiate such a discussion include, "What are you experiencing?", "I have a sense of you withdrawing from me/the group", and "How are you feeling about what is going on between us right now?" (Safran & Muran, 2000b). This

intervention encourages clients to explore their thoughts and feelings associated with the rupture, and the therapist can then respond empathetically and nonjudgmentally and discuss repair.

Given the scant evidence available on clinical guidelines for virtual group therapy, I draw the suggestions that follow from the experiences of mental health clinicians at BC Children's Hospital as well as from my personal experiences co-facilitating virtual group therapy. In virtual group therapy, facilitators can use the private chat function to check in with an individual group member (Dhariwal et al., 2021), particularly after a rupture has occurred. It would also be helpful to offer a channel for participants to reach out to facilitators when they are experiencing tension, such as being able to privately message facilitators on the platform. Clients can be instructed that if they need to private message a facilitator, they can message the facilitator who is in the "supportive" role at that time and who is not presenting, as they may be unable to attend to the rupture in that moment if they are presenting or facilitating a discussion. Additionally, when setting up the virtual meeting, facilitators may choose to disable the option allowing participants to private message each other (Dhariwal et al., 2021). This may promote group cohesion by reducing the risk of side conversations. It may also reduce the risk of member-to-member ruptures occurring through unmoderated discussions becoming disrespectful or inappropriate. If choosing to disable the member-to-member private messaging, participants can still chat with the facilitators and with the group as a whole. Dhariwal et al. (2021) also suggest that in order to better build rapport in virtual group therapy, facilitators can frequently use group members' names and verbally check in on how they are feeling. Finally, participants can be provided an opportunity to share their contact information when the group ends if they would like to stay in touch outside of the group (ensuring that consent has been provided individually for such), which can help foster feelings of support and community that clients would experience in a F2F therapy group (Dhariwal et al., 2021).

Therapists should be mindful that the therapeutic relationship can be ruptured. However, repairing ruptures that occur due to disagreement over therapy goals and misunderstandings can lead to a stronger alliance and, ultimately, better client outcomes. According to Weinberg (2020b), in virtual group therapy, it is important to screen each group member prior to accepting them in a group, just as facilitators do for F2F groups. Therapists can have a virtual meeting for screening, preparing and bonding with the group member. Part of this meeting can be to explain

technical issues and online etiquette, which may reduce the risk of ruptures occurring due to the virtual environment. In the present study, the following approaches and strategies emerged as helpful for clients in resolving therapeutic ruptures: Addressing ruptures in the here-and-now, asking for group members' input on how to move forward from ruptures, interrupting/removing disrespectful group members, and speaking to group members privately to address inappropriate behavior. Overall, the results from this study could be helpful in training therapists to recognize and address alliance ruptures at different levels in the group, which may improve the therapeutic alliance and ultimately, client outcomes.

Future Research

According to current research, virtual group therapy appears to be a viable alternative to in-person groups, especially when no other treatment options are available. However, more research is needed in the area, especially regarding the role of the therapeutic alliance in virtual groups, as well as how clients experience rupture and repair cycles. It is important to investigate ruptures and repairs from the client's perspective, as unresolved ruptures can cause a client to drop out of therapy or to switch therapists rather than trying to resolve the rupture (Eubanks-Carter et al., 2010), thus potentially not receiving the help they are seeking. Understanding how clients experience alliance ruptures in virtual psychotherapy has significant clinical implications for intervention strategies (i.e., weaving in conflict resolution with group therapeutic goals). Additionally, understanding clients' experiences of the therapeutic alliance may help therapists to obtain greater success in developing stronger therapeutic connections with their clients (Ackerman & Hilsenroth, 2003).

Future research could investigate both client and therapist perspectives of rupture and repairs, and go beyond retrospective accounts to actual observations of ruptures/repairs in-session. Additionally, future experimental research could compare therapeutic relationship development and rupture and repairs in virtual vs. in-person therapy groups. It would also be important to study the differences in efficacy and quality between the therapeutic alliance in virtual versus F2F groups. Given the importance of member-to-member connections in group therapy, future research should also focus on identifying the factors that enhance member-to-member therapeutic alliance in virtual group therapy. This research may maximize the potential benefits of virtual groups and better connect clients who may feel disconnected from other group

members in the confines of the connections in virtual group therapy. Further research could also explore the factors that contribute to client dropout in virtual groups, such as discomfort with the virtual environment, technical difficulties, or issues with group dynamics and ruptures. Finally, future research could investigate whether differences in therapeutic alliance in virtual vs. F2F groups result in different treatment outcomes.

Strengths and Limitations

One strength of the study is that we explored the clients' perspectives of their experience with ruptures and repairs. Speaking to clients is a particular strength over speaking with therapists, as therapists may be susceptible to demand characteristics, including positive self-presentation (Kortz, 2017). For example, some therapists may feel uncomfortable disclosing about sensitive topics such as experiencing alliance ruptures with their clients. Ruptures are a topic that is vulnerable to underreporting or simply denial from therapists as they may want others to see them as competent professionals. As a result, they may minimize their conflicts or misunderstandings with clients, which could be attributed to social desirability. However, since we interviewed clients rather than therapists, it is possible to be more confident that impression management was not an issue.

The qualitative approach that was used is another strength of the current study. The therapeutic alliance is complex, dynamic, and nuanced, and qualitative research has much to offer in terms of providing a rich and nuanced examination of psychotherapy processes (Doran, 2016). Furthermore, this study included participants who have completed a virtual group therapy experience, as well as participants who terminated their virtual group therapy experience prematurely, which gave us greater chances of seeing a variety of client perspectives (Coutinho et al., 2014). Although therapeutic alliance in group therapy describes three levels of relationships (member-to-member, member-to-therapist, and member-to-group), the majority of studies in the group therapy literature have used therapeutic alliance to represent the relationship between the individual member and the group facilitator(s) (Alldredge et al., 2021). This is a limitation in the existing literature; it does not provide a clear picture of therapeutic alliance as it does not address the multiple levels of relationships inherent in group therapy. A strength of the present study is that we explored clients' experiences of the therapeutic alliance at all three levels. Finally, another strength is that we were able to integrate the voices of youth and family clients from

multiple community service settings (i.e., mental health centres, addictions treatment centres) in order to inform best practices, which yielded broader findings than relying on one perspective.

