How Do Therapists Make Sense of Their Reactions Towards Clients: An Interpretative Phenomenological Analysis

Jacob Maunders

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

September 2010

Word count: 31646 (excl. references and appendices)

Abstract

This study attempts to contribute to our understanding of therapists' personal reactions (cognitive, affective, sensory or behavioural) towards their clients by adopting an in depth qualitative analysis. This study consists of semi structured interviews with six therapists who work mainly from a psychodynamic orientation. The transcribed interviews were analysed according to the principles of Interpretative Phenomenological Analysis (IPA). Three analytic themes were derived from the analysis: (1) self as a "measuring instrument", (2) managing reactions, and (3) therapist self care. The findings highlight the different ways that therapists understand and manage their reactions. The analysis of the interviews also reveals support for the theoretical trend in psychodynamic approaches towards a relational/intersubjective understanding of the therapeutic relationship. It is argued that therapists are embedded within the client's relational pattern, and furthermore, this is inevitable and to be welcomed.

Table of Contents

Table of abbreviations

CAT	Cognitive Analytical Therapy
CBT	Cognitive Behavioural Therapy
DA	Discourse Analysis
FDA	Foucauldian Discourse Analysis
IAPT	Improving Access to Psychological Therapies
IPA	Interpretative Phenomenological Analysis
NHS	National Health Service
TA	Transactional Analysis

Acknowledgements

This study would not have been possible without those who were interviewed. I would like to express my gratitude for their willingness to share their personal experiences. I am grateful for their time and the interest they showed in my research and I hope that participation was beneficial for them in some way.

A number of different people have assisted me with my project. I would like to thank my colleagues for their help and support throughout the duration of the course. The opportunity to discuss my research with others has been invaluable. Barbara Norbal deserves special thanks for her encouragement, patience and love. You have been there for me throughout the last four years and you have helped to keep me going.

Finally, I would like to thank my supervisors, Rachel Tribe and Jane Lawrence. For their commitment and guidance I will always be grateful.

I confirm that the work contained in this thesis is original except where other sources are cited.

Chapter 1: Introduction

This chapter begins with an overview of the research project. It presents the research question, the rationale for the research, the relevance to counselling psychology and a review of the literature.

1.1 Overview

The aim of this thesis is to contribute towards our understanding of the therapeutic relationship from a phenomenological perspective. In particular, it explores the importance of the reactions evoked in therapists to the therapeutic process. The interest in therapists' reactions is partly the result of developments in phenomenology which have been applied to the therapeutic relationship, moving clinical theory in an intersubjective direction (Diamond and Marrone, 2003; Fonagy and Target, 2003). From a developmental perspective, intersubjectivity asserts that the self always exists in relation to another. There has been a growing interest in self identity as constructed in relationship to others (Bretherton and Munholland, 1999; Strawbridge and Woolfe, 2003). According to these writers a sense of self is formed by the relationships one experiences in childhood and further developed throughout one's life. Whilst the self may be shaped by early experiences these writers emphasise that the self-concept does not necessarily remain fixed but is always being adapted and refined through experience.

From the psychotherapeutic perspective intersubjectivity means that the therapist cannot be a detached and objective observer. Instead, client and therapist are viewed as the meeting of two subjectivities who mutually shape the experience of each other. Recent developments in psychodynamic therapy often described under the heading of intersubjective approaches, place a greater emphasis on both client and therapist being open about interpersonal issues that are taking place between them (Mearns and Cooper, 2005; Safran and Muran, 2000). This has led to an interest not only in the clients' thoughts and feelings towards the therapist, but also the meaning of the therapist's reactions towards the client. Whilst it is generally agreed that therapists need to make sense of their reactions, Fauth (2006) has criticised much of the existing research for

placing the therapist in a passive and reactive position. For example, he argues that the countertransference research mostly assumes that the client's material connects with something in the therapist triggering a countertransference reaction. The present study points to the limitations of such a static and linear approach to understanding therapists' reactions. It attempts to highlight the complexity of the subject with an emphasis on exploring personal meaning and lived experience. Although there are a number of different perspectives on therapists' reactions, it is generally accepted that therapists need to understand and manage their responses (Fauth 2006; Hayes and Gelso, 2001; Peabody and Gelso, 1982; Robbins and Jolkovski, 1987; Van Wagoner, Gelso, Hayes and Diemer, 1991). In view of the importance of understanding therapists' reactions, the aim of the present study is to explore the experiences of therapists using an in depth qualitative analysis. The method used is Interpretive Phenomenological Analysis (IPA), which aims to explore participants' experience and how they make sense of that experience (Smith, Jarman, Osborn, 1999). In keeping with the inductive and exploratory nature of IPA, the research question has been formulated as the following: how do therapists make sense of their personal reactions towards clients?

1.2 Relevance to counselling psychology

It is widely accepted that the main principle of effective clinical practice is the ability to maintain an effective therapeutic relationship (Horvath and Symonds, 1991; Martin, Garske and Davis, 2000; Woskett, 1999). Developments in the field of counselling, psychotherapy and counselling psychology have led to an interest in discerning and defining the ingredients of successful therapeutic outcomes. It has also led to an increased scrutiny of the counselling process, which has led to attempts to formulate counselling psychology in terms of identifiable skills and practices (Burton and Davey, 2003). Particular interest has developed in the area of relational issues and processes. In psychodynamic theories the relationship is central and is considered to be the engine of change. Therefore, as Laughton-Brown (2010) argues, knowledge of psychodynamic theory is necessary for helping the counselling psychologist understand what is happening between therapist and client.

Counselling psychology has origins in phenomenological, existential and humanistic thinking that argued for the need to consider human beings in a holistic manner,

emphasising a search for meaning and understanding (Strawbridge and Woolfe 2003). It challenged behaviourism and psychoanalysis which were seen as overly deterministic (McLeod, 2003). It emphasises a view of reflective human beings with the capacity for choice as opposed to being determined by a range of internal (as in psychoanalysis) or external forces (as in behaviourism). As Fairfax (2008) points out, one of the distinguishing features of counselling psychology is the amount of attention paid to therapeutic process and phenomenological understanding rather than diagnostic criteria. The emphasis on self-reflection underlines the importance of a commitment to personal development and that is why personal therapy and supervision are such important parts of the training. Counselling psychologists are encouraged to be reflective and pay close attention to meaning and processes in therapy thus supporting a stronger therapeutic relationship. Therefore, it is hoped that the present study will contribute towards our understanding of process issues, which is directly relevant to the practice of counselling psychologists.

The historical origins of counselling psychology identifies it with the basic assumptions of qualitative research. It emphasises meaning, subjective experience and mutually constructed realities (Strawbridge and Woolfe, 2003). More generally, philosophical developments in psychology have seen a paradigm shift away from a reliance on quantitative research methods to a more balanced reliance on a mixture of quantitative and qualitative methods (Ponterotto, 2005). Qualitative research is concerned with understanding people's experience and how they make sense of their experience. These approaches are intended to allow new aspects of meaning and experience to emerge. Qualitative researchers are particularly interested in the individual's subjective world, thus facilitating a more in depth understanding of their experience. The objective is usually to explore, describe and interpret the experience of participants. This involves trying to understand the experiences of a comparatively small sample of participants from their own frames of reference (Reid, Flowers and Larkin, 2005).

1.3 Perspectives on therapists' reactions
Therapists may experience a range of thoughts, images, emotions and sensations at any one time, regardless of theoretical orientation. This section reviews the different perspectives on therapists' reactions.

1.3.1 Therapists' reactions as own conflicts or vulnerabilities

There is a large body of psychoanalytic literature on therapists' personal reactions called countertransference. The classical Freudian approach understands the relationship between therapist and client in terms of transference (Lemma, 2003). Transference is the largely unconscious process through which thoughts, feelings and behaviour originally experienced in childhood are transferred onto others. Psychopathology is understood to be the result of conflict between the instinctive urges and the defences against those urges. Since there will be an increase in pressure for the gratification of instinctual drives in the transference, this allows the therapist to examine the client's defences against the impulses and the compromises reached by the ego between id, superego and external reality. Therefore, the Freudian approach understands the client's behaviour towards the therapist as a misreading of the present based on the past.

In the Freudian conceptualisation, countertransference is seen as the therapist's transferential response to the client's transference which reflects the therapist's unconscious conflicts that need to be resolved (Lemma, 2003). Unresolved conflicts which originate in the therapist's childhood may become triggered by the client's transference, which may result in the therapist behaving in any number of ways. The therapist may distort the client's experience, thus clouding their judgement or it may result in them pursuing their own needs in the therapeutic relationship. From the classical perspective, countertransference is a hindrance that needs to be overcome and worked on to resolve the vulnerabilities that cause it. However, more recently it has been argued that it is also possible to consider the potential benefits of this sort of countertransference (Gelso and Hayes, 2007). An example could be those conflicts with which the therapist has reached a sufficient level of resolution resulting in them being more empathic. Gelso and Hayes (2007) would also argue that it is useful to consider difficult or unpleasant reactions that are not simply the therapist's transference within this definition because they also have the potential to impact the therapy. It could include conflictual reactions that emanate from difficulties that have occurred more recently in the therapist's life.

The understanding of countertransference as the therapists own conflicts has been described in cognitive behavioural terms as originating from the therapist's own beliefs

and automatic thoughts (Gelso and Hayes, 2007). Cognition refers to a number of mental processes such as attention, memory, thinking, decision making and problem solving. A key idea in cognitive theory is that people have schemas about the self and others which have often developed from early experiences. These schemas enable us to organise information and make sense of the world. In the same way that transference becomes a relationship template that is transposed onto others, therapists also have certain beliefs and ways of perceiving the world that may lead to selective attention and biases in interpreting information. Cognitive behavioural therapists inevitably have their own conflicts and vulnerabilities and there will be occasions when clients evoke conflictual reactions from their therapists. Furthermore, the way in which therapists understand and respond to their clients will to some extent be subjective and influenced by their own conflicts. Therefore the understanding and management of their reactions may be just as important as in psychodynamic approaches.

In contrast to psychodynamic writings, countertransference is discussed much less in the humanistic and experiential literature. Nevertheless, as Gelso and Hayes (2007) point out, the therapist's internal experience is still an important part of the therapeutic process. The difference is that the language of countertransference is replaced with language that is experiential in nature. However, there is another reason why countertransference is not referred to a great deal in the humanistic literature. There is a basic assumption in the humanistic approach that human beings are inherently good. Rogers (1961) talked about the core conditions necessary to facilitate the kind of personal connection needed to create the good enough relationship that enables clients to redefine themselves. Whilst these conditions have been described in different ways the common theme is the significance and worth ascribed to clients and level of engagement with them. The nature of human beings is towards growth and development and therefore the therapist's inner experience is something that is positive and realistic (Rogers, 1961). This contrasts with the often negative attributes of countertransference in psychodynamic thinking. Furthermore, when the therapeutic relationship is characterised by the core conditions, countertransference becomes less of an issue. However, it could also be argued that the emphasis on the 'here and now' and conscious awareness, risks becoming susceptible to the influence of unconscious influences on behaviour (Gelso and Hayes, 2007).

1.3.2 Therapists' reactions as response to client's style

An alternative view of countertransference as the therapists' conflicts is the view that it is a response to the client's transference or style of relating (Bateman, Brown and Pedder, 2000). This is also known as the complementary view. Clients may unconsciously pull for a particular response from others and the therapist experiences the pull to respond in a particular way. Object relational approaches understand countertransference as the client's unconscious communication and the concept of projective identification is central to this understanding (Lemma, 2003). According to this view the client projects unacceptable aspects of the self onto others who then begin to act in accordance with the projection. Splitting allows the split off feeling to be located in another person. The recipient contains the disowned aspects in the projectors mind and unwittingly begins to enact what has been projected. Therefore, therapists' reactions help them understand who they represent to the client during the activation of an internalised object relationship. However, this means that therapists must attend to their reactions and contain the projection without acting upon it (Bion, 1962; Fonagy and Target, 2003). Consequently, within object relational approaches countertransference becomes a technique for understanding the client's unconscious communications rather than interference as in the Freudian view.

That the therapeutic relationship creates an opportunity for understanding the client's relational world and providing the client with a different experience of relationships is a theme contained within psychodynamic writing (Bion, 1962; Fonagy and Target, 2003). Bion's (1962) concept of containment offers an understanding of the ways in which therapists might be able to provide a corrective emotional experience. The child's early development can be described in terms of projecting unpleasant feelings onto the mother. So long as the mother is able to manage the feelings projected into her without retaliating, then the child will learn that its fears are manageable. On the other hand, if the mother is unable to manage the difficult feelings aroused in her by the child, then the child reintrojects the feelings as potentially more threatening. Gravell (2010) explores the idea of containment and the way in which it might be helpful to counselling psychologists. On one level the analytic frame provides boundaries in terms of confidentiality, time keeping and location, hopefully creating a sense of stability for the client. The second level concerns the effect of the client's projections. By giving clients the opportunity to connect with painful experience, such feelings become more

acceptable to the individual. Therefore, a critical part of therapy involves providing the client with a new relational experience. As Gravell (2010) notes the emphasis on adopting a certain state of being with the client is crucial to psychodynamic therapies and probably humanistic ones as well.

Using the concept of an interpersonal schema, Safran (1990a; 1990b) has demonstrated how the integration of psychodynamic principles can help therapists from other orientations, particularly cognitive behavioural therapists, understand their reactions. An interpersonal schema can be understood as containing information relevant to the maintenance of relatedness with others. The strategies employed to maintain relatedness are linked to the prediction of outcomes of interactions with others contained within the schema. Interpersonal schemas are maintained by the way in which an individual's behaviour prevents disconfirmation of beliefs. For example, the individual who has learned that relatedness is contingent on always being available for other people may develop a strategy of consistently sacrificing their own needs thus depriving themselves of feedback that they are valued for other qualities. It is also suggested that interpersonal schemas are maintained by the way in which people evoke responses from others, which are consistent with their schema (Safran, 1990a; 1990b). For example, the person who believes that people are rejecting may have difficulty in developing intimate relationships. Consequently, other people may give up trying to develop relationships with them thus confirming the belief that other people are rejecting.

