

Intensive short-term dynamic psychotherapy (ISTDP) therapists'
experiences of staying with clients' intense emotional experiencing:
An interpretative phenomenological analysis

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A thesis submitted in partial fulfilment of the requirements of the School of
Psychology, University of East London for the degree of Professional Doctorate
in Counselling Psychology

April, 2019

Abstract

This study aimed to explore Intensive Short-Term Dynamic Psychotherapy (ISTDP) therapists' experiences of staying with their clients' intense emotional experiencing. Semi-structured interviews were conducted with five qualified ISTDP therapists. Participants' accounts were analysed using Interpretative Phenomenological Analysis. The analysis generated three superordinate themes: (1) "Opening that door": striving for emotional closeness, (2) Connection versus disconnection: what's happening in the room, and (3) "There's more of myself now": building one's own capacity. These themes were each supported by several subordinate themes that highlight the complexities and ambiguities inherent in intensive, experientially-focused therapeutic work from a psychodynamic perspective. The findings of the study reveal: (1) a paradox of the moment-by-moment precision aimed for by therapists, whereby effectiveness can be accompanied by a heightened focus on what gets missed; (2) how therapists make sense of the therapeutic relationship as a place of safety and risk; and (3) the importance of deliberate practice to help therapists build their capacity to work effectively with their clients' deep emotions. Participants' accounts also suggested that core features of the theory and practice of ISTDP, such as its analytic stance and active, collaborative style, aligns well with counselling psychology's concern for integrative, evidenced-based practice that prioritises the therapeutic relationship as the vehicle for change. Applicability to clinical practice in counselling psychology is highlighted. Future directions include research into the somatic experiences of therapists involved in helping facilitate a therapeutic experience of emotion with their clients.

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Abbreviations

ACT	Acceptance and Commitment Therapy
BPS	British Psychological Society
CBT	Cognitive Behavioural Therapy
CFT	Compassion Focused Therapy
EDT	Experiential Dynamic Therapy
HCPC	Health Care Professions Council
IPA	Interpretative Phenomenological Analysis
ISTDP	Intensive Short-Term Dynamic Psychotherapy
NICE	The National Institute for Health and Care Excellence
STDP	Short-Term Dynamic Psychotherapy

Acknowledgements

I would like to express my sincere thanks to my supervisors Dr Melanie Spragg and Dr Stelios Gkouskos for their encouragement and support with this project and throughout the programme. I would also like to thank Dr Lisa Fellin for inspiration and induction to the complexities and delights of doctoral research in counselling psychology. Thanks also to Dr Lymarie Rodriguez-Morales for her methodological support and for her dedication to helping me accomplish this research. I am grateful for the support of Dr Sharon Lewis who helped me develop this research idea and reach out to the ISTDP community. I would like to thank my research participants for their courage and generosity in agreeing to take part in this study and for the exceptional glimpse into their therapeutic worlds. I am also very grateful for the support of my fellow trainees for their good humour and steadfast companionship throughout the research and training process. I am grateful for the input of my viva examination team, Dr Catherine Athanasiadou-Lewis and Dr Jeeda Alhakim, for insights that greatly boosted the quality of my final submission, and to Dr Claire Marshall for her role as Chair and for support across the programme. My dear friend Professor Walid Saleh has been my touchstone and guardian angel, always there for me, and so I dedicate this research to him. Doctoral research is a privilege for the researcher that involves frequent sacrifices for those around them: a wholehearted thank you to my mother and family and friends for their love and care and for the financial support that made this rewarding experience possible.

Chapter One: Introduction

In order to create profound moments of meeting with patients, the therapist must be an emotionally engaged and available presence, capable of intimacy and closeness.... it involves exposing ourselves to our patient's intense feelings and often primitive unconscious material (not to mention our own!). We not only deal with a patient's feelings toward others, but encourage the patient to face, experience, and express [their] intense mixed feelings toward us directly. This requires a great deal of emotional stability on the therapist's part. The capacity to tolerate intimacy and closeness with another, while regulating our own emotions.... (Coughlin, 2017, p. 197)

1.1 Chapter One Overview

This introduction chapter first outlines the aims of the research. Next, I situate this study in a personal context by providing a brief outline of my professional journey that ignited my interest in carrying out a piece of doctoral level research into therapists' experiences of facilitating a therapeutic experience of emotion. I continue by foregrounding my epistemological and ontological position with the aim of introducing its philosophical foundations and my methodological choices, topics that are more fully explored in Chapter Three. This is followed by definitions of key terms of reference: "emotional experiencing", "intensity", and "staying with". The chapter concludes by outlining the relevance of this topic to counselling psychology, and the structure of the rest of the thesis followed by a chapter summary.

1.2 Research Aims

This study is the first of its kind that I know of to investigate therapists' experiences of staying with their clients' intense emotional experiencing. Its primary aim is to examine this phenomenon from the perspective of five Intensive Short-Term Dynamic Psychotherapy (ISTDP) therapists. This therapeutic modality was specifically selected on the basis of its intensive, emotion-focused approach. The research phenomenon is fundamental to ISTDP therapists' practice and therefore can be regarded as a focal point around which narratives of experiences can be described. How these accounts

differ and coincide is valuable in understanding therapists' experiences of the phenomena.

The description of the therapeutic task in the quote that introduced this chapter will likely be familiar to any therapist who values the therapeutic relationship and the therapist's use of self in helping their client overcome relational difficulties (Donati, 2016). My aim is to seek a better understanding of therapists' experiences of a process focused on feelings that are activated in the therapeutic relationship and are due to the therapist's efforts to bond with the client. Research that investigates the lived experience of therapists whose practice is based around the creation of "profound moments of meeting" with their patients is intended to be of use to any therapist who relates to these findings and apply them in their own practice (Kasket, 2017, p.231).

1.3 The Research Origins: A Personal Context

My personal interest in this question is in relation to my position as a trainee Counselling Psychologist. Part of the distinctiveness in the counselling psychologist's professional identity is evidenced in their capacity to work both with content and with interpersonal dynamics, referred to as "process", as they emerge throughout the therapeutic relationship (BPS, 2018a). In the second year of my training, I encountered clinical challenges that were particular to attending to unconscious processes and to the use of self that made staying with the client's deep emotions very challenging. I became interested in learning more on how therapists manage to maintain their focus on the client's emotion in the therapeutic space, however, there was no one study in the counselling and psychotherapy literature that focused on this aspect. As Chapter Two: Literature Review illuminates, the psychotherapy literature does provide examples of studies to related phenomena, such as therapists' experiences of working with countertransference and clinical difficulties. There is also a body of "wisdom" literature from experienced clinicians who highlight the importance of the therapist's capacity to bear their own emotions (Råbu & McLeod, 2016). Yet, based on the comprehensive literature review, there is no study that squarely explores what is like for therapists when they are working to stay with their clients' deep experience of emotion. I had attended an introductory ISTDP training and was motivated by the intensity of this approach

to focusing on clients' emotions and that this was a new modality and approach that was under researched. I had initially been researching third-wave cognitive approaches to emotions-focused work but took seriously the recommendation by Konstantinou (2014) of the need to advance the research knowledge base of the field through engagement with alternative research. ISTDP is one such alternative approach. This topic gave me the opportunity to conduct a critical inquiry by examining the topic of emotions-focused work from a different angle and offering possible alternatives to clinical practice (Feltham, 2010).

1.4 The Positioning of the Researcher

As all research begins with a set of assumptions that are based in philosophical reflection (Willig, 2013) it is important to note how my positioning aligns with the values that are made explicit in counselling psychology research (Kasket, 2012; Lennie & West, 2010). I was motivated to adopt an interpretative phenomenological approach and epistemology (Willig, 2012) for several reasons. Firstly, psychotherapy research and the phenomena it studies are socially constructed and based on the culturally shared values and beliefs that are rooted in a specific community, time and place. From a science-philosophical perspective, we encounter multiple "microworlds" out of which any specific psychotherapeutic body of knowledge becomes conceivable. ISTDP can be considered one such "microworld" of psychotherapy (Greiner, 2015, p. 104) and thus an idiographic approach that aims to illuminate particular aspects of therapists' experiences within their given context is valued and prioritised in this study. Secondly, pluralism is a given of research-based accounts of psychotherapy (McLeod, 2014). Critical reflection on research processes and procedures helps account for the differentiated understandings of the researcher's psychotherapeutic ideas and practices they investigate. By gaining deep insights into the complex phenomena that comprise psychotherapeutic activities, various psychotherapeutic approaches can better dialogue with each other. I have used basic principles and techniques of ISTDP in my clinical practice and position myself as someone who believes this modality has a great deal to offer the counselling and psychotherapy community, and the field of counselling psychology. Thirdly, researchers do not have direct access to participants' accounts of their experience. Any understanding is based on a process of intersubjective meaning-making (Larkin

& Thompson, 2012). It is imperative that I achieve and demonstrate awareness of my actions and motivations through ongoing and reflexive engagement with the key assumptions of research and the phenomena under study (Kasket, 2012). My position is both as an “insider” and “outsider” in the research. On the one side, I am familiar with the basic techniques and theory of ISTDP which means I can easily miss the taken for granted assumptions that other less acquainted researchers might capture. On the other side, it is possible to misunderstand aspects based on what is not known or experienced about the specific and technical ways in which ISTDP is practice and evaluated. This particular tension of my positioning and its impact on the research was managed through a range of reflexivity practices (Kasket, 2013) that are reflected on throughout the thesis.

1.5 Introduction to ISTDP

ISTDP is based on principles of psychodynamic and attachment theory (Abbass, 2015). The therapy's main objective is to help the client in overcoming their internal resistance to experiencing painful or unbearable feelings that are linked to an early attachment trauma. The client's unconscious avoidance of such feelings generates and maintains their distress. The therapist addresses this by engaging the client in innovative processes such as the monitoring of unconscious bodily signals, rapid management of defences, and the somatic experiencing of emotions (Malan & Coughlin Della Selva, 2006). Therefore, the experiencing and processing of emotion is what helps the client heal. Although there is a conscious therapeutic alliance, it is the unconscious therapeutic alliance, an innovative construct of the model, that the therapist builds with the client that reduces their symptoms and relational difficulties (Davanloo, 1987).

In the 1960s, Davanloo, the originator of the model, began recording and reviewing his psychotherapy sessions on video. By studying the verbal and non-verbal responses of his clients, he was able to verify the effectiveness of and develop his interventions. This led to new psychodiagnostic tools for assessing the client's emotional capacity and the precise moment-by-moment interventions to help facilitate a therapeutic experience of emotion. The ISTDP therapists' stance is not neutral yet holds the ground for the health of the client. The intensive aspects and precision of the method arise from the therapist's

attempts to intervene in the client's protective avoidance and harmful behaviours that undermine therapy and prolong suffering, as soon as they arise. Specific techniques are used to motivate the patient, develop a collaborative therapeutic alliance, robustly intervene in defences, foster the direct experiencing of previously warded off feelings, and cultivate a context for intimacy and trust between therapist and client (Coughlin & Katzman, 2013).

ISTDP employs key components that are salient in psychotherapy today, including a high level of emotional engagement, use of video for quality improvement, cognitive restructuring, and a here-and-now focus and evaluation. Extensive research has shown the ISTDP approach is clinically effective for a wide range of disorders, including depression, anxiety and psychosomatic and personality disorders. There are now over 40 published research studies, including randomised control trials, showing the benefits of ISTDP for clients held in long-term follow-up (Abbass, 2016). ISTDP also achieves good outcomes with treatment-resistant and complex populations (see Abbass, 2015, for a list of relevant studies and further information on the evidence base for the model.) See Chapter 2 for further information on the development and practice of ISTDP.

1.6 Terms of Reference: “Emotional Experiencing”, “Intensity” and “Staying With”

1.6.1 Emotional experiencing. Frosh (2011) highlights the definitional knot of “affect”, “feeling” and “emotion”. Definitions of these terms varied according to their varied use in theory, research, and practice, and pertinent usages are further referred to in Chapter Two: Literature Review. In this study, all three terms are used interchangeably. “Experiencing” an emotion means feeling it (Kuhn, 2014). This is in distinction to psychotherapy practice that focuses on feelings by talking about emotions instead of actually experiencing them. In this study, in order to overcome any confusion or ambiguities in meaning, participants were asked to define their understanding of their client's emotional experiencing and also, as discussed next, their understanding of intense emotional experiencing.

1.6.2 Intensity. Intensity in the widest sense refers to a descriptive quality of feeling. An intense experience of emotion in ISTDP, may include not just the ability to label a subjective feeling state, but also a visceral, physiological experience in the body and an awareness of the associated impulse (for example, to cry, hug, hit). Patients may defend against any of these aspects. Davanloo (1990) emphasised that in ISTDP, deep experience of feeling — including murderous rage — “does not come with any explosive outburst, but with a quiet, inner intensity” (1990, p. 7). Intensity may also have a “non-linguistic” quality that is hard to name or directly perceive yet potent (Frosh, 2011), which has implications for how the researcher elicits an understanding of such phenomena from participants’ accounts. How this challenge was addressed is discussed further in Chapter Three: Methodology.

1.6.3 Staying with. The “staying with” phrasing of the research question was carefully considered in personal communication with an experienced ISTDP trainer who stated that staying with their clients’ intense emotion is at the heart of “what ISTDP therapists do” in the work. By implication, this suggests a basic equivalence to adherence to the model. Staying with the client can thus mean any number of eventualities, in terms of their process of experiencing intense emotion. It can also reflect the attitude of the therapist who endeavours to be an “emotionally engaged and available presence” (Coughlin, 2017, p.95). ISTDP is thus a therapeutic approach with useful conceptualisations and techniques with a high regard for the therapeutic relationship and its processes. Likewise, in counselling psychology the therapeutic relationship is considered a unique and relational encounter wherein the existences of two people unite to produce a narrative that is co-created. As Parpottas (2012) asserts: “[c]ounselling psychologists work towards what is thought to be therapeutic by “staying with” the individual’s experience and also by paying attention to their internal and external processes” (p.97).

1.7 Relevance of the Study and Contribution to Counselling Psychology

This study’s findings aim to provide a unique and original contribution to the field of counselling psychology and therapists’ experiences research as follows. It is hoped that a clearer picture emerges of the complex demands and dynamics of what it is like for therapists to stay with client’s intense feelings.

Increasingly, affect focus and experiential aspects are important features of current and new brief therapies (Parry, 2019) as are ways of making effective use engaging emotions in therapy (Thoma & McKay). Therefore, the more we know about the challenges, consequences and ways of coping with difficulties, the better able the therapist is to be effective in their therapeutic work.

Technical aspects helpful to the therapist to consider in their own practice and development will be highlighted.

1.8 Thesis Style and Structure

Many sections of the thesis are my first person account to foster the readers' involvement with my research process as it unfolded and to best express my engagement with reflexivity. Also, the terms client and patient are used interchangeably throughout this study, as they reflect the respective preferences in counselling psychology and ISTDP. This thesis follows a conventional structure. After this introduction, Chapter Two provides a review of the literature associated with therapists' experiences of working with clients who are experiencing intense emotions, with critical reflection on the methods used to gain their perspectives. Chapter Three details the methodology and introduces the reader to the method of Interpretative Phenomenological Analysis (IPA) used for data collection and how I approached the research design, ethical considerations and how the stages of IPA were applied. In Chapter Four I present the findings, and then showing the themes that emerged from the data, supported by extracts from the transcripts. Chapter Five is a discussion of the themes in relation to the research question and gives my summary and conclusions of the research, with a review of outcomes set against the research aims given above. Following identification of the original research contributions made by this thesis, I conclude with a methodological critique of this study and implications for further directions for counselling psychology practice and future research.

1.9 Chapter One Summary

This study aims to explore the experiences of therapists engaged in staying with their clients' intense emotional experiencing. No published papers address the area of eliciting therapists' accounts of this phenomenon, which as the literature in Chapter Two will aim to show, is underexplored. It is important

to address this gap in the research due to the acknowledged issues these therapists face as they help clients heal from the effects of their early attachment trauma (Abbass, 2015; Coughlin, 2017; Frederickson, 2013). It is my intention that this research will facilitate an opportunity for a range of therapists and mental health practitioners to learn from first-person accounts of the experiences of ISTDP therapists. I therefore see this research project as well suited to values and priorities of the field of counselling psychology that regards subjective experience as essentially inherently dynamic, embodied, and relational and seeks to develop phenomenological models of practice and enquiry (BPS, 2018a). ISTDP and counselling psychology both share a belief in the importance of the uniqueness of the human encounter between therapist and client (BPS, 2018a; Coughlin, 2017). In producing knowledge that is sensitive to context, committed and rigorous, it is my hope that an increased understanding of therapists' experiences in this area will aid the development of research and practice in counselling psychology and inform the views of practitioners who are interested in emotions-focused therapeutic work.

Chapter Two: Literature Review

2.1 Chapter Two Overview

The aim of this chapter is to present the comprehensive literature review that I conducted prior to starting the study. The intention here is to provide a description of the findings of previous research that may support understanding of current issues and establish what is already known; provide a critical appraisal of relevant research and consider methodological implications both for the research findings and for my own study; and provide the rationale, research aims, and research question for this study. In conducting this literature review, I intended to create a clear understanding of what we know about the value of emotional experiencing in the therapeutic endeavour and what is already known about how therapists work to help clients experience deep emotion. Lastly, the research topic is further contextualised within clinical practice and counselling psychology more broadly. This review was then used to shape the research question in line with the most suitable methodological approach.

2.2 The Process of the Literature Review

This chapter is in part a summary of the process I have followed, in line with Kasket's (2012) guidance, in progressing from my research area to my research question. As detailed in the introduction chapter, I have engaged reflexively with my research question, to understand my positioning and the influence this may have on my project. Reflecting on how this has influenced my literature review process was done so that I could better bracket my preconceptions that may bias an otherwise open and curious engagement with the literature. Below I offer a definition of key terms and then go on to provide a critical evaluation of relevant frameworks, namely the psychodynamic understanding of emotional experiencing, explaining how these led to a focus on ISTDP. I then critically engage with the empirical literature of ISTDP and how this highlights a gap in the literature and to the rationale for the research question. Consequently, this literature review thus functions as my empirical, theoretical, methodological and personal rationale for my study (Finlay, 2011).

Strategies employed in the critical review of qualitative research adhered to Morse's (2015) criteria to help determine the rigour, validity, reliability, and

generalizability of the works in question. The data extraction strategy of Kasket (2012) that covers purpose of reading, relevance to my research, persuasiveness of author's argument, and what I make of the conclusion, was followed. Analysis of papers and other pertinent materials is in line with a distinguishing feature of counselling psychology that differentiates the field from the other applied psychologies, namely, its therapeutic undertaking and "explicit use of a phenomenological and hermeneutic inquiry" that emphasizes its reflexive and critical position when dealing with "medical, psychopharmacological, and classification literature as well as use of nomothetic (psychometric and neurological) testing" (BPS, 2018a, pp. 6-7). Evaluation of all research should include an appreciation of its philosophical assumptions and researcher positioning (Ponterotto, 2005; Willig, 2013). The co-creation of meaning and awareness of researcher-participant intersubjectivity is fundamental to the interpretation of the data (Morrow, 2005; Kasket & Gil-Rodriguez, 2011). Here, the intention of the quality evaluation is to examine, from within an interpretative phenomenological framework, how the research may be used to inform my understanding of the research area.

2.3 Defining Emotions and Emotional Experiencing

The emotions science literature is vast and detailing the various conceptualisations and definitions of emotions is beyond the confines of this study. However, as a useful starting point for this study, Hofmann (2016), who considers emotion in the therapeutic context, offers the following multi-modal definition of emotion (p. 2):

An emotion is (1) a multidimensional experience that is (2) characterized by different levels of arousal and degrees of pleasure–displeasure; (3) associated with subjective experiences, somatic sensations, and motivational tendencies; (4) colored by contextual and cultural factors; and that (5) can be regulated to some degree through intra- and interpersonal processes.

This quote highlights that to speak about emotions is to speak about many areas of psychology (Hayes, 2016): experience and the valence of experience, bodily arousal and sensation, culture and context, and social and self-regulation.

Emotional experiencing is therefore at the heart of human experience and is of fundamental importance in all therapeutic frameworks, even if of primary or more peripheral concerns. This study is interested in therapists whose work focused on this aspect and how the therapist experiences the complexities of these intersubjective processes.

2.4 Emotional Experiencing and the Therapeutic Endeavour

This section begins a critical examination of the studies previously completed to help in understanding the importance in psychotherapy of the therapists' attending to the client's intense emotions. The therapist's efforts to help a client experience their emotions has been a key theme throughout the history of psychotherapy, encompassing foundational ideas from psychoanalysis (Freud, 1923), to other more recent schools of thought, including short-term dynamic therapy (STDP) and third wave cognitive approaches (Hayes & Hoffman, 2017). Freud developed his ideas from believing in a cathartic model, where "making the unconscious conscious" was the essential curative factor in the therapeutic process, to the view that insight based on emotional experiencing was essential for bringing about enduring change (Schafer, 2018). Today, a key integrative principle is that both cognitive and affective aspects are important for producing therapeutic change (Whelton, 2004). The multifaceted and complex feature of emotion, described in the above cited definition, means that therapists are inevitably involved in making decisions about which element of emotional experience to prioritise in therapy, in relation to the presenting difficulty, and select techniques to use accordingly (Leahy, Tirsch, & Napolitano, 2011).

This integrative principle and varying clinical focus is reflected in a number of emotions-focused approaches, including STDP, humanistic emotions focused therapies (Greenberg, 2010), and third wave cognitive-behavioural approaches, such as Schema Therapy (Young, Klosko & Weishaar, 2003), Compassion Focused Therapy (CFT; Gilbert, 2009), and Acceptance and Commitment Therapy (ACT; Hayes, Strosahl & Wilson, 1999). These modalities each draw on a research base that helps build the rationale for the value of attending to emotions in psychotherapy. ACT for example, considers, though its theory of contextual functionalism, the role of experiential avoidance

(Hayes, Strosahl & Wilson, 1999), whereby arbitrary associations the person develops through language and cognition creates feelings and other experiential aspects that are avoided and often self-defeating. CFT (Gilbert, 2009), to offer a further example, adopts an evolutionary science-based view of people's difficulties in accessing their emotional regulation system as related to self-conscious processes, such as high shame and self-criticism (Gilbert & Proctor, 2006), and considers how clients organize around emotions in terms of attention, behaviour, thought, motivation, feelings, and physiology. These process-oriented approaches aim work within a contextual understanding of the experiential and emotional aspects of clients' difficulties.

Affective neuroscience has contributed to an understanding of emotions, personally and interpersonally, as experienced in the therapeutic space (Schore, 2007). A person's subjective experience of emotion occurs through what Damasio (1994) refers to "somatic markers", the signals that tell the person what is of importance to focus on. Abstract reasoning, the has been the central focus of a cognitive paradigm in research (Gilbert, 2009) emerges out of embodied experience that Barrett (2017) suggests is based in our affective experience rather than separate to it, as has been traditionally regarded (Griswold, 2010). Emotions offer the person a rapid, preverbal method of assessing danger (LeDoux, 1998) and the noting of salient features when encoding memories (Panksepp, 1988). They also effect interpersonal signposting and communication (Mayer & Salovey, 1997), help with the pursuit of life goals (Tomkins, 1962), assist social competency, and together with conscious thought brings about the narration of the self in context and across time (Angus & Greenberg, 2011). Emotions are then regarded as fundamental, yet difficulties arise with the identification of emotions, their modulation (i.e. dysregulated or under- or overregulated) and the expression and communication of emotions socially (Jurist, 2018).

A range of evidence now supports the approach of therapists' attention on encouraging affect (Thoma & McKay, 2015). For example, Foa and Kozak's (1986) emotional-processing theory suggested that enabling the modification of excessive fear responses requires activation of the underlying fear system. Activating emotion to boost the modification of fundamental cognitive-affective

structures provides a strong rationale for a range of interventions covering a diverse range of emotional difficulties. Furthermore, arousal and expression are correlated to a positive outcome in a range of psychotherapies. Emotional arousal reported as high at the beginning of therapy along with between-session habituation has been linked to positive outcomes in exposure therapy for anxiety disorders (Borkovec & Sides, 1979; Jaycox, Foa & Morral, 1998). A meta-analysis of 10 STDP studies demonstrated a positive association between therapist's facilitation affect and treatment improvement (Diener, Hilsenroth & Weinberger, 2007). Studies reporting observer-rated arousal of emotion in important phases of therapeutic episode was predictive of positive outcome in therapy (Missirlian, Toukmanian, Warwar & Greenberg, 2005). Lastly, neuroscientific research into the unconscious affective-relational functioning of the right brain (Schore, 2007), requires therapists to comprehend and utilise such processes with their clients, to foster enduring change. Deficiencies in emotional awareness and regulation are regarded as central aspect to most psychiatric disorders (Barlow et al., 2011). Increased attention to emotional activation and regulation in treatment is consistent with the emerging data on the nature of the underlying factors responsible for clients' distress (Barlow et al., 2011).

So to generate the type of emotionally-charged tenor required in the therapy room, therapeutic interventions are designed to activate and intensify the cognitive-affective and psycho-physiological aspects of emotional experiencing. Recent studies on what helps diminish unhelpful responses in exposure therapy have emphasised the importance of developing distress tolerance and the acceptance of emotional experience (Arch, Wolitzky-Taylor, Eifert & Craske, 2012; Bluet, Zoellner & Feeney, 2014; Craske et al., 2008); accommodation of new meanings derived through the experience of emotional also appears to be important in exposure therapy (Sobel, Resick & Rabalais, 2009). In emotion-focused therapy for depression, clients' meaning making of their emotional arousal enhanced outcome compared to that during treatment (Missirlian et al., 2005). Furthermore, the quality of emotional awareness experienced, coupled with the client's attitude toward it, is shown to have a strong correlation to outcome (Auszra, Greenberg & Herrman, 2013). Helping

clients to experience avoided emotions, therefore, is substantiated as a worthwhile endeavor for the therapist.

Measures of in-session affective experiencing that focus on attention to, acceptance, and differentiation of emotional experience, are linked to outcome in many therapies (Castonguay, Goldfried, Wiser, Raue & Hayes, 1996; Goldman, Greenberg, & Pos, 2005; Pos, Greenberg & Warwar, 2009, Watson & Bedard, 2006). Emotion-Focused Therapy (Greenberg, 2015), a process-experiential approach, is conceivably the most developed modality for working with emotions in psychotherapy, where the expressed aim of the approach is to “give words to moment by moment process of working with emotions” (p. 7). Yet the role of therapist is as a coach to help client with “differentiating underlying meanings and feelings and manifestation of primary emotional states” (p. 133). Town, Salvadori, Falkenström, Bradley and Hardy’s (2017) review of those measures more widely used and to help gather insights on the construct of affect experience in their study, which demonstrated that the in-session exercise of emotional experiencing can help to strengthen the therapeutic alliance. Thus, the therapies discussed centre on some aspect of emotion, whether talking “about” emotions, attention to somatic experiencing of emotions or on developing skills to communicate emotions to valued others.

Though these psychotherapeutic models may have different and contrasting theoretical bases, they nevertheless share a conception of emotional experiencing as a phenomenon that assumes shape in the context of human interrelatedness. These models acknowledge developmental processes, whereby repeated patterns of emotional interaction within the child-caregiver system produce ways of relating – object relations in psychodynamic therapies; meaning-structures in humanistic/existential therapies; distorted thinking in cognitive-behavioural therapies – that shape subsequent emotional experiences. These experiences recur in the significant relationship with the therapist who fosters an engagement with previously avoided feelings (Abbass, 2015). Dynamic approaches that attend to this will be the focus of the following two sections in this chapter. Where interests in emotion span all schools of psychotherapy, it has been more pertinent in recent psychotherapy research to seek to analyse the phenomenological bases rather than the theoretical or

technical conceptualisations (Moltu & Binder, 2014). Phenomenological enquiries are thus one way to produce convergence in how therapists from different therapeutic modalities facilitate emotional change processes. The above literature is produced from mostly quantitative research or process studies and reveals the paucity of research in investigation into qualitative research that may give a more contextual, subjective understanding of the therapist's experience. Qualitative research that helps us further understand the importance of focusing on client's deep emotional experiencing will be the focus of section 2.7 Researching In-session Emotional Experiencing in Psychotherapy Process Research onwards, and evaluated further in section 2.14 Rationale for the Current Study.

2.5 Historical Overview of the Development of STDP

As mentioned in the section immediately above, Freud's theories and approach, are at the root of psychoanalysis. At the heart of all psychodynamic practice is the interpreting of transference that brings inner conflicts to life in therapy. It was this focus on patient defenses and resistances in therapy, together with Freud's own engagement in short episodes of treatment, gave birth to brief dynamic psychotherapy (Davanloo, 1990). Nonetheless, as the theories of psychoanalysis to explain transference neurosis proliferated, analysis became longer, the sessions unfocused and the therapist passive. As a counter to this, Sandor Ferenczi, through his psychoanalytic approach, investigated innovations in technique, suggesting the necessity of active methods for particular neuroses. This arose out of his clinical observation that often an analysand will only be able to experience a positive connection to the analyst after the anger is first experienced. Otto Rank was also a proponent of the "active technique" (Meyers & Hoffer, 1994). His theoretical contribution regarding birth trauma included seeing the issue of separation and individuation as primary to the therapeutic work, which entailed a mobilizing of the patient's will to help motivate the patient towards dynamic change. Ferenczi and Rank (1986) in their 1925 publication highlighted the significance of using moment-by-moment transference interpretations of patients' early conflicts as repeated in the therapeutic relationship.