Regarding the study's limitations, the unique context in which data for the study were collected limits the generalizability of the current findings. In particular, the context of the COVID-19 pandemic might have exacerbated some of the difficulties described by participants in forming therapeutic relationships in virtual groups. The general lack of in-person connection available during this time period may have been a challenge that heightened clients' desire for face-to-face contact that they would have experienced in an in-person group. Another limitation of the study is not getting concrete indicators of ruptures/repairs such as reviewing transcripts, or in-session observations, which track the client's moment-to-moment experience in a session (Norcross & Lambert, 2018). Relying on participants' retroactive accounts of rupture and repairs is a limitation, as participants' memory of past ruptures/repairs may not be reliable. Clients may have trouble remembering the actions taken by the therapist to resolve the rupture if they left the session in a state of anger or dissociation. Participants may also minimize the occurrence of ruptures and be reluctant to discuss them (Kortz, 2017). In addition, clients may not be able to detect ruptures, especially low-intensity ruptures that were not perceived to be as significant or did not include moments of intense negative affect (Coutinho et al., 2014). However, we attempted to mitigate this limitation in this study by explaining to participants that ruptures are common, and that oftentimes these are not serious concerns; they may be small issues, but we are still interested in hearing about them.

Another possible limitation in the study is that we did not explicitly ask participants to disclose their age (as long as they met the inclusion criteria of being at least 12 years old at the time of the interview). Although this was not the main focus of the study, not being able to identify participants' ages was a limitation as it was not possible to see patterns in comparing older youths and younger youths' experiences. It is possible that had we asked for participants to disclose their age, younger youths may have reported different perspectives on the therapeutic alliance and rupture and repair process than older youths due to differences in developmental stage and ability to articulate their experiences or to be aware of the nuances of the therapeutic alliance. Additionally, younger parents and older parents may report different experiences of the therapeutic alliance and rupture and repair process.

Age is an important identifier as this information is used in data analysis and would have been helpful in responding to the research question on youth versus parent perspectives in the current study. Therefore, future research in this area should ask participants to disclose their age, including parent ages, to identify differences in experiences in the different age groups. Participants could be asked to disclose their age or to categorize their age into one of several ranges, such as 12-16, 16-24, 25-34, 35-44, etc. Knowing participant ages in the current study would have allowed me to more accurately describe my study participants, to outline which groups are represented (or not) in the sample, and to document demographic diversity in perspectives or experiences related to the topic of study.

Conclusion

The COVID-19 pandemic prompted social distancing measures across Ontario, which resulted in mental health and addictions agencies shifting their service delivery. Thus, in-person services were adapted to virtual services in order to support clients' mental health needs during a time of distress, uncertainty, and social isolation. This was one of the first studies that explored clients' experiences of the therapeutic alliance and rupture and repair in virtual group therapy. It is important to hear the experiences of clients participating in virtual groups, as their voices will inform the development of a hybrid service delivery model going forward in a post-pandemic world.

Given that some clients strongly preferred virtual groups for various reasons (i.e., clients managing social anxiety, or clients for whom transportation or childcare needs were a barrier to attending in-person services), and other clients strongly preferred in-person services (i.e., clients craving small talk interactions before, during, and after group), it is recommended that agencies that have the capacity to, offer both in-person and virtual groups. Counsellors can then assign potential clients to these group formats based on a discussion with the client about the client's needs and goals going into the group. Swift et al. (2018) conducted a meta-analysis of 53 studies and over 16,000 clients and found that preference accommodation was associated with fewer treatment dropouts (OR = 1.79) and more positive treatment outcomes (d = 0.28) than providing clients with a nonpreferred psychotherapy condition. In addition, research has found that preference accommodation works across clients and treatment types (Swift et al., 2013). Based on Swift et al.'s (2018) meta-analytic results, the researchers suggest that therapists should seek

to accommodate client preferences in psychotherapy, especially when strong preferences exist. Thus, counsellors may find it easier to form a therapeutic alliance with clients who had the option of choosing their preferred therapy format; they may find that ruptures can occur due to clients feeling frustration around their preferred format being unavailable.

The present study highlights clients' experiences of the challenges and complexity of forming therapeutic relationships and resolving ruptures in a virtual group environment. Participants struggled with issues that do not exist in an in-person group context, such as group members' video lagging, internet connection cutting out, and reduced eye contact and body language cues, which limited participants' ability to deepen emotional bonds in the group. However, adding in the video and audio cues to the group allowed the participants to feel an increased level of connection, which likely increased the level of support in the virtual group setting. Thus, clients were nonetheless able to develop therapeutic relationships and to take part in resolving therapeutic ruptures that occurred in group, which is consistent with Walther's (1992, 2011) SIP theory stating that individuals are able to develop connection and relationships, regardless of the medium of interaction.

Overall, comments from the virtual group participants suggest that despite any concerns, the format allowed them the opportunity to participate in a group they might not have otherwise been able to. A skilled group facilitator was necessary in order to encourage group cohesion, provide a safe space, and to initiate therapeutic repairs. Facilitators promoted a sense of comfort, safety, and openness among clients through the use of strategies such as encouraging visibility on camera, encouraging therapeutic member-to-member interactions, listening to clients' concerns regarding ruptures, addressing ruptures in the here-and-now, and involving clients' input in rupture repairs, all of which promoted therapeutic relationships to flourish. Based on participants' experiences in this study, it appears that creating this alliance in virtual therapy groups is possible, although it may take more time to develop and manifest differently (i.e., be perceived to not be as strong as) alliance in F2F groups.

To conclude, it is clear that ruptures in group therapy are complex, because there is less control over outcomes when multiple clients are involved. Even if a rupture is well-handled by the therapist, there is a risk that it may happen again. For instance, participants spoke about feeling irritated and disengaging due to some group members taking too long to share, and

turning this into a habit. Given that participants believed the onus is mostly on the facilitators to address these instances and to initiate repairs, it is important for clinicians to pay attention to each member's therapeutic alliance and actively attempt to develop and maintain alliance, as well as repair ruptures as they occur. Overall, in exploring clients' experiences of the therapeutic alliance and rupture/repair in virtual delivery of group therapy, the present study suggests that the unique challenges involved in virtual group therapy are not a deterrent to the implementation of virtual groups for addressing the mental health needs of Canadian youth and families.