The therapeutic relationship becomes an important means for assessing and challenging interpersonal cycles (Safran, 1990a; 1990b). The therapist can monitor their own responses to the client and use them to generate hypotheses about the client's interpersonal style. The aim is for the therapist to elicit new and more helpful behaviours from the client that will be repeated elsewhere in the client's life. This can be achieved in different ways. Firstly, through the therapist monitoring the reactions evoked in them by the client's interpersonal style, the therapist avoids reacting in the automatic way that would normally be elicited, thus beginning to elicit new interpersonal behaviours from the client. A second way consists of exploring what is taking place in the 'here and now' moment leading to an exploration of the unhelpful cycle that is being re-enacted in the therapeutic relationship. This can help the client to

identify and change aspects of their style that helps to maintain the interpersonal cycle. The therapist can monitor their own feelings and responses to the client and use them to generate hypotheses about the client's interpersonal style. This may involve providing feedback to the client about the reactions he or she evokes in the therapist. Although some approaches are more likely to work on this level with their focus on the analysis of transference and countertransference, Safran and Muran (2000) argue that advances in therapy generally have provided insights into the underlying processes within the relationship that can be integrated into other therapeutic approaches. Nevertheless, these incidents can hold therapeutic potential depending on how the therapist understands, responds and handles the situation, including the sometimes uncomfortable and painful reactions that the therapist experiences. Whilst the importance of being able to fully experience and contain such feelings has been emphasised by Safran and Muran (2000), part of the aim of the present study is to understand the processes that help therapists achieve this.

The enactment of core relational themes is a key idea in Cognitive Analytical Therapy (Ryle and Kerr, 2002). CAT represents an integration of psychoanalytic and cognitive ideas and began as an approach to measure the effectiveness of psychodynamic therapy. The identification of three kinds of interpersonal patterns explains the maintenance of problems. These are called dilemmas, snags and traps. Dilemmas describe behaviours limited to polarised choices. Traps are forms of behaviour that lead to consequences that confirm beliefs. In snags, goals are abandoned because of feelings of guilt about their achievement. These patterns are called procedures which explain the persistence of problematic behaviours. They combine mental experience, behaviour and external events including other people in a sequence. The reactions generated in a therapist may reflect the therapist's own reciprocal role procedures or be a response to the client's reciprocal role procedures.

1.3.3 The relational perspective

A view of therapists' reactions that reflects changes in philosophical thinking is the relational perspective (Fonagy and Target, 2003; Gelso and Hayes, 2007; Safran and Muran, 2000). Influenced by developments in philosophy, theorists recognise the interpersonal nature of the therapeutic relationship but argue that it is impossible for the therapist to stand outside of the therapeutic interaction. The relational approach is often

referred to as a two person psychology rather than the one person psychology characteristic of the traditional view. Instead of a neutral observer who is able to remain outside of transference enactments, relational theorists maintain that therapy is a co-construction and that the interaction is jointly constructed by both parties. This may mean that enactments of transference by the therapist are as likely as enactments by the client (Safran and Muran, 2000). From this perspective, the therapists' reactions must be the result of an interaction between the client and something already existing within the therapist. This can help the therapist to understand their own contribution to what is taking place in the relationship rather than regarding therapist reactions as something which is projected into the therapist by the client.

The relational approach challenges the traditional view that the therapist can have some objective knowledge of reality, whether it is the client's internal reality as in psychoanalysis or external reality as in cognitive behavioural therapy. Debates about subjectivity and objectivity reflect the influence of post modern thinking, particularly within psychodynamic approaches and has led to a shift towards relational, intersubjective and social constructionist positions within therapy (Mearns and Cooper, 2005). The development of relational and intersubjective approaches encourages therapists to enter their clients' relational worlds and use the relationship as a means to explore how the client interacts and experiences others. The therapist is seen as a full participant and the therapist's understanding of their involvement is incomplete and often takes place only after an exploration of the 'here and now' moment (Safran and Muran, 2000). With its emphasis on therapeutic process and subjectivity as compared to other psychological trainings, counselling psychology is particularly well placed to consider the potential of the therapeutic encounter.

The shift in psychotherapy towards a relational therapy has led therapists to question when and what to reveal to clients (Farber, 2006). Throughout the history of psychotherapy there have been strong differences of opinion about therapist self disclosure. The traditional position cautions against the therapist's self revelations as unnecessary intrusions that contaminate the transference. The role of the therapist was to be a blank screen onto which the client projected their conflicts. With the shift towards a focus on relationships in psychotherapy, the therapist's subjective experience and participation has become more important. Thus therapist self disclosure is allowed

and even welcomed as an intervention that can strengthen the therapeutic relationship and deepen understanding, including an awareness of the way in which the client may contribute towards problematic interactions with others.

Safran and Muran (2000) outline some key principles for exploring what is being enacted between client and therapist. An important idea is that the therapist shares with the client their thinking on how they arrived at an observation or interpretation to emphasise their subjectivity and encourage the client to engage in a collaborative exploration. The therapist's initiation of the exploration should be grounded in the therapist's immediate experience in the 'here and now'. The emphasis should be on awareness rather than change to avoid the risk of the client feeling blamed whilst the therapist also accepts responsibility for their contribution. For example, the therapist may say something like "I am aware of us becoming engaged in a tussle" or "I experience you as being critical at the moment". The point is to initiate an exploration of what might be taking place in the moment between client and therapist. Although there is a lack of consensus defining self disclosure, Farber (2006) draws attention to the key issues of how therapists decide when and what to reveal, whether some clients might be harmed and some might benefit. The key seems to be deciding who will benefit from the disclosure. Farber (2006) suggests that therapists should keep disclosure relevant to process issues, ask for feedback and avoid too much disclosure. Whilst self disclosure is posited to have a number of benefits, research in this area is still at an early stage suggesting that more in depth research identifying the consequences of different types of self disclosure would be helpful.

1.3.4 Management of therapists' reactions

The key difference in the understanding of countertransference relates to whether it is rooted in unresolved conflicts or issues in the therapist, whether it is the likely response to the client's style or whether it should include all of the therapist's reactions. As Gelso and Hayes (2007) point out, defined too broadly the term would have little scientific or clinical usefulness. If all emotional reactions were to be included there would be no need for the term. Furthermore, a need would arise for the term to be divided into those reactions which relate to the therapist's vulnerabilities and those which are a response to the client's material. Gelso and Hayes (2007) reserve the term only for those reactions which are predominantly the therapist's own conflicts, issues or

difficulties. However their definition of countertransference is more than just the therapist's transference response to the client's transference. It includes non-transference reactions to the client's non-transference material such as reactions relating to current difficulties in the therapist's life rather than their childhood.

Hayes, McCraken, Hill and McClanahan (1998) have developed a theory of countertransference by identifying its origins, triggers, manifestations, effects and management. The origins of countertransference refers to the therapists own personal conflicts from which countertransference arises. For example, common sources of countertransference were the unresolved conflicts related to family issues and the needs that the therapist had coming into the therapeutic situation. Whilst the roots of the countertransference are often found in early life, there are many emotional conflicts that occur in the present such as loss of a relationship or other difficulties. From a cognitive perspective, countertransference reactions might be thought of as originating in schemas, beliefs and automatic thoughts. Schemas enable therapists to organise information and make sense of the world but it may also cause them to selectively attend to and distort information.

Triggers are the actual events or client characteristics that elicit the therapists' personal conflicts. The client's material may trigger painful feelings related to those conflicts. Whilst researchers have looked for typical client behaviours that trigger countertransference, the study by Hayes et al (1998) suggests that it is the therapists' subjective experience of the therapeutic situation, rather than client material or behaviours, which largely determines whether countertransference is stimulated. The suggestion is that countertransference origins and triggers will depend on the therapist's subjective perception of an interaction. Client problems or styles do not seem to be predictive of whether countertransference is triggered. Rather than looking for categories of client triggers for countertransference we need to understand the interaction between client characteristics and behaviours with the therapist's issues in order to understand the trigger.

Manifestations are those reactions that therapists exhibit when their countertransference is triggered. Countertransference may be manifested as affect, cognition or behaviour. Many affective states such as anxiety, anger, sadness etc may be an indication of

countertransference. It is therefore a sign to look inward and find out what might be wrong. However, the existence of these reactions does not necessarily indicate countertransference as understood by Gelso and Hayes (2007).   Whether they are indicative of countertransference depends on their origins. For example, the presence of anxiety maybe a natural response to a situation that is experienced as threatening. Behaviourally, countertransference may manifest itself in different ways. For example, it may lead to withdrawal, or under or over involvement. The therapist may change the subject or ignore something that the client has said. The therapist may talk too much, offer too much support or affection. In the cognitive domain, the therapist may distort aspects of the relationship.

The effects are the impact that countertransference has on therapy and therapeutic outcomes. Therapists' personal reactions and the way in which they are dealt with are central to therapy process and outcome (Fauth 2006; Hayes and Gelso, 2001; Peabody and Gelso, 1982; Robbins and Jolkovski, 1987; Van Wagoner et al, 1991). Gelso and Hayes (2001) have reviewed a further nine studies which supports the idea that unmanaged countertransference adversely affects the therapeutic relationship. It can lead to unhelpful or detrimental behaviours that impact on therapeutic process and outcomes. The findings by Cutler (1958) are a demonstration of the impact of unmanaged countertransference. Therapists tended to either under or over estimate the frequency with which clients discussed material that touched upon their own conflicts. However this does not take into account that there may be some internal countertransference reactions that may even be helpful to the therapist who is able to understand and manage them.

Management of countertransference refers to the strategies used to reduce the likelihood of it affecting therapy. An understanding of countertransference management based on five factors was offered by Van Wagoner et al (1991). The first of these is *self insight*, which refers to the awareness of one's own feelings. This suggests that therapists need to reflect upon their own experience, especially when they have strong reactions. The second factor is therapist *self integration*, which includes the possession of a stable identity and an ability to differentiate oneself from others. This involves an awareness of boundaries between the client and the therapist, which enables therapists to put themselves aside for the client. At the same time the therapist needs to be able to

understand the client's world from the client's perspective. The third factor is *empathy* which allows the therapist to focus on and understand the client from the client's perspective without feeling overwhelmed. By being empathic the therapist is less likely to act out their own needs. The fourth factor is a*nxiety management* which refers to the therapists' ability to manage their anxiety and prevent it from contaminating their responses to the client. The therapist needs to recognise and tolerate the anxiety. Finally, *conceptualising ability* refers to the therapists' ability to draw on a theoretical framework to explain the therapeutic process. The therapist needs to have good theoretical knowledge and to apply it to the therapeutic work.

Robbins and Jolkovski (1987) suggest that a combination of self awareness in addition to a theoretical framework helps therapists to manage their reactions constructively and respond empathically. Robbins and Jolkovski (1987) present an interactional model of how counsellors manage their countertransference feelings based on their level of awareness of feelings and theoretical framework. This two factor model states that therapists who are aware of their reactions towards clients and who have a theoretical framework for understanding these feelings will be less likely to demonstrate countertransference behaviour such as withdrawal or over involvement. Participants were given measures of awareness of feeling and use of theory. They were also given tests that measure withdrawal of involvement. The results provided support for an interactional model of managing countertransference. Whilst awareness leads to less withdrawal of involvement, a combination of awareness and theoretical framework results in the least withdrawal. Empirical support for this model comes from Latts and Gelso (1995) who examined therapists' countertransference behaviour with rape survivors. The participants in this study described how a psychological formulation explained the interactions between client and therapist. This might include an understanding of the impact of a client's early life experiences and the way in which this affected the therapeutic relationship. This is consistent with a study by Peabody and Gelso (1982) which found that more empathic therapists were more aware of their reactions which predicted better management of countertransference. They found that countertransference behaviour (as measured by withdrawal of personal involvement) was negatively related to therapists' empathic ability.

Safran and Muran (2000) have suggested that meditation practice can help therapists to deal with their reactions. There are different types of meditation which vary according to their focus. One type of mediation referred to as mindfulness involves paying attention in a particular way with non-judgmental awareness (Mace, 2008). Whilst mindfulness is known for sitting and bringing the focus of attention to one's breath, there is an emphasis on integrating it into everyday activities. It involves "directing one's attention in order to become aware of one's thoughts, feelings, fantasies or actions as they take place in the present moment" (Safran and Muran, 2000, p 57). The aim is to become aware of our automatic ways of experiencing and responding. Thoughts, feelings and sensations are experienced for what they are and receive no more attention than any other aspect of experience. As Victor Frankl (2004) notes: "between stimulus and response, there is a space. In that space is our power to choose our response. In our response lie our growth and our freedom." Mindfulness then helps to increase the size of that gap between stimulus and response. An important exploration of the role that mindfulness can play in the therapeutic process can be found in the work of Bruce, Shapiro, Constantino and Manber (2010). They argue that mindfulness practice enables therapists to better attune to their own reactions which increases their ability to relate to clients.

In a review of the literature O'Driscoll (2009) has highlighted the link between mindfulness and therapeutic outcomes as helping to cultivate a decentred perspective, thus creating the space for reflecting on habitual patterns of reacting. Mindfulness also helps to cultivate acceptance and suspension of judgement on the part of the therapist and models acceptance of difficult feelings to the client. It may also be that mindfulness increases the capacity for empathy in the therapist. As therapists become more aware of their reactions they become more aware of mental processes involved in empathy. However, the research suffers from a lack of randomised controlled trials demonstrating the efficacy of mindfulness as well as clarification of the internal mechanisms of mindfulness. O'Driscoll's (2009) conclusion is that although mindfulness is not universally beneficial the benefits outweigh the drawbacks.