STDP, as it came later on to be known, had its origins in the 1940s whereby psychoanalytically-informed thinkers began developing models that formed into distinctive approaches. Alexander and French (1949) made vital contributions, by conducting the first clinical trial with the expressed focus of making psychoanalysis “briefer and more effective” (p.7). Whereas Freud regarded cathartic expression of emotion as the basis to overcoming early trauma, Alexander and French posited the “corrective emotional experience” as a further step in this process. It was not recovered memories, once repressed, which brought about therapeutic progress but rather the reverse: the intense reexperiencing of repressed memories in the actual relationship was the curative factor, whereby the patient learns a sense of autonomy through safe re-exposure. Here the patient's experiencing of their relationship with an emotional responsive therapist is seen as necessary and beyond the insufficiency of mere intellectual insight. Prioritising experiential aspects meant analysis could be achieved with shorter treatments that could, the authors claimed, achieve depth and overcome the patient's resistance. Alexander and French aimed to heighten the emotional intensity of sessions and focus on emotionally charged experiences, paved the way for in-session experiencing of intense emotions that were shared by patient and therapist.

Yet Alexander's (1953) view perhaps unintentionally retains the view of the analyst as all-powerful in their ability to inform patients about what they may be feeling. Balint and Malan took forward the idea of time limited therapy in ways that further challenged psychoanalysis' belief of the incompatibility of shortness with relationship. Balint's (1973) “focal therapy” was a three-stage view that the therapist must accept, understand and interpret unconscious material and discovered that patients could benefit from ‘deep’ interpretations in short term work. Sifneos's (1972) Short-Term Anxiety-Provoking Psychotherapy was an alternative focal and brief therapy that emphasised on the central role of anxiety in moderating access to primitive unconscious material. Yet attempts to develop effective tools for regulating anxiety were unsuccessful. Malan (1979) saw that such interventions were most helpful when linking patient's past and their current interactions with the therapist (triangle of persons), along with linking the patient's impulses, resulting defense and anxiety (triangle of conflict).

Thus, his model could help understand dynamic conflicts in the here and now, and their origin.

2.6 Development of ISTDP and Experiential Dynamic Approaches

In the 1960s, Davanloo's (1990) efforts to accelerate dynamic therapy led him to create a model with two key distinctive features that made his ISTDP the prototype for STDP approaches that followed (Osimo & Stein, 2012). First, he developed new ways of working with defences and conceptualising defences and resistance in therapy. Second, he employed highly specific techniques, such as Malan's trial interpretations, leading to rapid uncovering and experiencing of primitive aspects of emotion and illuminating aspects of human conflict, through a process of "unlocking of the unconscious". Key to this was the acknowledgement and confrontation of the patient's resistance. Davanloo used vivid, emotionally loaded language to speak to the unconscious of the patient and believed that only once the *unconscious* therapeutic alliance – an aspect of the alliance he was the first to label and emphasise – exceeded the resistance of the patient, could such resistance be undone. Davanloo (2001) theorised that the "twin factors of resistance the [complex] transference feelings" rise in the patient when they feel pressured from the therapist's attempts to bond (p.30). This informs the therapist's formulation in relation to Malan's triangles (slightly adapted by Davanloo). In the transference, "the client's powerful emotions, particularly towards the therapist, are defended against, but the therapist's constant interpretation of these leads to their expression in therapy" (Coren, 2010, p. 290). The therapist can then help the client override avoidance and feel their complex feelings, helping them heal their past trauma (Abbass, 2015).

What ISTDP preserves from classical psychoanalysis is its focus on transference and the value of insight, and to some extent, interpretation, though the latter Davanloo saw as possible only post-breakthroughs to the unconscious. The model draws from a Freud's (1923) structural theory of the mind – id, ego and superego – yet it is arguable more concerned with the functioning of the ego, rather than its structure, and the mechanical aspects of the triangle of conflict (impulse/feelings, anxiety and defense). Though ISTDP regards itself within the psychoanalytic tradition, whether such brief approaches

are 'different' is debatable but nonetheless are drawing on psychoanalytic ideas. From the 1960s onwards cultural and postmodernist aspects of emotion receive attention in the shift from "one-person psychology" (Wachtel, 2008) to two-person relational view (Aron, 1991), which brings intersubjectivity and the therapist's mutuality and involvement to the fore. This has led to number of contemporary psychological approaches that seek to integrate attachment theory and developmental psychology, and psychoanalytic concepts. These include, for example, Psychodynamic Interpersonal Therapy, Cognitive Analytic Therapy, Solutions-Focused Therapy, and Transactional Analysis (see Coren, 2010, for further details; Parry, 2019).

During the past thirty years, various approaches, stemming from Davanloo's application of scientific method to developing specific techniques that accelerate psychotherapeutic process, have been established and researched. Past students of Davanloo have elaborated on his theories within ISTDP (Abbass, 2015; Coughlin Della Selva, 2017), Others have elaborated on how the significance Davanloo gives to the attachment bond of child and caregiver relates to mental health, referred to as Attachment Based ISTDP (ten Have-de Labije & Neborsky, 2012). Modifications of Davanloo's principles, referred to often as experiential dynamic approaches (EDTs), whereby the titles indicate distinctive rather than similar aspects include Accelerated Empathic Therapy, Accelerated Experiential-Dynamic Psychotherapy, Intensive Experiential-Dynamic Psychotherapy, Mindfulness Informed Experiential Dynamic Therapy, Personality-Guided Relational Psychotherapy, and Affect Phobia Therapy (see Osimo, 2012, for details of the authors of these approaches).

Davanloo (1990) has across his career, still ongoing, built a large evidence base for ISTDP based on case-series research methodology that entailed him video recording all sessions, moment-to-moment analysis of the recordings, and successful interventions tried out with the successive clients. Then following termination, recordings were reviewed with clients to understand which interventions worked, and lastly long term follow up was performed. This methodology is successfully employed since then to generate the evidence base for the key clinical processes in ISTDP practice (Abbass, 2015). However,

the focus is on patients' response and outcome, whereas aspects of the therapists' experiences are less often reported. As stated by Davanloo (1990, p. 2): "I believe that dynamic psychotherapy can be not merely effective but uniquely effective, that therapeutic effects are produced by specific factors rather than nonspecific factors, and that the essential factor is the patient's actual experience of their true feelings about the present and the past." This is now less of an "uncompromising stance" (p. 2) today than it was, due to subsequent research in psychodynamic and experiential approaches and the established evidence base for the efficiency and effectiveness of ISTDP, as referred to in section 1.5 Introduction to ISTDP.

Despite a strong evidence base for the efficacy and cost-effectiveness of ISTDP, which far outweighs that of its EDT siblings, it has yet to receive government support in the UK context. Town and Abbass (2018) highlight in their paper on epistemological deficiencies in The National Institute for Health and Care Excellence (NICE) review methodology and its influence on recommendations that have served to limit options for psychodynamic therapies for complex and persistent depression, despite compelling evidence from recent randomised control trials (Fonagy et al., 2015; Town, Abbass, Stride, & Bernier, 2017). Currently, the brief psychodynamic psychotherapy most widely available in the UK is Dynamic Interpersonal Therapy (Lemma, Fonagy, & Target, 2012), a 16-session model for depression. The current political climate in the NHS and the overall position of psychodynamic therapy in public health is further addressed in Chapter 5: Discussion, section 5.2 Situating the research findings within the wider context of psychodynamic practice in the UK.

This section has outlined the development of psychoanalytically-informed STDPs, from Freud to EDTs that are based on analytically-informed practices, including the current brief dynamic UK context. In relation to the therapists' task, psychodynamic and experiential approaches can nonetheless be set apart from cognitive-behavioural therapies through their considerable attention to the client's gaining of emotional insight (Salvadori, 2010). Raised into consciousness via somatic experience of emotion, the client is thought to be able to better manage their previously avoided material. Malan (1979) highlights the experiential and dynamic tenor of this theory: "The aim of every

moment of every session is to put the patient in touch with as much of his true feelings as he can bear” (p. 74). The primacy of emotional experiencing in these dynamic approaches, of which ISTDP is one, are of interest to counselling psychology. Though at base a psychodynamic model, ISTDP is presented by some leading authors (Coughlin, 2017; Frederickson, 2013) as an integrative model of therapy. That is to say, theoretical integration as a model of intervention that is grounded in the moment-by-moment assessment of the client’s needs. See section 2.10 The Practice of ISTDP and Implications for the Role of Therapist for further discussion of the practice of ISTDP.

2.7 Researching In-session Emotional Experiencing in Psychotherapy Process Research

To my knowledge, there is paucity of qualitative research that has specific focus on working with client’s intense emotions. Yet the several studies that are concerned with this phenomena will receive attention in the remaining sections of the literature review. Psychotherapy research and developments in the theories of a wide range of therapy schools suggests that increased client in-session affect experiencing is linked to therapeutic change (Wiser & Arnow, 2001). Moreover, Coughlin (2017) highlights that sessions that are regarded by clients as intensely emotional are most often those labelled as “significant” (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; Goldfried, Raue, & Castonguay, 1998; Harnett, O’Donovan, & Lambert, 2010), and appear to have the most influence on outcome. This therefore has relevance for therapists in the development of specific skills in this clinical process. What continues to be investigated and developed are the features that show where a facilitation of emotional experiencing can be clinically useful.

In ISTDP, researchers have explored the process of clients’ in-session emotional experiencing (Town, Hardy, McCullough & Stride, 2012; Town, Salvadori, Falkenström, Bradley, & Hardy, 2017; Salvadori, 2010). The experiencing of emotions as foundational to change have a strong outcome factor in the process empirical data, from studies that measures the rise in feelings in relation to its influence on outcomes. These studies utilise video-material in case-series design to observe the affect peaks of the patient, and attempt to link this to therapist intervention. Town and colleagues (2017, p.

148) describes “affect experiencing” as: “[t]he in-session bodily arousal of emotions....[which] reflects the degree to which patients viscerally experience then express their feelings.” This construct of affect experiencing is detailed in metapsychological theory, yet the term “emotional processing” tends to be used as an all-embracing construct in referencing how emotions are widely attended to in psychotherapy (Frederickson, Messina & Grecucci, 2018). Such studies provide insight into patient variables but do not inform us about what this is like for the therapist or specifically, their emotional experiencing, which are significantly harder to capture in experimental studies.

2.8 Expert Therapists

An expert psychotherapy practice is one that consistently helps clients achieve their goals. (Hill, Spiegel, Hoffman, Kivlighan, & Gelso, 2017; Wampold & Imel, 2015). Research into the nature of therapist expertise brings our awareness to ideas and information across the natural and humanistic sciences, which can help to enhance therapeutic practice and add to our understanding of the therapist’s skill and expertise. Moreover, research suggests that experienced therapists show greater flexibility, are better at coping with complexity and severity of client difficulties, and are able to build better quality formulations of their clients than less experienced therapists (Oddli, Halvorsen, & Rønnestad, 2014).

Studies in this area of the literature consulted tended to coalesce around the area of clinical difficulties, but are without a direct focus on the therapist’s engagement in emotional experiencing. Nonetheless, some valuable insights can be drawn. Moltu and Binder (2014) found that skilled therapists experience their own involvement in challenging therapies as maintaining a “double awareness to create a relational space for growth” (p. 136). A key finding was the use of embodied experiences to achieved intimacy with clients. This study is helpful in offering a context of psychotherapeutic technique, yet seems concerned with the meaning-making processes of the client over their affective experiences.

The first examination of therapist wisdom by Levitt and Piazza-Bonin (2016) recruited and interviewed therapists, who were peer-recommended as

possessing wisdom, on how they enact wisdom in therapeutic process. One central category was: “Intelligence is not enough: Wise therapists have emotional intelligence grounded in difficult life experiences to better understand how to work through painful and powerful emotions” (p. 38). The authors found that “wise therapists” were considered capable of tolerating threatening emotions and also possessed interpersonal sensitivity to facilitate clients’ staying in contact. The counselling psychologist as researcher-practitioner, values the importance of the practitioner knowing their limitations whilst expanding their psychotherapeutic and professional knowledge, in the acquisition of new clinical skills (BPS, 2005; Health Care Professions Council, HCPC, 2015, 2016) and can draw from such studies to help guide their practice and development.

2.9 Therapists Effects

Psychotherapy research appears to point towards a greater variability in outcomes between therapists than therapies (Wampold & Imel, 2015). There is a great deal of evidence to support the hypothesis that therapist effects (differences in client outcomes between individual psychotherapists) are greater than treatment effects (differences in client outcomes between treatment modalities). Such findings suggest that there are therapist characteristics associated with 18 better patient outcomes, yet there is no accepted model that outlines what those characteristics might be. Of interest to the present study, then, is how research that relates to therapist effects can inform therapists and their real-world practice of providing a therapeutic experience of emotion.

Coughlin (2017) asserts that in contrast to their less effective colleagues, “therapists who demonstrated a mix of cognitive and emotional speech content, who conveyed warmth, and who were seen as actively listening to their clients, had a better overall connection with patients” (Sexton, Littauer, Sexton, & Tommeras, 2005, p. 110). As mentioned in the section 2.8 Expert Therapists Literature, the best therapists possess a number of wide-ranging qualities: they are confident but humble; lifelong learners with high levels of skill and expertise, who are simultaneously open to feedback; and are flexible but systematic in their approach (Wampold & Brown, 2005; Wampold & Budge, 2012). These therapists are skilled at handling negative emotions and are courageous in

handling conflict directly and non-defensively. Finally, they are ambitious and push themselves and their patients to work hard and endure discomfort in the pursuit of exceptional results. Coughlin (2017) thus asserts that since an enhanced sense of mastery and competence is a vital factor in healing, as well as in preventing relapse (Weinberger, 1995), attending to the patient's expanding sense of self must be included in the therapists' repertoire. Research suggests that the therapist variable is the most significant factor in creating this type of alliance. In other words, the most effective therapists are interpersonally skilled and able to forge a relationship for change even with patients with complex and long-standing difficulties (Frederickson, 2013). They seem to do so by managing negative feelings in the transference, helping the patient relinquish defenses, and actively encouraging clients to engage in a collaborative effort. Thus the research in this section helps illuminate, when considering therapist' effects, the complex interactions between the relational and technical aspects related to outcomes in psychotherapy.

2.10 The Practice of ISTDP and Implications for the Role of Therapist

One explanation for the effectiveness of ISTDP is that it incorporates many of the factors outlined in the section above into a comprehensive system of intervention (Coughlin, 2017). The process research highlights the importance of focus to effective outcomes for patients and the importance of defense work, whereby changes are predictive of improvement (Pennebaker, 1997). In light of the evidence base, the ISTDP therapist's main task is to help the client reach through their defenses to the experience of emotions. Once there, the therapist facilitates cognitive reflection and understanding of the emotional experience. ISTDP is thus not a cathartic therapy. Instead conscious reflection on emotional experience is key distinguishing good from poor outcome (Warwar & Greenberg, 2000). A deep and relational understanding of self and other was seen to have enduring value, but only clients who were emotionally involved in the process achieved that outcome (Pennebaker, 1997).

Davanloo (1990) observed what he called a *central dynamic sequence* whereby access to the unconscious is gained through persistence in the therapist in effectively and efficiently helping patients overcome their resistance.

Therapists use response to intervention as their primary diagnostic tool and their guide for intervention, leading to a tailor-made experience for the client. Abbass and Town (2013) outline the phases of the therapy along with empirical evidence supporting the main clinical processes. In the first two phases, the therapist uses inquiry and pressure – encouraging the client towards experiencing underlying emotion – to psychodiagnostically evaluate, through the client's response to intervention, suitability and plan for therapy. Monitoring and assessing the client's level pathway of anxiety may happen here, and psychoeducation used to help client modulate anxiety within a window of tolerance. In phases three and four, the therapist aims to help clarify and challenge collaboratively resistances to experiencing their complex transference feelings that have been mobilized as the result of a triggering event. Working with defenses is, after anxiety, referred to as the second detour (Frederickson, 2013) to an effective focus on emotion. For example, observing whether the patient resisting emotional closeness or their own internal experience, or whether defenses are viewed as natural or necessary or unwanted and excessive, and helping the patient with a cost-benefit analysis.

Once the client has seen and overcome their resistance and can directly experience their feelings, the fifth phrase of unlocking the unconscious can happen, whereby trauma-related memories surface and be reworked. This entails a focus on the somatic pathways for core emotion, such as anger, guilt, grief, sadness and love, so that these mixed feelings can be integrated. Being "in touch" with feelings is reached through the client labelling the emotion, observing and elaborating its physiological activation in the body and mobilizing the resulting impulses and action tendencies that are fearfully avoided. The last phase is supportive in helping recapitulate and consolidate the intrapsychic and interpersonal patterns and processes experienced by the client, by making sense of and thoroughly linking the client's impulses/feelings, anxiety and defenses with current and past figures. Such recapping of experience is seen to aid the development of coherent life narrative (Nerborsky, 2001) and long-term health and wellbeing.

Abbas (2016) highlights how working with transference leads to a challenge to the ISTDP Therapist:

“... this same work will tend to mobilize intense, deep zones of feeling in the therapist if [they] has not experienced these feelings up to that point in time. If the therapist does not allow [themselves] to feel the feelings [they] may end up with a burden of increased guilt and neurosis transferred to his patients” (p. 277).

Whereas it is expected that if the therapist can meet the person through their resistances, the therapist then has the ability to experience any of their own unprocessed feelings. The ISTDP literature refers to this as a “double unlocking of the unconscious” (p. 277), whereby a double therapeutic effect happens for both therapist and client.

Overall, this section aimed to give some indication as to why ISTDP is referred to as an advanced psychotherapy and offered as post-qualification training. Interventions that propel the client through the treatment algorithm are highly technical and specific, using video peer and self supervision to help observe and refine technique that so that pacing and depth of dynamic emotional experiencing can be optimised. The therapist must also sustain an attitude of curiosity (Coughlin, 2017), develop skills that reduce therapist errors that might give rise to resistance, and develop themselves personally, so they can involve themselves in emotional closeness and attunement that can facilitate change and growth in their clients.

2.11 Therapists’ Capacity to Reflect On and Use Their Own Emotional Experiences

Counselling psychology regards the therapeutic therapist relationship as the central means of change and thus sees the self of the therapist is as involved in the therapeutic process, regardless of the approach (Orlans and Van Scoyoc, 2009). The therapist’s capability to use their self effectively in the therapy is impacted by their capacity to be aware of how their thinking, emotions, needs and issues are brought about during their work. Training components such as personal therapy, experiential work and supervision become central activities through which a trainee’s understanding of the interaction between their personal and professional identities, and their capacity to apply themselves effectively in their work, is developed (Donati, 2016).

In ISTDP this means attending to one's own inner life, in order to ensure that the therapist can be emotionally present and open to connection with their clients (Coughlin, 2017). This goes hand-in-hand with the development of technical skills, through forms of deliberate practice, aimed at improving specific clinical skills outside of the session and monitoring improvement and outcome (Rousmaniere, 2016). Frederickson (2013) refers here to the 'craft' of psychotherapy, as well as the art and science of the discipline. To help clients in this mode thus requires skills and techniques that are integrated within a theory of human development. In keeping with the values of counselling psychology and its scientist-practitioner identity (Murphy, 2017), these skills must be coherent with a theory of change that is bolstered by the research base. Expertise is thus achieved through years of self-study, supervision, further training, personal psychotherapy. The ISTDP therapist also achieves this through the analysis of their own transcripts and videotapes (Abbass, 2004a).

2.12 Researching Therapists' Experiences

Research on therapists' experiences gives practitioners the opportunity to engage with other subjectivities and associated clinical practices that can be reflected on and transferred to the therapist's own practice. One of the roles of the counselling psychologist is the reflective-practitioner, which acknowledges their need to understand the therapist's experiences so they can continue to learn and develop their practice and clinical skills (Donati, 2016). The therapeutic relationship amounts to a complex matrix of intersubjective processes (Mitchell and Aron, 1999) to which both therapist and client make active contributions. This means that it is not necessarily easy for the therapist to perceive, disentangle or attribute objectively what "belongs" to them from what belongs to the client in any given interaction, though it may be important to do so, particularly if working with clients who present with complex relational difficulties. The importance of the issues noted here to counselling psychology practice is reflected in the HCPC's (2015) Standards of Proficiency, which state that counselling psychologists need to learn to manage "the ... emotional impact of their practice" (p. 8), to understand "the dynamics present in therapeutic and other relationships' understand the dynamics present in

relationships between service users and practitioners (p. 11), and to be aware of the “explicit and implicit communications in a therapeutic relationship” (p. 10).

Kenny (2014), in an attempt to understand such complex intersubjectivity, as just described, interviewed eminent clinicians regarding their psychoanalytically-informed practice. Kenny conducted a formal textual analysis programme and a conceptual thematic extraction process in identifying distinctions and commonalities in their accounts. Through an intensive dialogue with Allan Abbass regarding his ISTDP practice, some important aspects of the therapist’s experience are revealed. For example, Abbass reflects on his initial difficulty with confusing the active nature of the therapist with an attack on the patient, learning the importance of timing and clarifying interventions before challenging the patient’s behaviour. He comments also on his own anxiety response to the video case material as to linked to his own early attachment feelings, the importance and value of emotion physiology, the therapeutic effects and parallel experiences he experienced through the training, and the mirroring process he encounters through his and his patient’s joint emotional experiencing. These provide some coverage of only a few valuable glimpses into aspects the therapist’s experiences of staying with his clients intense emotional experiencing. The main authors and practitioners of ISTDP also provide insights through their books and articles (for example, see Abbass, 2015; Coughlin, 2017; Frederickson, 2013; ten Have-de Labije & Neborsky, 2012).

Countertransference is often regarded as comprising the therapist’s emotional responses to the client, and has been linked to negative outcomes in therapy when ignored, but also as a phenomenon that can benefit therapeutic work when reflected up and managed (Gait, 2017). Studies on this concept can offer insight into therapists’ experiences of how they deal with their clients’ emotion. Gait (2017), using the grounded theory method on qualified therapists’ experiences of the countertransference awareness and development, found that when experiences of feeling overwhelmed was managed in supervision and personal therapy, and through aspects related the therapeutic modality and context for the work, participants were capable of reflecting on their countertransferential responses and to grasp an understanding of their

experiences. Thus, they were able to develop their awareness in ways that benefited the therapeutic relationship. Yet when such aspects were not managed, participants would act out on their countertransference and would limit their availability in the therapeutic relationship. This study thus provided useful reflections on intensity for the therapist, though where this might be happening for the client also as less clearly delineated.

Athanasiadou and Halewood (2011) conducted a study drawing on methodology of grounded theory, to explore therapists' experiences of somatic phenomena in the countertransference, a topic that has received little notice despite evidence of its manifestation in therapy. They report that there was a noticeable gap in counselling psychology literature of the therapist's clinical use of their somatic states. The results showed that therapists understood their somatic experiences developmentally, as a "relating to the body" (p. 247) that united stages of "defensive operations", "intellectual reflections", "attributions of somatic ownership" and "recognitions of various working patterns in the management of somatic experiences". In addressing the aspects that comprise therapists' processing of their in-session experiences, the researchers found that therapy may likely be impacted when somatic phenomena are neglected or subverted. Athanasiadou and Halewood (2011) suggest replication studies with a broader sample of therapists from various professional contexts. This study provides interesting and novel insights into somatic experiences that convey a sense of what the process of relating to body in the countertransference, that is a related aspect to emotional experiencing of the therapist, though this is not covered, nor is the focus of the study.

2.13 Epistemological and Methodological Positioning in the Literature

The research in this literature review spans a broad range of methodological and epistemological stances, even if very few studies provide acknowledgement or discussion of their paradigmatic assumptions and positionings (Guba & Lincoln, 2005; Ponterotto, 2005). In counselling psychology, a prevailing view for relational therapists, and one that reflects my personal epistemological positioning, is that (Halewood, 2017): "...adopting a critical constructivist position towards the "expert" objective analyst while uncritically accepting the positivist findings of empirical research leads to

epistemological incoherence” (p. 99). The interpretative phenomenological approach I adopt in this study acknowledges that reality is can only be experienced through a process of intersubjective meaning-making, rather than discovered. The case study methodology applied in many ISTDP studies aims to overcome of the “privileged status” (Hoffman, 2009) afforded to neuroscientific and experimental research by devoting its energies to the in-depth case study approach as a way to progress psychotherapeutic knowledge and process. The metapsychological concepts in psychoanalysis that help determine the important clinical effects were developed through contextualized clinical observations rather than through of systematic research that takes an objectivist stance. Yet such an approach would apply a realist status to the status of the analysis, which is in contrast with the epistemological stance opted for in this study. Grounded theory methodology (Charmaz, 2013) employed in investigating therapists’ experiences was theory forming, rather than focused on the meaning-making of participant. Yet, in IPA studies, the purpose of presenting an enriching, contextual view of therapists’ experiences appeared to concentrate on related phenomena than emotional experiencing within a specific context and therapeutic setting.

2.14 Rationale for the Current Study

This literature review has thus shown there are gaps in the literature in terms of research focus and methodological approach. There are no studies that investigate the phenomena of the therapists' experience of their clients' deep experiencing of emotion. While some studies exist in other modalities, ISTDP was selected over these for the following reasons. Emotion-focused approaches share similarities in their attention to helping clients identify, process and express their emotions. Yet these approaches vary in the extent through which they either instruct clients on their feelings, use unconscious processes that entail the therapist’s use of self, and the intensity and acuteness of working with emotions. ISTDP, comparative to respective STDP and EDT approaches, has the strongest evidence base for holding firm to its commitment in ‘staying with’ clients intense emotional experiences. This makes this approach a suitable choice for this study’s focus.

Furthermore, a review of the qualitative research on therapists' experiences reveals that within ISTDP there appears to be a lack of research into the experiences of ISTDP therapists and the phenomena of how they stay with clients experiencing deep emotion. Observational studies undertaken have tended to focus on their adherence-based responses to clients, to show efficacy of ISTDP therapy. Wisdom literature and research on therapists' effects reveals the importance of the therapist's tolerating emotion of the client though without a direct focus on the phenomena of interest to this study. As the professional and practical opportunities for the counselling psychologist are under constant renegotiation as theory and praxis develops (BPS, 2018a), there is, consequentially, an important gap in literature that needs to be addressed. Developing our understanding of intensity of emotion that the ISTDP therapist endeavours to facilitate therapeutically with their clients and experience with them within the therapeutic relationship, seems relatively unique. The expert therapist and therapists' effects research supports the ISTDP assertion that this is a valued skill of therapists who aim for a high degree of clinical effectiveness in their practice. Further understanding what it is like will help offer counselling psychologists and other therapists across modalities gain insight into their clinical practice and professional identity, in view of this intensive, emotions-focused approach. Rather than legislating differences, it is hoped that this can add to the field's preference to pluralism of multiple models, in the spirit of learning from different practitioners and through the subtleties afforded through an investigation of therapists' subjective experience.

2.15 The Current Study and Research Question

The current study will address the following main research question: how do ISTDP therapists experience their client's intense experience of emotion? It is hoped that this broader enquiry to the typical moment-by-moment manner in which this group of therapists tend to reflect on the phenomena to be studied, can help generate contextualised knowledge (McLeod, 2017) within the therapy setting that can serve as a source of emergent and novel insights.

2.16 Chapter Two Summary

ISTDP has a very specific model of delivery, implying that the experienced ISTDP will be in agreement on what exactly is meant by "staying

with” and “client’s intense emotional experience”. Yet, the epistemological stance I adopt in this research means that I endeavour to elicit each participant’s understanding of these terms, and so a subset is gaining an understanding of how therapists understand these definitions, as well as their role in therapy (therapeutic process and outcome). This is an exploratory study that uses IPA to reach an understanding of this complex phenomena. What becomes clear from the above literature on therapists’ experiences is that, often, what people experience, and the way they understand that experience, will not map on to theories of therapy in any straightforward manner. Conducting this kind of research has the effect of inviting therapist-researchers to examine their basic assumptions about therapy, and arrive at a deeper understanding. The rationale for this approach will be further outlined in following, Chapter Three: Methodology.

Chapter Three: Methodology

3.1 Chapter Three Overview

This chapter details the methodology I developed for this study. First, I examine the development of qualitative methodologies and research in counselling psychology. Then I explore the development and application of IPA (Smith, Flowers & Larkin, 2009), involving in-depth, semi-structured interviews. The subsequent sections in this chapter narrate my research process. Here I describe participant recruitment procedures and sampling and the approach I used in the analysis and interpretation of my empirical data, with a view to highlighting the consideration I gave to quality issues in this study. Although my personal reflections and ethical considerations are included in specific sections, these important processes and research tools were drawn on throughout the design and implementation of this study and are therefore emphasized extensively in this chapter.

3.2 Purpose of My Research: Qualitative vs. Enriching Research

Counselling psychology has a long tradition of qualitative inquiry that seeks, as one of its aims, to challenge the orientation toward mainstream quantitative approaches in the field of psychology. These two different methodologies are typically conceived of as based in “contrasting ways of knowing” (McLeod, 2017, p. 395). Yet this distinction has been questioned, as one that sets up a false sense of homogeneity and thus a false opposition (Fasulo, 2015). I drew on Stiles’ (2015) classification of alternative purposes to psychotherapy research, which aims to avoid conflating purpose with method. These distinctions seemed to me valuable and desirable in understanding differences in research approaches and how they are achieved differently.