Funding

This project was supported by an Ontario Graduate Scholarship (2020-2021) as well as a CGS-M award from SSHRC (Social Sciences and Humanities Research Council) (2021-2022).

References

Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting the therapeutic alliance. *Clinical Psychology Review*, *23*(1), 1–33. https://doi.org/10.1016/S0272-7358(02)00146-0

Alldredge, C. T., Burlingame, G. M., Yang, C., & Rosendahl, J. (2021). Alliance in group therapy: A meta-analysis. *Group Dynamics, 25*(1), 13–28. https://doi.org/10.1037/gdn0000135

Arrow, K., Yap, K., & Chester, A. (2021). Group climate in online group cognitive behaviour therapy predicts treatment outcomes. *Clinical Psychologist, 25*(2), 153-163. https://doi.org/10.1080/13284207.2020.1829944

Bachelor, A. (2013). Clients' and therapists' views of the therapeutic alliance: Similarities, differences and relationship to therapy outcome. *Clinical Psychology and Psychotherapy*, *20*(2), 118–135. https://doi.org/10.1002/cpp.792

Banbury, A., Nancarrow, S., Dart, J., Gray, L., & Parkinson, L. (2018). Telehealth interventions delivering home-based support group videoconferencing: Systematic review. *Journal of Medical Internet Research, 20*(2), e25–e25. https://doi.org/10.2196/jmir.8090

Barak, A., Hen, L., Boniel-Nissim, M., & Shapira, N. (2008). A comprehensive review and a meta-analysis of the effectiveness of internet-based psychotherapeutic interventions. *Journal of Technology in Human Services*, *26*(2-4), 109–160. https://doi.org/10.1080/15228830802094429

Batastini, A. B., & Morgan, R. D. (2016). Connecting the disconnected: Preliminary results and lessons learned from a telepsychology initiative with special management inmates. *Psychological Services*, *13*(3), 283–291. https://doi.org/10.1037/ser0000078

Békés, V., & Aafjes-van Doorn, K. (2020). Psychotherapists' attitudes toward online therapy during the COVID-19 pandemic. *Journal of Psychotherapy Integration, 30*(2), 238–247. http://dx.doi.org/10 .1037/int0000214

Berger, T. (2017). The therapeutic alliance in internet interventions: A narrative review and suggestions for future research. *Psychotherapy Research*, *27*(5), 511–524. https://doi.org/10.1080/10503307.2015.1119908

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy (Chicago, Ill.)*, *16*(3), 252–260. https://doi.org/10.1037/h0085885

Bordin, E. S. (1994). Theory and research on the therapeutic working alliance: New directions. In A. O. Horvath & L. S. Greenberg (Eds*.), The working alliance: Theory, research and practice* (pp. 13–37). Wiley.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Burgess-Allen, J., & Owen-Smith, V. (2010). Using mind mapping techniques for rapid qualitative data analysis in public participation processes. *Health Expectations: An International Journal of Public Participation in Health Care and Health Policy*, *13*(4), 406–415. https://doi.org/10.1111/j.1369-7625.2010.00594.x

Burlingame, G. M., McClendon, D. T., & Alonso, J. (2011). Cohesion in group therapy. *Psychotherapy, 48,* 34–42. http://dx.doi.org/10.1037/a0022063

Chapman, C. L., Burlingame, G. M., Gleave, R., Rees, F., Beecher, M., & Porter, G. S. (2012). Clinical prediction in group psychotherapy. *Psychotherapy Research, 22,* 673– 681. http://dx.doi.org/10.1080/10503307.2012 .702512

Cipolletta, S., Frassoni, E., & Faccio, E. (2018). Construing a therapeutic relationship online: An analysis of videoconference sessions. *Clinical Psychologist (Australian Psychological Society), 22*(2), 220–229. https://doi.org/10.1111/cp.12117

Colli, A., & Lingiardi, V. (2009). The Collaborative Interactions Scale: A new transcript-based method for the assessment of therapeutic alliance ruptures and resolutions in psychotherapy. *Psychotherapy Research*, *19*(6), 718–734. https://doi.org/10.1080/10503300903121098

Comer, J. S., Furr, J. M., Kerns, C. E., Miguel, E., Coxe, S., Elkins, R. M., Carpenter, A. L., Cornacchio, D., Cooper-Vince, C. E., DeSerisy, M., Chou, T., Sanchez, A. L., Khanna, M., Franklin, M. E., Garcia, A. M., & Freeman, J. B. (2017). Internet-delivered, family-based treatment for early-onset OCD: A pilot randomized trial. *Journal of Consulting and Clinical Psychology, 85*(2), 178–186. https://doi.org/10.1037/ccp0000155

Cook, J. E., & Doyle, C. (2002). Working alliance in online therapy as compared to face-to-face therapy: Preliminary results. *CyberPsychology & Behavior, 5*(2), 95–105. https://doi.org/10.1089/109493102753770480

Coutinho, J., Ribeiro, E., Hill, C., & Safran, J. (2011). Therapists' and clients' experiences of alliance ruptures: A qualitative study. *Psychotherapy Research, 21*(5), 525-16. https://doi.org/10.1080/10503307.2011.587469

Coutinho, J., Ribeiro, E., Sousa, I., & Safran, J. D. (2014). Comparing two methods of identifying alliance rupture events. *Psychotherapy (Chicago, Ill.), 51*(3), 434–442. https://doi.org/10.1037/a0032171

Culnan, M. J., & Markus, M. L. (1987). Information technologies. In F. M. Jablin, L. L. Putnam, K.H. Roberts, & L. W. Porter (Eds.), *Handbook of organizational communication: An interdisciplinary perspective* (pp. 420–443). Sage.

de Haan, A. M., Boon, A. E., de Jong, J. T. V. M., Hoeve, M., & Vermeiren, R. R. J. M. (2013). A meta-analytic review on treatment dropout in child and adolescent outpatient mental health care. *Clinical Psychology Review*, *33*(5), 698–711. https://doi.org/10.1016/j.cpr.2013.04.005

Dhariwal, A., Dueck, R., Gillis, R., Macallum, C., McConnell, M., Rathgeber, M., Sinclair, S., Vo, D., & Vogels, S. (2021). *Best practices for virtual group therapy.* BC Children's Hospital. http://www.bcchildrens.ca/mental-health-services-site/Documents/Best_Practices_For_Virtual_Group_Therapy_January_2021.pdf

Dolev-Amit, T., Leibovich, L., & Zilcha-Mano, S. (2021). Repairing alliance ruptures using supportive techniques in telepsychotherapy during the COVID-19 pandemic. *Counselling*

Psychology Quarterly, *34*(3-4), 485–498. https://doi.org/10.1080/09515070.2020.1777089

Donovan, C. L., & March, S. (2014). Online CBT for preschool anxiety disorders: A randomised control trial. *Behaviour Research and Therapy, 58*, 24–35. https://doi.org/10.1016/j.brat.2014.05.001

Doran, J. M. (2016). The working alliance: Where have we been, where are we going? *Psychotherapy Research*, *26*(2), 146–163. https://doi.org/10.1080/10503307.2014.954153

Duncan, B. L., & Miller, S. D. (2007). *The Group Session Rating Scale*, Author.