Whilst the literature reviewed so far focuses on what therapists do to manage their reactions during the therapy hour, it may also be useful to know more about what therapists do in between sessions that helps them to manage their reactions. This is all

the more important as caring for those who are distressed is often stressful itself (Shapiro, Brown and Biegel, 2007). In a review of the literature Shapiro et al (2007) identified a number of consequences of stress on helping professionals such as depression, anxiety, emotional exhaustion, isolation, decreased job satisfaction and reduced self esteem. Stress may harm professional practice adversely affecting therapeutic outcomes. A number of factors associated with the nature of psychotherapeutic work have been identified that contribute towards stress (Hellman, Morrison and Abramowitz, 1987). These are maintaining the therapeutic relationship, caseload, professional doubt, work overinvolvement and personal depletion. A number of patient behaviours were also identified as sources of stress. These were negative affect, psychopathological symptoms, suicidal threats and passive-aggressive behaviours. Whilst the potentially damaging effects of stress have been identified, Deutsch (1984) points out that some degree of stress can be facilitative or stimulating.

1.3.5 Limitations of existing research

As Gelso and Hayes (2007) note countertransference research is still in its early stages. Research is needed to help therapists better understand their reactions and how to manage them. Specifically, as noted by Fauth (2006) much of the existing research has placed the therapist in a reactive position and has been limited to mainly exploring anxiety. Although the five factors have been identified as qualities that help therapists to manage their reactions there may be other qualities involved. Whilst research is needed to understand what makes countertransference less likely to occur we also need to understand more about how therapists manage their countertransference reactions once they have occurred. Self insight and awareness on a moment-by-moment basis seem particularly important. During sessions themselves therapists many use certain techniques to manage their reactions such as focussing on the client, suppression of thoughts or emotions, or doing the opposite and allowing themselves to fully experience the emotions (Safran and Muran, 2000). Further research would benefit from understanding more what therapists actually do in between sessions to manage their reactions.

1.4 Summary

This chapter has described the aims and rationale for the study. The limitations of the existing research have been addressed and it is hoped that this study will contribute to our knowledge in this area. The aim is to highlight the complexity of therapists' reactions including their usefulness whilst learning more about the internal processes that allow therapists to manage difficult reactions. This chapter has also described how counselling psychology in the United Kingdom has seen a paradigm shift away from an almost exclusive reliance on a natural science view and the use of quantitative methods towards one based on a human science view and a greater use of qualitative methods. IPA is one qualitative research approach developed specifically to examine and understand how people make sense of their experiences. The next chapter explores in more detail the issues concerning an IPA study.

Chapter 2: Methodology

This chapter reviews the methodology, research design and procedures used in conducting the research. Methodology refers to the approach adopted towards studying a particular research topic and is informed by the epistemological position. It should be differentiated from method which refers to the research technique that is adopted.

2.1 Principles of Interpretative Phenomenological Analysis

The aim of this research is to enable participants to describe how they make sense of their reactions towards their clients. IPA is a recent approach within UK psychology that attempts to extract the essential features and identify the essence of an experience (Smith *et al*, 1999). It began as an approach that occupies a position between positivism and social constructionism, enabling researchers to understand the meaning contained in accounts through an engagement with the participant. Research using IPA usually relies on data obtained from semi-structured interviews that allows the researcher to enter participants' experience as much as possible enabling participants to give as much detail as they can. IPA is informed by key areas of philosophical thought in phenomenology and hermeneutics.

2.1.2 Phenomenology

Phenomenology, existentialism and hermeneutics are long established ways of knowing in western intellectual life (McLeod, 2001) and they lie at the heart of IPA. Phenomenology is a philosophical approach to understanding experience which focuses on understanding the essential nature of an experience or the essence of a phenomenon (Ashworth, 2003). Phenomenology is interested in our experience of the world as it appears in our consciousness rather than abstract concepts about the world itself. According to this view, the object of our perception cannot be separated from our experience of it. Therefore, an object's manifestation in our consciousness constitutes its reality. A key philosophical issue in phenomenology is the concept of intentionality. It relates to the fact that our consciousness is always of something. Every experience is

an act of consciousness and an experience of something, whether we see an object visually, hear a sound or think something.

Phenomenological enquiry seeks to go beyond the natural attitude (a set of assumptions that we use to make sense of the world), which is achieved by bracketing off our assumptions (Ashworth, 2003). The term phenomenological reduction was used to describe the aim of transcending our natural attitude and to "experience a state of pre-reflective consciousness" (Willig, 2008, p.53). This allows us to describe phenomena as they appear to us in consciousness, free from other interpretations or preconceptions, thus reducing the phenomenon to its essential qualities. Phenomenology offers an alternative to the positivist and social constructionist positions by focussing on our perception of the world. The focus of enquiry is on the intentionality of a phenomenon. In addition, through investigation of many different perceptions, we can come to know something about the shared experience of a particular phenomenon.

2.1.3 Existentialism

Phenomenology is closely linked to existentialism. The existential perspective uses phenomenology as a method to explore existential concepts; to understand the nature of being or existence (Smith, Flowers and Larkin, 2009). The idea is that the natural attitude, which phenomenologists sought to suspend, is in fact the focus of inquiry. The research conducted by the psychiatrist R.D. Laing in the 1950s and described in the *Divided Self* (1960) remains a good example of phenomenological-existential research. Laing's (1960) aim was to understand the experience of schizophrenia. He concentrated on the individual's experience and argued that the experiences of these people could not be understood through traditional psychiatry or psychopathology but required a phenomenological approach. In achieving this he needed to set aside the assumptions that he had acquired through his training as a psychiatrist. For example, the medical language of disease, symptoms and treatment acted as a barrier to understanding what the clients might be experiencing. Having deconstructed the medical meaning of psychosis, he was able to explore the experience of schizophrenia from a new perspective.

2.1.4 Hermeneutics

Interpretative approaches to phenomenology accept that understanding cannot take place without some form of interpretation (Smith et al, 2009). Hermeneutics is an approach that was originally developed by theologians to interpret the meaning of the scriptures (McLeod, 2001). McLeod (2001) points out that although the term is often used to describe any approach to inquiry that relies on interpretation, what is properly meant by hermeneutics goes far beyond interpretation. It involves an understanding that interpretation takes place within a cultural and historical context. This means that the inquirer already has a pre-understanding which orientates the inquirer in relation to the text or topic. Additionally, in testing our preconceptions through open dialogue, either with the text or with another person, we can arrive at a better understanding of things as they really are. Smith et al (2009) refer to the 'hermeneutic circle' as a useful way of conceptualising the role of IPA researchers. It is concerned with the relationship between the part and the whole. In order to understand the part, we look at the whole and in order to understand the whole we look at the part. Whilst approaches to qualitative research tend to be described in a linear step-by-step way, in practice the process is iterative. A key tenet is that our understanding of a text takes place at different levels and we move back and forth through different parts of the data.

2.2 Epistemological position

Epistemology is the branch of science concerned with the relationship between knowledge and the knower and claims about the truth and the production of knowledge. (Ponterotto, 2005). The philosophy of positivism which is based on a model of science originating in the mid eighteenth century, stressed that knowledge claims must be derived from a rational, empirical method of knowledge creation, implying the existence of an objective outside observer (Strawbridge and Woolfe 2003). Since the discipline of psychology has its origins in the nineteenth century when the positivist model of science was prevalent, it is not surprising that it developed an emphasis on objectivity and observable phenomena. This led to a focus on behaviour rather than subjective experience since behaviour could more easily be observed and measured. In positivist versions of social science the aim is to produce results that lead to the

development of laws of human behaviour that can be generalised to the rest of the population.

The social constructionist position points out that what we perceive and experience is not a direct and unmediated representation of the environment. Instead, knowledge is constructed socially, historically, culturally and linguistically. From a postmodern perspective the quest for universal laws is replaced by an understanding that knowledge is contextualised (Kvale, 1996). The search for the truth and the discovery of underlying pre-existing meanings is replaced by the conception of the researcher as a co-author of the findings. IPA may be approached from what Madill, Jordan and Shirley (2000) refer to as a contextual constructionist position. Researchers working from this perspective are likely to be less concerned with evaluating their work according to realist criteria of objectivity and reliability. The contextual perspective contends that results will differ according to the context in which the data was collected and analysed. According to this approach, the participants' understanding, the researchers' interpretation and cultural aspects mediate the production of knowledge. The researcher inevitably brings their own assumptions and understandings, which will shape how the research is carried out. Therefore, although there is a strong subjective element to this type of research, different accounts are not invalidated by different perspectives. However, within this framework, there is a need to assess the extent to which the observations have been successfully grounded within the accounts that have given rise to them.

IPA is centrally concerned with cognition which has led to it being criticised by Willig (2001). Discursive approaches in psychology have challenged the assumption of mainstream psychology that language provides an unambiguous means to describe internal states and external reality. One version of Discourse Analysis (DA) is concerned with how people use discursive resources to construct their reality through language whilst Foucauldian Discourse Analysis (FDA) explores the availability of discursive resources within a culture (Willig, 2008). The range of constructions limits a person's ways of being or viewing the world. Nevertheless, people have thoughts about their experience and those are the focus of enquiry in IPA. At the same time, Smith et al (2009) would say that human beings seek meaning in their activities and they use discursive resources to make sense of that experience. Clearly, interpretation is an

important part of understanding cognition but this understanding is more nuanced than in mainstream cognitive approaches and cognition is never directly accessible. Thus, in the words of Safran and Muran (2000) "knowledge is both constructed and discovered" (Safran and Muran, 2000, p. 35).

2.3 Reflexivity and quality

Reflexivity involves understanding the role of the researcher and the research process in shaping the findings (Willig, 2001). The notion of reflexivity is described by Willig, (2001):

> There are two types of reflexivity: personal reflexivity and epistemological reflexivity. 'Personal reflexivity' involves reflecting upon the ways in which our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research. It also involves thinking about how the research may have affected and possibly changed us, as people and as researchers. 'Epistemological reflexivity' requires us to engage with questions such as: How has the research question defined and limited what can be 'found?' How has the design of the study and the method of analysis 'constructed' the data and the findings? How could the research question have been investigated differently? To what extent would this have given rise to a different understanding of the phenomenon under investigation? Thus, epistemological reflexivity encourages us to reflect upon the assumptions (about the world, about knowledge) that we have made in the course of the research, and it helps us to think about the implications of such assumptions for the research and its findings (Willig, 2001, p. 10).

Finlay (2003) has developed a version of reflexivity which she terms 'hermeneutic reflection' and occurs most explicitly within phenomenological-existential approaches. From this perspective, we cannot keep ourselves out of the research. Our findings are based on our own preconceptions and assumptions. These form the basis of our internal world and experience cannot be understood without them. However, we should still try to recognise our 'forestructures' and keep them separate from the phenomenon being studied. Reflexivity is therefore the "process of continually reflecting upon our interpretations of both our experience and the phenomenon being studied so as to move beyond the partiality of our previous understandings and our investment in particular research outcomes" (Finlay, 2003, p. 108). To understand the link between reflexivity

and reflection we need to examine the different layers of consciousness. At a minimal level of awareness we are caught up in the flow of experience whilst the reflective level involves undirected reflection on experience such as becoming aware of the heat of the sun whilst out walking. This is different from phenomenological reflection, the most reflexive level, which involves deliberate reflection on our own experience. The key point is that we do not have privileged access to our experience. We have to reflect on our experience and offer an interpretation which makes sense to us.

2.3.1 Reflexive note

Since interpretation is based on our prior experiences and assumptions, the findings of this study need to be put into context. My interest in the therapeutic relationship and the potential for an emotionally intense encounter, speaks to my own desire for authentic and genuine engagement with others. My interest in this area developed considerably after reading about relational depth which refers to a profound sense of engagement between therapist and client (Mearns and Cooper, 2005). The origins of this study also lie in an interest in the therapeutic relationship that has developed further over a number of years as a counselling psychologist in training. The topic of therapist's reactions seems particularly relevant to me as a trainee as I was often acutely aware of struggling with my own reactions towards clients. Sometimes this was related to the client's material whilst at other times it was related to my own worries and concerns as a trainee. For example, it was important for me to do well and appear competent particularly on those occasions when I did not feel competent.

Whilst my own experiences of being a therapist helped me to understand the participants, I also needed to be aware of how my own preconceptions may have influenced the findings in other ways. Because we may have been through similar training programmes and engaged in the work of helping others, I could identify with them and through understanding my own experiences, I could better understand theirs. At the same time, it was important for me to be wary of assuming that my experience was the same as theirs. Another important consideration is that the participants' accounts may have been influenced by what they knew about me. They knew that I was a trainee counselling psychologist and knew that I was interested in the subject of countertransference. My understanding of the literature in the field will have influenced my questions and the answers the participants gave. Therefore, the findings of the study

are a product of the interaction between the participants and me. The findings should be considered as tentative and limited to the specific group of participants.

2.3.2 The independent audit

Whilst validity and quality are important aspects of IPA research, the appropriateness of using the criteria for validity applied to quantitative research has been questioned when applied to qualitative research (Kvale, 1996). The independent audit is one way to assess validity in qualitative research (Smith et al 2009). The principle is to keep a paper trail so that someone could in theory follow the process from initial proposal to final report. Thus, this research project includes a file of material including the initial research proposal, upgraded research proposal, an interview schedule, audio recordings, annotated transcripts, tables of themes and the final report. Although the audit may be hypothetical, it helps the researcher be more rigorous about the claims. The purpose of the audit is not to find an account which is the one and only truth but to ensure quality and transparency. In terms of quality and validity, the interpretations of the participants' accounts were discussed with supervisors and peers. They were asked to check that the themes were grounded in the data with the hope that they would be able to identify any peculiarities. The extracts from the transcripts allow the reader to assess the consistency of my interpretations.