My research aimed to understand how ISTDP therapists experience staying with their client’s intense emotional experiencing. The purpose of my study thus fits with Stiles’ (2015) category of enriching research as my study likewise “seeks to deepen and enrich people’s appreciation or understanding of a phenomenon” (p. 160). Instead of developing a theory or fact-gathering, the purpose of my study is to promote an enriched and empathic understanding of the experiences of therapists who are engaged in providing a therapeutic

experience of emotion. An enriching-based understanding is the point of the study: one that seeks an aesthetic, empathic, and contextual appreciation of the phenomena in question.

3.3 Methodological Approach: Why Hermeneutic Phenomenology?

Following Willig's (2012) conceptual map of the possible epistemological positions available to the qualitative researcher in psychology, my intended aim of producing knowledge about my participants' subjective experience squarely positions my research within a phenomenological approach. Phenomenology aims to study and comprehend lived experience through an awareness of how a person involves themselves in the world. It is based on the hermeneutic phenomenology of Heidegger (2010) that acknowledged the impossibility of achieving direct access to a person's experiences. Through the collection of first-person accounts, it moves away from an interest in accurately capturing a "real" world but instead focuses on how the researcher interprets the participant's own interpretation of their experiences (Langdrige, 2007). Willig (2012) describes the role of the researcher here as like that of a *counsellor*. Rather than question the external validity of what the participant says, the researcher's role is instead to listen empathically to the participant's account of their experience.

The phenomenological view assumes multiple worlds whereby the same event (such as a therapeutic encounter) can be experienced differently and so this perspective takes an interest in the lived experience of the participant and what their world is like for them. It can give language to aspects of existence we already know implicitly yet have not expressed in depth, or alternatively, surprising insights can reveal themselves. As Finlay (2011) highlights, phenomenological research can deepen an understanding of therapeutic practice and processes and aid therapists in both their personal and professional development. This methodological focus is therefore a good starting place for a study on therapists' experiences. This position recognises the social-psychological and experiential world of the person as diverse. It also echoes the value the field of counselling psychology places on the humanistic and pluralistic attitude (Kasket, 2012) toward psychotherapy (Cooper & McLeod, 2011) and research practice (McAteer, 2010; Rafalin, 2010).

More specifically, my study adopts an interpretative phenomenological approach (Willig, 2013). Heidegger's (2010) hermeneutic phenomenology highlights the practice of interpretation as the key methodological task, based on the centrality of interpretation to all human understanding. Interpretative phenomenology shares a broadly realist ontology that does not deny the presence of underlying psychological structures but asserts that the experience of phenomenon can only be known through interpretation (Willig, 2013). Such an approach is positioned ontologically between realism and relativism. Rather than seek universal truths about phenomena, my inquiry rejects such realist, positivist approaches that would aim for an objective account of phenomena under study. Likewise, a totally relativistic, constructionist focus on the effect of language, is also eschewed as this would also not fully address the main aim of the study in exploring the meaning that therapists ascribe to the complex phenomena of staying with their clients' deep experiencing of emotion. Interpretative phenomenology was thus considered aligned with my research question and seen as a methodology that can attempt to apprehend and highlight the essence of an intelligible experience through interpretative practice (Langdrige, 2007).

3.4 Rationale for Using IPA

I have chosen IPA as the method most suited to address my research question. This is primarily due to IPA's epistemological underpinnings that engender a methodological commitment to exploring how a unique phenomenon is grasped and made sense of by particular people (Larkin & Thompson, 2012). IPA is a pluralistic approach that aims to understand the lived experience by incorporating the ideas of the key philosophers of phenomenology: Husserl, Heidegger, Merleau-Ponty, and Sartre. Smith, Flowers & Larkin (2009) provide detailed guidance on ways to investigate lived experience in a systematic way that is valuable for psychologists. An idiographic focus can best reveal the ISTDP therapist's subjective lived experience through an inductive process that centres on the participant's perceptions as opposed to other predefined categories. IPA can thus engage me as the researcher in a detailed exploration of my participants' lived

experience and locate the phenomenological account we generate together within a co-created reality (Smith, 2011; Willig, 2013).

Hermeneutics is a method of interpretation that views meaning as a socio-cultural product arising out of human action. The interpretation of a text is thus influenced by the person doing the interpreting (Gadamer, 2013; Heidegger, 2010). Understanding emerges through a practice of relating part of a text to the whole in a back and forth, circular process. Consequently, any interpretation a researcher offers will inevitably differ from the text's original meaning. Likewise, symbolic interactionism (Blumer, 1969; Mead, 1934) is important for explaining the situated and relational aspects of human understanding. Interactions between people and the sense people make of their lived world through shared symbols and social life, place language at the heart of the subjective meaning making processes of the person. It is through people's intersubjective and interpretative pursuits that they constitute their worlds and through which their sense of themselves and others emerges.

IPA therefore views contextual processes as fundamental to understanding our experiences, including the narratives participants give about those experiences. Drawing further on Merleau-Ponty's (2012) view that humans regard themselves as different from all other things, means a sense of self that is embodied, actively and holistically perceiving the world and others. The implication for IPA is that as researchers we can observe and feel empathy for our participants, but ultimately we only see phenomena from our perspective, and can never share entirely the participant's experience (Smith, Flowers & Larkin, 2009). Sartre's (1956) view of the self as an ongoing project of always becoming ourselves, means he sees our being in the world as always unfolding. Meaning-making is likewise unfolding for both the researcher and the participant through a double hermeneutics of empathic understanding of the participant's perspective whilst also questioning aspects of their accounts that they may be less aware of. Yet, IPA's idiographic focus is on the participant as the individual and entity to be understood in their own right (Smith, Flowers & Larkin, 2009). The researcher may nevertheless endeavour to move beyond the individual case to make more general statements about individuals.

Alternative methods, although of similar paradigmatic scope, were disregarded due to a lesser correspondence with the research aims and my epistemological position. These were grounded theory, discourse analysis, narrative inquiry and thematic analysis. Grounded theory (Charmaz, 2013) seeks convergences within a typically larger-sized sample to support broader conceptual explanations, whereas IPA is interested with providing detailed and rich accounts of the personal experiences of a smaller sample (Smith, 2004). Discourse analysis is doubtful concerning the accessibility of cognitions, a key aspect of IPA central to the sense-making process, and instead focuses on language and how it acts to construct or constrain social reality (Smith, Flowers & Larkin, 2009; Smith, Flowers & Osborn, 1997). Lastly, narrative inquiry (Murray, 2008), though of a constructionist orientation that can match well with the symbolic interactionism of IPA, and is concerned with sense-making, delimits meaning to story form that can be adequately considered within IPA without the story-form constraints (Smith, Flowers & Larkin, 2009). Additionally, thematic analysis (Braun & Clarke, 2006) may have been appropriate for an exploratory study of therapists' experiences but was dismissed due to its nomothetic, rather than idiographic focus.

Entering the lived experience of ISTDP therapists, and aiming to understand the uniqueness of each therapist's experiences within their context may help sensitise other therapists to the potential ways that ISTDP therapists might feel, think and respond, and in relation to their clients. Such studies are not directly concerned with psychotherapeutic processes or outcomes (Gelo & Manzo, 2015), but instead give therapists, what McLeod (2011) refers to as "essential background information". The purpose of such research aligns with Stiles' (2015) description of enriching research that is outlined above. Within the qualitative research literature, and IPA literature more specifically (Smith, 2011), there exists a number of studies in which the experiences of people living with health conditions and socio-cultural difficulties have been explored. The therapist can find such studies and their implications to be a crucial resource, as a way to attune to the uniqueness of the client's experiences, and transfer learning to their own clinical practice.

This section has considered the theory underpinning IPA and how this method uses theoretical approaches – phenomenology, hermeneutics, symbolic interactionism, and idiography – to guide its distinctive epistemological framework. Doing so has enabled me to ensure I have chosen a methodology that best reflects my personal and professional values and research objectives (McLeod, 2011). Having outlined the major research paradigm and the positioning of my own thesis within these paradigms, it can be concluded that the epistemological positioning of my study is specifically suited to my research question (Gelo, 2012). It is also aligned with the phenomenological roots of counselling psychology, taking a subjective stance with a focus on the meaning-making processes of individuals who participate in this study (McLeod, 2017).

3.5 IPA Method – The Research Process

The remainder of this chapter concentrates on steps I have taken to gather rich and exhaustive data from participants that could successfully give voice to their experiences through a sufficiently phenomenological and interpretative account of their narratives. I offer reflections on my response to the conceptual and practical difficulties I encountered, in order to provide a transparent account of my research journey in executing the design of my study and the collection and analysis of data (Tuffour, 2017).

3.5.1 Participant and recruitment procedures.

3.5.1.1 Sampling method. I used purposive sampling, the standard basis for data collection for IPA studies (Smith, Flowers & Larkin, 2009), to source participants. The suitability of the participant in being able to provide insight into the phenomena under study was a core criterion of selection. A consequence of this was a homogenous sampling that aimed for a rigorous understanding of experiences shared by a particular group, as well as those of the individual (Willig, 2013). ISTDP therapists are trained to work in an intensive and experiential manner that is emotions-focused, thus making them particularly useful participants for this study. The role and qualities of being an ISTDP therapist, therefore, boosts the likelihood of their insight to the experiences of staying with client's experiencing deep emotion and what it is like to work therapeutically in such instances.

3.5.1.2 Inclusion/exclusion criteria. To be invited to participate, participants needed to have completed the ISTDP core training at a recognised ISTDP institute and hold a minimum of 3 years' professional experience as an ISTDP practitioner. This decision was made in personal communication with an experienced ISTDP trainer, with over 10 years ISTDP experience, who advised on this criterion. A pragmatic balance was aimed for between securing the required number of participants and ensuring a sufficient degree of experience that could ensure adherence to the ISTDP model for the purposes of adequately addressing the research question. Participants needed to possess current membership/accreditation with a counselling or psychotherapy professional body (for example, the BPC, BACP, BPS and UKCP). The exclusion criteria were participants who were not currently practising ISTDP, or who were not delivering ISTDP as their primary modality of treatment. Participants who were for any reason unable to give informed consent or who had complaints pending with their professional body would also have been excluded. None of the exclusion criteria were encountered in the recruitment process.

3.5.1.3 Recruitment strategy. There were at the time of recruitment estimated to be around fifty ISTDP practitioners in the UK, including those currently in training who may not yet have the requisite experience to participate in the study. To ensure a purposively-selected, carefully-situated sample, I contacted ISTDP-UK, the UK-based organization for ISTDP who hold a central listings of registered ISTDP therapists. I provided this contact with the participant information sheet, which outlined the purpose of the research (see Appendix A) and a request to forward this information to the potential participants. My contact details were included so that participants could contact me for further information. Participants were also recruited via opportunities through my own ISTDP contacts, who offered to distribute my advert through their private contact listings of ISTDP therapists. Recruitment of participants via the snowballing method was also permitted, where participants forwarded on the research details to other potential participants, which happened in the recruitment of three of my five participants. It would have been possible to recruit from an international pool of ISTDP practitioners, and similar to the

process above, I distributed my advert through an ISTDP practitioner based in California. However, there were no responses to the advert, and so due to time constraints, I made the decision to concentrate my efforts on recruitment from within the UK.

3.5.1.4 Choosing the participants. I received six responses from current ISTDP practitioners who were suitably qualified and experienced to take part in the study. I corresponded with all participants via email, forwarding the recruitment advertisement and invitation letter, and inviting them to respond if wishing to take part. Participants were offered choices of location and time for the interview, where all venues chosen by the participants were their places of work. One interview was conducted by Skype via a personal computer from a private location. Skype interviews were offered as a substitute to face-to-face meetings to help broaden the participant pool (Hanna, 2012; Sullivan, 2012). Although six participants were interviewed, one participant requested post-interview for their data to be withdrawn, and so their data were not included in the study.

3.5.1.5 The five participants. Demographic details offered are intentionally minimal so that the participant cannot be identified from any such information or when considered together with the participant's words. Of the five participants included in the study, four described their gender as female and one as male. All had a minimum of three years' experience as an ISTDP therapist and all had completed their training at the ISTDP-UK institute. All were accredited psychotherapists who currently practiced ISTDP and classed ISTDP as their core modality. Thus, these commonalities across participants fulfilled Smith, Flowers and Larkin's (2009) guidance for obtaining a moderately homogenous sample that can produce a sufficient perspective that is suitably contextualized.

The sample size of five participants was deemed suitable, according to the guidance for doctoral studies of four to eight participants given by Smith, Flowers and Larkin (2009). This lower sample size allowed for a faithful adherence to idiographic focus of IPA and made it possible to present an analysis of greater depth and interpretation that might be inhibited by larger

sample sizes. All participants were attentive and effective in expressing their thoughts and feelings, in order to illuminate the particular research focus. This idiographic presentation helped illuminate the complex thinking and emotional processes these therapists faced in their moment-by-moment engagement with clients' intense emotional experiencing whilst also highlighting patterns across these individual accounts. Thus the benefit of the specific sample was in being able to capture detail on this group of psychotherapists who have shared particular experiences with clients that are of interest to therapists who work in an emotions-focused way and indeed any therapist hoping to understand further what it is like to stay with their clients' intense emotional experiencing.

3.5.2 Data collection. The standard method for IPA data collection, drawn on in this study, is a semi-structured, one-to-one interview. IPA researchers do not regard interviews as an objective and impartial method for collecting data (Rapley, 2001). The interviewer aims to engage with the participant flexibly and collaboratively, to identify and interpret the relevant meanings employed in making sense of the subject matter. The interview can aid the researcher in building a rapport with the participant that enables them to voice their particular beliefs and ideas through personal and in-depth discussion. ISTDP has a very specific model of delivery, implying that the experienced ISTDP therapist will be in agreement on what exactly is meant by "staying with" and "client's intense emotional experiencing". Yet, my epistemological stance entailed that I endeavour to elicit each participant's understanding of these terms, and so a subset is gaining an understanding of how they make sense of these definitions and apply them in their role in the therapy they deliver.

3.5.2.1 Interviews. Before the interview commenced, the demographics information form (see Appendix B) was given to and completed by the participant. I then read aloud the consent form (see Appendix C) to the participant to ensure a shared understanding of its contents before a signed copy was obtained. This also ensured participants were clear about their involvement and agreement with the study. All interviews were recorded digitally. An initial warm up question of "what drew you to ISTDP?" and then wider topics and areas of interest were introduced through open questioning,

such as how participants work as an ISTDP therapist. The interview schedule (see Appendix D) covered three topic areas, including participants' understanding of their focusing on clients' intense emotional experiences (e.g. how do you view intense emotional experience?), their experiences of staying with such emotionally intense moments (e.g. what is it like when the emotions a client experiences are particularly intense?), and their experience of their capacity to facilitate a therapeutic experience of emotion (e.g. what enabled you to stay with your patients' deep experiencing of emotion?). Prompting questions were used that followed participants' responses, in order to help highlight the key aspects of sense-making related to therapists' endeavours with a client experiencing deep emotion. At the close of the interview participants were handed a debrief form (see Appendix E), which contained details of further support should they need this. The same procedure was conducted via email for the Skype participant.

During the interviews, I aimed to remain sensitive and aware of non-verbal and non-behavioural communication (Pietkiewicz & Smith, 2014). All interviews were later transcribed verbatim, where all grammatical and verbal errata, laughter, significant pauses were retained to allow for full focus on the semantic meaning (Smith, Flowers & Larkin, 2009). For the Skype interview, though the guidance of Deakin and Wakefield (2014) on logistical and ethical considerations, was easily met, I found building rapport online more challenging than with face-to-face interviews. During the interview I had felt I was slightly less emotionally connected to the participant. This, on reflection was perhaps due to the lack of visual and sensory cues that might be available in an in-person interaction and feeling concerned about the impact of this on the participant. This meant I did not probe answers as fully as with the face-to-face interviews. Two key differences therefore resulted in data collected. First, the skype interview was the shortest in duration, at 40 minutes (whereas the longest interview was 73 minutes). Second, though rich data (Smith, Flowers & Larkin, 2009) was gathered, there was perhaps scope for a greater degree of depth in terms of the phenomena under study. Based on the learning and reflections from this interview, I believe that in the future I would be in a better position to overcome these challenges with future Skype interviews, however, for this study, no further online interviews were required.

Post-interview, I made reflections in my research diary regarding the interview, in terms of any impressions or expectations, and also a brief evaluation of my interview style, that I used as the basis to improve my approach in subsequent interviews. I used Kasket's (2016) reflexive list of questions helpful for interrogating and reflecting on the research process, the interviews and any pre-understandings about the participants that arose. For example, I had noticed that my perception of the participants as experienced and specialised practitioners had led to an erroneous assumption that they would therefore be "zipped up" (as it appeared to my mind) emotionally-speaking, in terms of having addressed their own early attachment traumas to an extent that they no longer manifest in the work. Yet participants' responses often challenged my expectations and as I began noticing this, I was able to explore this area more fully, including the contextual influences to such moments in the work, which may otherwise have been missed. It also meant I became more attentive to the sensitivity of the research by highlighting the sensitive nature of the topic and reminding participants at the start that they need only talk about what they would like, drawing on either personal or professional material as they wished. Such reflexive activity was thus crucial for identifying my positioning (Frost, 2016) and preconceptions that I was then able to foreground and use to improve my interviewing practices and progress my understanding of the phenomena under study.

3.5.2.2 Confidentiality, anonymity, and data security. Confidentiality of the data and anonymity of participants was ensured by locking paper transcripts and signed consent forms in a secure cabinet. Participants were informed that after data has been analysed, supervisors and examiners would also have access to sections from the anonymised transcriptions of interviews. Audio-recordings were uploaded onto a laptop and destroyed from the digital voice recorder and all electronic data, including audio recordings, were password-protected. Real names and identifying references were omitted from transcripts, and a pseudonym was assigned to each participant by the researcher. Only the main researcher had access to the names and identities of participants, which were stored separately from all transcripts. After the completion of the study, audio recordings and transcripts would be kept

securely and anonymised. These data would be stored for a period of three years, in the event that it is possible to publish the findings, and destroyed thereafter.

3.5.3 Data analysis. The data were analysed using IPA. As a novice researcher of IPA and qualitative research, I adhered closely but not prescriptively to the six steps outlined for the analytic process (Smith, Flower, & Larkin, 2009). Below, through description and reflexive commentary, I highlight how the methods of my research aligned with the wider philosophical commitments of IPA. I also highlight my efforts to draw on the six-step guidelines in a flexible and creative manner, based on my own research objectives and priorities. Some conceptual difficulties that I needed to overcome are discussed. As well as reviewing past IPA studies (Smith, 2011) and doctoral theses (for example Andersson, 2014; Spragg, 2013), I found the work of Huff et al. (2014) and Gee (2011) useful in helping me build the confidence to delve deeper into comprehending and conducting IPA in enriching research.

In order to appreciate as fully as possible the influence of my epistemological stance, it was important to consider my knowledge claims in relation to the data collected and analysed. The distinct ways of knowing reflected in the (psychodynamically-inclined) realist or constructivist position that informs much of the ISTDP research described in the literature review versus my interpretative phenomenological stance are also worth clarifying. The researcher in the critical realist mode (Willig, 2012) may consider the status of the data gathered as relativist (i.e. data does not necessarily accurately reflect reality) and yet the status of the analysis as realist (where theoretical explanations are used to accurately reflect what happens for the participant). In IPA, the interview text is understood as a verbal utterance of the participant's psychological processes (Willig, 2013), and thus shares the empiricist concerns of the critical realist stance. Yet in the same way that a concern for participant's meaning-making is not dependent on a truth value, my meaning-making processes are implicated in any interpretation I offer. Therefore, in this study I hold a relativist attitude towards the status of both the data and analysis (Willig,

2012), without any inclination to disavow the reality of those experiences for my participants.

3.5.3.1 Step one: Reading and re-reading. In this first step I repeatedly read the transcript in order to engage myself fully in the experiential world of the participant. I listened to the audios alongside reading the transcript, considering tone, volume and silences, as preparation for hearing the voice of the participant. This also helped me to imagine the participant's voice in later stages of the analyses. I also made notes about my own role in the interview, how I had handled the semi-structured format, particularly the open-ended process of following the participant's sense-making but keeping in mind key questions relating to the phenomena under study. I found this a necessary process in order to feel comfortable and confident to begin the next step of initial noting.

3.5.3.2 Step two: Initial noting – producing detailed annotations and comments. The transcript was presented in the first of three columns (see example in Appendix F). In the second column, I made notes of initial responses to anything interesting or significant in the transcript. Comments were descriptive (meaning or content the participant talks about), linguistic (how the participant uses language) and conceptual (arising questions or possibilities relating to theory that can enhance understanding; Smith, Flowers & Larkin, 2009). The final column was left for the next step of noting emergent themes.

I found the early stages of the initial noting for the first participant to be one of the most anxiety-provoking aspects of the analysis. It felt I had lost all reference to any of the knowledge claims I was holding to in my epistemological position and research approach. I reflected on this with peer researchers on my programme of study and could begin to understand my fears as the “drift back towards positivism”. This drift included the search for unambiguous answers and objectivity rather than bringing my own perspective to the data and valuing the intersubjectivity that is at the heart of good IPA and counselling psychology research and practice (Kasket, 2012). This predicament could be explained by my appreciating that my previous and first encounter in counselling psychology was as a quantitative researcher. Once I could appreciate that my subjectivity

would be what makes rather than “corrupts” the research, I was able to begin noting in a way that connected my pre-understandings with my emerging understanding of the participant. One way I coped with the restrictiveness of this was to write free text before and after the process of initial noting; before, to free myself up to encountering the text, and after, to try and capture anything from the participant’s account that I felt was not reflected in my initial noting. I then was able to return to these statements at various later stages to check I was speaking to the psychological concept as well as at the specific points of the analysis.

3.5.3.3 Step three: Annotating and developing emergent themes.

This stage of the research was aimed at directing the analysis from the annotations to apprehending a sense of the transcript in its entirety (Smith, Flowers & Larkin, 2009). I noted in the third column any potential themes that seemed to be suggested by what the participant had said and also any shared features and attributes that surfaced in the transcript. These themes were then transposed to another word document, along with line number and corresponding verbatim quotes, so the articulation of these themes could be easily evidenced and further examined for their phenomenological and interpretative rigour. Once satisfied with the themes, I transposed the themes to an online mapping tool, so they could be easily clustered by association and commonalities (Huff et al., 2014). Many versions of the maps were generated and re-arranged until all themes were clustered, retained separately or discarded, or amalgamated with themes of significant overlap.

In this step I faced challenges with the task of reducing the whole text and data set into parts, and in assuming the interpretive stance. I initially perceived the shifting of my focus from the participant to the phenomena under study as being unfaithful to their account. Consequently, in my first attempt at generating emergent themes I had mostly elevated the participant’s words to the level of theme. This generated themes that were phenomenologically grounded in the participant’s experience but lacking focus and psychological vigour. I reread Huff et al.’s (2014) example of adhering to the philosophical commitments of IPA, which helped me gain confidence in including my own understanding. I redid this stage over two days and was more at ease to

represent psychological themes that achieved more of an interpretative balance and were more focused towards the research area.

3.5.3.4 Step four: Searching for connections across emergent themes within the participant's account. Once many of the emergent themes were identified, it was possible to explore whether some of these themes could be subsumed under other themes (see Appendix G for a table of clustered emergent themes for one participant.) Here I used the research question as my guide to help prioritise which themes were retained or discarded, together with an overall sense of the participant's account against each theme. On my devised list of all the emergent themes that had been identified in the participant's account, I rearranged themes until all were appropriately clustered. I looked for connections among clusters using abstraction, subsumption, and polarization, as described by Smith, Flowers and Larkin (2009).

3.5.3.5 Step five: Moving to the next case and repeating steps one to four. Once the first four steps were completed for the first case, the same steps were repeated individually for subsequent cases. Alongside the analysis, I developed a preliminary version table of themes groupings until all three superordinate themes were added. The table was instrumental for analysing across cases where I trialed various arrangements of subordinate and superordinate themes. Eventually, a clear and robust set of themes revealed itself, producing a final version. Here I endeavoured to treat the next and subsequent cases on their own terms, to adhere to the idiographic commitment and focus on the individual. This entails, as Smith, Flowers and Larkin (2009) suggest, "bracketing" any ideas that emerge from the previous case when working on subsequent cases. I achieved this process of putting aside prior concerns by noting down such "intrusions" in a separate document, and dialogue with the current case by alternating the questions, "what have you told me so far?" and "what are you trying to say here?" These practices helped me develop the valuable skill in IPA of letting new themes emerge with each case.

3.5.3.6 Step six: Looking for patterns across cases. This final step entailed searching for patterns across all five cases. This was achieved by

building a table that contains the final superordinate themes with extracts illustrating each subordinate theme (Willig, 2013). To ensure researcher bias did not over-intrude on the participants' accounts through the generated themes, I re-read the original transcripts a final time to check that interpretations were rooted in the participant's account. Having documented all steps in the data analysis process, I now had a chain of evidence linking my decision-making from the initial noting to the end of the analysis. Additionally, my supervisors conducted small-scale audits of my work, performing their own brief analysis and discussing my initial annotations and emergent themes through to final themes. This way I could be sure my interpretations were valid in connection to the case being examined. (See Appendix H for table showing cross-reference to themes present in all cases).

Throughout, I found helpful Finlay's (2011) four watch-words for engaging with the analysis stage of the research. They are: dwelling, wonder, evidencing and ambivalence. *Dwelling* refers to the immersion in the data that happens throughout the analysis but contains its own inner rhythm of empathic approaching and stepping back from the data to get a feel for the participant's experience and to consider how it appears for them. Adopting an attitude of *wonder* involved attending to those parts of the transcript that were particularly resonant – I aided this process by having my research question in plain sight at all times during the analysis. *Evidencing* the analysis involved following an empirical commitment and ensuring the creative and interpretative elements were grounded in the data. This was an element of the analysis where I initially had the least confidence but felt this grow throughout the process of analysis. Lastly, capturing *ambivalence*, in order to illuminate the contradictions and ambiguities of human experience, was initially difficult for me to attend to, based on being overly committed to accuracy in wanting to "re-present" what the participants have said. I could see the limitations of this fairly early on in generating emergent themes, but also when looking for patterns across cases. I considered the multi-layered aspect of human experience within and across each case and ensured this had been properly captured in the emergent and final themes. Altogether, these processes helped me to feel confident that my interpretations of meaning and experience were "genuinely inductive" (Gee, 2011) and situated within the concerns and contexts of the participants.

3.5.4 Enriching research and quality. This study applied Yardley's (2000; 2008) evaluative criteria to assess the quality and validity of the research, as they provide a set of principles that are established in the phenomenological field for ensuring the rigour of the study (Finlay, 2011). This helped address the ongoing challenge of ensuring my research evenly reflected my interpretative phenomenological positioning (Willig, 2013) and was in tune with the philosophical commitments of IPA methodology.

3.5.4.1 Sensitivity to context. Sensitivity to context was established from the early stages of the research process. The literature review in Chapter Two aims to convey how the current understanding of emotional experiencing and the therapeutic endeavour is set within a combination of cultural tendencies and ideological influences that are intensified by psychology's focus on the individual. This is a crucial precondition to the interpretative process of IPA, that of the hermeneutic circle, that aims to achieve a more comprehensive understanding of the "part" of the phenomena under study, in relation to the "whole" socio-cultural context (Smith, Flowers & Larkin, 2009). Furthermore, I adhered to IPA's idiographic commitments by remaining sensitive to the participant as an individual whose unique views and experiences are shaped by their context. During the research process, I used reflexivity practices of keeping a research diary and reflecting on my process through use of supervision. This helped with recruiting and interviewing participants, and with interpretations made during the analysis and discussion, and particularly with recognising the contextual aspects of the researcher-participant relationship.

3.5.4.2 Commitment and rigour. I established commitment and rigour through an ongoing engagement with the research focus, and careful and rigorous data collection and analysis. Following Smith, Flowers and Larkin's (2009) advice for the researcher to develop their research competencies, I attended a research consultation group comprised of fellow trainees, attended IPA workshops and other research method lectures. The open-endedness of the semi-structured interviews allowed me to rapidly build good rapport with participants. Here I relied on my counselling psychology training and clinical therapeutic skills to help forge sound relationships. As described above, the

detailed account of the methodological and analytic process illuminates the vigorous and determined attempt to perform this research in a rigorous and attentive manner in line with Yardley's (2008) guidelines.

3.5.4.3 Transparency and coherence. Transparency and coherence in the research process and write-up was achieved through clear delineation of each stage of the research. The interpretative phenomenological stance I have adopted meant that I aimed to recognise that any interpretation I offered was rooted in my own experiences and "fore-understandings" (Heidegger, 2010) and thus I have been transparent about these through use of reflexive practices. Writing up of my research thus incorporates a sustained attention to my positioning as researcher, including a focus on the influence of my epistemology and psychotherapeutic perspective on my methodological choices. When reflecting on how I collected and analysed the data, I aimed for rich descriptions of my reflections on the data collection and analysis stages. Example reflections are included across this methodology chapter and other chapters, except the analysis chapter, which as an exception focuses solely on the participants' accounts.