Dunn, K. (2012). A qualitative investigation into the online counselling relationship: To meet or not to meet, that is the question. *Counselling and Psychotherapy Research, 12*(4), 316–326. https://doi.org/10.1080/14733145.2012.669772

Eppler, M. J. (2006). A comparison between concept maps, mind maps, conceptual diagrams, and visual metaphors as complementary tools for knowledge construction and sharing. *Information Visualization, 5*(3), 202–210. https://doi.org/10.1057/palgrave.ivs.9500131

Eubanks, C. F., Lubitz, J., Muran, J. C., & Safran, J. D. (2019). Rupture Resolution Rating System (3RS): Development and validation. *Psychotherapy Research*, *29*(3), 306–319. https://doi.org/10.1080/10503307.2018.1552034

Eubanks, C. F., Muran, J. C., & Safran, J. D. (2015). *Rupture Resolution Rating System (3RS): Manual.* Mount Sinai-Beth Israel Medical Center. http://dx.doi.org/10.13140/2.1.1666.8488

Eubanks, C. F., Muran, J. C., Safran, J. D., Hilsenroth, M. J., Lambert, M. J., & Norcross, J. C. (2018). Alliance rupture repair: A meta-analysis. *Psychotherapy (Chicago, Ill.)*, *55*(4), 508–519. https://doi.org/10.1037/pst0000185

Eubanks-Carter, C., Muran, J. C., & Safran, J. D. (2010). Alliance ruptures and resolution. In J. C. Muran & J. P. Barber (Eds.), *The therapeutic alliance: An evidence-based guide to practice* (pp. 74–94). The Guilford Press.

Frueh, B. C., Monnier, J., Yim, E., Grubaugh, A. L., Hamner, M. B., & Knapp, R. G. (2007). A randomized trial of telepsychiatry for post-traumatic stress disorder. *Journal of Telemedicine and Telecare*, *13*(3), 142–147. https://doi.org/10.1258/135763307780677604

Garceau, C., Chyurlia, L., Baldwin, D., Boritz, T., Hewitt, P. L., Kealy, D., Söchting, I., Mikail, S. F., & Tasca, G. A. (2021). Applying the Rupture Resolution Rating System (3RS) to group therapy: An evidence-based case study. *Group Dynamics, 25*(1), 89–105. https://doi.org/10.1037/gdn0000137

Gentry, M. T., Lapid, M. I., Clark, M. M., & Rummans, T. A. (2019). Evidence for telehealth group-based treatment: A systematic review. *Journal of Telemedicine and Telecare, 25*(6), 327–342. https://doi.org/10.1177/1357633X18775855

Gibson, K., & Cartwright, C. (2014). Young people's experiences of mobile phone text counselling: Balancing connection and control. *Children and Youth Services Review, 43,* 96–104. https://doi.org/10.1016/j.childyouth.2014.05.010

Golden, B. R, & Robbins, S. B. (1990). The working alliance within time-limited therapy: A case analysis. *Professional Psychology, Research and Practice*, *21*(6), 476–481. https://doi.org/10.1037/0735-7028.21.6.476

Greene, C. J., Morland, L. A., Macdonald, A., Frueh, B. C., Grubbs, K. M., & Rosen, C. S. (2010). How does tele-mental health affect group therapy process? Secondary analysis of a noninferiority trial. *Journal of Consulting and Clinical Psychology, 78*(5), 746–750. https://doi.org/10.1037/a0020158

Grondin, F., Lomanowska, A. M., & Jackson, P. L. (2019). Empathy in computer-mediated interactions: A conceptual framework for research and clinical practice. *Clinical Psychology: Science and Practice, 26*(4), 17. http://dx.doi.org/10.1111/cpsp.12298

Hanley, T. (2012). Understanding the online therapeutic alliance through the eyes of adolescent service users. *Counselling and Psychotherapy Research, 12*(1), 35–43. https://doi.org/10.1080/14733145.2011.560273

Hawley, K. M., & Garland, A. F. (2008). Working alliance in adolescent outpatient therapy: Youth, parent and therapist reports and associations with therapy outcomes. *Child & Youth Care Forum*, *37*(2), 59–74. https://doi.org/10.1007/s10566-008-9050-x

Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy, 48*(1), 9–16. https://doi.org/10.1037/a0022186

Johnson, J. E., Burlingame, G. M., Olsen, J. A., Davies, D. R., & Gleave, R. L. (2005). Group climate, cohesion, alliance, and empathy in group psychotherapy: Multilevel structural equation models. *Journal of Counseling Psychology, 52*(3), 310–321. https://doi.org/10.1037/0022-0167.52.3.310

Kazdin, A. E., Whitley, M., & Marciano, P. L. (2006). Child-therapist and parent-therapist alliance and therapeutic change in the treatment of children referred for oppositional, aggressive, and antisocial behavior. *Journal of Child Psychology and Psychiatry*, *47*(5), 436–445. https://doi.org/10.1111/j.1469-7610.2005.01475.x

Khanna, A., & Jones, G. B. (2021). Envisioning post-pandemic digital neurological, psychiatric and mental health care. *Frontiers in Digital Health, 3,* 803315–803315. https://doi.org/10.3389/fdgth.2021.803315

Khatri, N., Marziali, E., Tchernikov, I., & Shepherd, N. (2014). Comparing telehealth-based and clinic-based group cognitive behavioral therapy for adults with depression and anxiety: A pilot study. *Clinical Interventions in Aging*, *9*, 765–770. https://doi.org/10.2147/CIA.S57832