2.4 Conducting Interpretative Phenomenological Analysis

Research using IPA usually makes use of data obtained from semi-structured interviews that enable participants to describe their experience in detail. This section discusses the procedures involved in recruiting the participants and other preparatory work.

2.4.1 Participants

The choice of participants needs to be consistent with the principles of IPA. This means that the participants are selected because of the insight that they offer into the phenomenon under investigation. The objective was to recruit a sample that satisfied the criteria for homogeneity which is related to IPA's inductive principles (Smith et al, 2009). Analyses are tentative and cautious so that the findings from different studies are built up cumulatively. Therefore, it was decided to recruit participants who work from a psychodynamic perspective. The rationale for this is that psychodynamic

practitioners pay particular attention to the relationship and they way in which therapist and client are relating to each other. The common factor between these therapists was the focus on relational processes which meant they met the criteria for homogeneity. Participants were recruited using the snowballing technique starting from friends and colleagues. The therapists ranged in experience from four years to twenty six years. Three participants were female and three were male. The first therapist was trained in cognitive analytical therapy; the second participant was a psychoanalytical psychotherapist; the third was a psychodynamic counsellor; the fourth was a psychosexual therapist who worked psychodynamically; the fifth a relate counsellor who also worked psychodynamically; and the sixth had an integrative training but had a particular interest in working psychodynamically. The table below gives some details about the participants. Pseudonyms have been used to protect confidentiality.

Name	Training	Period since qualification
Sarah	Cognitive Analytical Therapist	4 years
Simon	Psychoanalytical Psychotherapist	26 years
Richard	Psychodynamic Counsellor	25 years
Katharina	Psychosexual Therapist	5 years
Mark	Relationship Counsellor	13 years
Carol	Integrative Counsellor	7 years

Table: the participants

2.4.2 Interview schedule

The six participants were interviewed face-to-face about their reactions towards clients. Semi structured interviews are considered to be the most appropriate form of data

collection for IPA (Smith et al, 2009). The aim in IPA studies is to enable the participants to describe their experience of the phenomenon under investigation. Semi structured interviews allow the researcher to be flexible and to follow up interesting leads in more detail. There is always the option to ask the participants to clarify or expand on areas. After the initial interview schedule had been designed it was subsequently reviewed by peers. The guide was also evaluated in a pilot interview and based on this the schedule was modified before being used with all subsequent participants (see appendix 1). The interview schedule started with a question about the therapeutic relationship and its role in therapy. The participants were then asked about what processes they attend to in therapy followed by problematic situations. The schedule continued with questions about how the examples they gave affected them.

2.4.3 Ethical considerations

Research ethics approval was obtained from the National Research Ethics Service and from the University of East London's Ethics Board (see appendices 2 and 3). Before deciding whether to take part the potential participants were given an information sheet providing details about the study (see appendix 4). Once they had decided to participate they were asked to sign a consent form which confirmed confidentiality and their anonymity (see appendix 5). The British Psychological Society's guidelines on the use and retention of data will be adhered to. The interviews were recorded by a digital voice recorder and transferred to a laptop, which is kept at home. The transcribed interviews will also be stored on the laptop. The researcher is the only person who will have access to the data and a password will be required to access the data. The data has been anonymised to protect the identity of the participants.

Because of the personal nature of the interviews, there was a possibility that participants could have found some of the questions distressing. They were free to decline any questions without any negative consequences and the intention was to remind them of this if at any point they appeared to be having difficulty. They were also reminded that the interview could be stopped and they could withdraw from the study if they wish. Apart from advising them to consult with their supervisor, it would also have been suggested that they contact their staff counselling service, or their therapist if they had one. There was a possibility that the researcher could become distressed whilst listening to the content of the interviewees' material in this study. Any issues that emerged

would have been discussed with the research supervisor. Consideration was also given to the potential risk that arises from the fact that the researcher was travelling to a venue of the participant's choice. Someone else was notified of the researcher's whereabouts and the expected duration of the interview.

2.4.4 Data analysis

Smith et al's (2009) recommendations for IPA were followed to analyse the data. The interviews were audio recorded and transcribed verbatim. Each transcript was read several times by the researcher and coded in a free textual analysis. The aim of this initial noting is to produce a detailed set of notes on the data. This level of analysis can be broken down into three discrete processes with differing focuses. The first is descriptive comments which describe the content of what is said. The second is linguistic comments which focus on the participant's use of specific language. The third is conceptual comments, which involves a move to a more theoretical level. Exploring the connections between the initial notes led to the development of emergent themes which were given relevant titles. It involves an attempt to create a statement that captures the essence of what was said. Whilst these themes reflect the original words of the participants, they also reflect the analyst's interpretation. Two specific ways of looking for connections between themes are called abstraction and subsumption (Smith et al, 2009). It involves identifying patterns across themes which may be termed master themes. With abstraction, higher order themes emerge as a result of putting themes together and developing a new name. Subsumption is similar to abstraction but in this case an emergent theme becomes a master theme itself as it draws together related themes. The next step involves moving to the next case and repeating the process. Once each transcript has been analysed and a table of themes has been produced for each, the next stage is to look for patterns across cases. Some themes will represent higher order themes which more than one case shares. This stage also helps to highlight the differences between participants as well as the similarities that they may share.

2.5 Summary

This chapter has reviewed the methodology, research design and the procedures used in carrying out the research. IPA has developed as an approach to understanding

experience and is informed by developments in phenomenological and existential philosophy. Epistemological issues from the perspective of positivist and constructionist positions in relation to research were reviewed. Because of the large number of qualitative approaches available, it is important for researchers to make their epistemological position clear to allow them to be appropriately evaluated. This chapter has also considered issues surrounding quality and reflexivity in qualitative research, specific issues in carrying out the research and analysis of data.

Chapter 3: Analysis

As stated in chapter 1, the study reported here examined therapists' reactions towards their clients. This chapter is organised in terms of the salient themes that emerged during the analysis.

3.1 Personal reflections on the participants

Consideration has been given to issues of reflexivity relating to the epistemological position, quality in qualitative research and the role of the researcher. Willig (2008) suggests that reflexivity in qualitative research has much in common with the way in which therapists use their own reactions in order to gain a better understanding of their clients. The trend in psychodynamic approaches towards viewing the therapist as an active co-participant parallels the development of the role of the researcher in qualitative research. This has led me to wonder about the interaction between me and each of the participants. Since this research is about the process of therapy and the reactions evoked in therapists, my own reactions during the interviews were important data to be considered. This is because the relationship between the participants and me has influenced the accounts that they gave and the nature of my analysis.

3.1.1 Richard

Richard trained as a psychodynamic counsellor and has an interest in Jungian approaches. I interviewed him in his office at his work place, a staff counselling service in an NHS hospital. The interview took place at lunchtime and he was eating his sandwiches when I arrived. I experienced him as friendly and welcoming and I found myself feeling at ease. I knew from meeting him before that he had a good sense of humour and I looked forward to the interview. At the end of the interview he joked about payment, to which I replied that he should post his invoice to me. Nevertheless, despite the light hearted attitude he takes his work seriously and expressed strong views about the recent changes within the NHS following the introduction of Improving Access to Psychological Therapies (IAPT). On this subject at least, I was mindful that he felt quite strongly about it. He spoke clearly and was quite forthright which appeared

to demonstrate a self confidence and assuredness in his knowledge about different therapeutic approaches.

3.1.2 Mark

Mark trained in marriage guidance and works mainly with couples from a psychodynamic perspective. I had been put in touch with him via a colleague. The interview took place at his home and I was meeting him for the first time. I experienced him as warm, friendly and approachable. He gave detailed and considered answers to my questions. I was aware of refraining from jumping in too quickly with any questions in case he was still pondering his response. I was also aware of a reticence about probing too much with Mark. During parts of the interview he talked about painful and difficult emotions that sometimes emerged during therapy. Upon reflection, I think my reticence was at least partly an awareness of his sensitivity and my desire to be respectful. This was the longest interview out of all six which I think is a reflection of how useful he found it. He said that he was glad of the opportunity to be able to talk about his practice at such length as it was not something that he was able to do very often. I was pleased that he had found the experience useful and rewarding.

3.1.3 Katharina

Katharina is a psychosexual therapist who works psychodynamically. As with Mark, I was meeting her for the first time after being put in touch with her by the same colleague. We had arranged via email to meet in a cafe of her choice. I found her engaging, friendly and approachable and soon felt at ease. She told me that she is a sensitive person, which she attributed to being an emotional caretaker of her mother as she was growing up and consequently she is very aware of others' feelings. I felt drawn to her and enjoyed her company. I found her happy to initiate disclosures and I had no concerns about probing more deeply. She seemed like a sociable person and I sensed that she welcomed the opportunity to talk about her practice. With hindsight it is interesting to reflect on whether the fact that she is from a southern European country had an impact on the data we generated together. It seems that within her culture hospitality is an important part of social life and is often extended to outsiders. My experience of the interview may be a reflection of that.

3.1.4 Simon

Simon trained as a psychoanalytical psychotherapist and has worked in the NHS for a number of years. I interviewed him at his work place, a psychotherapy department in a large mental health trust. In contrast to the informal feel of the interview with Richard or Katharina, the interview with Simon felt much more businesslike. At my arrival and after ringing the buzzer at the entrance to the department, a secretary answered through the intercom, asked me to come in and sit in the waiting area. When Simon arrived to greet me he was pleasant and polite as usual. I already knew him in a professional capacity and I had come to expect him to be more formal than say Richard. Indeed, there was no joking during or after the interview as there was with Richard. I felt that I was there very much to do a task, which left me feeling less relaxed than I had done with other participants. I was impressed by what I perceived as his professionalism and knowledge of the subject, and the confidence with which he spoke. I noted the way in which he dismissively put aside the participant information sheet that I gave him. He was open about his arrogant side although his candidness was quite engaging. However, I found myself feeling somewhat reticent and slightly nervous whilst conducting the interview, perhaps reflecting my own assumptions about needing to appear professional and competent, particularly in his presence.

3.1.5 Sarah

Sarah is a cognitive analytical therapist and she stands out as the participant who was particularly keen to talk about her experiences. Indeed, she had volunteered to be a participant after I had talked to her about my research project whilst I was on placement. Whereas I experienced Mark as quietly reflective, I noted Sarah's openness and immediate willingness to talk about her experiences, particularly about some of her negative reactions towards clients. In fact, I was struck by the fact that so much of the interview focussed on her negative reactions. This may have been partly because we had previously discussed the importance of managing difficult reactions towards clients and this may have influenced what she chose to talk about. It seems that often, these feelings were connected with some negative self evaluations that emerged during the course of working with clients. Nevertheless, her enthusiasm for her work, and in particular cognitive analytical therapy, was quite clear to me. She talked a lot and quickly and whilst I was pleased that she had much to say, it was clear that she felt strongly about the importance of working with process in therapy.

3.1.6 Carol

As with Mark and Katharina, I was meeting Carol for the first time after she had finished her working day. She had been trained integratively but works mainly from a psychodynamic perspective. I had been put in touch with her through a mutual acquaintance. I experienced Carol as polite and friendly from the start and I found myself warming to her more as the interview progressed. She is a manager working in the NHS and some of the reactions I experienced towards her were at least partly a replay of some of the reactions that I commonly experienced as a junior member of a team in an NHS setting. Relating to her as a manager, I may have been more inclined to maintain what I considered a respectful distance. However, as the interview developed and she spoke more about herself and her experiences I related to her less as a manager and more as a person with a history who has reflected on her past and how that has affected her. I found that she tended to speak quite softly and sensitively which I interpret as a reflection of her warmth and kindness.

3.2 Themes

Although there is no single approach to the analysis of data in IPA, the approach recommended by Smith et al (2009) is used here and involves a line by line analysis of the interview transcripts and the identification of emergent themes in individual cases and across cases. As a starting point, each transcript was read a number of times in order to become familiar with the participants' accounts. Notes were made in the right hand margin of the transcript about key points or preliminary interpretations. The left hand margin was used to note emergent themes. These were themes that captured the essential meaning of the section of transcript. The themes were then listed on a separate sheet which helped to identify connections. Some of the themes were clustered together under a master theme. The result was a table of themes for each transcript. The table of themes for each transcript was compared to that of the other transcripts. Connections were identified which produced a final table of master themes for all of the transcripts. Within the transcript extracts identifying names and places have been substituted to protect anonymity. The following extract demonstrates the initial noting stage of analysis after reading of the transcripts:

Int. So you're aware of how they're backgrounds and the things which have happened to them and influences how-
C. Absolutely
Int. They are with you.
C. Yeah, and also looking at their current patterns of relationships and I think very often the way a client reacts to me or communicates with me will give me clues about how they respond to other people in the rest of their lives and how I feel about them gives me important clues about how other people might feel about them or respond to them. If the client is particularly isolated or struggle to make relationships, there are normally clues in the relationship that I have with them and the impact that they are having on me might perhaps reveal why how other people -

She observes how the client behaves towards her because it may be typical of how they behave towards others. This is important because their interpersonal relationships may be the source of their problems.

Therefore, she monitors her own feelings as they may be similar to the feelings that the client elicits in others, which is important for understanding the impact the client has on others.