3.5.4.4 Impact and importance. Yardley (2008) regards impact and utility as the ultimate criterion by which to assess the quality of research. I hope this study will broaden an understanding of what it is like for therapists when working with clients who are experiencing intense emotion. There is currently very little research highlighting therapists' experiences in this area, particularly from the modality of ISTDP. Moreover, I hope the application of the findings can be extended, both to widen our understanding of the emotions-focused work of ISTDP therapists, and in a small-scale way enable therapists to relate more openly to their own capacity to engage with the deep emotions of their clients. This fits with a key aim of enriching research that does not seek to give a detailed account of broader populations but relies on its audience to discover ways to transfer their observations and interpretations to their own contexts (Stiles, 2015).

3.5.5 Ethical considerations. Ethical approval for the study was granted by the University of East London's Ethics Committee (see Appendices I

and J). I abided by the BPS (2018b) code of ethics and conduct and (2014) code of human research ethics to help maintain an awareness of and guide the approach to what was covered by the ethical approval. The information sheet given to participants gave details and rationale for the study, including what would be asked of participants, and how their data would be used and anonymised. The consent form that participants signed emphasized that they had read the information sheet relating to the research study, and that the nature and purposes of the research had been explained to them. It also confirmed that participants had had the opportunity to ask any questions, and had an understanding of what was being proposed and the procedures in which they would be involved. Due to the sensitive nature of the research topic, I debriefed participants at the close of the interview. This was to check for any distress that may have been present as a result of the interview. This included the option to discuss and identify further support from a supervisor or personal therapy. To ensure my personal safety when interviewing, I made contact with a third-party prior to and after the interview.

3.6 Chapter Three Summary

This chapter detailed my chosen research methodology and positioning for this study. It explained the processes of data collection and IPA analysis, including my reflexive engagement. This “enriching research” study adopts an interpretative phenomenological epistemology. My research process and adherence to methodological commitments were described. Quality criteria and ethical considerations for the study were presented. Chapter Four presents the analysis that followed from the design of the research and the data collection and analysis.

Chapter Four: Analysis

4.1 Chapter Four Overview

This chapter aims to provide an in-depth exploration of the three superordinate themes which were constructed during the interview, transcription and IPA process, supported and illuminated by extracts from the participants' accounts.

4.2 Overview of Themes

In this section I describe in detail the three superordinate themes that emerged from the data. They are: "opening that door": striving for emotional closeness; connection versus disconnection: what's happening in the room; and "there's more of myself now": building one's own capacity. The themes connect to areas of psychological relevance in relation to therapists' experiences of helping bring about a therapeutic and often intense experiencing of emotion for clients. Table 1 presents the three superordinate themes, in which data from all five participants have contributed. The table also shows the related subordinate themes, in which three or more participants (around half the total number, Smith, Flowers & Larkin, 2009) have made contributions. All subordinate themes are based on at least three participants' accounts. Where prevalence of themes is highlighted, the following phrases are used consistently throughout this chapter to indicate presence in cases: "all participants" = all five cases; "nearly all" = at least four cases; and "most" = at least three cases. As indicated by the exploration of the analysis throughout this chapter, the superordinate and subordinate themes are interrelated, and their influence is multidirectional in nature.

Table 1 Superordinate and subordinate themes

Superordinate themes	Subordinate themes
“Opening that door”: striving for emotional closeness	<ol style="list-style-type: none"> 1. “It’s really rewarding”: the motivating power of seeing a person change 2. “Not giving up on the route to getting there”: persevering through resistance 3. “Trying to decide where to go next and how to proceed”: pressure and focus on accuracy
Connection vs disconnection: what’s happening in the room	<ol style="list-style-type: none"> 1. “A shared experience”: connection and intimacy in the therapeutic encounter 2. “It’s painful not to be able to reach a patient”: feelings of frustration and inadequacy 3. “Talking to myself”: remaining calm and professional
“There’s more of myself now”: building one’s own capacity	<ol style="list-style-type: none"> 1. “You get better...you get more emotion in the room”: building emotional tolerance 2. “Those minute flickers”: observing and reflecting on inner emotional life 3. “Knowing enough about myself”: using and protecting the self

4.3 Superordinate Theme One: “Opening That Door”: Striving for Emotional Closeness

This first superordinate theme clusters together subordinate themes that recognise the contradictory features that arose from participants’ talk of their striving for emotional closeness in their therapeutic work. The title of the theme draws on the metaphor of the door to symbolize the challenging resistances in the process of change that the therapist and client may face. The theme presents the different ways in which participants spoke about how working with patients’ defences against intimacy in the therapy room brings difficulty and challenge for the therapist but also comfort and reward. This included noticing patients’ immediate responses to having a caring other persevere through their

resistances to closeness. Similarly, therapists also face such exposure in helping facilitate a therapeutic experience of emotion. The motivating aspects of the work were therefore accompanied by challenges to help overcome patients' resistances. Striving to more accurately deliver interventions, therapists may face greater pressure and focus on avoiding misses or missteps in their practice. This theme therefore captures the underlying tension between the sense of achievement in effecting the reaching through to emotion but also at times the sense of anxiety and attention to the pressures of achieving intimacy. Three subordinate themes emerged: (1) "It's really rewarding": the motivating power of seeing a person change; (2) Moment-to-moment precision viewed as comfortable vs difficult to deliver; and (3) "Trying to decide where to go next and how to proceed": pressure and focus on accuracy.

4.3.1 "It's really rewarding": the motivating power of seeing a person change. All five participants reflected on their initial experience of being drawn to the precise nature of ISTDP as an effective way of working and witnessing physical changes in the client in the room. Participants regarded the video material of casework they viewed at conferences as a powerful influence on their decision to train in the ISTDP model. This is illustrated by Raelyn's emphasis on effectiveness and the comparison with her then current way of working:

... what really drew me was seeing um video material of ISTDP in practice, so actually seeing the work, seeing the interventions, and seeing the result ... so effectiveness and I suppose, being more active in the work, as a therapist, moving away from the blank screen, and to being, you know, quite an active therapist.
(R, 14)

Raelyn's repetition of "seeing" perhaps highlights the importance for her of bearing witness to effective practice and also being able to notice the benefits of this. Raelyn views the more active therapeutic stance in light of her own prior experience, revealing her assumption of the neutral psychodynamic stance she was feeling less close to as a more passive way of helping show patients their unconscious inner world. Judith was, likewise, struck by seeing parallels with what "rings true" with her own clinical experience and that her response to the theory, "Yes. That makes so much sense", was backed up by what she saw on video. (J, 49). David (20) links the keenness of his emotional response to

witnessing the intensity that was reached through the work. Emma, too, was impressed by the speed and efficiency of the work she witnessed in the time sequence in the videotapes, seeing in hours what might have taken her years to achieve in her way of working: "... So it just, it blew my head off, it really did" (E, 15). Emma uses a very powerful metaphor to recall an almost incredulous response and the mode of questioning that followed seems emotionally charged. That Emma, unlike Judith, could not yet see how effects were being achieved, appears to have contributed to her "mind blown" reaction and the extremely strong impression the tapes had on her. Beverly was impressed by what was achieved in a single session:

... Um, I remember thinking that if psychotherapy is uh like going to someone who massages a bit of you that's hurting - um gently massages it - ISTDP seemed like a surgeon taking a very sharp scalpel and very carefully cutting out, s- the thing that was causing the problem, um, which was very effective but it's a sharp scalpel and you have to know how to, how to use it. Or you can, kind of, do some damage. That's, kind of, how I thought about it, and I came away from that thinking, I want to learn how to do this type of therapy. And if I can't do that of therapy, I don't want to do the other type anymore...It had a very profound effect on me. (B, 19)

Beverly's interesting metaphor appears to highlight how in the same way a surgical scalpel consists of two parts – a blade and a handle – the importance of the practitioner who holds that handle and their discernment in the precise application of ISTDP "tools". It seems that part of this "profound" and revelatory experience for Beverly, in terms of informing her future direction, was related to a great sense of responsibility in approaching this way of working.

All participants reported the value of observing helpful change in the being of the patient and how an appeal for the therapist is witnessing, in their therapeutic work, signals of the healing for the patient. It also helps understand the focus on the patient and their understanding and assessment of the patient through how they present physically in the room. Raelyn highlights how when helping the patient having that emotional experience she can "literally see a person change" (R, 652):

they will be more better put together, more physical uh posture and tension, but I don't mean tension in a bad way, I mean in a good way like not slumping, like sitting up, they will somehow

look better. So you do see those very positive changes. You see a massive drop in anxiety levels, right, so there's lots and then you see improvement in symptoms, so there's lots of things that encourage you, I think, just to know that you're doing a good thing, and not harming the person. (R, 654)

Raelyn's sense-making of a "good" or "bad" way of sitting is based on the notion that various means that patients use to avoid emotion can reveal themselves in the patient's body positioning. Raelyn's focus on the patient's emotional physicality is closely linked to her ability to assess their health and progress. The encouragement she feels, when successfully helping the patient forgo the use of emotionally avoidant responses that are generating their symptoms, perhaps reveals how discouraging and uncertain this can be also for the therapist before this point. Emma, likewise, is invigorated by the physical changes she observed in patients in terms of how they relate to and "feel about themselves" (280):

Uh that's *exciting* (eyes widen) - it's really rewarding. And again - I can see in my mind the person I saw today, um started three days ago with someone who looked very very different from the way she ended up looking today, w-when we were going through something which was highly charged. And she started to emerge and just look. And give out a sense of a very different sort of presence and strength. (E, 281)

Emma here emphasises how gratifying it is seeing true emotion expressed through the body of the patient. There is sense of the "real" self of the patient transpire which Emma regards as healthful. Emma lists physical aspects in the way Raelyn does, but instead speaks of "presence and strength" that are nonetheless *seen* by her as qualities that are somehow emanating out of the patient. Whilst Raelyn and Emma identified patient examples in the therapy room, Beverly also found reassurance and encouragement from seeing changes in people in her personal relationships (B, 512/575). This presupposes that reassurance from within the sessions may not always be enough for Beverly, thus she experiences further validation for her approach as helpful. In this subordinate theme, participants' motivation in the work through the appeal of seeing in-session changes in the patient. This is an aspect that connects with the next subordinate theme where participants reflect on their views of their work as easy versus difficult to deliver.

4.3.2 “Not giving up on the route to getting there”: persevering through resistance. All participants made reference to the ease of working with patients at the level of emotion in comparison to difficulty of helping them reach beyond their resistances. Drawing on symbolism of the travel and the journey helped participants convey a sense of the process and the vigorous motion in continuing through the tough terrain of the emotional landscape shared by patient and therapist.

Beverly here emphasises the opportunity and challenges early on in the work:

what brings up emotions, particularly in the first session, is the experience of being with someone, who, um, is really paying attention, and is not put-off, is hopefully not put off, by their manoeuvrings, to put you off the scent, and to avoid the emotions which are painful to them. So the experience, I think, of being with someone who's not frightened to um keep them moving towards experiencing those emotions. I think that touches a place of longing in most patients - to be really seen and to be really attended to. And it may not be something they're conscious of. (B, 120)

Beverly reveals here that it can be frightening to stay with clients who might push her away. Participants also pointed to, as Beverly does here, to the need to be compassionate in their approach and how this is understood within the context of attachment trauma for the client and their need for care and acceptance. Beverly's description captures the dynamism and energy to this process and also highlights aspects of intimacy that are likely experienced unconsciously by the patient. The unconscious ways that patients protect themselves in the therapy room can be challenging for the therapist. David likewise refers to the challenge of unconscious aspects to patient motivation in offering a distinction that helps him ascertain the degree of difficulty in the work:

But where a patient is, you know, I I don't wanna say, but you know, honestly, earnestly, doing their best (laughs) uh and obviously suffering, that's not difficult, no, and then, of course, when they're in touch, most of the time, you know, with themselves or even in defence, you know – put differently, is where there's a good alliance, I guess, is another way to put it, good working alliance – then it's not difficult. (D, 448)

David's laughter here highlights his intentionally ironic use of the phrase "obviously suffering", which seems to indicate his understanding of such patients as less challenging than a patient whose suffering is not obvious to them. The latter might suggest a discord between what the therapist observes versus what the patient observes, whereas David's double mention of "alliance" assumes there is greater consensus and contact between therapist and client regarding the direction and task of therapy.

Most participants talked about how they can most often locate a sense of ease in the work: "It's quite interesting and enjoyable. Yeah, I-I don't find it difficult to stay with them" (R, 181). "I mean, most of the time I feel very very comfortable in the therapist chair. I feel very very comfortable. It doesn't throw me - but there are those moments where, you know, as I say" (E, 248). Although Emma is most often comfortable, there are "those moments" of difficulty in the work that she describes elsewhere as momentary confusion or impairment in performance or concentration on where she is in the sequence of interventions (489). Judith points to a difficulty that arises from sharing the same defences as the patient:

...intellectualising - I mean, I can in- I-I that's one of my defences. And if I'm not careful, instead of spotting it as a defence in the patient, I I can just go along with them and intellectualise and we can have and then I suddenly think, 'actually, hang on a minute, we've totally lost the focus here. This isn't what we want to be doing'. And I'm actually meant to be showing them what they're doing when they're using intellectualising but cause it's something I do very naturally as well, um, I can easily get drawn down that road. (J, 434)

Judith appreciates here that what she, as the person of the therapist, does naturally and unknowingly to avoid feeling may obscure the work. "Going along" here thus means cooperating or facilitating the patient's avoidance. This collusion is understood by Judith to be a co-creation between her and her patient, but with an awareness that it is she who needs to be "careful" in getting caught in dialoguing with patient's resistance.

All participants point to some aspect of their own defences getting in the way of the work and two participants highlighted intellectualising – talking about, rather than doing therapy – when matched in the patient's defences as raising

an added difficulty in the work. This subordinate theme about not giving up on the helping clients reach through their resistances highlights the perseverance in navigating tough terrain with courage and compassionate stance. The comfort versus difficulty of delivering moment-by-moment precision is reflective of the tension in participants' accounts related to their attempts to respond accurately and immediately to patients' responses, but sometimes without the full awareness required to do so. The next subordinate theme connects this sense of difficulty in relation to focusing the work with its implications for the therapist, including feeling anxiety and the pressures of getting it right.

4.3.3 “Trying to decide where to go next and how to proceed”:
pressure and focus on accuracy. Nearly all participants highlighted feeling pressured in maintaining their focus on the patient and on the accuracy of their interventions. One of the effects of such pressure was anxiety as part of an initial response to encountering particular difficulties in the work. Though the following four excerpts could be included as examples in the following superordinate theme of what might be “happening in the room”, they are instead included under this theme due to their specific link with the pressure of time that results from the moment-by-moment precision that the therapist strives for in their practice. Beverly describes her bodily state that is particularly linked to self-criticism that arises as a result of difficulties in the work:

... anxiety is what I'd be aware of - what I have been aware of in that situation. So, it may be that there's anger underneath that - that wouldn't surprise me. I haven't been in touch with anger at the time, because I think I'm too busy, and, kind of, trying to decide where to go next and how to proceed. (B, 428)

Beverly describes aspects that she has awareness of in those tough situations, yet highlights that she has trouble ascertaining her emotional state beyond the anxiety due to the pressure to respond to the patient. Her repetition of “aware” seems intended to convey the great deal that is beyond her full awareness. Emma, likewise, describes this as :the spike of anxiety, it is the sort of coming out, uh and just reflect- uh responding in a more immediate way I suppose” (E, 245), though for contrasts this experience as rare compared to her usually more “comfortable” position (E, 248) in the work.

Judith, like Beverly, could identify a possible awareness of anger behind the anxiety, but only on reflection, after the fact:

... I don't have time to process what I'm feeling about that level of contempt towards me...and be effective with her therapeutically. But but yeah what I was feeling was anxiety at the time.... But maybe, I don't know, maybe it's more healthy. (J, 296)

Judith describes how the challenge of therapeutic effectiveness relies on her not attending in this moment to her own internal experience of rage and instead focusing on the patient and their feelings towards her. Judith's reflection of "maybe it's more healthy" to have an anxiety response reveals here her ambivalence of the value of anxiety. Judith may mean an anxiety response is healthier than she supposes, and that it is better to respond in anxiety rather than defend in other ways. Raelyn likewise reflects on anxiety she noticed as an observer of herself when viewing her own session tapes: "I couldn't see it in the moment, but I could see myself like moving away (leans back in seat), so there must have been anxiety in me" (R, 136). Raelyn's leaning back in her seat seems to recreate the moment her own anxiety led to a "distancing" between her and the patient.

Nearly all participants reflected on challenging therapeutic situations they may handle differently in hindsight. David highlights (258) that the demand to be present and engaged is something he expects of his own standards and also what he knows is helpful. The personal and professional self meet for David in this demand to be present:

I think the thing that makes it difficult to stay with, um, for me ... is the persecutory element, which is pretty much inherent in anything that you're learning. But, particularly, I think, in ISTDP unfortunately, this idea that ... there's a, kind of, right way to do it and the right question to ask - that you should be watching every minute twitch of the patient's face that - or body, that you need to be, you know, on the defences.... And of course, there's a truth to it, but ... the tone in which it's transmitted ... makes it difficult ... to simply be present and sit with what's happening.... (D, 696)

David sees these "persecutory" pressures as inherent to the ISTDP model and the way it is transmitted to therapists. He seems to suggest that if the therapist is thinking all the time of what they should be doing, it leads to a

disembodied state that interferes with the therapist's capacity to be present and close to the patient. The repetition of "right" here emphasises that when presence is helpful for the patient, it may erroneously be experienced as "wrong" by the therapist, whereby a pre-reflective quality of the therapist's inner experience is lost or not extended to the patient.

Most of the participants reflected on how such pressures led to missed opportunities of interactions with patients where the feelings were directed toward the therapist. Beverly reflected on how a patient's reflective and active engagement in identifying key therapeutic process has helped Beverly identify a moment where focus is lost: "... by allowing myself to go into defence mode and make myself the focus there, rather than just sticking with the patient's anger (B, 234)". Judith relates the experience of contempt directed towards her from the patient: "...but I guess I hadn't processed it. I mean, if I'd seen her again, I'd have been a bit more ready, you know, to to look, you know, ... with my question, 'what's just come up?' (J, 318). Raelyn, likewise, highlights a missed opportunity of anger in the patient that was "pretended and ignored" by both her and the patient "...that was there, on a gut level... it was never verbalised or explicit" (R, 432):

So that can be a challenge for people and me included actually, working with it directly to you – not that I mind, being killed or being killed, raped, murdered and lots of things, but opening that door and saying, 'well, what is the feeling toward me as you're sitting there?' That can be one of the hardest places to go, I think. Yeah. (R, 401)

Opening the door of bringing herself more fully into the relationship as one of the most difficult aspects of the work for Raelyn. Raelyn's striking statement that she does not mind being "killed, raped, murdered", in the client's portrayal of such an event, is positioned as something that is easier than the experience of first inviting the client to notice the implicit, non-verbalised feeling of rage that involves Raelyn.

This subordinate theme revealed the pressure and feelings of anxiety that participants may experience when faced with difficulties in their attempts to execute moment-by-moment precision. The immediacy of the situation suggests there is not enough time to process other feelings that may be present

and that participants may aim to respond to patients in a way that is therapeutically beneficial. The predicament of “trying to decide where to go next and how to proceed” is beset by limitations that are not necessarily known at the time but are yet accompanied by a pressure to move beyond them.

Together these three subordinate themes comprise the comforts and hardships of the participants’ striving for emotional closeness, and in particular the challenges of helping clients overcome their resistances. “Opening that door” highlights the specificity of the work, as it represents the door that either client or therapist would ordinarily prefer to keep closed. Participants spoke of the perseverance and compassion required to reach the stage where client is able to experience previously avoided feelings. The moment-by-moment attention to this process raises immediate challenges in deciding where to focus the work through the ISTDP model. The participants interpreted their anxiety in such moments as evidence of not having enough time to process their feelings. The underlying tension between achieving success versus feelings of anxiety when about to potentially miss something important is further explored in the superordinate theme two, which highlights participants’ accounts of their responses and reflections of what happens in the therapeutic encounter.

4.4 Superordinate Theme Two: Connection vs Disconnection: What’s Happening in the Room

This cluster of subordinate themes highlights what is happening in the room for participants when staying with their clients’ intense emotional experiencing. The polarity of connection vs disconnection in the title of this superordinate theme aims to describe the underlying ways in which participants tended to describe their experiences based on an assessment of their success in the work. Therapy that is going well entails a sense of connection with the patient, whereas therapy that is not going so well tended to be accompanied by an assumed feeling of disconnection. The three subordinate themes capture the various aspects of this polarity: (1) “A shared experience”: connection and intimacy in the therapeutic encounter; (2) “It’s painful not to be able to reach a patient”: feelings of frustration and inadequacy; and (3) “Talking to myself”: remaining calm and professional.

4.4.1 “A shared experience”: connection and intimacy in the therapeutic encounter. All participants refer to their understanding of the therapeutic encounter as a shared experience that can be deeply intimate for therapist and patient. Emma here describes the value of helping the client experience their emotions:

What's best about it, what's good ... is to be able to share with- that experience with them, to see that anxiety diminish. So someone who's very tormented and very tense and all over the place - as you go through it and you stay with them, you see that diminish. (E, 275)

Emma describes as meaningful the staying with the turbulence and confusion of the client to a lessening of their severe physical and mental suffering. Likewise, Raelyn views her “emotion focused” work as healing: “my belief is that you need some form of emotional experiencing ... in order to heal ... I think it's a it's an experience of intimacy isn't it, sharing emotional experiences, it's a high level of intimacy. (R, 68) Raelyn clarifies that she values this experience of intimacy as central to healing.

David further's Raelyn's sentiment to assert that it is “possibly the most intimate that you get with anyone, even your partner... so it's a very unique uh special uh experience” (D, 266). David's description of this type of encounter as perhaps “the most intimate” may be an acknowledgement of the private and personal nature of exploring feelings that are never before expressed that is individual to each patient. Whereas Beverly refers to the benefit to her from this shared experience of expressed emotion:

... and then it just lifts. Cause it's it's come out - it's been shared, it's been felt, it's been contained ... the and the mood lifts and one's then able to function again has an incredible effect. So in that instance as well I think this work has helped me. Not be not allow myself to be pushed out the door. (B, 585)

Beverly's phrase of “pushed out the door” refers to being able to withstand the feelings of the other who is perhaps resisting emotional closeness. Part of connecting for Beverly entails perseverance in overcoming these resistances. “Contained” for Beverly has an atmosphere to it of safety that was perhaps not there moments before. All participants made distinctions

between how they approach emotions, both negative and positive. Judith describes what it is like helping a patient experiencing positive emotion:

... I have one patient here and just before he left, you know, he just sort of reached out to touch me that's just, you know he just really grateful and um had that impulse to, you know, touch, to hold, I guess. That, that's the love impulse. (J, 163)

The gesture of touch by the patient towards Judith here seems to indicate a level of intimacy that is shared by both herself and her patient. David (272) draws from Buddhist concepts to help articulate the depth of intimacy:

There's uh a sense of, well uh difficult to describe, but um, a sense of merger isn't right. It's really a connection. It's really a kind of freedom of connection with, you know, your environment, with the outside world, with other people, which is your very - is joyful um and releasing. So it is slightly like that ... Letting go of isolating boundary around the small self, the small sense of self. And I'm sure patients must experience that too with me, in a room. (D, 281)

The sense of connection that David attempts to convey here does not seem limited to between people but seems to stretch beyond their “entrapped separation” (279) to the “outside world”. David seems to describe “these two people experiencing emotion” (274) as a shared form of meditation. “Letting go” of an “isolating boundary” here suggests effecting a connection through which the pain inherent to the “small self” – a term in Buddhism that refers to the unique, individual and separate self – is released. Though David has been tentative in his description here he nonetheless seems thoroughly convinced about the shared aspect of this encounter, as something felt by his patients also.

The sharing of difficult emotions and intimacy, included for most participants, a focus on emotional resonance through specific emotional states or feelings. All participants talked about moments where they were feeling what the patient feels. Beverly describes here how she notices the feeling in the patient before they themselves have shown this visually or reported it:

You might see the, sort of, swallow or watery eyes or um a rise in anxiety but there's also, particularly with grief, I quite often find myself feeling it ... a strong grief response or an impulse to cry or just a, kind of, feeling in my chest. But um, but, a sad feeling in

my chest. And, often if I get that um, and I inquire, I'll find that the client is feeling something similar. (B, 168)

Beverly here is relying on what is both seen and unseen, the visual aspects of the patient's physiology as it relates to their feeling but also her own felt sense as a reflection of the patient's feeling. Likewise, Judith talked about feeling the feelings of the patient, even sometimes, as in this instance, before she herself notices the feeling of sadness in the patient: "I could just feel it. And then ... I saw a little bit of fear in her and I said, 'what's coming up just now?' and then the sadness came" (J, 175). Judith, like Beverly, here emphasises her moment-by-moment attunement to the patient's emotional state, where the feeling of the therapist is still informed by observation of the client's response.

David highlights how emotional resonance "if things are going well" (236) with a patient can be "enlivening":

... depending on the, on the particular emotion, uh you know, I'll feel pain or I'll feel rage or I'll feel angry. I don't mind any of that. That's ... pretty good. As I said, it's part of feeling alive and also ... it's great to be so engaged with another human being. It's like a moment of real connection, which is, you know, a beautiful thing. (D, 237)

The context of being "engaged with another human being" has significance for David, in terms of an openness to feeling what are typically regarded as negative or unpleasant feelings. That this feels "pretty good" speaks to the power of the connection he experiences with the patient as one that is deeply satisfying, the beauty of which seems inextricably bound to the lived space. Raelyn, too, highlights the energising aspect to experiencing an emotional resonance with the patient: "whether I'm sitting with the patient or whether I'm in a training watching videos" (R, 148). Raelyn's experiencing of similar energy through watching tapes highlights how such a process can transcend space and time. Participants' focus on the visual convey here in this idea of shared emotional experience something that is unseen but very much *felt*.

Each of the extracts in this superordinate theme presents the sense of connection and intimacy that results from what participants considered to be a shared emotional experience. A further aspect of connection that is

experienced in the room, happens where the therapist is able to feel to what the patient feels, in a way that is helpful and informative for the therapy. It seems that achieving emotional resonance requires an openness of the therapist but also the patient and so this links to the superordinate theme as an example of connection that takes place in the therapeutic space. The next subordinate theme begins to look at the other side of this polarity, the disconnection that can occur between therapist and client when engaged in intense emotions-focused work.

4.4.2 “It's painful not to be able to reach a patient”: feelings of frustration and inadequacy. All participants described difficult encounters they experienced whilst aiming to stay connected to clients who were experiencing intense emotions. This subordinate theme captures the often-resulting feelings of frustration and inadequacy that arise for the therapist during difficult therapeutic encounters. David describes an example where he felt his understanding of the patient who was chronically in tears had reached an important limit: “I think liking a patient is important actually. I didn't really like her” (D, 166). David seems to be recognizing the therapeutic relationship as impacted by the ‘real’ person of the patient, beyond their defences, as important in the therapist’s ability to express “sympathy” or “compassion”, which he views as essential to good work. David also described “the most horrendous experience” of his career that occurred recently with patient:

I got just totally - all I can say is - overwhelmed, uh, by, I think, looking back, a mixture of fear and persecutory guilt. But I wasn't experiencing that in a quite so defined way, as I now describe it, it was just an overwhelming experience of being, kind of, like, slightly losing boundary, in the worst sense, um of fear.... So I really lost it. I mean, you know, my capacity to think was, like, gone, my capacity to attend to my emotions was, kind of, not so good. (D, 614)

David seems to be attempting to make sense of his emotional experiences that were somewhat inexpressible. The isolation he describes seems existential rather than merely relational, where not being able to look after his own emotions means he has “lost” the ability to do the same for his patient. A contradiction is revealed that though David elsewhere describes ways in which

he has built his capacity to attend to his emotions yet he experiences this encounter later on in his career.

Most participants described moments in the work where their management of their expectations – of themselves or their patients – in moments of disconnection were pronounced. Beverly highlights what she describes elsewhere as her “self-critical mode” (374) that happens when regarding herself as a “bad therapist” (375) as opposed to staying with the patient’s feelings:

I hear it, I think, 'uh, is she right? Did I do that?' Um, 'I shouldn't have done that'. So that puts me slightly on the back foot. Uh, then I'm thinking, 'do I apologise for doing that? Do I acknowledge doing that? Apologise for doing that? But is she- is it fair? Is that right? Did, did I do that? Or is she being unfair to me?' And I get into that sort of thinking process um or I, I have done in the past, which takes me completely away from the focus on her anger and remembering that it may be related to her experience of her mother and how, you know, how that is being re-enacted. (B, 380)

Beverly recites here her self-questioning process rapidly and without apparent effort, seeming to simulate a crowding effect that complicates her decision-making processes and shifts her “focus” away from noticing the re-enactment of the patient’s past relational dynamics.