Kivlighan, D. M., Lo Coco, G., & Gullo, S. (2015). Is there a group effect? It depends on how you ask the question: Intraclass correlations for California Psychotherapy Alliance Scale-Group items. *Journal of Counseling Psychology, 62*(1), 73–78. https://doi.org/10.1037/cou0000046

Kivlighan, D. M., Lo Coco, G., Oieni, V., Gullo, S., Pazzagli, C., & Mazzeschi, C. (2017). All bonds are not the same: A response surface analysis of the perceptions of positive bonding relationships in therapy groups. *Group Dynamics*, *21*(3), 159–177. https://doi.org/10.1037/gdn0000071

Kivlighan, D. M., London, K., & Miles, J. R. (2012). Are two heads better than one? The relationship between number of group leaders and group members, and group climate and group member benefit from therapy. *Group Dynamics, 16*(1), 1–13. https://doi.org/10.1037/a0026242

Kortz, L. (2017). *Understanding the working alliance and alliance ruptures in online psychotherapy from the therapist's perspective* (Publication No. 10688809) [Doctoral dissertation, University at Albany, State University of New York]. ProQuest Dissertations Publishing.

Kotob, F., Styger, L., & Richardson, L. P. (2016). Exploring mind mapping techniques to analyse complex case study data. *Faculty of Business - Papers (Archive)*. 958. https://ro.uow.edu.au/buspapers/958

Kozlowski, K. A., & Holmes, C. M. (2014). Experiences in online process groups: A qualitative study. *The Journal for Specialists in Group Work, 39*(4), 276–300. https://doi.org/10.1080/01933922.2014.948235

Krogel, J., Burlingame, G., Chapman, C., Renshaw, T., Gleave, R., Beecher, M., & MacNair-Semands, R. (2013). The Group Questionnaire: A clinical and empirically derived measure of group relationship. *Psychotherapy Research*, *23*(3), 344–354. https://doi.org/10.1080/10503307.2012.729868

Lingiardi, V., & Colli, A. (2015). Therapeutic alliance and alliance ruptures and resolutions: Theoretical definitions, assessment issues, and research findings. In O. C. G. Gelo, A. Pritz, & B. Rieken (Eds.), *Psychotherapy research: Foundations, process, and outcome* (pp. 311–329). Springer Vienna. https://doi.org/10.1007/978-3-7091-1382-0_16

Lo Coco, G., Tasca, G. A., Hewitt, P. L., Mikail, S. F., & Kivlighan, D. M., Jr. (2019). Ruptures and repairs of group therapy alliance. An untold story in psychotherapy research. *Research in Psychotherapy (Milano).*, *22*(1), 352–352. https://doi.org/10.4081/ripppo.2019.352

Lopez, A., Rothberg, B., Reaser, E., Schwenk, S., & Griffin, R. (2020). Therapeutic groups via video teleconferencing and the impact on group cohesion. *mHealth, 6*, 13–13. https://doi.org/10.21037/mhealth.2019.11.04

Lorentzen, S., Sexton, H. C., & Høglend, P. (2004). Therapeutic alliance, cohesion and outcome in a long-term analytic group. A preliminary study. *Nordic Journal of Psychiatry*, *58*(1), 33–40. https://doi.org/10.1080/08039480310000770

Marmarosh, C. L. (2021a). Ruptures and repairs in group psychotherapy: From theory to practice. *International Journal of Group Psychotherapy*, *71*(2), 205–223. https://doi.org/10.1080/00207284.2020.1855893

Marmarosh, C. L. (2021b). Ruptures and repairs in group psychotherapy: Introduction to the special issue. *Group Dynamics*, *25*(1), 1–12. https://doi.org/10.1037/gdn0000150

McGill, B. C., Sansom-Daly, U. M., Wakefield, C. E., Ellis, S. J., Robertson, E. G., & Cohn, R. J. (2017). Therapeutic alliance and group cohesion in an online support program for adolescent and young adult cancer survivors: Lessons from “Recapture Life”. *Journal of Adolescent and Young Adult Oncology, 6*(4), 568-572. https://doi.org/10.1089/jayao.2017.0001

McMillan, L. J., McCarthy, M. C., Muscara, F., Anderson, V. A., Walser, R. D., O’Neill, J., Dimovski, A., Rayner, M., Nicholson, J. M., Hearps, S. J. C., Read, P. A., Morrison, E., McCabe, K., & Williams, K. (2022). Feasibility and acceptability of an online acceptance and commitment therapy group for parents caring for a child with cerebral palsy. *Journal of Family Studies*, *28*(4), 1338–1354. https://doi.org/10.1080/13229400.2020.1822198

Miller-Bottome, M., Talia, A., Safran, J. D., & Muran, J. C. (2018). Resolving alliance ruptures from an attachment-informed perspective. *Psychoanalytic Psychology*, *35*(2), 175–183. https://doi.org/10.1037/pap0000152

Morland, L. A., Greene, C. J., Rosen, C. S., Foy, D., Reilly, P., Shore J., He, Q., & Frueh, C. (2010). Telemedicine for anger management therapy in a rural population of combat veterans with posttraumatic stress disorder: A randomized noninferiority trial. *The Journal of Clinical Psychiatry*, *71*(7), 855–863. https://doi.org/10.4088/JCP.09m05604blu

Morland, L. A., Mackintosh, M.-A., Greene, C. J., Rosen, C. S., Chard, K. M., Resick, P., & Frueh, B. C. (2014). Cognitive processing therapy for posttraumatic stress disorder delivered to rural veterans via telemental health: A randomized noninferiority clinical trial. *The Journal of Clinical Psychiatry, 75*(5), 470–476. https://doi.org/10.4088/JCP.13m08842

Muran, J. C., Safran, J. D., Gorman, B. S., Samstag, L. W., Eubanks-Carter, C., & Winston, A. (2009). The relationship of early alliance ruptures and their resolution to process and outcome in three time-limited psychotherapies for personality disorders. *Psychotherapy: Theory, Research, Practice, Training, 46*(2), 233. https://doi.org/10.1037/a0016085

Norcross, J. C., & Lambert, M. J. (2018). Psychotherapy relationships that work III. *Psychotherapy (Chicago, Ill.)*, *55*(4), 303–315. https://doi.org/10.1037/pst0000193

Norton, P. J., & Kazantzis, N. (2016). Dynamic relationships of therapist alliance and group cohesion in transdiagnostic group CBT for anxiety disorders. *Journal of Consulting and Clinical Psychology, 84*(2), 146–155. https://doi.org/10.1037/ccp0000062

O'Keeffe, S., Martin, P., & Midgley, N. (2020). When adolescents stop psychological therapy: Rupture-repair in the therapeutic alliance and association with therapy ending. *Psychotherapy (Chicago, Ill.)*, *57*(4), 471–490. https://doi.org/10.1037/pst0000279

Patton, M. Q. (1990). *Qualitative evaluation and research methods* (2nd ed.). Sage Publications.