The next stage involved returning to the transcript and using the left hand margin to transform the initial notes into themes, which takes the analysis to a more abstract level while still being grounded in the participants' words:

Therapeutic relationship is a re-enactment

Reciprocation

Int. So you're aware of how they're backgrounds and the things which have happened to them and influences how-
C. Absolutely
Int. They are with you.
C. Yeah, and also looking at their current patterns of relationships and I think very often the way a client reacts to me or communicates with me will give me clues about how they respond to other people in the rest of their lives and how I feel about them gives me important clues about how other people might feel about them or respond to them. If the client is particularly isolated or

32

struggle to make relationships, there are normally clues in the relationship that I have with them and the impact that they are having on me might perhaps reveal why how other people -

The next stage of the analysis involves drawing together the emergent themes and organising them into superordinate themes that highlights the main aspects of the participants' accounts. There are different ways to do this but one way recommended by Smith et al (2009) and used here involved typing the themes into a list and moving them around to form clusters of related themes. These clusters are given a theme title which captures the nature of the themes:

She observes how the client behaves towards her because it may be typical of how they behave towards others. This is important because their interpersonal relationships may be the source of their problems.

Therapeutic relationship is a re-enactment

Self as a measuring instrument

Therefore, she monitors her own feelings as they may be similar to the feelings that the client elicits in others, which is important for understanding the impact the client has on others.

Reciprocation

The next step involves moving to the next case and repeating the process whilst bracketing the findings from the first case as far as possible. The first subtheme referring to re-enactment was dropped as there were few extracts to support it and therefore it was merged with 'reciprocation'. Once the process has been completed for each case, the next stage involves looking for patterns across cases which leads to a table of superordinate and master themes for the whole group, which is presented in the appendix 6.

The themes were ordered so that they created a coherent narrative. Only the most salient themes were included in the final write up and those themes that were not well supported by the data were dropped. Before the write up, the consistency of themes with the transcripts was checked again. Analysis of the data contained within the interviews is revealed in a number of themes for the group and the master themes identified are presented here:

- Self as a "measuring instrument"
- Managing reactions
- Therapist self care

As can be seen, the participants made sense of their reactions in a number of different ways. Reactions were understood as the subjective experience of being in the room with the client, hence the term "measuring instrument" used by Simon and taken as the title for the theme. Reactions were also understood as a manifestation of difficult feelings that needed to be managed. This included reactions which were understood as emanating from the client's material and those emanating from the participants' own style of relating. The division between those reactions which are a response to the client's presence and the participants' difficult reactions is a rough guide as with many attempts to categorise complex observations. Nevertheless, the proposed dichotomy provides a convenient framework for presenting an account of the analysis. Finally, the participants discussed how demanding the work is and the importance of looking after themselves.

3.2.1 Master theme: self as a "measuring instrument"

The participants emphasise the importance of the therapeutic relationship as a means for understanding the client's internal world and the way in which the client relates to the therapist. This master theme was characteristic of every participant although not every subordinate theme was applicable. Nevertheless, all of the participants discussed the importance of the therapeutic relationship as a means for understanding their clients and Simon's description of himself as an instrument for measuring the relationship gives the

theme its title. Three subordinate themes emerged and are described. These are (1) reciprocation, (2) self disclosure, and (3) empathy.

Reciprocation The participants frequently described the client's behaviour towards them as the repetition of experiences of relationships learnt in childhood, which implies another whose reciprocation is sought. This subtheme begins with some extracts that describe how the participants view the client's presenting difficulties. For example, Richard briefly refers to the impact of early childhood experiences:

> You say for instance, we know up to the age of five, this was present in your household and we can speculate that the reaction formation to that is going to be this because this or anxiety, terror about certain things and does this still affect the person as an adult? Well, we would expect it to and lo and behold they come here reporting anxiety and things and whatever it may be and you say there you are. You know, it's easy to see that this particular habit, if you wish, set up in the first five years of life is still operating thirty years later.

Psychological defences such as reaction formation develop as a result of early experiences that may manifest themselves in the therapeutic relationship. With this in mind, Mark pays particular attention to the way in which a client responds to an intervention as their response can be an important source of information:

> You have to think about how they respond to that. How they respond to being challenged or having something uncomfortable pointed out. Because it's not a criticism.

An example of what can happen when thoughts and feelings from the past are inappropriately projected onto the therapist is offered by Sarah. Whilst working with a client she had to cancel a session due to sickness, which the client apparently interpreted as some kind of rejection:

> Um, there was a client that I had recently. I was off sick for our session and I think that she, she was concerned I suppose unconsciously that somehow something about her made me sick.

Sarah understood her client's behaviour as an expectation that she would be rejected or let down, which had been confirmed when Sarah had to cancel the session. The client's response provided useful information about her presenting difficulties.

The client's behaviour towards the therapist may be an indication as to how the client forms relationships generally. Therefore, Simon pays particular attention to the way in which his clients form a relationship with him:

> Well, um I suppose in a way that psychotherapy which I think is distinct from counselling but psychotherapy is the treatment of pathologies of relationship and therefore in the sense of what do I pay attention to, I pay attention to the kinds of ways and the kinds of relationship that the patient seems to form with me minute by minute in the treatment setting and is going to bear very much on the discussion about countertransference later.

Therefore, the therapeutic relationship offers a basis for reflecting on the client's interpersonal behaviour, hence the importance of the reactions elicited in him. Sarah draws a comparison with other therapeutic approaches to illustrate the importance of attending to her own reactions:

> Listening, it's hard work, listening to yourself, listening to the client. My mind may drift off and what does this feel like? How do I feel in the room? How does the person make me feel? Am I yawning? Am I bored? Am I sad? Am I irritated? You know. And again, I think if you are too busy concentrating on doing the task you are going to miss some very valuable information about the patient [pause]. And I have been moved to tears. I have had some very, very moving experiences that's been really, really painful

She allows herself to be in touch with feelings of engagement or lack of, thus helping her to enter her client's relational world. Furthermore, she sometimes finds the experience very painful. This extract seems to demonstrate that she is very expressive and it is noticeable that she repeats her words when describing how moving and painful it can be listening to others' experiences. It was striking how comfortable she seemed talking about painful feelings. This suggests that she is used to experiencing difficult emotional reactions and talking about them. The intensity of her reactions also indicates

that she is easily affected by her clients and allows herself to become emotionally involved. Emphasising the strength of her reactions could also be interpreted as a possible attempt by her to reinforce the importance of therapists' reactions and to highlight the distinction with other therapeutic approaches.

To be able to attend to one's own experience of being in the room with a client requires patience according to Richard:

> But you learn to be patient, to be quiet, allowing things to evolve as they should in the time that they need to is very helpful. And I know that that's not always possible in today's therapeutic modern army when you've got limited staff but that's certainly the way I was trained and it works for me, yeah. And I don't think there is any reason why that shouldn't work in short term work either. I think if you, if your patient knows that you've only got six or twelve sessions you should still benignly, should benignly indifferent then they still have the space to use that time rather than you forcing them into you've gotta get better.

In highlighting the importance of patience, Richard seems to be drawing a comparison with the time limited nature of modern therapeutic work and the emphasis on achieving targets. His assertion that clients are forced to get better in today's therapeutic approaches suggests that he feels strongly about this. It seems to demonstrate his confidence in the therapeutic approach in which he was trained. It is also perhaps an indication that he interprets these changes as a devaluing of the principles that are important to him in his therapeutic work. One of the principles which seem to be important to him is therapist neutrality. It is a psychoanalytic term that is used to characterise the attitude of the therapist with respect to their reactions (Lemma, 2003). To distinguish this from a kind of cold or indifferent neutrality, Richard borrows a term from Bion (1962) indicating an authentic concern for clients:

> Stay neutral, benign. I think, I borrowed, I use from Bion which is benign indifference, a kind of [inaudible] and relatively neutral place but not in a sadistic place.

Richard is likely to experience a variety of responses to the client but the implication is that he should let go of the desire to achieve an aim with the client as this will limit his ability to be fully present in the moment.

Being more fully present may allow the therapist to monitor their own reactions more carefully. Therefore, Simon uses his experience of being in the room with a client as a source of understanding how they are relating to him:

> I went through a training that required me to have quite an extensive personal therapy as part of the training and I think the rationale for that is that if you are going to use the self, that's the measuring instrument by which you gauge the nature of the relationship the other person is forming, then you have to calibrate it, that measuring instrument so I think that personal therapy is a process of calibrating your own character, your own personality, your own relationships to enable you to at least make the claim that I can form some sort of judgement of the relationship that this patient is making, which is of some objective therapeutic value

Personal therapy seems to have helped him to differentiate between those reactions which are a response to the client's style of interacting and how he typically reacts to others more generally. His use of some slightly mechanistic metaphors seems to be suggestive of a rather technical understanding of his reactions and the therapeutic relationship. This is reminiscent of the stereotype of the Freudian therapist who applies a psychoanalytic scalpel to dissect the client's mind to reveal their secrets. In this case, he applies his expertise to help the client more fully understand their unconscious workings. As such, he appears to adopt a more distant or expert stance towards his clients than some participants who seemed to be more emotionally involved. This is perhaps reflected in the contrasting reactions that I experienced. I felt somewhat more distant from Simon than other participants who I perceived as more fallible and therefore easier to relate to.

Carol points out that her own feelings generally towards the client provide information on how others may also experience the client:

Yeah, and also looking at their current patterns of relationships and I think very often the way a client reacts to me or communicates with me will give me clues about how they respond to other people in the rest of their lives and how I feel about them gives me important clues about how other people might feel about them or respond to them. If the client is particularly isolated or struggles to make relationships, there are normally clues in the relationship that I have with them and the impact that they are having on me might perhaps reveal why how other people -

The feelings elicited in her by the client may be a clue to the way in which other people in the client's life experience the client. This is important because the reactions they elicit from others may be the source of the difficulties they are presenting to therapy. One way to think about this is that the responses elicited from others, may lead to behavioural consequences that reinforce interpersonal patterns. Therefore, Carol views her reactions as a therapeutic tool for understanding the client's behaviour.

An example of what can happen if the therapist is not attending to their own reactions sufficiently well is offered by Mark. He worked with a man who was quite seductive in his relationships, and although Mark would normally refrain from disclosing personal information, he found himself making unintentional disclosures:

It's quite interesting because I worked with a man I saw for a while and he had this, he was a bit of philanderer with women and he wasn't very happy about that but he was so seductive in our relationship. He, he managed to get all sorts of things out of me. I equated the two situations and actually talked to him about it.

It appears that the client was quite enticing in his relationships and Mark was enticed to be more revealing than is characteristic of him. He made an observation about what was happening between them which initiated an exploration of the 'here and now' moment. The fact that he allowed himself to become more disclosive than is usual for him may also suggest that he found the experience positive. Perhaps he liked the experience of a more mutual two way interaction which might point towards Mark's more interactive nature. Nevertheless, this is an example of the way in which positive feelings in the therapist has the potential to lead to a form of collusion or avoidance.

The question of how therapists manage their reactions is discussed in the second part of the analysis.

Self disclosure Sarah finds that disclosing some of her reactions to the client helps to initiate a discussion about how they might be relating to each other:

> There is something else. So I may have to say: "It feels as if you're trying to
> please me. Can we look at this?"

Perhaps the client may have difficulties around assertiveness and the therapeutic relationship may be an opportunity to explore the way in which the client behaves compliantly with the therapist. However, a judgement needs to be made about whether the therapist's intervention is likely to be of some benefit to the client. The following extract from Carol illustrates the delicate judgement that therapists need to make when deciding how to respond to a client and by extension whether to self disclose:

> Yeah, I think so. I mean I think there are times when I you know when I can
> be over challenging when a client isn't ready and that can be
> counterproductive either because they become upset or they don't really hear
> you or I've done the opposite and been quite collusive with clients, you know
> perhaps the client whose filled with self pity instead of perhaps being a bit
> too lax in maybe helping them see what part they played in whatever it is

Whilst it is important to avoid reinforcing or collusive responses it can be difficult to know when to be challenging:

> Making them feel persecuted you know it's, it's not always easy to tread that
> line between so empathic that actually you're not helping them move on and
> being over challenging before a client's ready for it

Carol must balance the benefits of expressing herself in a genuine manner, reflecting the depth of the relationship whilst also treating the client sensitively. These two extracts seem to demonstrate Carol's sensitivity towards her clients. The fact that her clients matter to her is expressed in the dilemma between helping them to resolve their

difficulties whilst respecting their feelings, which appears to be a reflection of her warmth.

Mark experienced a similar dilemma to Carol and is reflected in the following observation:

> In the early part of this conversation we were talking about what we kind of
> add onto people, confronting them, challenging them. You've got to be
> careful there not to add more onto them and yet it's quite important to
> challenge it and understand the frustration as well.

The impact of his interventions on the client is just as important for Mark as it is for Carol. I found Mark to be quietly thoughtful and reflective, and I also warmed to him. Whilst reflecting on this extract and the interview itself I am reminded of the phrase that still waters run deep. In other words, he was quiet and thoughtful, and it seemed he had much to talk about.

The issue of knowing when to self disclose is elaborated on by Carol when she points out that it might be helpful for a client to hear the impact that they are having on the therapist:

> It might be quite helpful to just be able to let them know the impact that
> they're having on me because that might give them clues about how other
> people might be responding to them. So it's always about measuring up
> whether a client can take it. Are they able to hear it? Will they benefit from
> it or will it be helpful to them

Carol's disclosure of her feelings is taken as being potentially beneficial to the client. Identifying a reaction that she might be experiencing in relation to the client helps to raise the client's awareness of their behaviour and the possible impact this has on others. However, she must attempt to reconcile a tension between the need to be helpful to the client whilst being respectful and maintaining a sense of safety. This sounds like a very subtle process which presumably relies on her sensitivity and knowledge of the client, possibly also based on communication that takes place at a non-verbal level. She

may be able to pick up on changes in the client's internal state through subtle changes in facial expression or body posture for example.