Similarly, Judith highlights how for her that process of “self-doubt” (203) can move quickly to a form of “self-attack” in some instances, with patients that act toward her in a manner – for example, entitled or “contemptuous” – that touches on her history of being devalued: “I um can very easily think, 'oh God, I'm I'm absolute- I can start easily going into self-attack, I'm I'm clearly no good, I really am rubbish, I must be doing something terribly wrong here'” (J, 209). Although able to reflect on these thoughts beyond the moment, the ease and certainty of the thoughts that beset Judith here is striking, whereby an appreciation of her own attachment history that might help her separate from these punitive thoughts is presently absent.

Emma also identifies a punitive element that arose in a pivotal moment of having helped the patient express their sexual feelings towards her:

I suppose a, sort of, a punitive thing came in that I was doing something wrong that somehow I was encouraging this man to ... that I was leading him on in some way and that's the that's the point I had to clarify in my head to be able to clarify it with him. (E, 517)

Emma elsewhere (504) indicates there may be something to sexual impulses that bring about an “inhibition” in her that is not there with the patient’s “angry impulses”. Emma’s self-consciousness of “leading him on” and the “punitive thing” is imbued with a worry of “doing something wrong”, which may hamper the straightforwardness that she finds moments later to help the patient deal with his sexual feelings. Raelyn highlights how feelings of frustration can arise when the capacity of the patient to tolerate their emotion has been misunderstood by the therapist: “because you're like, ‘why aren't we having the big breakthroughs and the rage...’, but for that you have to stay where the person is with emotional experiencing and how much can they actually tolerate” (R, 505).

David elsewhere (315) highlights a sense of disconnection that he describes as “two separate ... scared individuals...trying to make some kind of contact with each other”. Here, as he describes the consequence of such feelings of frustration, that sense of loneliness is captured:

... I'm sitting here with, um, anger, pain, frustration, uh, on my own - patient not experiencing, patient going off on their own thing. Not in any state of conflict about what they're saying. You know, just kind of gaily, like, defending or whatever else. So it's it's painful to be left with that, it's painful not to be able to reach a patient. (D, 505)

Frustration, here, for David, is borne out of the discrepancy in what the therapist and patient are experiencing, where the patient is identified with their defences. What is “beyond reach”, David seems to be suggesting, is the unconscious, helpful part of the patient that seeks emotional health and closeness to others. A consequence of this, repeated twice, is a “painful” experience for David that seems tantamount to rejection, of the therapist’s input, if not indeed the therapist’s self.

The excerpts in this subordinate theme capture the sense of painful isolation and disconnection or withdrawal from connection that results from or is

exacerbated by the feelings of frustration and inadequacy experienced by the therapist. Participants' accounts in this subordinate theme convey a sense of the inevitability of the therapist's deviation from staying with their patient's intense feelings but that this is knowledge that is achieved or remembered with hindsight rather than accessed during their feelings of frustration. The next subordinate theme moves on from these last two subordinate themes, which relate moments of disconnection in the therapy room, by relating the ways in which participants described their ways of coping when finding it difficult to stay with their patients' intense emotional experiencing.

4.4.3 “Talking to myself”: remaining calm and professional. This subordinate theme described the ways participants coped with their difficult therapeutic encounters. All participants described inner self-talk as their moment-by-moment ways of coping with disconnection and their attempt to reengage with their patient or to help assure themselves during their difficult encounters. Emma described how she coped with the confusion and “shutting down” (474) that arose when attempting to work more specifically with the sexual feelings the patient had expressed towards her:

... I wasn't giving him a clear enough message about the reality of what was possible and what isn't possible. The minute I realised that, I was able to do something about it, and it was fine. You know, it became very clear that that's what's inside him and that he has feelings towards me, and then he also has feelings that I'm not going to go along with what he wants. So we were sort of back on track (E, 492)

This extract reveals the complicated processes at work simultaneously in the therapeutic space. Emma is trying to ascertain what is real in the portrayal with the client versus his “true” feelings for her and the “reality” of his expectations and her own role in generating these. Here she seems to reason or “realise” her way out of her confusion though clarifying for herself where she is located in the process of staying with her patient. Emma elsewhere draws on questions – “ok so what is going on?” (265) or “come on, stay with it – let's see where we're going and get a handle on this – don't shy away from it” (474) – to help assist her with getting “back on track”. Raelyn also describes a process of self-talk used to help her cope with her visceral reaction to her client's sadistic imagery that arises in their defence-work:

I think in my head, I had to, I was just sort of talking to myself, and saying just just sort of distance a bit, just stay with it, like zone out a little bit, just kind of, so trying to get a bit of mental distance, maybe not listen so closely, just sort of distance internally (laughs) sort of not show your shock, of course, or your discomfort and just thinking please let this be over soon (laughs) before I throw up. (R, 281)

“I think in my head” is an interesting statement that makes it seem as if that is where her total self is in that moment of trying to obtain some “mental distance”. Raelyn understands her self-talk as an attempt to achieve this “distance” from her state of fusion with the patient’s difficult feelings and impulses. Perhaps her laughter at her recalling her attempts to “distance internally” and wish to “please let this be over soon” is an acknowledgement of her own internal conflict of wanting to stay with the patient yet be distanced from them. Also, too, the disparity between what therapist and client may be thinking in the moment. Rather than the form of a wish, David described a similar sentiment to Raelyn’s self-talk, but in the form of a memory:

Um, so I think, I think maybe the, even when I was, you know half-crazy with it, I think, just the memory that um things pass, and I had things might help, and but that was that was helpful. (D, 655)

David here experiences the truism of “things pass” – that every situation ends – as helpful. Yet, this excerpt also conveys the sense of uncertainty that David is experiencing in this moment. As well as relying on “cute couple of deep breaths” (J, 317) Judith, when likewise faced with the unknown, relies on a “layer of professionalism” (315):

.... I just relied on all my years of remaining calm, remaining professional, keeping my anxiety under control, storing it for, I'm gonna think of, you know, 'look at this later myself'. Um eh yeah and just keeping it, y-you know, keeping the therapy to, you know, just keeping her in the room with me actually, cause I do think she got up at one point. (J, 327)

Alongside regulating her anxiety, Judith also describes a deliberate process of “storing” her responses for reflection later on. Beverly likewise highlights how she attempts to keep connected with a patient who is experiencing anger towards her:

...I recognize it. I remember it. I go, 'okay, I know this - focus on the patient, focus on the feeling. Go through the questions -

where is she experiencing it, et cetera, in the body?' Keeping it, keeping the-the - your, my and the patient's focus on the patient's internal experience - being aware of mine, but not making that the, you know, the thing that's leading my thinking. Um, and that's helped a lot. That's helped a lot - that kind of keeps you on the right, on the right path. (B, 450)

Beverly, here, conveys a sense of how she can reconnect with her patient through a focus on the "patient's internal experience". Beverly also goes on to describe how the "patient appreciates that" (457) also, which seems to reinforce and justify her focus whilst also serving as a clear sign of maintaining a connection to her patient that would otherwise be hard to keep. As well as linking to the previous two subordinate themes in terms of the disconnection participants experience, the current subordinate theme, in describing participants' accounts of their attempts to reconnect with clients, links almost full-circle to the first subordinate theme of viewing what happens in the space as "a shared experience".

This subordinate theme has revealed some of the reactions that therapists experience in difficult therapeutic encounters where the therapist's reaction itself seems to interrupt or disrupt their efforts to stay connected with the patient and their intense emotional experiencing. Participants thus described an emotional shutting down, a visceral response to patient's sadistic imagery, and the sense of feeling overwhelmed by feelings that are hard to pinpoint.

These three subordinate themes are linked by what happens in the therapeutic encounter when the therapist is aiming to stay with their patients' intense emotional experiencing, and more specifically how this arises in moments of connection versus disconnection between therapist and patient. The background to this therapeutic enterprise is an appreciation of and aim for a shared experience of intimacy and connection that is healthful for both patient and therapist. In such moments, the therapist relies on their capacity to feel what the patient is feeling, which is experienced as intimate and beneficial. The last two subordinate themes evoke various aspects associated with disconnection in the therapeutic encounter, in terms of therapist's reactions to difficulties, the resulting feelings of frustration and inadequacy and how they

cope with such moments through self-talk to help regain or maintain connection with their patients, in offering them a therapeutic experience of emotion. What is revealed throughout this superordinate theme is the extent to which emotion is something felt, both as something graspable or unknowable, versus what is speakable between therapist and client.

4.5 Superordinate Theme Three: “There’s More of Myself Now”: Building One’s Own Capacity

The final superordinate theme completes the analysis and consists of three subordinate themes that describe the way participants talked about technical aspects that relate to therapist’s practice and ongoing development. All participants reflected on how with greater capacity comes assurance around their very sense of self. Whereas the two previous superordinate themes have described what therapists experience and encounter in their work of staying with their clients’ intense feelings, this last superordinate theme concentrates more on participants’ accounts of how they achieve this. This includes participants’ reflections on how they have built their own emotional capacity. Capacity here refers to the therapist’s or patient’s ability to bear, observe and understand their feelings, as reflected in the final two subordinate themes of the first superordinate theme and participants’ accounts more broadly. The three subordinate themes are: (1) “More emotion in the room”: improving clinical effectiveness; (2) “Those minute flickers”: observing and reflecting on inner emotional life; and (3) “Knowing enough about myself”: attending to unprocessed feelings.

4.5.1 “You get better...you get more emotion in the room”: building emotional tolerance. This subordinate theme aims to capture what therapists perceived as helpful for building their own capacity for bearing and holding their own emotions. All participants discussed the value of supervision and training as essential to building their sense of capacity. Raelyn described the value of watching videotaped cases from the “countless conferences” (201) that have helped her build up a tolerance for emotion:

so that builds your capacity to go to the emotional breakthroughs
and then of course I've sat with my own clients and as you get

better at doing ISTDP so you get more emotion in the room. (R, 203)

Raelyn's use of "breakthroughs" here refers to Davanloo's term to describe the emergence of previously warded off emotions into consciousness (ten Have-de Labije & Neborsky, 2012). "Go to" here suggests breakthroughs as a place the therapist helps the client to reach, and that Raelyn's greater effectiveness in this leads to "more emotion in the room", where she believes "the healing is gonna be" (210). David talks about his taking up of space rather than emotions:

... it does feel like I've got a bigger space inside me. Um, and I think I'm less embarrassed, as well, by it. Um, it's also very linked with intimacy because if you're feeling something, you know, more fully, you're more vulnerable, that you're more alive and more open. So I think, yeah, I'm less embarrassed maybe, by the presence that feeling an emotion brings, by the connection that it brings, um, which is a massive shift to the way I used to be (D, 591)

David here describes an expansiveness to his sense of self that feels bodily but also psychic, even spiritual. He describes being in relationship to the client on a profound level of closeness. The contradiction of greater vulnerability with openness enabling David to be present and connected with clients is transformative in terms of how he characterises himself in this moment compared to an early version of himself: vibrant and forthcoming, rather than emotionally aloof and solitary. In this later description, David seems to slip into a personal rather than mere professional description showing a marriage between the two aspects. Judith describes this learning process in practical terms:

...I guess the more times you encounter it, the more times you see it, and the more times you see it in different patients...you get quicker at spotting them and then you get quicker at seeing what they're doing, and quicker at stopping yourself if you're going down that route. (J, 444)

Judith goes on to illustrate this process through talking about the benefit of recognising signals of defences in both herself and her patients. Using the defence of "intellectualising" (449) as an example, Judith says she now hears her "internal supervision" brining her back on track. Judith elaborates on what was helpful about having her own tapes reviewed during her training as helping her to "see exactly" (J, 67/73) the interventions she made and their impact on

the patient through their responses. Judith thus felt she had “learned so much” from this admittedly “exposing” (76) practice. Most of the participants also reflected on the value of their engagement in ISTDP personal therapy.

Judith describes the self-knowledge she received from ISTDP supervision, where how after a previous therapy that lasted many years, “I did not know my defences”. Yet:

after five minutes with my supervisor, I could, she named all, named 10 of my defences, and I’m like (gasps, laughs)...I remember her going (clicks fingers) duh-duh-duh-duh, and I was like, ‘there’s nowhere to hide’. (J, 464)

Words alone can do little to describe the astonishment Judith seems to have experienced at the rate at which this self-knowledge was revealed to her, and is perhaps more fully captured in the rapidity of her finger clicks and the phrase “duh-duh-duh-duh”. That there was “nowhere to hide” suggests that with previous supervisors, there may have been ways to not readily admit her in-session use of defences with patients, whereas her ISTDP supervision provided an opportunity to best honour her commitment to effective practice. All participants highlighted the importance of contact with peers, through supervision and attendance at conferences. Beverly highlights here how this has helped her better attend to her self-critical processes:

being able to-to talk about what we’re doing, what we find difficult....that’s helpful, knowing that others have similar struggles. Um, that quietens the self-critical voice a bit (laughs). (B, 636)

When difficulties are encountered in the work, her self-critical voice may assume they apply only to her, whereas knowing that others encounter the same difficulties, helps to minimize this. Overall in this subordinate theme, participants value a range of activities that have helped them build their emotional capacity, including review of own and other therapists’ video case sessions, supervision and its therapeutic effects, personal therapy, and peer contact that they experience currently and in their ISTDP training. The different ways participants spoke about getting ‘more emotion in the room’ highlights how this applies to both the therapist as well as the patient. The value of achieving this is not just in greater achieving effectiveness in the work but also the impact

of this on the person of the therapist. The personal and professional self appear to unite when both patient and therapist can experience their feelings in the therapeutic space.

4.5.2 “Those minute flickers”: observing and reflecting on inner emotional life. This subordinate theme aims to capture the subtle experiences that participants reported as significant evidence of their increased capacity to bear and notice their client’s intense emotional experiencing. All participants talked about language they use as important for helping the client focus on their internal experiences. Beverly describes finding the “more robust challenging therapist” role is “not easy” (326):

... finding the right words to deliver those interventions has been difficult because you need to do it in a way that doesn't make your patient feel told off or judged or coerced in any way. It's gotta be delivered in a way that feels loving and that feels like you're getting them - you're understanding something. (B, 327)

Beverly seems to highlight the importance of her role in its more challenging mode to the patient is also inextricably tied to a commitment to foster the patient’s self-compassionate engagement with their inner world. All participants highlighted that their ability to be more present with the client through their sense of improved observation of the client. David similarly described his current practice as:

... a lot less persecutory. It's a lot less artificial and 'doing'. It's more like 'being', uh so the therapy, kind of, more happens through me....it feels much more like what I am and do anyway....it's like playing the piano, it's um, you know, obviously you use your reading notes. Right, but it's but it's kind of happening through you. (D, 526)

David draws on the simile of the piano to communicate how he is now better able to draw consciously on the techniques of ISTDP, as a “being” that is “happening through” (531) as a “state of flow” that is “much more present”. All participants commented on their improved ability to observe shifts in their patient’s and own experiences that they may have been more likely to miss in the earlier stages of their practice. Emma describes this in relation to her overall goal of helping the patient to access their feelings:

So I've always got that goal in mind, that we're trying to get at those feelings. And, you-you know, at the beginning, it may just be a tiny tiny little flicker of sadness. And I think in my old way of working, you know, those minute flickers - I probably probably wouldn't have even seen - whereas now I see them and I can really make use of those and bring them to the-the other person's attention. (E, 118)

Through a comparison of her current self with her less experienced self, Emma here refers to her now being able to better observe the patient and therefore start to “deepen the experience” (124). The phrase “minute flickers” highlights the briefness and faintness of emotions that Emma might previously have missed. Raelyn addresses the concerns of observing patients who may pose a risk to themselves or others:

I feel like my basic training helped me with that [i.e. ‘risk and harm’], I think there are people...again very few ...have that psychopathic anti-social trait, that are harming people, will harm people, will misunderstand you...but I think you need your own basic training, and understanding of anxiety pathways, to make those distinctions, so that also makes it easier for me to go these places. (R, 669)

Raelyn here is referring to a concern – rare and extreme in this example, but a more general tension that exists in the work – that by inviting patients to internally explore their hidden feelings and impulses, they may then misunderstand this endeavour and go on to act out those impulses in their real life. However, for Raelyn, her training and understanding of “anxiety pathways” allows her to conduct a more complete and accurate assessment of the patient’s psychopathology. Effectively handling this concern thus frees Raelyn to go “to these places” with her patients that she believes can be part of a healing experience for them. Overall, in this subordinate theme, participants reflected on their learning and development of their ability to observe and reflect back to their patient’s their emotional inner lives.

4.5.3 “Knowing enough about myself”: using and protecting the self. In addition to learning specific skills to address the difficulties and complexities of the clinical situations that therapists encounter, most participants commented on the ways in which the work brought them in touch with their own unprocessed feelings and how this entails a decision on how to conduct themselves in such moments. Throughout participants’ accounts is

emphasised the importance of being able to face their own emotions and intimacy with their patients and how there are opportunities in supervision and personal therapy to develop this. This subordinate theme aimed to capture the differences in approach to this aspect, in terms of the extent to which the therapist involves their own personal material in the work. Raelyn gives her take on “how much you let yourself go” (315) in the work, where the therapist might reach their own breakthroughs of unprocessed feelings alongside that of the patient’s:

I don't go there, cause I think that would feel too difficult to contain my own, what response might come up in me. So I I stay very much just sort of cognitively with what the client is saying with their experience...Yeah. Yeah I don't go there in my own mind, I don't – what might come up for me, if it was my mother or father or something like that, I don't. (R, 319/326)

Raelyn, preferring to keep a cognitive distance in the work, fearing the involvement of her own personal material will lead to distraction away from the focus of the client. Judith considers an example of a clinical case in which her supervisor had her role-play the patient, whilst her supervisor role-played what Judith “should have done” in the session under review:

...and then I, I had a huge amount of grief come up, I mean, like I mean it was, it was in the group. It was like about half an hour of grief. And um and then she, she said at the end of it, ‘now you'll be able to help your patient’. And there's just something about that that patient's, the the defences that were aligned, some of the same sort of history that, like, because I, because it was in-unresolved in me, I couldn't quite go there with her. (J, 356)

Judith here describes an experience where there were therapeutic effects in supervision that were helpful to her reflection on a difficulty in practice and healing, in the sense that she resolved a personal difficulty that would allow her to “go there” with future patients. David (678) also considered a return to ISTDP personal therapy for a difficulty the specifics of which touched on “something I know I have a problem with”. Most participants talked about having ISTDP therapy during own training:

And it's about knowing enough about myself - I can't always be sure that I'm getting it right - but feeling comfortable enough with myself and my reactions. I mean, that's the only thing I can go on. I mean, if I if I can feel comfortable about my reactions, my

responses, then I can help the other person do the same thing.
(E, 393)

The value of personal introspection is crucial for Emma in her capacity to “feel comfortable” with her emotional responses in a way that allows her to help her patients do likewise. This subordinate theme is characterised by a commitment to deliberate forms of practice that are designed to maintain and improve their own emotional capacity – and through their ability to observe emotional shifts in their patients. These practices allow the therapist to maintain their moment-by-moment precision to help their patients experience their emotions and to help patients and themselves manage challenges to moments of connection, and confidence in the approach of the therapist.

Superordinate Theme Three: Technical Aspects Related to Therapists’ Practice consolidates participants’ account of their experiences of the technical aspects important to their practice and development. All participants recognised the value of building their own capacity to bear emotion to help their patients with this endeavour. All participants also talked about the value of noticing minute shifts in their clients as helpful for staying with their patients’ intense emotional experiencing, as it enables them to recognise the value and progress of their efforts to facilitate this. The participants spoke in different ways about the degree to which they develop themselves as the person of the therapist through work. This appears to be underpinned by important features of the participant experiences in their professional contexts – for example, the way in which the supervisor works – and their own personal histories and contexts, which may provide opportunities or hindrances when trying to focus on the patient.

4.6 Analytic Summary

This analysis explored the experiences of five ISTDP therapists working with patients who are experiencing intense emotions. The superordinate themes were presented in a specific order to elucidate and encapsulate the distinctive and emergent nature in which participants narrated their in-session experiences. Each superordinate theme captures a rich and textured portrait of the essential aspects to understanding participants’ overall experiences, where individually these themes would not convey the full account of the participants.

In summary, superordinate theme one captures the different ways participants talked about the ease and hardships of their striving toward emotional closeness with their clients. Participants described how they were motivated by seeing the physical changes in clients as confirmation of their moment-by-moment approach to working with emotion. The importance of perseverance in helping clients reach beyond their resistances to facing previously unavowed emotion was emphasized, along with the compassionate and collaborative stance to attend to client's patterns of relating. The feelings of anxiety and pressure to deliver consistently accurate and precise interventions, forms a backdrop to what happens in the room – the focus of superordinate theme two. Participants tended to describe what happens as experiences of connection, where the work goes well, versus disconnection, where difficulties are encountered in the room. Connection and a shared sense of intimacy are the therapy's *raison d'être* and are reached in part through an emotional resonance between therapist and client. The moments of disconnection are challenging for the therapist who must consider many layers of emotional experience – their patients' and their own – and technical aspects and adherence to the ISTDP model. Difficult encounters were mostly characterised as difficult feelings expressed towards the therapist that were difficult to bear and engendered a reaction in the therapist that was deemed unhelpful, as it shifted attention and focus away from the patient. The therapist's feelings of frustration and inadequacy provide further sources for disconnection, which are overcome by ways of coping through internal self-talk that included self-questioning and self-reassurance, figuring out where therapist and patient are in the sequence of interventions, and using interventions aimed at regaining an overall focus on the patient. Superordinate theme three captures the technical aspects related to the development of the therapist and how they have increased their capacity to tolerate their own feelings, and their capacity to observe and reflect on both their patients' and their own emotional experiencing. Participants were all concerned with the development of the person of the therapist but varied in their talk about where they saw the opportunities for this in the work.

4.7 Chapter Four Summary

In this chapter, I outlined the themes that emerged through the process of IPA, together with supporting evidence of excerpts from the interview transcripts. In Chapter Five I will apply and reflect on these findings in order to answer the research question “what are ISTDP therapists’ experiences of staying with clients’ intense emotional experiencing?”

Chapter Five: Discussion

5.1 Chapter Five Overview

In this chapter I outline the key findings of this study and discuss both how they relate to the research question and the research literature. The relevance to counselling psychology practice and implications for therapists who are likely to encounter intense feelings with their clients are discussed. A methodological critique and quality issues of the study are examined. This is followed by a reflexive section about the research process, implications for future practice and research and a conclusion to the study.

5.2 Situating the Research Findings Within the Wider Context of Psychodynamic Practice in the UK

IPA's commitment to understanding the participants' subjective views and the psychological focus brought to bear on their personal meaning in relation to the wider contexts (Smith, Flowers, & Larkin, 2013) entails that I situate my interpretations within the broader literature, by engaging in dialogue with my research and psychotherapy research and theory related to my topic. In particular, I discuss the application of my findings with reference to the current political climate in the NHS and the overall position of psychodynamic therapy in public health. Equally, it is important to contextualise the findings within the discipline of counselling psychology. The purpose of this study was to explore how ISTDP therapists stay with their client's deep emotion and thereby enrich the way counselling psychologists can understand and reflect on this aspect of their clinical practice. I drew on the IPA methodology and its inductive process in conducting interviews and data analysis that are expected to guide the researcher towards "new and unanticipated territory" (Smith, Flowers & Larking, 2013, p. 113). Consequently, the discussion draws in places on additional literature to that covered in Chapter 2 Literature review. I highlight below how the findings extend the current literature to offer a significant original contribution to knowledge in the field (Kasket & Gil-Rodriguez, 2011).

In the global context of evidence-based practice that holds RCTs as the gold standard, psychodynamic therapy's struggle to show itself as an empirically supported has led to a decline in public provision (Fonagy, 2015).

Yet in a recent research update, Fonagy (2015) found support for psychodynamic therapy in a range of conditions, where nearly all studies included were forms of STDP. This type of treatment has a good evidence base with an efficacy comparable to CBT (Abbass et al., 2014). A growing body of research supporting efficacy for STDPs and their technical attention to creating more accelerating therapeutic outcomes, as compared to the classical long-term psychoanalysis, have made, within the UK context of the NHS, briefer forms of dynamic therapy an appealing option in for treating particular mental health conditions. STDP has been seen as cost-effective whilst distinguishing itself from CBT by preserving key elements of analytic therapy, for example, its consideration of clients' early life, unconscious feelings and defences, through the therapist's use of self in the therapeutic relationship (Shedler, 2010).

Despite this evidence some have argued that a focus on cost-effectiveness has engendered an over-exclusion of approaches, such as STDPs. McPherson, Rost, Town and Abbass (2018) argue that NICE recommendations of psychological therapies is limited by their review methods that leads to their evaluation of evidence for therapies, such as some STDPs, as being of insufficient quality. NICE is charged with the responsibility to issue guidelines that directly impact on access to treatments for patients with depression through the NHS. For example, first treatment recommendations for low level depression tend to be trialled in the following order, CBT self-help, CBT, interpersonal therapy, CBT, counselling and STDP. This means patients can end up having to refuse a great number of treatments before learning about the existence of or receiving STDP (McPherson & Beresford, 2019).

It is important to consider the impact of this political climate of narrow evaluation of therapies, and the potential side-lining and innovation of STDPs, in relation to the participants' accounts. Accordingly, the participants' accounts can be understood in the context of their minority status, both within psychodynamic practice and the wider psychotherapy world, given that there were only around 50 ISTDP practitioners in the UK at the point of data collection. As a minority group, practitioners may expect a potential lack of understanding from those in other modalities and perhaps as a result exercise a degree of carefulness in which they discuss their practice. Yet, at the same

time, STDPs are examples of approaches that are at the cutting edge of applying findings from affective neuroscience and evolutionary-based understandings of the physiology of emotion (Coughlin, 2017; Frederickson, 2017). The excitement of being at the frontier of what is considered effective in psychotherapeutic practice was something that was transmitted through how participants discussed their therapeutic work. By elucidating this accelerated way of working, with its affective, moment by moment focus on unconscious processes, it is hoped that this presents counselling psychologists with the opportunity to evaluate the value and positioning of short-term psychodynamic approaches that are appealing but may currently not in full view.

5.3 Summary of the Research

This study of participants' accounts of their experiences of staying with their clients' intense emotional experiencing has revealed three main findings. Firstly, participants' experiences of their motivations and the demands of their intensive, experiential and emotion-focused work as ISTDP therapists, revealed a paradox of precision. The satisfaction in participants' experiences of how they approach and achieve moment-by-moment precision can lead, paradoxically, in other moments, to feelings of anxiety that relate to pressures of time and an increased focus on what is missed. What appeared to be revealed for participants is an assumption that precision can be achieved at all times, which despite knowing this to be untrue, seems to be actively believed by participants in such moments. Elements of this paradox may likely be familiar to all therapists but talk of this by participants seemed heightened due to the precise and intensive nature of their clinical approach. Secondly, participants talk revealed an understanding of the therapeutic relationship and safe and risky. The in-session experiences that participants described, broadly delineated by the degree to which the work progresses successfully, were understood as an intimate and shared experience when the work is going well versus the sense of disconnection and frustration for the therapist when encountering challenges in the therapeutic relationship. Also captured in participants' accounts were how little of the emotional contact between therapist and client could be made known or rendered through words. Lastly, the many of forms of reflection and development needed to help contain therapist's reactions to difficult encounters suggested the importance of deliberate practice in helping bear one's own

emotion and observe it in the room. Below I address each of the superordinate themes in relation to the existing literature. The final structure of themes is intended to be neither explanatory nor a model of what is “out there” but is a representation of my analysis that captures properties of the participants, our researcher-participant interactions, and the wider world (Smith, Flowers & Larkin, 2009).

5.3.1 Paradox of precision. This finding underpins and links different features of the participants’ experiences, where their accounts seemed to encompass two diverse aspects of their moment-by-moment approach in the work. Together these features comprise a paradox of precision, where the more value that is placed on precision, the more this requires a level of astuteness and responsiveness that are often beyond the immediate ability of the therapist to deliver with an extremely high level of confidence. This underlying tension is balanced by the effectiveness and gains achieved and an appreciation of the difficulties in the work, together with reflection on their anxiety and what is missed in the work. Subordinate theme 4.4.2 “It’s painful not to be able to reach a patient”: feelings of frustration and inadequacy, touches on the hidden misconception of the paradox of precision of superordinate theme one, that participants seemed to sometimes take on, that the therapist ought to achieve precision with every intervention. Superordinate theme one “Opening that door”: striving for emotional closeness, captures an inherent paradox where the aim and achievement of moment-by-moment precision also entails greater focus on where precision is missed or avoided. This reveals that perhaps in certain moments the erroneous mythology that precision can be achieved every time is hard at times for participants to shake off. Yet precision is at the same time often reached by participants through the same deliberate practices that engender the paradox.

The precise aspects that participants talked about were consistent with those identified as key in the main ISTDP literature, in terms of the focus on assessing patient variables, and in choosing and assessing the impact of their interventions (ten Have-de Labije & Neborsky, 2012). All participants described a sense of feeling invigorated when helping clients experience their avoided emotions, which they found motivated them in the work to pursue this approach

even in challenging moments. In particular, the power of seeing a client's physicality change, as a sign of therapeutic progress, was valued by all participants. Yet, in contrast to these more appealing aspects, participants also described the pressures and difficulties associated with staying on track and accurately delivering the sequence of interventions. These moments were accompanied by feelings of anxiety and the pressure to get it right, and the focus on missed opportunities that may then lead to self-critical responses.