Payne, L., Flannery, H., Kambakara Gedara, C., Daniilidi, X., Hitchcock, M., Lambert, D., Taylor, C., & Christie, D. (2020). Business as usual? Psychological support at a distance. *Clinical Child Psychology and Psychiatry, 25*(3), 672–686. https://doi.org/10.1177/1359104520937378

Pietrabissa, G., & Simpson, S. G. (2020). Psychological consequences of social isolation during COVID-19 outbreak. *Frontiers in Psychology, 11,* 2201. https://doi.org/10.3389/fpsyg.2020.02201

Quirk, K., Miller, S., Duncan, B., & Owen, J. (2013). Group Session Rating Scale: Preliminary psychometrics in substance abuse group interventions. *Counselling and Psychotherapy Research, 13*(3), 194-200. https://doi.org/10.1080/14733145.2012.744425

Rutan, J. S. (2021). Rupture and repair: Using leader errors in psychodynamic group psychotherapy. *International Journal of Group Psychotherapy*, *71*(2), 310–331. https://doi.org/10.1080/00207284.2020.1808471

Safran, J. D, & Muran, J. C. (2000a). *Negotiating the therapeutic alliance: A relational treatment guide.* Guilford Press.

Safran, J. D., & Muran, J. C. (2000b). Resolving therapeutic alliance ruptures: Diversity and integration. *Journal of Clinical Psychology*, *4*(4), 233–243. https://doi.org/10.1002/(SICI)1097-4679(200002)56:2<233::AID-JCLP9>3.0.CO;2-3

Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. *Psychotherapy (Chicago, Ill.)*, *48*(1), 80–87. https://doi.org/10.1037/a0022140

Shirk, S. R., Caporino, N. E., & Karver, M. S. (2010). The alliance in adolescent therapy: Conceptual, operational, and predictive issues. In *Elusive Alliance* (pp. 59–93). American Psychological Association. https://doi.org/10.1037/12139-002

Sibley, M. H., Comer, J. S., & Gonzalez, J. (2017). Delivering parent-teen therapy for ADHD through videoconferencing: A preliminary investigation. *Journal of Psychopathology and Behavioral Assessment, 39*(3), 467–485. https://doi.org/10.1007/s10862-017-9598-6

Simpson, S., Richardson, L., Pietrabissa, G., Castelnuovo, G., & Reid, C. (2021). Videotherapy and therapeutic alliance in the age of COVID-19. *Clinical Psychology & Psychotherapy, 28*(2), 409–421. https://doi.org/10.1002/cpp.2521

Sucala, M., Schnur, J. B., Brackman, E. H., Constantino, M. J., & Montgomery, G. H. (2013). Clinicians' attitudes toward therapeutic alliance in eTherapy. *Journal of General Psychology, 140*(4), 282– 293. https://doi.org/10.1080/00221309.2013.830590

Sumner, E. M., & Ramirez, A., Jr. (2017). Social information processing theory and hyperpersonal perspective. In P. Rössler, C.A. Hoffner & L. Zoonen (Eds.), *The International Encyclopedia of Media Effects* (pp. 1-11). Wiley. http://dx.doi.org/10.1002/9781118783764.wbieme0090

Swift, J. K., Callahan, J. L., Cooper, M., & Parkin, S. R. (2018). The impact of accommodating client preference in psychotherapy: A meta-analysis. *Journal of Clinical Psychology, 74*(11), 1924-1937. https://doi.org/10.1002/jclp.22680

Swift, J. K., Callahan, J. L., Ivanovic, M., & Kominiak, N. (2013). Further examination of the psychotherapy preference effect: A meta-regression analysis. *Journal of Psychotherapy Integration, 23*(2), 134–145. https://doi.org/10.1037/a0031423

Tasca, G. A., Compare, A., Zarbo, C., & Brugnera, A. (2016). Therapeutic alliance and binge-eating outcomes in a group therapy context. *Journal of Counseling Psychology*, *63*(4), 443–451. https://doi.org/10.1037/cou0000159

Terry, G., & Hayfield, N. (2021). *Essentials of thematic analysis*. American Psychological Association.

Tryon, G. S., Collins Blackwell, S. C., & Hammel, E. F. (2007). A meta-analytic examination of client-therapist perspectives of the working alliance. *Psychotherapy Research, 17*(6), 629–642. https://doi.org/10.1080/10503300701320611

Vigerland, S., Lenhard, F., Bonnert, M., Lalouni, M., Hedman, E., Ahlen, J., Olén, O., Serlachius, E., & Ljótsson, B. (2016). Internet-delivered cognitive behavior therapy for

children and adolescents: A systematic review and meta-analysis. *Clinical Psychology Review, 50*, 1-10. http://dx.doi.org.proxy.bib.uottawa.ca/10.1016/j.cpr.2016.09.005

Wade, S. L., Gies, L. M., Fisher, A. P., Moscato, E. L., Adlam, A. R., Bardoni, A., Corti, C., Limond, J., Modi, A. C., & Williams, T. (2020). Telepsychotherapy with children and families: Lessons gleaned from two decades of translational research. *Journal of Psychotherapy Integration*, *30*(2), 332–347. https://doi.org/10.1037/int0000215

Walther, J. B. (1992). Interpersonal effects in computer-mediated interaction: A relational perspective. *Communication Research, 19*(1), 52-90. http://dx.doi.org/10.1177/009365092019001003

Walther, J. B. (1996). Computer-mediated communication: Impersonal, interpersonal, and hyperpersonal interaction. *Communication Research*, *23*(1), 3–43. https://doi.org/10.1177/009365096023001001

Walther, J. B. (2011). Theories of computer-mediated communication and interpersonal relations. In M. L. Knapp & J. A. Daly (Eds.), *The Handbook of Interpersonal Communication* (4th ed., pp. 443–479). Sage.