Empathy There can hardly be any doubt that the ability to understand and to some extent share the client's feelings is the foundation of the therapeutic relationship. The ability to understand or imagine oneself as another person appears to be a complex process. It involves understanding emotions, desires, beliefs and physical states. Mark points out that the depth of understanding between him and the client develops over time:

> There's a different comfortableness. When people have been coming for some time you just get to a different level, it's a much deeper level, unconscious and it's just very different. And so therefore the communication tends to be like you know if you've been together for a while, there's a lot of short hands, which is quite interesting. It doesn't have to be spelt out. And people will say things further on in the therapy that they would never have said in the beginning. So I suppose that's building trust [pause].

There is a depth to the relationship that Mark develops with his clients which is related to the development of trust and more non verbal communication. Moreover he seems to be comfortable with relating to his clients at this level and they feel more able to share the more intimate aspects of their experience. Since I found being in Mark's presence quite calming and reassuring we might speculate that his clients experience a similar response making it easier for them to develop trust in him. His thoughtful and calm presence is likely to feel containing to his clients.

Whilst the analysis has revealed how useful it is for therapists to attune to their own reactions in helping them to understand their clients, Katharina was the only participant to explicitly refer to her somatic reactions as a source of understanding:

> So if I'm feeling uncomfortable I'm always curious of how the client feels. But I have a list of um, I don't know if you're aware of body therapy

She has a list of expressions of feelings that she uses to help clients to connect with and express their feelings:

Yeah, I've got a list of um expressions that you would be able to describe
your body, how your body feels and I've got a list, because sometimes they
feel very, although they're intellectually um very fluent and their vocabulary,
that doesn't apply to their body. I've got a guide of words that they can use
to describe if they feel really stuck. They might look at it and say this is how
I'm numb here or [inaudible] you know anything. So it's and I guess through
me I guess the client starts working.

Focussing on her somatic reactions may give her some clue as to how the client feels
physically. Methods such as going through the list can help people express feelings
when talking is not an easy option or if they use it defensively. Katharina goes onto
describe a specific type of meditation which is focussed on the body:

I also do meditation. Um part of my meditation is also, [inaudible]
meditation which is very bodily oriented work or you can switch like today it
was pure trauma therapy where we looked at what the body feels um and was
purely relationship between child experience, childhood experiences how
they still hold onto the body so, in a cathartic way

Katharina states that she often represents "the mother" to her clients' "internal child":

Um I am aware that sometimes I represent the mother to my clients and it's
interesting because, with my patient work, I work a lot with addictions and
my work is strictly adult related and, but what comes into the room is the
child so it's an interesting relationship that develops where I want to take care
of the child and interestingly is the one that comes in with trauma.

It seems that "mother" is a metaphor that she uses to describe her nurturing and caring
self, thus providing a sense of safety for clients who have been through traumatic
childhood experiences:

Yes. It's interesting. Clients that present with, the majority have massive
attachment disorders so it's taking care of that. I'm not saying that I
suddenly become the mother of all my clients. That's not possible but
allowing that safety and room and also I work with adults who are victims of
childhood sexual abuse and it's a huge horror when they look back so

43

> providing that safety but interestingly when I look at it myself I'm a mother
> in my personal life to two young kids. I take care of that and what it
> represents to me.

There is a parallel between the nurturing feelings she experiences towards her clients and her experiences of being a real mother. She describes a tendency towards being caring, supportive, accepting and loving. Perhaps this is reflected in the reactions I experienced towards her. She seemed to enjoy the opportunity to talk about her practice and my comfortableness in her company was perhaps a reflection of her caring nature. This extract demonstrates that there is some overlap between those reactions that would be a likely response to the client's material and those which emanate from her own ways of interacting. This is explored in more detail in the following section.

3.2.2 Managing reactions

Each participant spent a significant part of the interviews talking about managing their reactions towards clients, including those relating primarily to client material and those relating to their own conflicts or vulnerabilities. Whilst the participants viewed their own experience as data on the client, there was also recognition that therapists have their own personal life history and ways of making sense of the world. It is clear from the analysis that there may be some overlap between those reactions which are an expectable response to the client's material and the participants own conflicts, vulnerabilities or idiosyncratic ways of interacting. For example, therapists' uncomfortable reactions may not simply just be the result of their unresolved issues nor entirely caused by the client. If it was simply the therapists' unresolved issues then the conflicts would be triggered all the time with every client. If it was caused entirely by the client then all therapists would experience the same response to the client's characteristics and behaviours. However, the principles for managing reactions apply to both types of reactions and for this reason they have been grouped together under the same master theme. Within the master theme of managing reactions there are two subordinate themes. These are: (1) managing responses to client material and (2) managing own conflicts or vulnerabilities.

Managing responses to client material Whilst the therapist's willingness or ability to be impacted by the client may facilitate a deeper level of engagement, the following extract from Katharina highlights the importance of maintaining boundaries:

> Yeah. I'll tell you what. I looked very much into it because there is a situation where um I was picking so much, where I was picking up so much feelings from a client who was sexually abused as a child so much so that the client was not feeling it and I did worry about that. Um I mean the client did feel a bit but mine was really, really extreme, uncomfortable. I went away and I looked into what that meant and um, um called, we have projective identification, um what I was describing is over identification when you overly identify with a client's feelings and almost make them your own and you find it very difficult to let go. You carry the client with you in your personal life, you think about them.

Although it is important for her to be able to connect with her feelings, Katharina seems to have felt overwhelmed by the experience. Whilst projective identification often refers to the projection of intolerable ideas or beliefs about the self that the other begins to enact, it is also used here to describe the process of empathy. The implication is that the client has split off or disowned their experience in some way and it has been located in Katharina with the result that she has experienced the client's pain as if it were her own. Although this suggests that she initially struggled to manage the feelings aroused in her, a psychodynamic understanding of her reactions seems to have allowed her to respond to her experience in a more reflective and or constructive fashion.

A similar experience is described by Richard. He explains that he had a very powerful reaction to a client telling him about a series of ear operations that she had as a child. Before the operations were completed she was in a lot of pain and was almost deaf:

> Now when this was being revealed to me I had the most extraordinary sensation of falling into the most extraordinary pit of despair because part of the process is the use of internal imagination to place yourself in an empathic place with the patient. It then occurred to me that scary and horrible as that was that exactly where she would have been with this unremitting pain going on for year after year after year until the final operation around eleven fixed it completely. Um that's the sort of thing, you get those occasionally and they

are very alarming. You have to have them, but they're not particularly, you
don't seek that kind of, does that…?

This is an example of how Richard's feelings helped him to empathise with his client at
a profound level of contact and engagement. The aspect that stands out from this
extract is the strength of the reaction elicited from him as indicated by the repeated use
of the word "extraordinary" and his description of how "alarming" the experience was
for him. Initially, the experience has a quality of heaviness about it, of feeling
overwhelmed or of struggling to cope. However, it seems that once he became aware
that his experience was similar to how his client felt, he was able to think in a more
reflective way and possibly communicate this to his client. Reflecting on his experience
may have helped to prevent him from pushing the feeling away or unwittingly acting
upon it in some other way.

Katharina had talked about how meditation has informed her practice. She is asked
whether the meditation helps her to be more aware of her reactions and she explains that
it helps her be in touch with her experience and that of her clients:

Oh yes because you are constantly switched on which at some point I
wouldn't be able to stay in a room where I knew, where I could feel
somebody was depressed or stressed. I could straight away pick it up and
make it my own so it came to a point where I needed to recognise it and not
take it on. That's why I need to do some bodywork so I can let go.

Her account suggests that meditation helps her to observe her experience and refine her
capacity for self reflection. The result is that she is very sensitive and aware of her
reactions. A consequence of this is that she can be left feeling burdened with some
strong emotions, underscoring the importance of attending to her own welfare.

The following is an extract from the interview with Sarah. A key idea in CAT is the
concept of reciprocal role procedures. These are patterns of relating which have
developed in childhood and involve an expectation of certain behavioural responses
from others:

> Well I think working with borderline personality disorder, there's always that
> risk of people um [brief pause] unconsciously trying to reject you or trying to
> elicit certain responses that are very familiar patterns to them. I'm being
> rejected or, or um a game of narcissistic type of patient. So it's always
> something that I am very, very aware of and certainly in CAT we use
> reciprocal roles. The client will do their utmost to try and elicit quite
> negative responses from therapists. Unconsciously they are really going to
> try and have quite a powerful effect on the therapeutic alliance. Um so
> somebody could be quite grandiose, quite "I know better than you". "Who
> are you?" as the therapist so again you've got to watch your own triggers and
> your own responses

Thus Sarah can experience her clients as attempting to elicit a negative response
from her. It could be the borderline client who anticipates rejection and behaves
in a way that this becomes self fulfilling, or it could be a narcissistic client who
behaves in a grandiose manner. It seems that the behaviour of a client with
narcissistic personality traits in particular, is likely to trigger some strong
reactions. She appears to take offence to a client with inflated self importance
who might attempt to put her down and is ready to defend herself. It seems that
this sort of client behaviour will 'press her buttons', perhaps because it leaves her
feeling diminished. If she is not alert to her reactions she could be drawn into an
unhelpful dynamic. Fortunately, a theoretical knowledge of the client's
behaviour helps her to monitor her reactions and respond accordingly.

One client affect that can be difficult to manage is hostility. Responding to hostility
from a client involves the constructive management of difficult feelings that arise when
the therapist is confronted by the client. Richard uses the metaphor of "the chair" to
illustrate one way in which he thinks about the feelings that he experiences in response
to being verbally attacked by a client who was explosive with rage towards him:

> Exactly, yeah because very often what they're angry about isn't you or
> wasn't me it's what I represent in their mind.

He goes onto explain that when he was a professional musician, the other musicians in
the orchestra were hostile towards the principle violin which intrigued him:

It didn't matter who it was. They're not gonna, it didn't matter who he was.
He'd come in, sit in the chair and within ten minutes everybody would hate
him. And I could never work out why because I used to think he was quite
an ordinary bloke to me – quite talented but – and it struck me that it isn't the
person, it was the chair they were angry with. If it was empty, they'd be
angry with the chair. It can be an enormously important experience for
patients that come in that are generally not actually seeing you. They are
seeing what you represent in the chair. And a good way of thinking about it
is: they're angry with the chair.

The knowledge that the client is possibly projecting experiences from the past onto him
allows him to view the attack as against something he represents rather against him. It
seems that he views his true self as obscured from the client's view by the client's own
projections or distortions. It seems that this understanding may provide a sense of
safety. Although Simon takes a similar view to Richard he acknowledges that the client
may make some accurate observations about him:

Well, I mean, although this is open to being misheard, it's water off a ducks
back because the point is that I don't believe very much at all of what goes on
in a psychotherapy session is about me as a person because one of the reasons
why I am, you know opaque or a blank screen or whatever it might be in that
way, I've put a lot of time and effort into being trained and developing the
skill of being relatively blank is so that people can make whatever they want
of me but I don't regard what they make of me as being about me, except
sometimes yes I would expect some accurate perceptions, I would expect my
patients and my friends to be able to agree about some things that Simon is
and the weller the patient the more like the patient – the friend's perception
the patients perception might be and might include the unflattering things my
friends would say as well as the flattering things. Um, the iller the patient,
the less reality based I would expect that perception of me to be.

He accepts that his clients may make some accurate observations about him to some
extent. This extract is one of a number in which Simon refers to himself in the third
person. We might understand this as a device to highlight the distance he has from his
experience enabling him to adopt an observational stance. It may also help to impart an
air of objectivity when he is speaking thus presenting himself as more credible.

Referring to himself in the third person may therefore be a way of raising the importance of his account and by extension his own status.

Simon takes the example of a psychotic patient to illustrate how at one end of the extreme of psychological health, an individual will bend external reality to conform to internal reality:

> If you go and see a psychotic patient and they tell you they know that really you are Prince Charles and you have been sent by the Pope to control them, it doesn't touch you. You don't think that either you are Prince Charles or that you are doing the Pope's instructions. Well, that's what I feel about what most things that patients feel about their therapist.

The majority of the things that his clients feel about him seem to affect him very little as they say more about the client than they do about him. Therefore he can remain largely unknown to his clients and be a blank screen which allows him and the client to make sense of how the client is relating to him.

It is interesting to contrast the above with Sarah's account of dealing with a critical client. She was on the receiving end of a number of verbal attacks and developed an interesting strategy for managing the situation:

> Oh you are going to be the recipient of, I had one very, very, very borderline client and I had to do visualisation techniques as in I was wearing a suit of armour because she was attacking me so much verbally.

The visualisation technique and the knowledge of the client's reciprocal role procedures helped her to manage the experience of being attacked:

> Because she was really, really, really was trying her utmost to get me to reject her which would therefore reinforce her "everybody rejects me". She was very, very difficult. She criticised the way I walked, the way I dressed, my technique. I mean she basically just completely trashed everything about me but I withheld, I kind of contained that. We built up a very, very strong therapeutic alliance because I didn't reciprocate. That took a lot of supervision. She was a nightmare.

It seems that Sarah found the experience very uncomfortable indeed but her understanding that on some level the client was trying to elicit her rejection helped her to make sense of and manage her reactions. This knowledge, combined with the visualisation technique helped her to maintain a reflective stance in relation to her reactions. The intensity of her reactions suggests that she takes the client's criticisms personally, perhaps because it connects with a sense of vulnerability leading her to feel undermined. Indeed, the intensity of the reactions she experiences underlines the importance of staying reflective:

> Oh yeah, yeah. I mean you have a very intense relationship for sixteen
> sessions, twenty-four and it's quite highly charged. It's quite a lot of work.
> It is, yeah. It can be quite painful [pause].