The paradox of precision was also talked about in relation to the therapist's role in helping bring avoided emotions into awareness to a degree of intensity that can help healing to occur without the client feeling overwhelmed. This way of working was seen as distinct from clients merely talking about emotion rather than feeling it. The participants described how they often feel comfortable in this role but also emphasised difficult aspects. The requirement of empathic attunement in order to maximise healing, yet needing also to withstand the client's unconscious efforts to evade conscious experiencing of emotion, is a further paradox of the therapist's role that was highlighted. That obtaining the "right" level of emotional experiencing was described as challenging is consistent with the accounts of other ISTDP therapists (Abbass, 2015; Coughlin, 2017; Frederickson, 2013).

The resulting feeling of anxiety was a strong issue that was evidenced in all participant accounts. The participants interpreted their anxiety as arising due to the pressure of not having enough time to process their feelings at the same time as maintaining a focus on the client. Although precision helped the therapist achieve accuracy, participants also talked about feelings of uncertainty, which were influenced by the patient, the therapist and what is co-created between them in that particular moment. The feelings of anxiety were experienced as helpful in moments where they felt there was no time to consider their own emotions, yet, at other times, this was also thought to interfere with their ability to focus on or stay with the patient's emotional experiencing. Here, this is not to suggest that the more precise the therapist is, the more imprecise they become in moments of difficulty. A more nuanced meaning, based on participants' accounts, is intended. The paradox of precision captures the contradictions that arise as a result of the greater

emphasis placed on precision, which lead to clinical situations where participants felt, either in the moment or on reflection, the required level of intelligence and responsiveness was often beyond their immediate ability to deliver with a high level of confidence or their desired competence.

The metaphor of the ISTDP therapist as surgeon, referred to by two participants was intriguing, as it seemed to reveal participants' concerns for the care of the client, through awareness of the precision and potential harm that can be caused if the tools of therapy are not used precisely. The drawing on this analogy may have been influenced by the fact that Davanloo, originator of the model, originally trained as a surgeon (Coughlin, 2017). Yet the focus on missed opportunities and the pressure participants felt to "get it right" highlighted a tension between their uncompromising focus on the details of the patient's internal experience but also a persistent sense of the larger vision that relates to the person and their relational goals for therapy. Abbass (2016) highlights this in relation to transference with the therapist, where "if these transferred feelings are not experienced they result in repression of another load of rage and guilt toward the therapist increasing his psychic burden of guilt and need to self-destruct" (p. 277). Hence the importance and concern placed on the therapist's accurate intervening in a client's anxiety and defences before they develop, so that their dynamic unconscious impulses and feelings can emerge, is not unfounded.

Together these multiple aspects reveal a contradiction that can be interpreted as a paradox of the moment-by-moment precision that lies at the heart of participants' efforts to stay with their clients' intense emotional experiencing. One participant commented in relation to the origins of the model and how a punitive aspect in the approach to precision had been transmitted through the training in ways that were both regarded as helpful and unhelpful for the participant. Abbass (2004b) has highlighted the poles of idealising and devaluing behaviours as evident in therapeutic training programmes, and how this may be heightened in approaches such as ISTDP where technical precision is pronounced. Kuhn (2014), however, highlights that ISTDP is becoming easier to learn as trainings get better at teaching it. He links the difficulties to the origins of there being one therapist with one way of teaching that perhaps

did not suit all students. He also points out that the teaching of skills is one aspect, but the humanity of the approach has to be found by each practitioner, through infusing their training with their own humanity, to arrive at that individuals' "right way" of doing ISTDP. This aspect is captured in participant accounts where there were concerns about the language and being empathic and also ability to notice how to work within the anxiety thresholds of the patient so the therapy is effective and compassionate, prioritising the clients' worldview and perceptions.

The participants talked about their emotional reaction and enthusiasm for the power of the videotaped material of cases they initially viewed at conferences, where they witnessed the process of therapists' interventions and somatic responses in helping clients access their avoided feelings in an effective and efficient manner. The draw to the model for participants was in witnessing an effective way of working which many participants found appealing, linking this to a more "active" therapeutic stance that was in contrast to their previous practice. Coughlin (2018) likewise supports a link for her between passion for the work and her drive towards effectiveness: "Finding a highly effective method that I was passionate about that really increased my effectiveness. I was motivated to ... do the best work I could possibly do" (p.27). Participants talked about the value of witnessing the changes in the physicality of the client as helpful for their ongoing motivation and confirmation of their approach as helpful for the client. Part of the motivation for using moment-by-moment precision to help clients access their emotions is thus the reward of seeing its beneficial effects in the therapy room.

The findings in this section have identified many distinctive features that are pertinent to counselling psychology's tension between its scientist- and reflective-practitioner identities. Together, these identities unite the scientific need for "rigorous empirical enquiry" with a therapeutic and practice-based relationship, rooted in the relational, which values empowerment of the client on their own terms (BPS, 2005, p. 1). Counselling psychologists draw from both identities and often work in a focused, precise, and active manner in their cyclical approach to assessment, formulation, intervention and evaluation (HCPC, 2015). They, too, share similar concerns for competent practice, both

during and beyond training, whether model specific or linked to therapeutic processes, such as facilitating clients' emotional experiencing. As a result, counselling psychologists are in a strong position to consider the tensions that may arise from this key process in facilitating a therapeutic experiencing of emotion.

5.3.2 The therapeutic relationship as safe and risky. Almost all participants talked about their experience of the therapeutic relationship as safe and risky in a number of ways. First, safety in terms of presence and emotional resonance with the client in moments of connection. Second, moments of feeling unable to feel or think or get emotional close to the client were accompanied by a fear of losing boundary or intense loneliness and longing to be seen. Third, in terms of feared consequences for the client when immobilised in the work. A striking aspect was the way in which describing emotions was often challenging and how the somatic aspects of experience that were hard to put into words occurred instead through their body-to-body communication with clients. Ogden and Fisher (2015) emphasise the inherent tension that "[t]herapy is always a dance of safety and risk, not only for clients but also for therapists" (p. 49). Similar to Odgen's body oriented, trauma-focused approach, participants' talk tended to see, in part, risk and safety through the lens of affective neurobiology (Schore, 2007), whereby an implicit and intersubjective 'being with' the client, whereby residues of their memories and past emerged in unbidden and unconscious manner. This finding links the hardships and comforts for striving for emotional closeness, with the theme of connection and disconnection that frames an understanding of what happens in room, and the need to build capacity, discussed in the section just below (see 5.2.3. The importance of deliberate practice).

A key aspect in all participants' accounts was of the therapeutic relationship as a shared and intimate experience that is central to the patient's healing. Reminiscent of Buber's (2013) "i-thou" relationship, whereby both persons are accepting of and open to the other, holding each other in mutual regard, both therapist and client are responding creatively in the moment rather than the "i-it" relationship that is based on habit and instrumental ways of responding, which instead may describe participants' fears in-session when

feeling disconnected from the client. Wampold (2015) refers to this as the “real relationship” that is based on realistic perceptions and genuineness as an aspect he sees as a necessary pathway in all effective psychotherapy. Yet, additionally, participants spoke of the poignancy in their connection to clients when they allow a “presence” to emerge. The context of a safe and empathic connection experienced within the therapeutic relationship was understood by participants to be active in disconfirming client’s fears of emotional closeness and the bedrock to the healing of difficult emotions (Frederickson, 2013). All participants expressed this understanding in terms of attachment theory whereby the caregiver provides emotional regulation for the child as a blueprint for the client’s future relationships. Relational psychoanalysis – also an approach that has been argued to fit well the discipline of counselling psychology (Gkouskos, 2017) – refers to this as “relational configurations” (Perlman & Frankel, 2009, p.110). Such facilitation of the client’s experience of healing by the agency of sharing feelings in a context of feeling safe and connected is a central principle of counselling psychology practice (Sugarman, 2016).

Connection and a shared sense of intimacy are conceptualised as the therapy’s key purpose (Frederickson, 2013) and participants talked about how this is achieved in part through an emotional resonance between therapist and client. The therapist’s emotional resonance whereby they feel the feelings of the client describes the attunement of the therapist in a bodily sense, that can allow for what one participant called the “unlocking” of the patient’s “life force”. This aspect is something that is very important and particular to ISTDP and other experiential dynamic approaches (Osimo & Stein, 2012) and the sustained attention to this by participants is not as comprehensively represented in counselling psychology’s interest in other affective processes, such as emotional processing (Murphy, 2017). The bodily aspect, and very much felt experience, however, may be similar to Eugene Gendlin’s (2010) description of “felt sense” and the implicit aspect the therapist is trying to attend to, as well as what is going on in the therapeutic relationship between two persons.

On the other side of the polarity drawn out in this subordinate theme, participants described moments where they felt disconnected from their clients' experiencing of emotion or issues arising in the work that resulted in reactions in the therapist that lead to withdrawal from connection. Participants varied in the reactions and situations they described, including distancing in the therapist due to an aversive response to sadistic images, not liking the client and finding it difficult to demonstrate empathy, and feeling overwhelmed by a patient with similar defenses to the therapist. One participant's response was to "shut down" when sexual feelings were expressed towards them, which the therapist felt was in part due to a feeling of confusion that arose over the how the therapist's intention to explore this in the work might be received by the client. Therapists' experiences of erotic transference and sexual feelings appear in a number of studies in counselling psychology and psychotherapy (Kotaki, 2016; Mann, 1997; Rodgers, 2011). These studies' findings align with the participants' experience of feeling unprepared for such encounters. There are differences in the literature over the degree to which sexual feelings are classed as a different form of feeling. Yet in this study, the participant in this instance felt the lack of clarity about how to proceed was not due to these feelings being handled differently to other forms of feeling, but was based on her own inhibitions in relation to sexual feelings that momentarily impeded clarity on how to direct the therapy. It may therefore be that some feelings are experienced as more intensely personal and the complexities of how they are understood could benefit from further exploration in training and supervision.

All participants talked about feelings of frustration and inadequacy and the origins of these feelings seemed influenced by a number of different factors. Rizq (2012) has identified feelings of inadequacy as a primary experience for therapists working with clients who experience particular relational difficulties that lead therapists to doubt their effectiveness. One understanding in ISTDP's theory of frustration is "anger plus inhibition" (Kuhn, 2014, p. 109), which may be drawn on further to help interpret the unexpressed feelings of participants who talked about not having enough time to attend to their complex feelings. An important consideration arises as to how it is, in an approach that is geared towards "reaching through [the] resistance" of the client (Abbass, 2015), that therapists inevitably manage to build often unconscious expectations of the

client that go against an otherwise deeply informed understanding of the client's defensive structure. Research into therapists' feelings of incompetence (Thériault, 2003), perhaps an overlapping construct with inadequacy, similar to the complexity of participants' accounts, recognises such phenomena as multiply determined, which in turn speaks to the complexity of the therapist-client interaction and the therapist's efforts to make sense of this and respond to clients in the here and now.

Similarly, these complex processes in which therapists respond to clients, particularly in difficult encounters, were conveyed in the ways in which participants spoke about their ways of coping. All participants drew on an internal process of self-talk in various ways to help move through their current difficulty and to get back on track, including offering encouragement and guidance to help with reconnecting with the client. Self-talk as a therapists' strategy are used and described in Hill, Nutt-Williams, Heaton, Thompson, and Rhodes (1996) study of therapists' retrospective recall of impasses. The literature drawn on in discussing this second superordinate theme affirms the challenges participants talked about in relation to connection and disconnection in the therapeutic relationship, whereby the complexity of processes related to therapist's reactions and feelings of frustration are highlighted. The in-depth, psychologically and phenomenologically informed intimacy that participants described is core to the counselling psychology identity (Fairfax, 2016) that seeks psychosocial perspective that understands the individual in context.

5.3.3 The importance of deliberate practice. All participants connected their reflective practices with the key therapist competency of the ability to cope with their own experiences while being at the same time available to the encounter with client. The literature on the therapist's development shows the value of reflective process in learning therapy skills and practice (Bennett-Levy, 2006; Bennett-Levy & Beedie, 2007; Stoltenberg, 2005), as well as enhancing the therapist's professional development (Schon, 1983; Thompson & Thompson, 2008). In research by Chow et al. (2015) participants' accounts identified, as a key factor in therapeutic competence, time spent in "deliberate practice", described by Blair (2016) as vigorous self-supervision and reflection on practice (see Coughlin, 2017; Frederickson, 2013 and

Rousmaniere, 2016 who are leading proponents of deliberate practice from within ISTDP approach). Blair (2016) highlights a potential danger in counselling psychology and psychotherapy whereby therapists' effectiveness plateaus out over time, once they reach a certain degree of comfort and confidence (Nyman, Nafziger, & Smith, 2010). Thus, feedback-informed approaches provide a useful way of maintaining and developing therapeutic skills.

Participants also talked about particular technical aspects that relate to their practice and development. The importance of supervision, including videotape review and experiential practice, were emphasised, and also the value of attending conferences, peer group support, and personal therapy as helpful for building their capacity to experience and observe their own emotions and responses in therapy. The value of reviewing video-case material – at conferences, and in training and supervision – was highlighted by all participants as helpful for building their capacity to bear their own emotions and intimacy with their clients. One participant's comment that "[t]here's nowhere to hide" when reviewing tapes in supervision was very powerful coming from a therapist. This perhaps suggests there is less chance for exaggeration of skill level and of outcomes in the session (Abbass, 2004a). Frosh (2011) highlights an important aspect relevant to the professional self of the therapist: "Relational integrity is an important life goal for people, and that depth of feeling – the capacity to experience emotion without hiding from it – is an important marker of such integrity" (p.25).

All participants talked about their improved capacity to observe and reflect on the inner emotional life of their clients. Emotions expressed in the client were referred to by one participant as "those minute flickers", recognising the fleeting and ephemeral nature of observing their clients. Abbass likewise conceptualises this aspect as "...those flash moments [in which] you can pick up the subtle passage of feeling that gets covered over really quickly—instantly repressed or projected outward" (Kenny, 2014, p.220). Most participants commented that to achieve this, they have to be comfortable and relaxed enough to notice their own emotions and reactions and not fear and avoid them, so they can be real in their relationships with clients. One participant points out

the value of basic training, and then an understanding of anxiety pathways that is provided with ISTDP training. This seems to imply a reliance on previous psychotherapy training as something to be built on, through study of the advance techniques (Abbass, 2015) of the ISTDP model. For participants, building capacity was an ongoing learning process of developing expertise in reading or working more with the implicit and non-verbalized aspects of emotional experiencing as well as what is explicit, visually through the body and in clients' talk and behaviour.

5.3.4 Summary of the discussion of superordinate themesIn short, the phenomenon explored is being studied in-depth for the first time, yet findings of this study reflect those of prior literature, linking with the experience of ISTDP therapists and other psychotherapists working in an experiential manner. The tensions inherent in participants' experiences of working with moment-by-moment precision, staying connected with clients, and development of their capacity and observation of the physiology of emotion, has offered a richer understanding of therapist experiences of staying with clients' intense emotional experiencing. These tensions and paradoxes will be the focus of the next section that considers these in relation to the interests of counselling psychology.

5.4 Working with the Therapeutic Relationship from an ISTDP Theory Perspective

Given that this is the first piece of research in counselling psychology conducted solely on the modality of ISTDP, its relevance and use to the field in light of participants' accounts is worth highlighting. ISTDP is model focused on the dynamic unconscious but with a "cognitive" frame – in terms of how participants reported intervening in the client's defences, the pragmatic approach to helping clients regulate their anxiety, and the importance of conscious reflection on their emotional states. It can be argued that due to its pragmatic aspects, such as the active stance of the therapist, as outlined in the above discussion of themes, ISTDP is a modality that has focused more on technical aspects and "doing" therapy. However, participants have offered a clear picture of how the therapeutic relationship operates in their practice of staying with client's intense emotions, and how the empirically supported

metapsychology of ISTDP (Abbass, 2015), which draws innovatively on more traditional concepts of psychodynamic psychotherapy, can inform the practice of counselling psychologists who may wish to apply ISTDP in their clinical work.

Counselling psychology is seeing a move towards working in the therapeutic relationship in an integrative manner that is increasingly transtheoretical, whereby 'schools' of therapy are being eclipsed by convergences in psychotherapy science. As Lambert and Norcross (2017) highlight, therapies are complementary not contradictory when you start to consider individual patients. As supported by participants' accounts, in order to build their conceptualisation of the individual the ISTDP therapist, in the context of the therapeutic relationship, helps the client address their relational conflicts that are the result of attachment trauma. To achieve this, they rely on a client-informed understanding of transference, and countertransference and the therapist's use of self (HCPC, 2015; 2016). The relational focus at the heart of counselling psychology is thus visible in many aspects of practice of ISTDP as it has been related by participants in their accounts of their experientially-focused work.

5.5 Methodological Critique of the Study and Quality Issues

Having outlined some of the original contributions to our knowledge of how the ISTDP therapist experiences their clients' intense emotional experiencing, the following outlines considerations of the methodological features of the study and quality issues.

5.5.1 Critique of IPA. As mentioned in Chapter Three: Methodology, IPA was selected due to its ability to provide a rich and nuanced understanding of the subjective lived experiences for a handful of participants (Smith, Flowers & Larkin, 2009). A conceptual and practical critique (Brocki & Wearden, 2006; Tuffour, 2017; Willig, 2013) of this choice of methodology and how it was actioned and reflected on through this research is considered below.

5.5.1.1 The role of language. Firstly, IPA is assumed, in comparison to more discursive approaches, to give insufficient attention to the integral role that language plays in representing experience (Willig, 2013). Yet, in line with

Smith, Flowers and Larkin's (2009) response to this criticism, this study accepts that meaning-making happens in the context of the participants' stories and how they use language. Thus any insight gained into experience is always already bound through language. This study, however, aimed to investigate therapists' subjective experiences, where a comprehensive examination of individual narratives suffices in assuring credibility of the study.

5.5.1.2 The suitability of participants' accounts. A second criticism of IPA relates to its reliance on participants accounts' and researchers' experiences, and the degree to which the method can apprehend the experience and its meanings versus mere opinions (Willig, 2013). This being the case, it is important to ascertain whether participant and researcher are skilled enough and able to convey the nuances of experiences. All participants in this study had the ability to articulate in a sophisticated manner their experiences. Yet there are aspects that perhaps hindered participants' abilities here. For example, there is huge amount of sensitivity in discussing one's own professional conduct and experiences, and especially more so when being asked to make comment on client work and their emotional and mental health. So whilst participants had access to the requisite degree of fluency, there were factors of sensitivity that perhaps limited their permission to describe their experiences. My own skills in data collection are reflected on in the reflexivity section below. Overall, the richness of the data and analysis detailed in this study shows that this was not a key concern.

5.5.1.3 IPA's descriptive nature. Thirdly, IPA's focus on perceptions, it is argued (Willig, 2013), limits understanding, where seeking to comprehend lived experiences may not help to account for why they happen. Studies should be robust by aiming to investigate the conditions that bring about the experiences, which are situated historically or social-culturally beyond research parameters. Yet, this study has aimed to avoid this criticism, through providing an analysis in IPA that is interpretative, idiographic and contextual (Smith, Flowers & Larkin, 2009), and thereby able to get close in understanding something of the cultural positioning of the experiences participants talked about.

5.5.1.4 Cognition and phenomenology as discordant. Lastly, the claim that IPA is focused on mental action is perceived to be incompatible with some aspects of phenomenology, and its role in IPA is not fully grasped (Willig, 2013). Smith, Flowers & Larkin (2009) reply that the method's focus on sense- and meaning-making encompasses forms of reflection that chime with the cognitive paradigm.

5.5.1.5 Quality issues. This piece of research intended to study a specific phenomenon with a particular therapist population within a particular modality and UK context. In terms of the rigour (Yardley, 2008) of the study it is worth noting the primarily subjective nature of IPA as an approach where the researcher offers their interpretation of their participants' interpretation of lived experience (Smith, Flowers & Larkin, 2009). That my participants would have given a different narrative to a different researcher is undoubtable and was a question I reflected on throughout (McLeod, 2014). For example, how might participants' accounts have been modified if they were speaking to someone fully immersed in the practice of ISTDP and also someone qualified rather than someone in the midst of their primary clinical training? Overall, I felt my researcher positionality (Frost, 2016), as someone who had received introductory training and was using basic ISTDP principles in my psychodynamic clinical practice, meant I had at various points an "insider/outsider" status that allowed for a balance between empathic and suspicious interpretation that is valued in IPA.

A second aspect, in terms of the rigour of the study, related to the completeness of the analysis. The first superordinate theme draws from data that was gathered around the question, 'what drew you to ISTDP'? The rationale for asking this question was to enable me to achieve a good degree of closeness with participants early on in the interview and to direct the interviews towards participants' focus on their understanding of their work with their clients. Initially, I considered that responses to this question would not be central to phenomena, and that only data that spoke to in-session experiences would be included in the analysis. This view was based on my understanding of Smith's (2011) quality criteria for good IPA where he highlights the importance of providing "a clear focus...providing details of a particular aspect" of the

phenomenon (p. 24). However, on reflection, and given the exploratory nature of my research topic, I decided to include data at the broadest level of sense-making possible, in order to reflect the contextual aspects that may help further understand what motivates the participant in the room when working with their client's intense emotions. This made the analysis, in my view, more interpretative rather than merely descriptive, and also more developed through an elaborated account of the emerging themes. This approach thus also represents an example of contextualising the interview through additional data, as espoused by Smith, Flowers and Larkin (2009).

The transparency and coherence (Yardley, 2008) of this research, in terms of how I can know whether the themes I have identified in the data are a true reflection of participants' experience (McCleod, 2013), was a particularly vivid concern in the data analysis. That IPA is fundamentally a relational approach (Finlay, 2011) was most evident in my attempts to make meaning of participants' accounts. Regular support and guidance from my supervisory team and contact with fellow IPA researchers in my cohort was invaluable to gaining not only an understanding of participants' words but in bringing to life my own faithful translation and interpretation of their accounts. Furthermore, the analysis was audited by an experienced IPA researcher, in order to track my keeping to the methodological commitments in building a rich picture of therapists' experiences that is interpretative as well as descriptive, and thus also trustworthy and credible (Hefferon & Gil-Rodriguez, 2011).

5.6 Reflexivity on the Research Process

Reflexivity is regarded as a further quality criteria that helps guarantee the rigour of the research through the researcher's reflection on their assumptions and knowledge and the influence of this, as well as their role and input, on the research process (Kasket, 2012).

Much of my personal reflexivity throughout the research centred on some of my individual characteristics as a researcher and their influence on the study. In particular, my reflections focused on the process of my engaging positionality and owning my perspective as a researcher (Frost, 2016; Kasket & Gil-Rodriguez, 2011). A part of my personal motivation to undertake this research

was to learn from experienced therapists about their way of working that would speak to important clinical processes and their application to practice. My own position as a trainee had led to me positioning the experienced therapists who participated in my study as 'experts'. This positioning showed up in a variety of initially unconscious assumptions that were useful to have considered in order to limit their undue influence on the study: initial drafts of my interview schedule were highly technical and conceptual, rather than the everyday language that IPA favours (Smith, Flowers & Larkin, 2009); my interviewing style was at times timid on the basis of feeling anxious about "getting it right" from an ISTDP perspective (which I realised was not a part of my role as interviewer) and that I should be asking questions that were merely relevant to participants rather than to the interests of the study; and in the data analysis and write up of the study, I was initially tentative on the basis of feeling an allegiance to the participants' experience rather than translating this experience in light of the phenomena under study. Through these reflections, I was better placed to limit their influence on the research. I was also able to better understand and articulate their relationship to my research topic, my approach to the participants, and the influence of the context in which I was conducting research in counselling psychology.

Much of my epistemological and methodological reflexivity (Kasket, 2012; Willig, 2013) related to my attempts to adhere to the philosophical commitments of IPA and grapple with the ontological and epistemological stance of interpretative phenomenology. I chose this stance in relation to my research aims and could appreciate ways in which my subjectivity, and indeed the subjectivity of any other researcher, would shape and limit the research accordingly. I could acknowledge how a shift in my epistemological positioning would alter the knowledge gained. Two of the greatest dilemmas that I engaged with, particularly at the initial noting stage, were: (1) how does an IPA researcher begin to make sense of the experience of the other? I was unable to locate useful guidance other than the general advice of 'jumping in' to the data with initial observations, and felt throughout the research the ongoing tension of the degree to which this is subjective and empirical; and (2) what counts as "experience" in interpretation? A related question was, what is the frame of reference for conceptual comments in IPA that the researcher draws on in

interpreting participants' accounts? I initially assumed a very limited view of what counts as "experience" and "psychological concepts" and found that bracketing these terms when facing this analysis and concentrating on meaning-making, helped free me from these conceptual limitations.

5.7 Implications of Findings for Practice in Counselling Psychology

The findings of this research have relevant implications for the practices of counselling psychologists and the broader practice of psychotherapy. Counselling psychologists may benefit from developing an awareness of their own motivations and responses to staying with their clients' intense emotions and of the benefit of this to the therapeutic relationship. The finding that participants rely heavily on their theoretical framework suggests that counselling psychologists may draw from this in helping them to identify and understand and better observe their own emotional experiences.

The deliberate practices (Rousmaniere, 2016) that participants discussed, such as videotaped supervision and peer review, indeed help focus on the unique developmental path of each therapist, in terms of their capacity to bear their emotions and stay with their clients' intense feelings, but also provide opportunity for further scrutiny and a focus on "getting it right". Those responsible for training and supervision may consider the benefits of such practices but may also need to consider the punitive aspects raised in participants' account in the ongoing development and support of therapists. For example, in the preparation and management of feelings of anxiety and frustration and the self-critical responses that arise. Also, further to one participant's talk about drawing on their meditation practice to help cope in times of difficulty, programmes that aim to comprehensively address these burdens of training and therapeutic practice by improving trainees' compassion towards self and others may be a helpful starting point (Beaumont & Martin, 2016).

Participants' accounts offer a view of ISTDP as an integrative, evidence-based approach, incorporating clinical expertise, and attachment-based understanding of dynamic unconscious processes that are helped into conscious experience and processed within the therapeutic encounter. Other

therapists can draw from this model and explore ways to incorporate its techniques of intervening in clients' defences and regulating anxiety, and in helping clients experience their emotions. This study of ISTDP therapists' experiences touches on the "tension of polarities" that exist in so-called natural versus human sciences, that lead in practice to a balance of effective technique and relational aspects that address the whole person (Murphy, 2017). The counselling psychologist holds a firm commitment to evidence-based practice, yet the value in an evidence base differs according to epistemological and ontological standpoints. This research does not resolve this debate, but hopefully will introduce counselling psychologists to ISTDP as a modality that is evidence based, theoretically integrated and valuable to counselling psychology and the science of psychotherapy.

It is important to reflect on the numerous ways this research has impacted positively on my own clinical practice (Kasket, 2012; 2013). Participants' accounts have further alerted me to the value of attending to a client's emotional physiology, including an increased knowledge of anxiety and emotional pathways, so I can better notice and gauge what is happening for the client emotionally in the room. The participants' accounts also elucidated their phenomenological commitment to responding to the client through a focus on their reactions and in seeking feedback from the client about those responses. I too have found great benefit and creativity in this prioritising of the client's subjectivity and uniqueness, where adding this element to my practice. Thus, in researching and writing my doctoral thesis, I have found that my own personal definition of counselling psychology as it relates to me as a practitioner-researcher has evolved to include greater belief in focused and pragmatic ways to help empower clients, and in envisaging non-hierarchical relationships where the therapist draws on their expertise to help the client address their relational difficulties.

5.8 Implications for Future Research

The findings have revealed important aspects of the phenomenon that could be further investigated, including therapists' reactions to clients displaying similar defensive structure to their own – an aspect common to participants' difficult encounters – and the somatic phenomena in countertransference and

therapists' way of relating to the body (Athanasiadou & Halewood, 2011), an aspect which often eluded participants. As the development of the person of the therapist was talked about in divergent ways, further phenomenological study of therapists' experiences of this could help elucidate this. Finlay (2006) highlights how replicating research can broaden horizons by generating new knowledge and interpretations. Exploring the experiences of other ISTDP therapists based at other institutes or therapists working in similar modalities, such as experiential dynamic therapies, may offer further understanding of contextual aspects and their influences. Relatedly, it would be interesting to see how therapists stay with their clients' intense emotions in modalities where emotional experiencing is not the primary focus.

The same phenomena could be explored from diverse paradigms (Morrow, 2007). As participants' accounts made reference to the fleeting and ephemeral nature of emotional experience, "those minute flickers", creative methods could be employed to better apprehend emotional content. For example, Grid Elaboration Method, a free association approach (Hollway & Jefferson, 2000) that has been shown to fit well with a thematic analysis (Park, 2016) has been used to address features of thought and behaviour that arise via emotionally laden, nonconscious processes. A critical realist approach would allow for incorporation of ISTDP theoretical framework to aid understanding or theory-building. Other methodological approaches, such as the single case and video-case-series methodologies, used to good effect in ISTDP to explore patient variables (Salvadori, 2010; Town et al, 2017), could be employed to examine therapists' emotional capacity in relation to key therapeutic processes and outcomes.