Weinberg, H. (2020a). Online group psychotherapy: Challenges and possibilities during COVID-19—A practice review. *Group Dynamics: Theory, Research, and Practice, 24*(3), 201-211. http://dx.doi.org/10.1037/gdn0000140

Weinberg, H. (2020b). Online group therapy: In search of a new theory? In H. Weinberg, & A. Rolnick (Eds.), *Theory and practice of online therapy: Internet-delivered interventions for individuals, groups, families, and organizations* (pp. 174–187). Routledge.

Yalom, I., & Leszcz, M. (2020). *The theory and practice of group psychotherapy* (6th ed., pp. 53–76). Basic Books.

Zack, S. E., Castonguay, L. G., & Boswell, J. F. (2007). Youth working alliance: A core clinical construct in need of empirical maturity. *Harvard Review of Psychiatry*, *15*(6), 278–288. https://doi.org/10.1080/10673220701803867

Appendix A

REB Certificate

24/02/2023

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

CERTIFICAT D'APPROBATION ÉTHIQUE | CERTIFICATE OF ETHICS APPROVAL

Numéro du dossier / Ethics File Number	S-02-23-9053
Titre du projet / Project Title	Therapeutic Alliance and Clients' Experiences of Ruptures and Repairs in Virtual Group Therapy
Type de projet / Project Type	Thèse de maîtrise / Master's thesis
Statut du projet / Project Status	Approuvé / Approved
Date d'approbation (jj/mm/aaaa) / Approval Date (dd/mm/yyyy)	24/02/2023
Date d'expiration (jj/mm/aaaa) / Expiry Date (dd/mm/yyyy)	23/02/2024

Équipe de recherche / Research Team

Chercheur / Researcher	Affiliation	Role
Angelica KIBETS	Faculté d'éducation / Faculty of Education	Chercheur Principal / Principal Investigator
David SMITH	Faculté d'éducation / Faculty of Education	Superviseur / Supervisor

Conditions spéciales ou commentaires / Special conditions or comments

550, rue Cumberland, pièce 154
Ottawa (Ontario) K1N 6N5 Canada

550 Cumberland Street, Room 154
Ottawa, Ontario K1N 6N5 Canada

613-562-5387 • 613-562-5338 • ethique@uOttawa.ca / ethics@uOttawa.ca
www.recherche.uottawa.ca/deontologie | www.recherche.uottawa.ca/ethics

Appendix B

Social Media Recruitment Posters

Appendix C

Recruitment Email to Agencies

Hello [CONTACT AT PARTNERING AGENCY],

I hope this email finds you well. I am writing because I am part of a community-university research collaboration, and we are very interested in hearing from youth and parent clients of mental health/addictions agencies in the local community about their experiences participating in virtual group services offered by agencies like yours.

I would be very appreciative if you could help us to share the information about our study to your agency clients through your social media feeds. Participants in the study will receive a $25.00 Amazon gift card for participating in a 30-minute individual interview. Their contribution to the study will help to advance our understanding of how clients experience virtual group-based services, ultimately benefiting the clients and the agencies like yours that serve them.

I'd be happy to answer any questions that you or your clients have related to participating in this research project.

Many thanks,

Prof. David Smith, PhD, CPsych

Email: David.Smith@uottawa.ca

Appendix D

Additional Information Email

If they contact for additional information, we will send the following text:

If they contact to schedule an interview, we will send the consent form.

French version will follow

Additional information text:

My name is Dr. David Smith, and my colleagues and I are working with agencies who provide mental health and addiction services to youth and families in the community. We are interested in hearing the voices of youth and parent clients of these agencies regarding their experiences participating in virtual group services. Participation in this study will consist of a 30-40 minute virtual interview (on Zoom or other similar platform or by phone) with a Research Assistant working on this project. As thanks for taking part, you will receive a $25 Amazon gift card.

During this interview, you will be invited to talk about your experience of using virtual group services. The interview will be audio-recorded so we can accurately capture our discussion. Your participation will help us to better understand if virtual group services are helpful to youth and families and how we can improve these services for future clients. Please note that the interview will be conducted in English or French. To be able to take part you must be 12 years of age or older and have used virtual group services from any of the agencies partnering in this study.

Your decision to take part in this research study will have no impact at all on the services received and/or relationship with any agency. This research study is being conducted independently, and the agencies will not know who takes part.

If you have any questions about the study, please contact me by email at david.smith@uottawa.ca.

Appendix E

Consent Form

Université d'Ottawa
Faculté d'éducation

University of Ottawa
Faculty of Education

Tel/Tél : 613-562-5804
Fax/Téléc :613-562-5144

145, Jean-Jacques Lussier
Ottawa ON K1N 6N5 Canada

www.education.uOttawa.ca

Informed Consent Form

STUDY NAME: Using evidence to connect children, youth, and families to effective in-person, virtual, or blended care

WHO ARE WE AND WHAT ARE WE DOING?

We are mental health and addiction researchers who work in the Faculty of Education and School of Psychology at the University of Ottawa. We are partnering with mental health and addiction agencies in the Ottawa region who provide services to youth and families. This project is funded by an Ontario Centre of Excellence for Child and Youth Mental Health Innovation grant. We are hoping to hear from youth and parent clients at these agencies about their experiences participating in virtual group services.

WHO CAN TAKE PART?

We are looking to speak with youth and parents who have participated virtually in group services offered by a mental health and addiction agency in Ottawa, Ontario. You can take part if you are **12 years** of age or older and have used virtual group services from any of the agencies partnering in this study. We will be recruiting on a "first come, first served" basis, up to a maximum of 15 youth and 15 parent/guardian participants for this research study.

WHAT WILL YOU BE ASKED TO DO?

You will be asked to share your thoughts and feelings about, and experiences with, virtual group-based services in a 30-40 minute conversation with a member of our team. We would ask questions like "Looking back on your experiences participating in virtual groups, what stands out to you most about this experience?" And "What do you think worked well in virtual groups and what could be improved?"

The interview will be conducted by teleconference (Teams or Zoom) or by phone, based on your preference, on a day and time that is best for you. The interview will be audio recorded.

HOW DOES TAKING PART HELP?