When he is confronted with the client's hostility it is important for Richard to remain calm and grounded:

> Um, I listen, I'm quiet, I think about it. I try to understand quite what the
> particular negative reaction may be in the patient. It's very helpful. It's also
> very helpful that you don't stop, I, as a therapist don't stop thinking in the
> face of somebody's hostility or anger

And when he allows himself to experience the uncomfortable feelings, their intensity begins to subside:

> Well what it does and this is the most curious of, it's almost counter intuitive
> isn't it, is that once you're through the sort of painful bit, the confronting bit,
> the heat has been taken out of the situation, the irrational bit has kind of
> subsided, then you get the growth of trust, that the patient knows they
> actually can be angry in your presence, at you even and um can be quite
> insulting

He invokes the idea of fully experiencing and confronting his emotions as opposed to being defined by or struggling to avoid them. His relationship to his experience seems to shift and something begins to flow more easily. He experiences the discomfort and observes himself doing so resulting in a reduction in the intensity of his emotions. This

then leads to a growth in trust between him and his client. The therapeutic relationship becomes stronger when the client realises that the therapist understands the depth of their experience. Richard spoke with confidence which suggests a positive overall appraisal of his self worth which perhaps means that he is less likely to engage in negative self evaluations when criticised.

Carol talked specifically about using her empathy in relation to managing hostility from a client:

> Um, [pause] I manage it by being aware of the feelings and trying to, I mean
> I think it's important to always remain empathic and remain on the client's
> side

Remembering why the client has reacted in the way that they have done, perhaps in terms of their history, helps her to remain empathic and calm in the face of aggression:

> I mean, you know I've worked violence, with clients who have been quite
> aggressive, threatening and I think, people say I'm quite calm. I do have, the
> more aggressive they get, the calmer I get and that does tend to calm down
> the client.

Since I found Carol's presence quite calming it is easy to imagine her having a similar effect on her clients. She tries to manage confrontation by trying to understand what the client is angry about:

> Yeah and I think if you try, one of the things you have to do is try and
> understand and if they're feeling angry and if they're behaving aggressively I
> think it's about trying to understand why um and also trying to understand
> what it is that they want that you're not giving to them because very often if
> the client is frustrated there's a good reason for it rather than you know just
> becoming defensive which is easy to do particularly you know NHS [laughs].

It could be easy to become defensive but this could prevent her from understanding her clients as she would be thinking of herself rather than them. Once again, we see evidence from this extract of her endeavouring to place herself in the client's shoes

whilst not allowing self interest to influence her. She tries to remain empathic even when it is difficult to do so.

Katharina explains that some of her clients have a history of violence or fantasies of violence or abuse and it was important for her to protect herself and not be adversely affected by it:

> Oh yeah, yeah. I will give you an example. I talked a lot about me being the internal, the mother in the relationship so I work with the child. There are times that, with client work, my internal child will er connect with the internal child of the client. The problem is if the internal child of the client is quite aggressive it will attack my child, which is actually very quiet and timid at times and so in those situations, it gets to me and my adult cannot rescue, that's what it becomes and it's something that I have accepted might happen. It's, I'm aware of it. I'm aware of when it happens and how it's more likely to happen so it's about me bringing back myself as much as I can back to the adult rather than the parent because the parent will not respond well to an aggressive child.

It can be seen from this extract there are some similarities between the way she conceptualises her relationship with the client and Transactional Analysis (TA). In TA, the focus moved away from internal psychological dynamic processes towards an emphasis on people's interactions (Berne, 1961). Changing these interactions became the means for addressing people's psychological problems. It uses the Parent-Adult-Child model to describe how people are structured psychologically. Katharina is aware of her timid side and it appears that she can become afraid. Although she does not state exactly what she is afraid of perhaps there is a general sense of vulnerability that comes from the anticipation that a client may say something hurtful or critical. Therefore she must take steps to protect herself psychologically from aggressive clients:

> Yeah, so it's about taking care of that and bringing it back to either my adult or my professional relationship with the client.

She is then asked how she knows which role she is in or which state she is responding from:

> Oh, you do know, you do know. You might have to think about adults who
> have a history of abuse, whatever that abuse is. If I am connecting with them
> from a child's place within myself. I know because I start getting scared. So
> it's my fear that tells me. So I recognise it um and it's important I guess for
> the client because if they are stuck in that stage, they want to work with that
> stage, it's important to recognise it but being able for my safety to come out
> of it as soon as I feel that

She recognises when she is responding from her "child" because she begins to feel
fearful which alerts her. She then invites the client to respond from their adult:

> Being aware of it within the session is very important and recognising it
> when it happens so it might be paraphrasing or whatever when we're talking
> or asking the client to say what it means for them, what's going so the
> moment you bring the meaning into the session they have to think as an
> adult.

Using her understanding of TA she brings the interaction between her and the client
back to the adult-to-adult interaction, which helps the client to think and take a more
objective point of view towards their feelings. This helps both of them to find the space
to reflect on their feelings before responding. By bringing the interaction back to the
adult she is able to protect herself and minimise the risk of feeling abused.

Managing own conflicts or vulnerabilities This subordinate theme begins by looking at
an extract from the interview with Mark. He observes that quite often his clients can
become a mirror for him in the way that they reflect what is going on for him at that
time:

> Quite often, I mean this happens. The problems people bring, quite often
> somehow reflect what you've got going on for you at the time. That sort of
> thing happens. And so how does that work? That works, that I might, coz
> I've got something going on for me, which I'm probably not aware of
> unconsciously or something's happened in my life and they become the
> mirror for me in a way. That's the strange sort of thing that goes on and so
> I'm aware of that in them.

If a client's experience is similar to his own, he recognises it more easily and is more sensitive to the particular issue:

> Or, or at a particular time, because it's happening to me, I'm more sensitive to it and aware of it in them [inaudible]. And so there maybe something else which I miss completely. Sometimes it happens, oh I've got that going on too [laughs]. That's turning it back on me rather than what's happening here. We all experience that sometimes. People bring things we've got going on. I suppose that makes us a bit more empathetic or something in that way or more open to understanding, kind of process it.

At the same time, there is also a risk that he may miss something else and his laughter suggests an irony that sometimes people can see what they expect to see including therapists and this is something that needs to be guarded against. Therefore, he may end up either under or overestimating certain aspects of clients' material. Mark identifies another source of his own conflicts:

> I tend to want to be a bit more interactive with clients. That's my natural inclination anyway [inaudible] although that was a useful experience.

His natural style is to be interactive but he feels quite conflicted when he is not able to be as helpful as he would like. Nevertheless, he tries to hold off from his tendency to want to give advice and tries to allow the client to reach their own conclusions:

> Yeah [pause]. There are clients, especially individual clients tend to say that they come and they use the sessions as a place to talk about things that they've got nowhere else to talk about them. And that takes time to build up that trust or they can say these kind of terrible things that they think they think. So what do I, how do I respond to that? I mean it's quite difficult. I do have quite a lot of [pause] I kind of feel sad about, or [pause] I can't do anything about other than our relationship because they're in positions in their life where they um difficult so I suppose I feel quite impotent at times. Because as a person I'm a fairly doing, can do sort of person so I find it quite difficult sometimes to sort of listen and not say what to do but I know that by sitting and listening and people allowing themselves to talk things through and come to their own conclusions although that's quite difficult.

Mark seems to identify with a perception of himself as proactive and as a problem solver. However, he struggles with feelings of impotency when he feels that there is little he can do to help a client change a situation in their life. This seems to go to the heart of the conflict for Mark as his sense of identity as a capable person is undermined leaving him feeling incapable or inadequate in some way. This conflict is perhaps heightened by the feelings of sadness he experiences on behalf of his clients. It is noticeable that he pauses twice when describing how he feels, perhaps contemplating his reaction and getting in touch with his feelings. Despite the difficulty he sets aside his need or desire to do something for the client and allows them to reach their own conclusions. We might wonder whether his affiliative nature is sometimes communicated to his clients, which demonstrates how the therapeutic encounter involves contributions from both client and clinician.

This extract from Mark is chosen as a further example of the way in which client and therapist mutually influence one another:

> I'll tell you what's quite interesting too is that I make contact with my clients initially over the telephone although increasingly not always um so I've got a relationship to a degree before they even come into the room and that's quite interesting because sometimes I have an assumption about what somebody's going to be like, look like and I don't always get it right which is interesting. They don't appear to be how I, so that's quite interesting. So what have I given there, what have I projected there and what have they given me? Increasingly, the first contact is via email. You pick up things from that too.

He makes assumptions which are partly linked to something he may have picked up from the client and partly linked to what he has projected. His assumptions are not always correct which is interesting for him. Perhaps this is interesting because he wonders what that means about himself. He seems to use the discrepancy as a learning experience and demonstrates an open and curious attitude towards himself.

Katharina has a clear idea about where in her life some of her reactions are rooted. In particular, she notices that her sensitivity to others is related to her early childhood experiences as an emotional caregiver:

It's more likely to happen to therapists that um as kids were the emotional

care takers of their own parents [interviewer: oh, okay] which is true for me

In addition to her childhood experiences as an emotional caregiver, she also has the added benefit of her training:

Yeah, it's nature plus now you have now you have been equipped with the

knowledge and the theory and you go into full speed into picking up, so you

get to a point where I will be feeling what the client is feeling and the client

will be saying a few minutes later, like really early on and so the work I've

done with taking care of myself is recognising that actually that's quite good

Not only has she been trained from childhood to be empathic through her experiences of being a caregiver but she now also has the benefit of her training and theoretical knowledge to help her attune to her clients more. This makes it all the more important that she attends to and manages her reactions.

Carol also describes how some of her early life experiences have influenced how she experiences her clients. In particular, she described some of the difficulties she experiences with clients who are unable or unwilling to take responsibility for changing:

Um and [pause] I'm trying to think specifically what pushes my buttons. Um

[pause] I think dunno working with substance misuse a lot of people are very,

very stuck erm in a place where they feel the whole world is conspiring

against them and everything that happens to them is somebody else's fault

and will take no responsibility for change and that's very hard um and I think

that's generally quite hard but I also think coming from a family where my

mother was quite like that, much milder, she was always, she was quite bitter.

I suppose maybe that rung bells for me in terms of my own, [pause] you

know I find dealing with people who are very stuck.

She appears to re-experience some of the negative feelings that she experiences towards her mother. She also described how the difficulty manifested itself with one client who seemed unable to envisage making any changes in her life:

Yeah, yeah, certainly. I've got one client at the moment who although she's about my age she reminds me quite a bit of my mother in terms of the way she expresses herself. The difficulties she has in particular areas you know sometimes I find myself kind of resp – almost about to respond in the way I might respond to my mother. Um but I think it's important for me to be aware of that really so that I don't confuse

It is difficult for her when working with a client who does not take responsibility, eliciting reactions similar to those that she experiences towards her mother. Perhaps she feels a degree of anger because the relationship with her mother could be difficult and this is something she is reminded of by her client. Her mother's behaviour is at odds with her own values as she seems to see herself and others as responsible for making their own choices. This account emphasises the importance of containing reactions that trigger the therapist's conflicts related to their own early life experiences.

Dealing constructively with unpleasant or painful feelings can be challenging for the participants. Avoidance may be one of the less helpful ways of dealing with uncomfortable experience:

You have to have very, very good supervision and again, patients are going to make you feel lots of different things. I remember working with a very, very disturbed male and I went into pleasing him and working really hard and striving but in supervision, what I was aware of was that I was terrified of my own anger towards this patient so unconsciously I adopted a very passive, working hard um because I was frightened, one of my own anger because he was quite an abusive male. [Interviewer: right okay] And I was frightened of his anger.

It seems that Sarah avoided experiencing her anger by working very hard. These feelings were so overwhelming that she was initially unable to allow herself to experience them. She has gone to the opposite extreme in order to obscure or suppress what she seems to have perceived on some level as dangerous feelings. Whilst she appears to feel threatened by his behaviour, she is also terrified of her own anger. Whilst any reasonable person would be expected to have some negative reactions about the violence her client is perpetrating towards his partner, Sarah seems to feel particularly offended and outraged. Perhaps she is afraid that she will be unable to

control her feelings and retaliate in some way on behalf of her client's partner and also to protect herself. Nevertheless, her hostility might suggest that further enquiry would be useful to understand its origins in her own character or life experiences to limit its impact on the therapy.

Whilst Sarah was training she had personal therapy with a CAT therapist which helped her to discover her own reciprocal roles:

> Yeah and also obviously when I was doing my training I had to have my own CAT. So obviously I knew what my own reciprocal roles were. I knew what my own snags and dilemmas were so again, um I could easily reflect and think, you know am I getting into my own dilemma? Am I getting into my own trap? Am I getting into my own snag? You know.

The knowledge of her own reciprocal role procedures has helped her to identify when they are being triggered during therapy. As previously described, snags, traps and dilemmas are examples of problematic procedures (Ryle and Kerr, 2002). A snag is a procedure in which goals are abandoned either because of guilt or because of the anticipated reaction of others. A trap is a procedure that generates behaviour which produces consequences that are considered to confirm the belief. Thus, it becomes a self reinforcing pattern. Finally, a dilemma is a procedure that restricts possible roles to 'either or' choices such as either keeping things bottled up or risk being rejected. Sarah's personal therapy has raised her awareness of her reciprocal role procedures which has proved very helpful to her in her client work.

She identified a belief or a dilemma during training that she must do everything perfectly. The consequences of making a mistake appeared to lead to some negative self attributions:

> I think one of my own dilemmas was that I've got to be a perfect therapist or I am crap. So again, I had to work a lot on that because there is no such thing as the perfect therapist. So in the early days I was working really hard, really striving and if I didn't get it spot on oh I'm crap, I'm a rubbish therapist. In my own CAT I had to look at my own dilemmas which was really helpful.

The belief that she must do everything perfectly or that she is in some way defective as a therapist has clearly been a burden for her, particularly when she was training. This kind of belief involves thinking in all or nothing terms such as a person interpreting one mistake as evidence of complete failure as opposed to the alternative more helpful perspective that distinguishes self worth from making a mistake.