The phenomenon studied here may also be worth exploring in other emotions-focused or experiential modalities. As a cross-sectional view of one-off interviews were used in this study, a longitudinal study exploring how therapists manage within particular cases may highlight additional features. Comparative studies may also highlight shared and divergent aspects between approaches that share an experiential and dynamic focus. The nature and extent of counselling psychology's experiences of this phenomena could be

researched to better establish the relevance to the field of some of the implications found in this study.

5.9 Summary of the Study

This exploratory study is the first of its kinds to present an in-depth look at what it is like for ISTDP therapists to stay with their clients' intense emotional experiencing. It offers an interpretative phenomenological perspective on the subtleties and complexities inherent in participants' experiences of their in-session experiences and the technical aspects of the development of their capacity to endure intense emotions. The study illustrates how an important issue for therapists and their ongoing development is attending to the paradox of moment by moment precision, whereby the therapist achieves greater effectiveness but at the cost of a greater focus on what they miss in the work. The therapist's experience of the therapeutic relationship as safe and risky also revealed the sense of comfort in the work and also the sense of threat to the self. Findings also suggested important ways of coping with difficult encounters and helpful suggestions for building the capacity of the therapist through forms of deliberate practice. Consideration of ISTDP as an integrative, multidimensional approach that aligns to the values of counselling psychology was presented. The findings can form the basis of future research into therapists' experiences of staying with their clients intense emotional experiencing and other aspects of the therapists' experience of providing an emotions-focused, experiential approach that takes place within the context of a healing and human relationship.

References

- Abbass, A. (2004a). Small group videotape training for psychotherapy skills development. *Academic Psychiatry*, 28, 151-155.
<https://doi.org/10.1176/appi.ap.28.2.151>
- Abbass, A. (2004b). Idealization and devaluation as barriers to psychotherapy learning. *Ad Hoc Bulletin of Short-Term Dynamic Psychotherapy*, 8(3). Retrieved from
https://istdp.ch/sites/default/files/downloadfiles/AA_Idealization.pdf
- Abbass, A. (2015). *Reaching through resistance: Advanced psychotherapy techniques*. Kansas City, MO: Seven Leaves Press.
- Abbass, A. (2016). The emergence of psychodynamic psychotherapy for treatment resistant patients: intensive short-term dynamic psychotherapy. *Psychodynamic psychiatry*, 44(2), 245-280.
<https://doi.org/10.1521/pdps.2016.44.2.245>
- Alexander, F. (1950) *Psychosomatic medicine: It's principles and applications*. New York: Norton.
- Andersson, H. (2014). *Therapists' experiences of the therapeutic alliance with clients with drug problems: An interpretative phenomenological analysis* (Doctoral dissertation). University of East London, London. Retrieved from
http://roar.uel.ac.uk/4024/1/Henrike_Andersson_Thesis_Amended_June_2014.pdf
- Athanasiadou, C., & Halewood, A. (2011). A grounded theory exploration of therapists' experiences of somatic phenomena in the countertransference. *European Journal of Psychotherapy & Counselling*, 13(3), 247-262.
<https://doi.org/10.1080/13642537.2011.596724>
- Balint, E., & Norell, J. S. (1973). *Six Minutes for the Patient: interactions in general consultation*. London: Tavistock.
- Barlow, D.H., Ellard, K.K., Fairholme, C.P., Farchione, T.J., Boisseau, C.L., May, J.T.E. & Allen, L.B. (2011). *Unified Protocol for Transdiagnostic Treatment of Emotional Disorders*. New York: Oxford University Press.
- Barrett, L. F. (2017). *How emotions are made: The secret life of the brain*. London: Macmillan.
- Beaumont, E., & Martin, C. J. H. (2016). A proposal to support student

- therapists to develop compassion for self and others through Compassionate Mind Training. *The Arts in Psychotherapy*, 50, 111-118.
<https://doi.org/10.1016/j.aip.2016.06.005>
- Bennett-Levy, J. (2006). Therapist skills: A cognitive model of their acquisition and refinement. *Behavioural and Cognitive Psychotherapy*, 34(1), 57-78.
<https://doi.org/10.1017/S1352465805002420>
- Bennett-Levy, J., & Beedie, A. (2007). The ups and downs of cognitive therapy training: What happens to trainees' perception of their competence during a cognitive therapy training course?. *Behavioural and Cognitive Psychotherapy*, 35(1), 61-75.
<https://doi.org/10.1017/S1352465806003110>
- Blair, L. J. (2016). The transition from trainee to qualified counselling psychologist. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket & V. Galbraith (Eds.), *The handbook of counselling psychology* (4th ed.) (pp. 549-566). London: Sage.
- Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Berkeley: University of California Press.
- Borkovec, T. D., & Sides, J. K. (1979). The contribution of relaxation and expectancy to fear reduction via graded, imaginal exposure to feared stimuli. *Behaviour Research and Therapy*, 17(6), 529-540.
[https://doi.org/10.1016/0005-7967\(79\)90096-2](https://doi.org/10.1016/0005-7967(79)90096-2)
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77– 101. Retrieved from
<https://www.tandfonline.com/doi/abs/10.1191/1478088706qp063oa>
- British Psychological Society. (2005). *Division of Counselling Psychology: Professional Practice Guidelines*. Retrieved from
<https://shop.bps.org.uk/division-of-counselling-psychology-professional-practice-guidelines.html>
- British Psychological Society. (2014). *Code of Human Research Ethics*. Leicester: The British Psychological Society. Available at:
<https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/BPS%20Code%20of%20Human%20Research%20Ethics.pdf>
 [Accessed 7.Aug.2018].
- British Psychological Society. (2018a). *Standards for the accreditation of Doctoral programmes in counselling psychology*. Retrieved from

https://www1.bps.org.uk/system/files/Public_files/PaCT/counselling_accreditation_2018_web.pdf

- British Psychological Society. (2018b). *Code of ethics and conduct*. Retrieved from <https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/BPS%20Code%20of%20Ethics%20and%20Conduct%20%28Updated%20July%202018%29.pdf>
- Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and health*, 21(1), 87-108. <https://doi.org/10.1080/14768320500230185>
- Buber, M. (2013). *I and Thou*. London: Bloomsbury.
- Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effect of cognitive therapy for depression: a study of unique and common factors. *Journal of consulting and clinical psychology*, 64(3), 497-504. <http://dx.doi.org/10.1037/0022-006X.64.3.497>
- Charmaz, K. (2013). *Constructing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.
- Chow, D. L., Miller, S. D., Seidel, J. A., Kane, R. T., Thornton, J. A., & Andrews, W. P. (2015). The role of deliberate practice in the development of highly effective psychotherapists. *Psychotherapy*, 52(3), 337. <https://doi.org/10.1037/pst0000015>
- Cooper, M., & McLeod, J. (2011). Person-centered therapy: A pluralistic perspective. *Person-Centered & Experiential Psychotherapies*, 10(3), 210-223. <https://doi.org/10.1080/14779757.2011.599517>
- Coren, A. (2010). *Short-term psychotherapy* (2nd ed.). London: Palgrave Macmillan Limited.
- Coughlin, P. (2017). *Maximizing Effectiveness in Dynamic Psychotherapy*. Abingdon: Routledge.
- Coughlin, P. (2018). Structured Interview on Psychotherapy Expertise. In *The Integrative Therapist*, 4(2), 26-27. Retrieved from https://cdn.ymaws.com/www.sepiweb.org/resource/resmgr/integrative_therapist/Integrative_Therapist-v4-2.pdf
- Coughlin, P. & Katzman, J. (Guest Editors). "Intensive Short-Term Dynamic Psychotherapy." *Psychiatric Annals*, 43:11, 486–489.

- Davanloo, H. (1987). The unconscious therapeutic alliance. In P. Buirski (Ed.), *Frontiers of dynamic psychotherapy: Essays in honor of Arlene and Lewis R. Wolberg* (pp. 64-88). Philadelphia, PA, US: Brunner/Mazel.
- Davanloo, H. (1990). *Unlocking the Unconscious: Selected papers of Habib Davanloo*. Chichester: Wiley.
- Davanloo, H. (2001). Intensive short-term dynamic psychotherapy: extended major direct access to the unconscious. *European Psychotherapy*, 2(2), 25-70.
- Deakin, H., & Wakefield, K. (2014). Skype interviewing: Reflections of two PhD researchers. *Qualitative research*, 14(5), 603-616.
<https://doi.org/10.1177/1468794113488126>
- Donati, M. (2016). Becoming a reflective practitioner. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket & V. Galbraith (Eds.), *The handbook of counselling psychology* (4th ed.) (pp. 55-73). London: Sage.
- Fairfax, H. (2016). The role of counselling psychology in secondary adult mental health care. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket & V. Galbraith (Eds.), *The handbook of counselling psychology* (4th ed.) (pp. 511-529). London: Sage.
- Fasulo, A. (2015). Do we really want a future as qualitative psychologists? *Integrative Psychological and Behavioral Science*, 49(4), 670-680. <https://doi.org/10.1007/s12124-015-9317-3>
- Feltham, C. (2010). *Critical thinking in counselling and psychotherapy*. London: Sage.
- Ferenczi, S., & Rank, O. (1986). The development of psychoanalysis. *Classics in Psychoanalysis Monograph Series*, Mo 4,68.
<https://doi.org/10.1177/000306519404200309>
- Finlay, L. (2006). 'Rigour', 'ethical integrity' or 'artistry'? Reflexively reviewing criteria for evaluating qualitative research. *British Journal of Occupational Therapy*, 69(7), 319-326.
<https://doi.org/10.1177%2F030802260606900704>
- Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world*. London: Wiley-Blackwell.
- Fonagy, P. (2015). The effectiveness of psychodynamic psychotherapies: an update. *World Psychiatry*, 14(2), 137-150.

<https://doi.org/10.1002/wps.20235>

- Fonagy, P., Rost, F., Carlyle, J., McPherson, S., Thomas, R., Fearon, P., ... Taylor, D. (2015). Pragmatic randomized controlled trial of long-term psychoanalytic psycho- therapy for treatment-resistant depression: The Tavistock Adult Depression Study (TADS). *World Psychiatry*, 14(3), 312–321. <https://doi.org/10.1002/wps.20267>
- Frederickson, J. (2013). *Co-Creating Change: Effective Dynamic Therapy Techniques*. Kansas City, MO: Seven Leaves Press.
- Frederickson, J. J., Messina, I., & Grecucci, A. (2018). Dysregulated Anxiety and Dysregulating Defenses: toward an emotion regulation informed dynamic psychotherapy. *Frontiers in psychology*, 9(2054), 1-9. <http://dx.doi.org/10.3389/fpsyg.2018.02054>
- Freud, S. (1923). *The Ego and the Id*. London: Hogarth Press.
- Frosh, S. (2011). *Feelings*. Abingdon: Routledge.
- Frost, N. (2016). *Practising research: Why you're always part of the research even when you think you're not*. London: Palgrave.
- Gadamer, H. (2013). *Truth and method*. London: Bloomsbury Academic.
- Gait, S. (2017) *Does the development of countertransference awareness influence the therapeutic relationship? A grounded theory analysis* (Doctoral thesis). University of the West of England. Retrieved from <http://eprints.uwe.ac.uk/30240>
- Gee, P. (2011). 'Approach and Sensibility': A Personal Reflection on Analysis and Writing Using Interpretative Phenomenological Analysis. *Qualitative Methods in Psychology Bulletin*, 11, 8-22.
- Gelo, O. C. G. (2012). On research methods and their philosophical assumptions: "Raising the consciousness of researchers" again. *Psychotherapie und Sozialwissenschaft*, 14(2), 111-130.
- Gelo, O. C. G.555 & Manzo, S. (2015). Quantitative approaches to treatment process, change process, and process-outcome research. In *Psychotherapy Research* (pp. 247-277). Vienna: Springer.
- Gendlin, E. T. (2010). *Focusing: How to Open Up Your Deeper Feelings and Intuition*. London: Rider.
- Gilbert, P. (2009). *The Compassionate Mind*. London, UK: Constable and Robinson.
- Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with

- high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, 13(6), 353-379.
<https://doi.org/10.1002/cpp.507>
- Gkouskos, S. (2017). Psychodynamic approaches. In V. Galbraith (Ed.) *Counselling Psychology*. Taylor & Francis.
- Goldfried, M. R., Raue, P. J., & Castonguay, L. G. (1998). The therapeutic focus in significant sessions of master therapists: A comparison of cognitive-behavioral and psychodynamic-interpersonal interventions. *Journal of consulting and Clinical Psychology*, 66(5), 803-810.
<http://dx.doi.org/10.1037/0022-006X.66.5.803>
- Goldman, R. N., Greenberg, L. S., & Pos, A. E. (2005). Depth of emotional experience and outcome. *Psychotherapy Research*, 15(3), 248-260.
<https://doi.org/10.1080/10503300512331385188>
- Greenberg, L. S. (2010). Emotion-focused therapy: A clinical synthesis. *Focus*, 8(1), 32-42. <https://doi.org/10.1176/foc.8.1.foc32>
- Greenberg, L. S. (2015). *Emotion-focused therapy: Coaching clients to work through their feelings*. American Psychological Association.
- Greiner, K. (2015). Psychotherapia Academica Universitatis: A Philosophical Argument for the Academic Discipline of Psychotherapy. In O. C. G. Gelo, A. Pritz, & B. Rieken (Eds.), *Psychotherapy Research* (pp. 93-116). Vienna: Springer.
- Guba, E. G., & Lincoln, Y. S. (2005). Paradigmatic controversies, contradictions, and emerging influences. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3rd ed., pp. 191–215). Thousand Oaks, CA: Sage.
- Hanna, P. (2012). Using internet technologies (such as Skype) as a research medium: A research note. *Qualitative Research*, 12(2), 239-242.
<https://doi.org/10.1177%2F1468794111426607>
- Harnett, P., O'Donovan, A., & Lambert, M. J. (2010). The dose response relationship in psychotherapy: Implications for social policy. *Clinical Psychologist*, 14(2), 39-44.
<http://dx.doi.org/10.1080/13284207.2010.500309>
- Hayes, S. (2016). Foreword. In S. Hofmann (Ed.). *Emotion in therapy: From science to practice*. New York: The Guilford Press.

- Hayes, S. C., & Hofmann, S. G. (2017). The third wave of cognitive behavioral therapy and the rise of process-based care. *World Psychiatry*, 16(3), 245-246. <https://doi.org/10.1177/2167702618772296>
- Hayes, S. C., Strosahl, K., & Wilson, K. G. (1999). *Acceptance and commitment therapy: Understanding and treating human suffering*. New York: Guilford.
- Health & Care Professions Council. (2015). *Standards of proficiency: Practitioner Psychologists*. London: HCPC. Retrieved from http://www.hpc-uk.org/assets/documents/10002963SOP_Practitioner_psychologists.pdf
- Health & Care Professions Council. (2016). *Standards of conduct, performance and ethics*. London: HCPC. Retrieved from <http://www.hcpc-uk.co.uk/assets/documents/10004EDFStandardsofconduct,performanceandethics.pdf>
- Heidegger, M. (1927/2010). *Being and time* (J. Stambaugh, Trans). Albany: New York Press.
- Hefferon, K., & Gil-Rodriguez, E. (2011). Interpretative phenomenological analysis. *The Psychologist*. Retrieved from <http://psycnet.apa.org/record/2011-23560-004>
- Hill, C. E., Nutt-Williams, E., Heaton, K. J., Thompson, B. J., & Rhodes, R. H. (1996). Therapist retrospective recall impasses in long-term psychotherapy: A qualitative analysis. *Journal of Counseling Psychology*, 43(2), 207-217. <https://doi.org/10.1037/0022-0167.43.2.207>
- Hill, C. E., Spiegel, S. B., Hoffman, M. A., Kivlighan Jr, D. M., & Gelso, C. J. (2017). Therapist expertise in psychotherapy revisited. *The Counseling Psychologist*, 45(1), 7-53. <https://doi.org/10.1177%2F0011000016641192>
- Hofmann, S. G. (2016). *Emotion in therapy: From science to practice*. New York: The Guilford Press.
- Hollway, W., & Jefferson, T. (2000). *Doing qualitative research differently: Free association, narrative and the interview method*. London: Sage.
- Huff, J. L., Smith, J. A., Jesiek, B. K., Zoltowski, C. B., Graziano, W. G., & Oakes, W. C. (2014). From methods to methodology: Reflection on keeping the philosophical commitments of interpretative phenomenological analysis. In *Frontiers in Education Conference (FIE)*,

2014 *IEEE* (pp. 1-9). IEEE.

<http://doi.ieeecomputersociety.org/10.1109/FIE.2014.7044253>

Jaycox, L. H., Foa, E. B., & Morral, A. R. (1998). Influence of emotional engagement and habituation on exposure therapy for PTSD. *Journal of consulting and clinical psychology*, 66(1), 185-192.

<http://dx.doi.org/10.1037/0022-006X.66.1.185>

Kasket, E. (2012). The counselling psychologist researcher. *Counselling Psychology Review*, 27(2), 64-73.

Kasket, E. (2013). The counselling psychologist researcher. Supplementary material to accompany *Applied Psychology*, edited by G. Davey (2011).

<http://bcs.wiley.com/he->

[bcs/Books?action=resource&bcsId=6466&itemId=1444331213&resourceId=29315](http://bcs.wiley.com/he-bcs/Books?action=resource&bcsId=6466&itemId=1444331213&resourceId=29315)

Kasket, E. (2016). Carrying out research. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket & V. Galbraith (Eds.), *The handbook of counselling psychology* (4th ed.) (pp. 228-243). London: Sage.

Kasket, E. (2017). *How to Become a Counselling Psychologist*. Abingdon: Routledge.

Kasket, E., & Gil-Rodriguez, E. (2011). The identity crisis in trainee counselling psychology research. *Counselling Psychology Review*, 26(4), 20-30.

Kenny, D. T. (2014). *From id to intersubjectivity: Talking about the talking cure with master clinicians*. London: Karnac Books.

Konstantinou, G. (2014). The relationship of counselling psychology training with CBT: Implications for research and practice. *Counselling Psychology Review*, 29(3), 43-54.

Kotaki, V. (2016). *An exploration of how therapists experience erotic feelings in therapy* (Unpublished Doctoral thesis). City, University of London.

Retrieved from

<http://openaccess.city.ac.uk/16054/1/Kotaki%2C%20Venetia%20%28redacted%29.pdf>

Kuhn, N. (2014). *Intensive Short-term Dynamic Psychotherapy, a Reference*. North Charleston, SC: Experient Publications.

Lambert, M. & Norcross, J. (2017). Psychotherapy integration in counselling psychology. In D. Murphy (Ed.). *Counselling psychology: A textbook for study and practice* (pp. 150-168). London: Wiley-Blackwell.

- Langdridge, D. (2007). *Phenomenological psychology, theory research and method*. Harlow, Pearson Education Limited.
- Larkin, M. & Thompson A. R. (2012). Interpretative phenomenological analysis in mental health and psychotherapy research. In D. Harper, and A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp.101-116). West Sussex: Wiley & Sons.
- Leahy, R. L., Tirsch, D., & Napolitano, L. A. (2011). *Emotion regulation in psychotherapy: A practitioner's guide*. New York: Guilford Press.
- LeDoux, J. E. (1998). *The emotional brain: The mysterious underpinnings of emotional life*. New York: Simon & Schuster.
- Lennie, C., & West, W. (2010). Dilemmas in counselling psychology research. *Counselling Psychology Quarterly*, 23(1), 83-89.
<https://doi.org/10.1080/09515071003665296>
- Levitt, H. M., & Piazza-Bonin, E. (2016). Wisdom and psychotherapy: Studying expert therapists' clinical wisdom to explicate common processes. *Psychotherapy Research*, 26(1), 31-47.
- Malan, D., & Coughlin Della Selva, P. (2006). *Lives transformed: A revolutionary method of dynamic psychotherapy*. London: Karnac Books.
- Mann, D. (1997). *Psychotherapy, An Erotic Relationship: Transference and Countertransference Passions*. London: Routledge.
- Mayer, J. D., & Salovey, P. (1997). What is emotional intelligence? In P. Salovey & D. Sluyter (Eds.), *Emotional development and emotional intelligence: Implications for educators* (pp. 3–31). New York: Basic Books.
- McAteer, D. (2010). Philosophical pluralism: Navigating the sea of diversity in psychotherapeutic and counselling psychology practice. In M. Milton (Ed.). *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues*, (pp. 5-19). West Sussex: John Wiley & Sons Ltd.
- McLeod, J. (2011). *Qualitative research in counselling and psychotherapy*. London: Sage.
- McLeod, J. (2014). *Doing research in counselling and psychotherapy (2nd ed.)*. London: Sage.
- McLeod, J. (2017). *An Introduction to Qualitative Research in Counselling*

- Psychology. In D. Murphy (Ed.). *Counselling psychology: A textbook for study and practice* (pp. 394-407). London: Wiley-Blackwell.
- McPherson, S., & Beresford, P. (2019). Semantics of patient choice: how the UK national guideline for depression silences patients. *Disability & Society*, 1-7. <https://doi.org/10.1080/09687599.2019.1589757>
- McPherson, S., Rost, F., Town, J., & Abbass, A. (2018). Epistemological flaws in NICE review methodology and its impact on recommendations for psychodynamic psychotherapies for complex and persistent depression. *Psychoanalytic Psychotherapy*, 32(2), 102-121. <http://dx.doi.org/10.1080/02668734.2018.1458331>
- Mead, G. H. (1934). *Mind, self, and society from the standpoint of a social behaviorist*. Chicago: University of Chicago Press.
- Merleau-Ponty, M. (1945/2012). *Phenomenology of perception*. London: Routledge.
- Mitchell, S. A., & Aron, L. (Eds.). (1999). *Relational perspectives book series, Vol. 14. Relational psychoanalysis: The emergence of a tradition*. Mahwah, NJ, US: Analytic Press.
- Meyers, H. C., & Hoffer, A. (1994). The development of psychoanalysis by Sándor Ferenczi and Otto Rank (1924). *Journal of the American Psychoanalytic Association*, 42(3), 851-862. <https://doi.org/10.1177/000306519404200309>
- Moltu, C., & Binder, P. E. (2014). Skilled therapists' experiences of how they contributed to constructive change in difficult therapies: A qualitative study. *Counselling and Psychotherapy Research*, 14(2), 128-137. <https://doi.org/10.1080/14733145.2013.817596>
- Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of counseling psychology*, 52(2), 250. Retrieved from <http://psycnet.apa.org/buy/2005-03263-015>
- Morrow, S. L. (2007). Qualitative research in counseling psychology: Conceptual foundations. *The Counseling Psychologist*, 35(2), 209-235. <https://doi.org/10.1177%2F0011000006286990>
- Morse, J. M. (2015). Critical analysis of strategies for determining rigor in qualitative inquiry. *Qualitative health research*, 25(9), 1212-1222. <https://doi.org/10.1177/1049732315588501>
- Murphy, D. (2017). *Counselling psychology: A textbook for study and practice*.

- London: Wiley.
- Murray, M. (2008). Narrative Psychology. In J.A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods*, 2nd Edition (pp.111-132). London: Sage.
- Neborsky, R. J. (2001). Davanloo's method of intensive short-term dynamic psychotherapy. In M. F. Solomon, R. J. Neborsky, L. McCullough, M. Alpert, F. Shapiro, & D. Malan (Eds.), *Short-term therapy for long-term change* (pp. 16-53). New York, NY, US: W W Norton & Co.
- Nyman, S. J., Nafziger, M. A. and Smith, T. B. (2010). Client outcomes across counselor training level within a multitiered supervision model. *Journal of Counseling and Development*, 88, 204–209.
<https://doi.org/10.1002/j.1556-6678.2010.tb00010.x>
- Oddli, H. W., Halvorsen, M. S., & Rønnestad, M. H. (2014). Expertise demonstrated: What does it mean to be an expert psychotherapist. *Society for the Advancement of Psychotherapy*. Retrieved from
<http://societyforpsychotherapy.org/expertise-demonstrated/>
- Ogden, P., & Fisher, J. (2015). Sensorimotor psychotherapy: Interventions for trauma and attachment (Norton series on interpersonal neurobiology). London: WW Norton & Company.
- Orlans, V. & van Scoyoc, S. (2008). *A Short Introduction to Counselling Psychology*, London: Sage.
- Osimo, F., & Stein, M. J. (Eds.). (2012). *Theory and practice of experiential dynamic psychotherapy*. London: Karnac Books.
- Panksepp, J. (1998). *Affective neuroscience: The foundations of human and animal emotions*. New York: Oxford University Press.
- Park, J. (2016) *Another door into a new world waiting to be explored': a psycho-social investigation into the transition experiences of young adults with autism using the Grid Elaboration Method* (Doctoral thesis) University of Essex and Tavistock & Portman NHS Trust. Retrieved from
<http://repository.essex.ac.uk/17269/>
- Parpottas, P. (2012). Working with the therapeutic relationship in cognitive behavioural therapy from an attachment theory perspective. *Counselling Psychology Review*, 27(3), 91-99. Retrieved from
<http://psycnet.apa.org/record/2012-32981-006>
- Parry, S. (Ed.). (2019). *The Handbook of Brief Therapies: A practical guide*.

- London: SAGE Publications Limited.
- Pennebaker, J. (1997). *Opening Up: The Healing Power of Expressing Emotions*. New York: Guilford Press.
- Perlman, F., & Frankel, J. (2009). Relational psychoanalysis: a review. *Psychoanalytic Social Work*, 16(2), 105-125.
<https://doi.org/10.1080/15228870903200277>
- Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal*, 20(1), 7–14. <https://doi.org/10.14691/CPPJ.20.1.7>
- Ponterotto, J. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, 52(2), 126-136. <https://doi.org/10.1037/0022-0167.52.2.126>
- Pos, A. E., Greenberg, L. S., & Warwar, S. H. (2009). Testing a model of change in the experiential treatment of depression. *Journal of Consulting and Clinical Psychology*, 77(6), 1055-1066.
<http://dx.doi.org/10.1037/a0017059>
- Răbu, M., & McLeod, J. (2016). Wisdom in professional knowledge: Why it can be valuable to listen to the voices of senior psychotherapists. *Psychotherapy Research*, 1-17.
<https://doi.org/10.1080/10503307.2016.1265685>
- Rafalin, D. (2010). Counselling psychology and research: Revisiting the relationship in the light of our 'mission'. In M. Milton (Ed.) *Therapy and beyond: Counselling psychology contributions to therapeutic and social issues*, (pp. 41-55). West Sussex: John Wiley & Sons Ltd.
- Rapley, T. J. (2001). The art (fulness) of open-ended interviewing: some considerations on analysing interviews. *Qualitative research*, 1(3), 303-323. <https://doi.org/10.1177%2F146879410100100303>
- Rizq, R. (2012). 'There's always this sense of failure': an interpretative phenomenological analysis of primary care counsellors' experiences of working with the borderline client. *Journal of Social Work Practice*, 26(1), 31-54. <https://doi.org/10.1080/02650533.2011.579695>
- Rodgers, N. (2011). Intimate Boundaries: Therapists' Perceptions and Experience of Erotic Transference within the Therapeutic Relationship. *Counselling and Psychotherapy Research*, 11(4), 266-274.
<https://doi.org/10.1080/14733145.2011.557437>

- Rousmaniere, T. (2016). *Deliberate practice for psychotherapists: A guide to improving clinical effectiveness*. New York: Routledge.
- Salvadori, A. (2010) *Is the experiencing of affect therapeutic? An investigation into the relationship between affect experiencing, degree of inhibition and distress in Intensive Short-Term Dynamic Psychotherapy*. DClinPsy thesis, University of Sheffield. Retrieved from <http://etheses.whiterose.ac.uk/id/eprint/1043>
- Sartre, J. P. (1956). Being and Nothingness, trans. *Hazel E. Barnes*. New York: Philosophical Library.
- Schafer, R. (2018). *Insight and Interpretation: The Essential Tools of Psychoanalysis*. Abingdon: Routledge.
- Schon, D. A. (1983). *The reflective practitioner: How professionals think in action*. New York: Basic Books.
- Sexton, H., Littauer, H., Sexton, A. & Tommeras, E. (2005). Building the alliance: Early therapeutic process and the client-therapist connection. *Psychotherapy Research*, 5, 103–116. <https://doi.org/10.1080/10503300512331327083>
- Shedler, J. (2010). The efficacy of psychodynamic psychotherapy. *American psychologist*, 65(2), 98–109. <http://dx.doi.org/10.1037/a0018378>
- Sifneos, P. (1972). *Short-Term Psychotherapy and Emotional Crisis*. Cambridge, MA: Harvard University Press.
- Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative research in psychology*, 1(1), 39-54. Retrieved from <https://www.tandfonline.com/doi/abs/10.1191/1478088704qp004oa>
- Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health psychology review*, 5(1), 9-27. <https://doi.org/10.1080/17437199.2010.510659>
- Smith, J. A. Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.
- Smith, J. A., Flowers, P., & Osborn, M. (1997). Interpretative phenomenological analysis and the psychology of health and illness. *Material discourses of health and illness*, 68-91. Retrieved from <http://psycnet.apa.org/record/1997-08490-003>
- Spragg, M. (2013). 'Life just kind of sparkles': Clients' experiences of being in a

- Cognitive Behavioural Group and its impact on reducing shame in Obsessive Compulsive Disorder (OCD)* (Doctoral dissertation). University of East London, London. Retrieved from <http://hdl.handle.net/10552/3085>
- Stiles, W. B. (2015). Theory-building, enriching, and fact-gathering: Alternative purposes of psychotherapy research. In O. Gelo, A. Pritz, & B. Rieken (Eds.), *Psychotherapy research: General issues, process, and outcome* (pp. 159– 179). New York: Springer-Verlag.
- Stoltenberg, C. D. (2005). Enhancing professional competence through developmental approaches to supervision. *American Psychologist*, 60(8), 857. <https://doi.org/10.1037/0003-066X.60.8.85>
- Sugarman, L. (2016). Designing your life map. In B. Douglas, R. Woolfe, S. Strawbridge, E. Kasket & V. Galbraith (Eds.), *The handbook of counselling psychology* (4th ed.) (pp. 41-54). London: Sage.
- Sullivan, J. R. (2012). Skype: An appropriate method of data collection for qualitative interviews?. *The Hilltop Review*, 6(1), 10. Retrieved from <https://scholarworks.wmich.edu/hilltopreview/vol6/iss1/10>
- ten Have-de Labije, J., & Neborsky, R. J. (2012). *Mastering intensive short-term dynamic psychotherapy: Roadmap to the unconscious*. London: Karnac Books.
- Thériault, A. (2003). *Therapists' feelings of incompetence: A grounded theory analysis of experienced clinicians* (Unpublished doctoral dissertation). McGill University, Montreal. Retrieved from http://digitool.library.mcgill.ca/webclient/StreamGate?folder_id=0&dvs=1535575912352~357
- Thoma, N. C., & McKay, D. (Eds.). (2014). *Working with emotion in cognitive-behavioral therapy: Techniques for clinical practice*. Guilford Publications.
- Tomkins, S. (1962). *Affect imagery consciousness: Volume I: The positive affects*. New York: Springer.
- Town, J. M., Abbass, A., Stride, C., & Bernier, D. (2017). A randomised controlled trial of intensive short-term dynamic psychotherapy for treatment resistant depression: The Halifax depression study. *Journal of Affective Disorders*, 214, 15–25. <https://doi.org/10.1016/j.jad.2017.02.035>
- Town, J. M., Hardy, G. E., McCullough, L., & Stride, C. (2012). Patient affect experiencing following therapist interventions in short-term dynamic

- psychotherapy. *Psychotherapy Research*, 22(2), 208-219. <https://doi.org/10.1080/10503307.2011.637243>
- Town, J. M., Salvadori, A., Falkenström, F., Bradley, S., & Hardy, G. (2017). Is affect experiencing therapeutic in major depressive disorder? Examining associations between affect experiencing and changes to the alliance and outcome in intensive short-term dynamic psychotherapy. *Psychotherapy*, 54(2), 148–159. <https://doi.org/10.1037/pst0000108>
- Tuffour, I. (2017). A critical overview of interpretative phenomenological analysis: a contemporary qualitative research approach. *Journal of Healthcare Communications*, 2(4), 52. <https://doi.org/10.4172/2472-1654.100093>
- Wachtel, P. (2008). *Relational theory and the practice of psychotherapy*. New York: Guildford Press.
- Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, 14(3), 270-277. <https://doi.org/10.1002/wps.20238>
- Wampold, B.E. & Brown, G.S. (2005). Estimating variability in outcomes attributable to therapists: A naturalistic study of outcomes in managed care. *Journal of Consulting and Clinical Psychology*, 73, 914–923. <https://doi.org/10.1037/0022-006X.73.5.914>
- Wampold, B.E. & Budge, S.L. (2012). The 2011 Leona Tyler Award address: The relationship—and it's relationship the common and specific factors of psychotherapy. *The Counseling Psychologist*, 40, 601–623. <https://doi.org/10.1177/0011000011432709>
- Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. London: Routledge.
- Warwar, S., & Greenberg, L. S. (2000, June). *Catharsis is not enough: Changes in emotional processing related to psychotherapy outcome*. Paper presented at the annual meeting of the International Society for Psychotherapy Research, Indian Hills, Chicago.
- Watson, J. C., & Bedard, D. L. (2006). Clients' emotional processing in psychotherapy: A comparison between cognitive-behavioral and process-experiential therapies. *Journal of Consulting and Clinical Psychology*, 74(1), 152-158.