Some people enjoy having a voice and sharing their personal experiences and stories. What you share will help us better understand virtual groups so we can

try to improve mental health/addiction services for youth and families.

ARE THERE ANY RISKS TO TAKING PART?

During the conversation you may choose to share some difficult experiences you have had or difficult feelings you have felt. This can be upsetting sometimes. You are welcome to take a break, skip questions, or end the conversation at any time.

DO YOU GET ANYTHING FOR TAKING PART?

Everyone who takes part in the interview will receive a $25 gift card as a small thank you for their time.

WHO WILL KNOW YOU TOOK PART AND WHAT YOU SAID?

We will keep everything you say private. No one from your family, school, or the agencies where you have received services will know you took part. The information you share will only be used for written reports and presentations. We will never use your name, specific location or any other identifying information you provide in any report or presentation. If something you say is used in a report, a fake name or something like “a 12-year old in Ottawa” would be used.

By taking part in a teleconference or telephone interview, someone around you may overhear what you are saying. We suggest choosing a quiet, private place to talk to us so our conversation won’t be overheard by others.

HOW DO WE KEEP YOUR INFORMATION SAFE?

The audio recordings and transcripts (the written version of what you say) will be kept on a password-protected laptop. Transcripts will also be stored securely using encryption and password protection on Microsoft OneDrive. The audio recordings and transcripts of our conversation will be named with a code instead of using your name. Only the researchers who are directly involved in the study will have access to the password protected file that links the code with your name.

HOW LONG DO WE KEEP YOUR INFORMATION?

The information you share along with the audio recordings and transcripts of our conversation will be kept for five years.

CAN YOU CHANGE YOUR MIND ABOUT TAKING PART?

You don’t have to take part if you don’t want to. If you choose to take part, you can skip questions or stop the conversation at any time. You will still receive the $25 gift card if you decide to stop taking part after the interview has started. If you do choose to stop taking part, everything you have shared will be deleted.

QUESTIONS?

If you have any questions about taking part, let us know by getting in touch with the lead researcher, Dr. David Smith [Email: David.Smith@uottawa.ca phone #: 613-562-5800 (ext. 4344)]

If you have any questions about the ethics of this study, you can contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5, Tel.: (613) 562-5387, Email: ethics@uottawa.ca

YOU UNDERSTAND WHAT IS INVOLVED AND WANT TO TAKE PART.

You have read and understood what is involved and agree to take part in the above study led by David Smith of the Faculty of Education at the University of Ottawa. *(Participant will provide verbal consent or write a note indicating agreement in the video chat box once they have reviewed the consent form with the researcher.)*

Participant's name	Date:
Researcher's name	Date:

Please print or save a copy of this consent form for your personal records.

THANK YOU ON BEHALF OF OUR TEAM.

Appendix F

Interview Guide

Contextual Information on Services Received

1. Tell me about the virtual group that you participated in during the past year.
   - the name of the agency that offered the group;
   - the general purpose of the group; the issues the group addressed
   - the duration of the group: how often and for how long were group sessions?
   - How many sessions did you attend in total?
   - Did people join at the beginning and stay through to the end (fixed membership); or did people move in and out of the group, like a drop-in group (open membership)?
   - Was your facilitator a professional (a counsellor or therapist) or a peer (a parent)?

Logistical and Technical Processes Related to Participating in Virtual Group Services

2. How did you learn about this group, and what was the registration process like to get into the group?

3. What platform did you use to access the group, e.g., by telephone, or teleconference (Zoom, Teams)? How did that work for you, e.g., were there any problems around connecting to the group meetings?

4. Were there any technical/logistical/equipment problems that emerged during the group meetings, e.g., using the teleconferencing platform, scheduling sessions, setting up hardware, managing connectivity issues, having an adequate device, adequate space (e.g., private) to participate in group sessions?

Experience of Being a Client

5. How was it for you to stay tuned in and focused during the virtual group meetings?
   - What helped you to maintain your focus?
   - What, if anything, caused you to lose your focus, even momentarily, during sessions?
   - How did these factors impact your experience in the group?

6. What was the experience like for you to be part of this group and to participate in the group discussions?
   - Did you learn things at meetings that were useful to you; were there "take-aways" from group sessions that you could apply to situations outside sessions?
   - Did you notice changes in yourself that were the result of participating in this group?
   - Did you find that participating in the group was sufficient to meet your needs; did you search out any other services to get the help you needed?

The Alliance

(Agreement on goals)

7. You likely came to the group with some personal goals. Do you feel that these goals were met in the group sessions?
    - What role did the group facilitator play in helping you to achieve your goals?
    - What role did the other group members play in helping you to achieve your goals?
    - Did anything happen in the group that got in the way of your meeting your goals?

(Agreement on tasks)

8. What did you think of the activities and the discussion topics in the group session?
    - Did you find them useful; did they help you in achieving your goals?
    - Can you give an example of when the group activity was/was not useful to you?

(Bond)

9. How well do you think the group facilitator understood you and accepted you?
    - Can you give an example of something that happened in the group that showed that the group facilitator understood and accepted you?
    - Did anything happen in the group that made you feel that you were not understood or accepted?

10. How well do you think the other group members understood you and accepted you throughout the group experience? Did you feel like you "belonged" to the group?
    - Can you give an example of something that happened in the group that showed that group members understood and accepted you?
    - Did anything happen in the group that made you feel that you were not understood or accepted?

11. During the sessions, did you feel comfortable and safe to share personal thoughts and feelings?
    - What was it about the group that helped you to feel comfortable and safe to share your personal thoughts and feelings?
    - Did anything in the group or anything about the virtual format make you feel that it was unsafe to share your personal thoughts and feelings?

Ruptures and repairs

(Rupture)

12. Did you ever feel tension or feel upset, even a little bit, in a group session?
    - What happened in the group that made you feel this way?
    - What did you do when this happened?
    - What thoughts and feelings did the incident evoke in you?

(Repair)

13. Were the incidents that created the tension/upset addressed by the facilitator or by the group members?

- What did they do to address the issue?
- Was this helpful to you? Did the steps they took resolve the issue that caused the tension?
- How did the incident affect you and your experience in the group?
- Was there anything else that others should have done at the time but didn't?

14. Before we wrap up the interview, is there anything else you'd like to add about your experience in the virtual group that you found particularly helpful or unhelpful?