- Weinberger, J. (1995). Common factors are not so common: The common factors dilemma. *Clinical Psychology*, 1, 45–60.
<https://doi.org/10.1111/j.1468-2850.1995.tb00024.x>
- Whelton, W. J. (2004). Emotional processes in psychotherapy: Evidence across therapeutic modalities. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice*, 11(1), 58-71.
<https://doi.org/10.1002/cpp.392>
- Willig, C. (2012). Perspectives on the epistemological bases for qualitative research. In H. Cooper (ed.), *The Handbook of Research Methods in Psychology*. Washington, DC: APA. pp. 5-21.
- Willig, C. (2013). *Introducing qualitative research in psychology*. London: McGraw-Hill Education.
- Wiser, S., & Arnow, B. (2001). Emotional experiencing: To facilitate or regulate?. *Journal of clinical psychology*, 57(2), 157-168.
[http://dx.doi.org/10.1002/1097-4679\(200102\)57:2<157::AID-JCLP3>3.0.CO;2-8](http://dx.doi.org/10.1002/1097-4679(200102)57:2<157::AID-JCLP3>3.0.CO;2-8)
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology and Health*, 15, 215–228. <https://doi.org/10.1080/088704400008400302>
- Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (2nd ed., pp. 235-251). London: Sage.
- Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York: Guilford Press.

Appendix A: Participant Information Sheet



INVITATION LETTER

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator

Alan Flynn

Contact Details: u1426788@uel.ac.uk

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in a research study. The study is being conducted as part of my Professional Doctorate in Counselling Psychology programme at the University of East London.

Project Title

How do ISTDP therapists experience staying with their clients' deep experiencing of emotion within the therapeutic relationship?

Project Description

This study aims to capture individual accounts of how ISTDP therapists experience their clients' intensely-felt emotions within the therapeutic relationship.

You will be interviewed individually for approximately forty-five minutes. During this time, you will be invited to offer a detailed account of your experience of working with your client's intense mixed feelings, which may relate to particular events arising from your therapeutic work and relationships.

Due to the potentially emotional responses that interviewing about experiences may evoke, participants will be asked about who they can contact for support should any concerns arise.

Confidentiality of the Data

Confidentiality and anonymity will be ensured by locking paper transcripts and signed consent forms in a secure cabinet. After data has been analysed, supervisors and examiners will also have access to sections from the anonymised transcriptions of interviews.

Audio-recordings will be uploaded onto a laptop and destroyed from the digital voice recorder and all electronic data, including audio recordings, will be password-protected.

Real names and identifying references will be omitted from transcripts, and only the main researcher will have access to the names and identity of participants, which will be stored separately from all transcripts.

After the completion of the study, audio recordings and transcripts will be kept securely and anonymized. These data will be stored for a period of three years, in the event that it is possible to publish the findings, and destroyed thereafter.

You will be given the chance to ask any questions after the interview, which will provide you with an opportunity to further discuss how your data will be used and stored.

Confidentiality will be maintained unless a disclosure is made that indicates that you or someone else is at serious risk of harm. Such disclosures may be reported to the project supervisor or relevant professionals/authority.

Location

Interviews will take place face-to-face or via Skype at your preferred confidential setting.

Disclaimer

You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason.

If you wish to withdraw from this research project, you are able to do so within two weeks of this interview by emailing the researcher with your request. Should you withdraw within two weeks of your interview, all data belonging to you will be electronically and physically destroyed by the researcher, and none of the information you have provided will be used. After the two-week period, your anonymised data will be used in the write-up of the study.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor:

Dr. Melanie Spragg, School of Psychology, University of East London, Water Lane, London E15 4LZ (tel:+442082234396. Email: m.spragg@uel.ac.uk)

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Tel: 020 8223 4004. Email: m.j.spiller@uel.ac.uk)

Thank you in anticipation.

Yours sincerely,
Alan Flynn
u1426788@uel.ac.uk

Appendix B: Demographics Questionnaire



DEMOGRAPHICS QUESTIONNAIRE

Please can you provide us with some information about yourself, that can help to anonymously describe the sample of participants who take part in this research.

Please describe your:

Gender _____.

Ethnicity _____.

Age _____.

Please provide details of your:

Professional Role(s) _____.

Professional Body _____.

Years of professional experience as an ISTDP therapist _____.

ISTDP Institute where core training was completed (if not ISTDP-UK) _____.

_____.

Please circle:

Do you currently practice ISTDP	YES	NO
--	------------	-----------

Is ISTDP your core modality of practice	YES	NO
--	------------	-----------

Appendix C: Consent Form



CONSENT FORM

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

How do ISTDP therapists experience staying present with their clients' intense emotional experiencing?

I have read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my interviews will be audio recorded, and I give my consent to this. I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher(s) involved in the study will have access to identifying data. However, if significant risk to my life or others' lives is disclosed (particularly relating to children and vulnerable adults) an appropriate referral to the relevant services may be made and depending on the nature of the risk may be disclosed to relevant authorities, after discussion with research supervisor and yourself beforehand, if possible. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent, I understand that I have the right to withdraw from the study within two weeks after the date of my interview, without disadvantage to myself and without being obliged to give any reason.

I understand that this research may be published in the future in academic journals/books maintaining full anonymity and that anonymized quotes will be used in publications.

Please tick if you give permission to be contacted by the main researcher in the event that clarification is needed after the interview has taken place. ☐

Participant's Name (BLOCK CAPITALS)

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

Researcher's Signature

.....

Date:

Appendix D: Interview Schedule

INTERVIEW SCHEDULE

1. UNDERSTANDING – therapist's views of their focusing on patient's emotional experiencing

To start, I am interested to know what drew you to ISTDP?

Can you tell me about how you work as an ISTDP therapist?

What is your understanding of 'emotional experiencing' in ISTDP?

For example, what happens in the room, for patient/therapist/alliance, etc.?

How do you view 'intense emotional experiencing' in ISTDP?

2. EXPERIENCE – therapist's experiences of staying with patient's intense emotions

What is it like when the emotions a patient is experiencing are particularly intense?

Can you give an example? What was it like staying with the patient?

How did you experience yourself / patient / alliance?

Can you describe some of the differences you have experienced in emotional intensity
with this patient / compared to other patients?

How, if at all, has your way of working with emotional intensity changed over time?

3. CAPACITY – therapist's capacity to facilitate a therapeutic/experiencing of emotion

What enabled you to stay with patients' deep experiencing of emotion?

What has been helpful for you in cultivating this capacity? What gets in the way?

How do you view your own development of this capacity?

What further support do you think you could have received to help develop this capacity?

What do you think might be helpful for other trainees/practitioners to consider?

Any other thoughts, feelings or reflections that you would like to share that I haven't asked about?

Appendix E: Debrief Form



DEBRIEF FORM

UNIVERSITY OF EAST LONDON

Debrief Form

Thank you

Thank you for taking the time to participate in this research. The aim of this study was to explore how therapists experience staying with their clients' deep emotional experiencing within the therapeutic relationship.

Your contributions to this study will complement the development of information in this area, which is currently under researched. This study may also provide insight into therapists' capacity to experience their clients' intense feelings and how this could be further supported to facilitate their clients' therapeutic experience of emotions.

Withdrawing

If you wish to withdraw from this research project, you are able to do so within two weeks of this interview by emailing the researcher with your request. Withdrawing your interview from the project will mean that all data belonging to you will be electronically and physically destroyed by the researcher, and none of the information you have provided will be used. After the two-week period, your anonymised data will be used in the write-up of the study.

Data protection

The demographic details that you have provided are for purposes of analysis. Data arising from this interview will be used anonymously, and selective quotes will be anonymised to support the data. All data will be retained securely and anonymously as outlined in the consent form for three years after the interview takes place, in accordance with the Data Protection Act (1998), allowing for its potential use for future publications arising from this research.

Distress following participation

Sometimes talking about experiences and events can touch on difficult emotions or raise personal or professional concerns. If you do experience distress or have concerns associated with taking part in this project, please speak to your supervisor or personal therapist (if in therapy) for further support.

Further questions or concerns

If you have any questions or concerns about how the study has been conducted, I can be contacted on the following email address:

Alan Flynn
University of East London
u1426788@uel.ac.uk

For any concerns relating to the study, please contact Director of Studies for this project:

Dr. Melanie Spragg
University of East London
m.spragg@uel.ac.uk

Appendix F: Transcript Analysis: Initial Noting Extract

Extract from one participant's (Raelyn) initial noting stage, illustrating exploratory comments and emergent themes against the transcript.

Line no.	Transcript	Exploratory Comments	Emergent Themes
136	R: I mean, I actually, I think, I think, if I looked at video tapes earlier on, I couldn't see it in the moment, but I could see myself like moving away (leans back in seat), so there must have been anxiety in me, so I think it comes overtime, being com-, being very comfortable with it, comes and I'm not sure that there's a short cut to that. So it's like eh, you-you build up your own tolerance, but I actually um, I mean I think I have sat with a lot of people sobbing, I have sat with a lot of people going to murderous, torturous, primitive, sadistic rage, so there, I guess in some ways there's a distancing in me as well, not to say that I don't, you know, I have that sort of, it doesn't – I wouldn't say it affects me so deeply. I mean sometimes when people are grieving the loss of a child, it's very hard not to cry myself, um, but, uh, but I enjoy it, I-I find it very, it's like, I think it unlocks some kind of life force in the patient and I think it does to me as well. I mean, whether I'm sitting with the patient or whether I'm in a training watching videos, there's a there's energy associated with emotions which is very very, yeah, energising. Yeah, so I enjoy it, is the short answer.	<p><i>'I think' repetition perhaps highlights distancing.</i></p> <p>video tapes offer reflection on in-session responses</p> <p>Assumption that the moving away is due to anxiety</p> <p>Does not feel anxious now in the same way</p> <p>Acknowledgement that this takes time.</p> <p><i>distancing in second tense? 'but I actually' separates herself from other therapists?</i></p> <p><u>Is anger the hardest emotion for her/others to tolerate?</u></p> <p>Explanation entails reflection on client experiences</p> <p><i>Underlying difficulty articulating her position? <u>Does position go against perceived view of therapists/person as therapist?</u></i></p> <p>The energy or life force linked to emotions is transmitted and is not limited to time or space.</p> <p>Shared experience of emotion</p> <p><u>Is it energising because it has been previously unfelt or because merely it is being felt?</u></p>	<p>A distancing in me</p> <p>Building emotional tolerance</p> <p>Levels of rage (emotion)</p> <p>Enjoyment</p> <p>A shared experience</p> <p>Emotions as energizing</p>
152			

Appendix G: Clustered Themes For One Participant

A clustered themes table for one participant (Emma).

<p>The appeal of the speed and effectiveness Physically seeing changes I just accepted the cognitive experience</p> <p>Shared and intimate experience A shared language Sharing the experience This is a collaborative effort</p> <p>Using more of self in the work Knowing enough about myself so I'm comfortable with my reactions I was able to use much more of myself You have to be prepared to take a risk Prepared to go to those places inside yourself</p> <p>What helps to stay with intensity Therapist as really genuinely interested in the other person Support of colleagues/supervision Seeing the benefits helps you stay with it</p> <p>Emotions as difficult to articulate Emotional experiencing as fleeting Different levels of intensity I just go with it – intensity as difficult to articulate?</p>	<p>The therapist's role We're always trying to get back to those early feelings Watching the body It's a very lonely way of being My job is just to give a little nudge We're trying to get at those feelings</p> <p>Ways of coping So active mentally on the patient not therapist's own body All kinds of images came up Talking myself down Anxiety in the body Challenge to not react to sadistic images the client brings</p> <p>Therapist's reaction A punitive thing came in A conflict between the portrayed and the real I became quite sort of 'uh uh'! Inhibition around sexual feelings Clarifying with the client A shutting down when sexual feelings are expressed</p> <p>What it feels like Comfortable but not pleasant A very creative way of being</p>
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Appendix H: Cross Reference to Theme Table

A cross-reference to theme table indicating presence of theme in cases.

	R	J	D	B	E	
“Opening that door”: striving for emotional closeness	✓	✓	✓	✓	✓	
“It’s really rewarding”: the motivating power of seeing a person change	14 654	49	20	19 512 575	15 281 404	5
“Not giving up on the route to getting there: persevering through resistance	27 181	434	448	39	248	5
“Trying to decide where to go next and how to proceed: pressure and focus on accuracy	136 218 424 432 401	296 318	258 696	234 428	245 248	5
Connection vs disconnection: what’s happening in the room	✓	✓	✓	✓	✓	
A shared experience: connection and intimacy in the therapeutic encounter	68 148	163 175	237 266 281	168 585	169 275	5
“It’s painful not being able to reach a patient”: feelings of frustration and inadequacy	171 505	209	166 315 505 614	374 380	200 474 517	3
“Talking to myself”: remaining calm and professional	281	317 327	655	450	492 265	5
“There’s more of myself now”: bulding one’s own capacity	✓	✓	✓	✓	✓	
“You get better...you get more emotion in the room”: building emotional tolerance	203	67 73 464	✓	636	✓	3
“Those minute flickers”: observing and reflecting on inner emotional life	669	444	526	327	118	5
“Knowing enough about myself”: using and protecting the self	319 326	356	✓	✓	393	3

Note: ‘All participants’ = 5, ‘Nearly all’ = 4, ‘Most’ = 3

Appendix I: Application for Research Ethics Approval

UNIVERSITY OF EAST LONDON
School of Psychology

**APPLICATION FOR RESEARCH ETHICS APPROVAL
FOR RESEARCH INVOLVING HUMAN PARTICIPANTS**

**FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING &
EDUCATIONAL PSYCHOLOGY**

Your details

1. Your name:

Alan Flynn

2. Your supervisor's name:

Dr Melanie Spragg

3. Title of your programme:

Professional Doctorate in Counselling Psychology

4. Title of your proposed research:

Working Title:

An Interpretative Phenomenological Analysis of how Intensive Short-Term Dynamic Psychotherapy (ISTD) therapists' experience staying present with clients' complex feelings within the therapeutic relationship.

5. Submission date for your research:

August 2018

6. Please tick if your application includes a copy of a DBS certificate

☐

7. Please tick if you need to submit a DBS certificate with this application but have emailed a copy to Dr Mary Spiller for confidentiality reasons (Chair of the School Research Ethics Committee) (m.j.spiller@uel.ac.uk)

☐

8. Please tick to confirm that you have read and understood the British Psychological Society's Code of Human Research Ethics (2014) and the UEL Code of Practice for Research Ethics (See links on page 1)

☒

About the research

9. The aim(s) of your research:

This study will focus on ISTDP therapists and specifically examine their experiences of staying present with their client's complex feelings during the ISTDP therapeutic process.

As such, this research aims to provide an interpretative phenomenological analysis of how ISTDP therapists experience these feelings during the unlocking of the unconscious. The overarching research question will be *how do practising ISTDP therapists make meaning of their experiences of their ability to focus on their clients' complex feelings within the therapeutic relationship?*

This is a valuable but under researched area of ISTDP, which is an evidence based, brief term psychotherapy shown to be effective for a broad spectrum of emotional difficulties, including anxiety and treatment resistant depression (Abbass, 2015). Case study research shows how therapists respond to clients to help facilitate therapeutic experience of emotions, but there is no research that specifically examines how therapists understand and experience staying present with their clients' complex feelings.

This research aims to provide insight into how ISTDP therapists make meaning of their experiences of staying present with their client's deeply-felt emotions and into therapists' ability to focus on their client's here-and-now experience in therapy. The findings of this research may also be applicable to other therapeutic modalities of practice.

10. Likely duration of the data collection from intended starting to finishing date:

March 2017- August 2018.

Methods

11. Design of the research:

A qualitative approach has been chosen for this study. The methodological framework that will be adopted is Interpretative Phenomenological Analysis (IPA) in order to grasp ISTDP therapists' lived experiences of staying present with their client's complex feelings within the therapeutic relationship. This method of enquiry will allow for the exploration of the subjective interpretation of participants' unique experiences. Interviews will be semi-structured, lasting approximately 45-60 minutes. These will be audio recorded and subsequently transcribed verbatim. Once transcribed, the data is analysed in line with IPA, which involves taking an idiographic and interpretative approach with the data. The data will be re-read numerous times to identify themes, which will be connected and clustered to generate superordinate themes. This iterative process will be repeated with each case.

12. The sample/participants:

Demographics

Demographic information will be gathered through a short questionnaire (see Attachment A) in relation to: Age, ethnicity, gender, years of professional experience as a police officer and role within the police service in the U.K.

Sampling:**Inclusion criteria:**

- Participants will need to be over 18 years of age.
- Participants will be registered/hold current membership/accreditation with a professional body (counselling/psychotherapy).
- Participants will have completed the ISTDP core training at a recognized ISTDP institute.
- A minimum of 3 years' professional experience as an ISTDP practitioner. (This decision was made in personal communication with an experienced ISTDP trainer, with over 10 years ISTDP experience, who advised this criterion as a pragmatic balance between securing required number of participants and ensuring sufficient degree of adherence to the ISTDP model for the purposes of addressing the research question).
- Participants may be drawn from an international sample of ISTDP practitioners who fulfil the above criteria, as the phenomena of staying present with clients feelings is expected to be universally significant for this population. (There are estimated to be around 50 ISTDP practitioners in the UK).

Exclusion criteria:

- Participants who are not currently practising ISTDP.
- Participants who are not delivering ISTDP as their primary modality of treatment.
- Participants who are unable to give informed consent.
- Participants who have complaints pending with their professional body.

Sample size:

- 6-10 participants will be recruited in order to provide a comprehensive, in-depth examination of each individual's experience. This follows the recommended sample size for a professional doctoral level research using IPA as outlined in relevant literature (Smith et al., 2011).

Method of recruitment:

- Participants will be sourced purposively via referral. I aim to contact ISTDP organisations that have central listings of registered ISTDP therapists. I will provide them with information outlining the purpose of the research, the participants that I aim to recruit for my study and my contact details so that I can provide further information. The main organisation I aim to contact is ISTDP-UK and also, should it be necessary, other nationally-based ISTDP organisations, for example, in the US and Canada.
- Participants will also be recruited via opportunities through my own contacts (e.g. An ISTDP trainer, who trains on the introductory and core training of ISTDP in the UK, has offered to distribute my advert through her list of contacts of ISTDP therapists.)
- Via snowballing since participants may also make referrals.

(See Attachment B for recruitment advertisement)

13. Measures, materials or equipment:

- An interview schedule will be used (see Attachment C) as well as a digital audio-recorder.

14. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

N/A

15. Outline the data collection procedure involved in your research:

Data Collection Procedure involves:

- Giving the participants an invitation letter that outlines the nature and purposes of the research and participants' rights.
- If they agree to take part, providing participants with a consent form to read and sign before interviewing them.
- Interviews will last approximately 45 to 60 minutes.
- Participants will be asked a number of questions followed by prompts in relation to their understanding and experiences of their here-and-now focus on clients' complex feelings within the therapeutic relationship.
- Interviews will be audio-recorded and subsequently transcribed for analysis.
- Face-to-face Interviews will take place at UEL Stratford Campus either at pre-booked rooms in the department of psychology, at pre-booked rooms at University Square or alternative confidential settings specified by the participant.
- Interviews may also be conducted via videoconferencing, through a trusted, user friendly, encrypted and secure video communication system (e.g. Skype), where face-to-face interviews cannot be conducted (e.g. due to geographical distance).
- For reasons of safety, I will let someone know when and where I will be conducting each interview and will contact them before and after each one takes place.

3. Ethical considerations

Please describe how each of the ethical considerations below will be addressed:

16. Fully informing participants about the research

- Each participant will be given an invitation letter outlining details of the researcher, a description of the project, information regarding how the data will be kept confidential, outlining their right to withdraw and contact details of the researcher and supervisor. This will be provided prior to interview.

(See Attachment D for invitation letter).

17. Obtaining fully informed consent from participants:

- Each participant will be given a consent form which confirms that they have read the information sheet relating to research study they have been asked to take part in.
- The consent form will also outline that participants understand that their involvement in the study and their data will remain strictly confidential. In addition, it will highlight that they have the right to withdraw from the study within two weeks after the date of interview without disadvantage to themselves and without being obliged to give any reason.
- A copy of the consent form will be given to them to keep.

(See Attachment E for consent form).

18. Engaging in deception, if relevant:

- The proposed research involves no deception.

19. Right of withdrawal:

- Participants will be advised that they have the right to withdraw from the study within two weeks after the date of their interview without disadvantage to them and without being obliged to give any reason. Withdrawing from the study will mean that all data belonging to the participants will be electronically and physically destroyed by the researcher and that none of the information they have provided will be used. Following the two-week period, the interview will be analysed as an anonymous part of the collective body of data.

20. Anonymity & confidentiality: (Please answer the following questions)

20.1. Will the data be gathered anonymously?

NO

21. If NO what steps will be taken to ensure confidentiality and protect the identity of participants?

- Confidentiality and anonymity will be ensured by locking paper transcripts and signed consent forms in two separate secure cabinets.
- Participants will be informed that supervisors and examiners will also have access to sections from the anonymised transcriptions of interviews.
- Audio-recordings will be uploaded onto a laptop and destroyed from the digital voice recorder.
- All electronic data, including audio recordings, will be password-protected.
- Real names and identifying references will be omitted from transcripts, and only the main researcher will have access to the names and identity of participants, which will be stored separately from all transcripts.
- After the completion of the study, audio recordings and transcripts will be kept securely and anonymised for a period of three years in the event that it is possible to publish the findings.
- The confidentiality of clients of participants needs also to be raised at the outset of the interview and participants will be given the chance to ask any questions after the interview which will provide an opportunity to reassure them of how the data will be used and stored.

22. Protection of participants:

- Given that these are reflective practitioners who will engage in a regular practice of discussing and expressing sensitive and emotionally laden aspects of their work with supervisors/line managers/peers and perhaps also in personal therapy, it is unlikely that participants will experience distress through participation in this research or be at risk of harm that is greater than in their ordinary life. Participants will, however, be in advance made aware of the potentially emotional responses that the interview may evoke. I will be mindful of participants becoming upset or distressed. All participants will be advised to contact their supervisors should any concerns arise.

23. Protection of the researcher:

- I will ensure that I let someone know the location and time of each interview. Prior to each interview I will use a mobile phone to let someone know that the interview is starting and I will also let them know when the interview has finished.

24. Debriefing participants:

- Participants be given time at the end of the data collection task to ask questions or raise concerns. This will provide an opportunity to re-assure them about what will happen to their data.
- A debrief letter will be given to participants after interview, thanking them for their participation, reminding them about what will happen to their data, and highlighting the name and contact details of an appropriate helpline for them to contact, should they experience any distress or concern as a result of participating in the research.

(See Attachment F for Debrief Letter).

25. Will participants be paid?

NO

The incentive will be that they are contributing to the body of knowledge in the under-researched area of ISTDP.

26. Other:

Competence: I am a second year Counselling Psychologist in Training and have clinical experience of working on a one-to-one basis with individuals under emotional and psychological distress. I have attended training on assessing, reviewing and managing risk and have clinical experience of working with clients who present with deeply felt emotions. I have also undertaken four days of training in ISTDP therapy so I can best facilitate and be responsive to participants who may choose to discuss technical or theoretical notions of therapy.

Supervision: My doctoral research supervisor has ample clinical and research experience and I can additionally seek advice from her in relation to handling participants' risk and other issues pertaining to my management and facilitation of high quality research interview experience for participants. .

4. Other permissions and ethical clearances

27. Is permission required from an external institution/organisation (e.g. a school, charity, local authority)?

NO

28. Is ethical clearance required from any other ethics committee?

NO

29. Will your research involve working with children or vulnerable adults?*

NO

30. Will you be collecting data overseas?

NO

5. Signatures

TYPED NAMES ARE ACCEPTED AS SIGNATURES

Declaration by student:

I confirm that I have discussed the ethics and feasibility of this research proposal with my supervisor.

Student's name: Alan Flynn

Student's number: u1426788

Date: 12/06/2017

Declaration by supervisor:

I confirm that, in my opinion, the proposed study constitutes a suitable test of the research question and is both feasible and ethical.

Supervisor's name: Melanie Spragg

Date: 12/06/2017

Appendix J: Notice of Ethics Review Decision

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates

REVIEWER: Florentia Hadjiefthyvoulou

SUPERVISOR: Melanie Spragg

COURSE: Professional Doctorate in Counselling Psychology

STUDENT: Alan Flynn

TITLE OF PROPOSED STUDY: An Interpretative Phenomenological Analysis of how Intensive Short-Term Dynamic Psychotherapy (ISTD) therapists' experience staying present with clients' complex feelings within the therapeutic relationship

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.
2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below): In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.
3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below): In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY (Please indicate the decision according to one of the 3 options above)

Approved

Minor amendments required (for reviewer):

n/a

Major amendments required (for reviewer):

ASSESSMENT OF RISK TO RESEARCHER (for reviewer)

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

<input type="checkbox"/>	HIGH
<input checked="" type="checkbox"/>	MEDIUM
<input type="checkbox"/>	LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer (Typed name to act as signature): Florentia Hadjiefthyvoulou

Date: 10/6/17

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

Confirmation of making the above minor amendments (for students):

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name (Typed name to act as signature):

Student number:

Date:

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: <http://www.uel.ac.uk/gradschool/ethics/fieldwork/>