It can be seen from the following extracts that Mark's experience has parallels with Sarah's account of feeling inadequate in her work at times. It seems that for both of them, their clients behaviour had touched upon something that had undermined their sense of self worth. Mark describes how he defends against clients' "negative transference" because his initial reaction is to interpret it as evidence that he has made a mistake:

> And, I don't always quite know um and I suppose I don't want to get it
> wrong and I think in my own work I tend to defend against negative
> transference coming back at me so I need to work on that in supervision and I
> need to be careful about that

Initially at least, the meaning of making a mistake for him is that he is inadequate in some way:

> Well, sometimes I feel just inadequate. Opportunity there. But then again I
> will go away and think about it and I'll write notes up for my session and talk
> about it in supervision and I will take difficult situations there and they come
> back again and we get on with it. All it does is help me understand a bit
> more about [inaudible] in the world and who I am to them and who am I, I'm
> not quite sure and who they are to me.

Mark's reaction is to "defend" against the discomfort to compensate for feelings of inadequacy. Perhaps on some level he will ignore or not fully attend to what the client has expressed in order to protect himself. Nevertheless, he acknowledges that the experience is an opportunity to learn more about the client and about himself. He wonders who he represents to the client and who the client represents to him. We can only speculate about this. Perhaps hostility from a client triggers a response that he learned towards critical others at some earlier point in his life. Furthermore, he seems

to be aware of the impact that his response might have on a client. Namely that from a psychodynamic point of view, the expression and acceptance of negative feelings towards the therapist, allows a client to understand and own destructive feelings (Bateman, Brown and Pedder, 2000). Instead of splitting off aspects of the self, the client is able to integrate it and make changes in attitude and free him or herself from limiting roles in relation to others.

Whilst Mark and Sarah sometimes wrestle with feelings of inadequacy, Simon struggles with his arrogant side when a client tries to belittle him:

> Now I am reasonably arrogant, it's my own right and I therefore particularly
> don't like being patronised because I tend to think "I patronise you, you don't
> patronise me, let's get that clear". So when this patient is being as I see it,
> quite arrogant and patronising I think I can see that and think that it's very
> important to take that up because I think it's an important part of the patient's
> difficulty and I think because she becomes then terribly frightened that
> people will attack her. It's not important to take it up because it's bad
> manners, it's important to take it up because it really, really, really damages
> her relationships. She has to keep putting herself above people, she has to
> keep making them the ones who are in the wrong and she's the one, yeah, so
> I think there are real reasons why we need to work on that but I know that
> there is a way in which she does that she gets a response out of me. She
> treads on a bit of me which is actually the bit which is quite like her

His initial impulse is to want to put the client in her place. Nevertheless, he is able to make room between his internal and external responses to present the client with an opportunity to explore the way in which she is relating to him in the moment. Being aware of his own arrogance helped him to contain his reaction and respond more thoughtfully and constructively. His candid acknowledgement of his arrogance suggests that he is aware of regarding himself as self important or superior. However, he draws an analogy with the work of an oncologist to explain why it is important to be aware of his own motives when working with clients:

> But I think it behoves anybody working therapeutically to be able to ask
> themselves what their motives are. I don't even mean psychologically. I
> think any oncologist ought to, not just be able to, but actually really ought to

ask themselves "why am I saying this patient should accept a very unpleasant and invasive chemotherapy, radiotherapy treatment. If it's because six months of suffering now might give them ten good years afterwards, that's fine. But if it's because six months of suffering now might allow them to have nine months of less good life but I'll feel good because at least I was able to do something. As opposed to having to face my powerlessness "then take your chemotherapy and shut up about it". You know so that there are, it really is important to question your motivation if you're going to do anything that involves impinging on other people's lives

To summarise, the therapist must avoid encouraging the client to live some aspect of their life in a certain way for reasons that come from the therapist's life rather than the client's. He must therefore reflect on his motives and put aside his own need to present himself as superior.

He goes onto explain that personal therapy has helped him to become more reflective and more aware of how he relates to others:

Now I think as you know [pause] yeah I suppose what, I suppose what I think it does is make me in every more aware of my own limits and the limits of my power to control others to make them do what I want them or need them to do. And I think at a personal level it has implications for the work I think that it helps to make more of one's unconscious workings conscious, which gives you some chance of managing or controlling them, not that you won't feel it anymore but that you will be quicker in saying "Hang on Simon you are doing that thing you do. Hold on. Don't do this". And, it possibly you have to relate it to that and are they really behaving in the way you think they're behaving or is this another example of the way you tend to experience all relationships or experience many relationships.

He relies on a conscious process of examining his own thoughts and feelings thus cultivating an observational stance towards his reactions. He describes this as a form of "self supervision":

Well, if you're successful, and you are not actually abusing the patient, you manage not to then it is a process of self supervision in the session, more or less say "stop it Simon, you're getting out of hand. This is him not you or

this is you not him". So I mean you are constantly trying to monitor
everything you say and choose your words quite carefully and then see what
the effect is and sometimes the effect is unexpected and the question is "why
did that happen"? What, what, or you have to attend to the patient's, the
nature of the patient's complaint if the patient complains, or the nature of the
patient's linking to him, their sort of, they become very subservient and very
keen to agree. Why is that? Are you trying to impose something on them

As well as monitoring his own reactions he must monitor the effect of his behaviour on
the client. Perhaps there is a risk that his arrogance can lead him to impose himself on
others which is something he must be vigilant for.

The participants' different reactions pose different challenges in terms of how they
manage those reactions. Consequently the participants have had to work on their
personal development in supervision and their own therapy. Developing an awareness
of themselves in relationships and how they interact has helped the participants to stand
back and observe their responses. For example, whilst Simon has at some point
developed an awareness of his tendency towards being arrogant, Sarah and Mark are
aware of unhelpful beliefs driving feelings of inadequacy. The suggestion is that Simon
has higher self esteem and is therefore less likely to feel undermined or to experience
feelings of inadequacy when a client is critical.

3.2.3 Master theme: therapist self care

So far the participants have talked about how they understand and make sense of their
reactions to their clients. Broadly speaking, their reactions are something to be used in
the service of therapy. They also talked about the importance of managing
uncomfortable and difficult reactions. However, there is a sense in which the work,
although rewarding, can be emotionally demanding. Therefore, it is important for
therapists to be aware that there is an element of vulnerability in their work.
Furthermore, engaging in self care activities seems to help them understand and manage
their reactions. All of the participants except for Richard mentioned this aspect of their
work. There are three subordinate themes: 1) impact on self, 2) coping strategies, and 3)
time period.

Impact on self Katharina points out that although the subject of the research is therapists' personal reactions she has spoken a great deal about taking care of herself:

> You cannot ignore that huge part of how vulnerable you could become and
> the type of work we do and how important it is.

As we have seen in earlier parts of the analysis, this sense of vulnerability comes from a number of sources. Simply listening to clients' difficult past life experiences can be distressing for Carol:

> Um I don't know how much of it is about, I mean I think, I think any kind of
> extreme distress um is, can be quite difficult and obviously with the client
> group I work with here a number of them have had experiences of a lot of
> abuse, physical, sexual, emotional and you do, you know, spend a lot of time
> listening to people talk about things that happened to them in the past and
> that can be quite distressing.

Whilst the source of Carol's difficulty may be related to listening to stories of suffering, Katharina has described her inner "child" as being quite timid and therefore vulnerable to attacks from the client's inner child. The impact appears to be that she can be left feeling vulnerable but her "internal mother" plays an important part in looking after her:

> But my internal mother is the one is the good mother to me who says "take
> care of yourself" rather than just looking at it "oh here is another child".
> Rather than seeing it like another responsibility is erm making sure I'm okay
> within this relationship.

It seems to be important that she recognises when she is need of some self nurturing and there is an appreciation of the fact that she needs to take care of herself. She appears to have a relationship with herself in which she is able to offer herself help and support which suggests a positive level of self acceptance and self worth.

Simon uses the time between meeting clients to understand those difficult reactions that emanate from his unconscious.

I think I think the um it can certainly affect you um but not as it were the manifest stuff, not the stuff where someone says "I hate you, you're so unreasonable, you're rude, you're inconsiderate, you're only in it for the money". That stuff doesn't bother me at all. But the nature of the psychological contact that results in my unconscious meeting their unconscious, I can be left feeling very unsettled and unhappy, cross and whatever it might be and part of the work is to try to process those feelings so that I can understand what they tell me about me and what they tell me about the patient, what is mine, what is theirs, how those are interacting.

The process of understanding and managing his reactions also takes place outside the therapeutic hour. It seems that awareness, insight and distance from his issues or personal problems are an advantage. This is in direct contrast to how he might experience those conflictual reactions emanating from his unresolved problems that are brought to the fore by his interaction with the client. When he is asked about the difference between those reactions which are difficult to deal with and those that are not he reiterates the distinction between conscious and unconscious reactions. He also goes onto say that he must continue to analyse himself to prevent things from getting in "under that radar":

What's conscious and unconscious. The stuff that I receive consciously I can process absolutely fine. The stuff that I receive unconsciously because of course I still have an unconscious. No matter how much work I have done trying to know it and make aspects of consciously knowable to me, um still this stuff gets in under that radar and I have to do a lot of work on myself to try and process these toxins that I am constantly taking in and indeed to try to control and contain the toxins I might be giving out if I wasn't processing as best I'm able what goes on in me. It's very possible for patients - for therapists to start unload their illness into the patient.

This extract illustrates how important it is to remain vigilant and alert to the taking in and giving out of "toxins". He appears to use the time between sessions to work through these "toxins". We might understand that by using the word "toxins", he is referring to projective identification processes which occur in the course of therapy. An awareness and removal of these "toxins" allows the therapist to continue without causing harm to the client. His work has also impacted on his social life:

I mean I think it's very demanding work and I think in some ways makes you quite anti social. I certainly don't think it's been good for my social life.

It seems that his work has affected his personal relationships as it makes him less inclined to be sociable. Perhaps because of his work he experiences relationships in a different way and reflects more on how he is interacting with others generally. We might speculate that he regards himself as having greater insight into the underlying processes at work during social interactions and as such does not deign to become involved in superficially plausible interactions that have hidden motives.

Coping strategies The potential vulnerabilities to self and clients underlines the importance that the participants place on supervision as a source of support and maintaining competence to practice. The following excerpt from Carol seems to cover the main aspects of this theme:

Um so I think it's about getting a different perspective really as well as being able to off load, trying to make you [inaudible] depressed or whatever. You know it's a kind of safety valve thing. But also it's just helpful view of someone maybe observing the dynamics happening in the relationship that you may have missed or other things that you could be bringing into it so that's really helpful and you know have people observe about me the way I might be responding to things to get me to reflect about why I might be responding in a particular way to someone, I haven't thought about it. So as well to try and maintain the ethical boundaries and to ensure that you, you know you're working in an ethical way.

As well as offering guidance on her clinical work, supervision provides an opportunity to ventilate and thus provides a safety valve. But it also helps to identify the dynamics taking place between her and the client. Another way of coping is offered by Mark who makes use of his support network:

I suppose I go into my own dream world from time to time. I will know that sometimes I've had a difficult day if I have some difficult dreams at night. It's the sort of thing that comes along sometimes. Or early in the morning I'll be working on, going over something that's just gone on. I have a wife so things get talked not in detail get talked through there so I'm not on my own

65

with it. I have quite a big network of colleagues who I maintain contact with.
So in my experience we talk to each other about those thoughts, those
feelings, the feelings that we have.

Other strategies for coping include exercise and meditation. Katharina's meditation
practice has helped her look after herself and she gives an example of how meditation
has helped her cope with migraines to illustrate how it helps:

I know that the migraine is about to come. So my old self, coming back to
the meditation and how useful, my old self would have said panic, panic,
panic. You've got two kids how are you going to take them out of the
swimming pool? They've just arrived. How are you going to take care of
them and how are you going to drive back home? And the panic would have
made the migraine much quicker in terms of progress because when this
happens you have a bit of time before you take your pills for the headache to
kick in.   So in the swimming pool I tried to stay as calm as possible and say
okay I can cope with this. I know what is happening. And very, very
strangely, obviously I couldn't meditate but because I was able to say okay I
can deal with this. This is happening here.

Katharina is referring to a time in the past before she learnt to cope better with her
migraines. Previously she would have experienced a sudden and overwhelming
increase in anxiety preventing her from thinking logically. Since starting her meditation
practice she seems to have slowed down and becomes less agitated. Furthermore, as a
result she seems to have gained an identity as someone who is able to manage difficult
experiences as a mother and a therapist.

Time period The participants continued to reflect on how they used to manage in the
past when less experienced. Sarah described the development of a greater level of self
acceptance:

It's about knowing your own boundaries. It's not heroically "we're going to
get to the end of this therapy and I am going to make this person better" and
that taught me a lesson: no, stop. That's okay. You're not a failure as a
therapist if you say that. "I cannot help you anymore". That's okay to say
that and that was a huge relief.

It appears that she has learnt to acknowledge her limits without seeing herself as a failure. She has become less self critical and perhaps more accepting of her imperfections.

Katharina contrasts her more laid back approach to physical exercise with the way that she used to approach exercise:

> Mmm. They keep me healthy but not in the sporting exercise framework but in a looking into myself, taking care of myself and that's why I don't play a lot of extreme sports, um I don't enjoy, I used to. I like more into taking it easy, stretches, breathing, focussing on my body. And swimming I love because I'm from Corsica. The water has always been, in my mind, the water is purifying, um, which is true and um there's a very soothing thing for me to go into the water. I do it as much as I can. Um it's interesting because talking about working with difficult subjects, difficult clientele, picking up all these emotions. How do I get rid of them? Those are my tools.

Whilst she used to enjoy more extreme sports she would rather take a more leisurely approach to exercise now. Engaging in less intense forms of activity has helped her to slow down and become calmer. These are the tools that allow her to manage or 'let go' of her emotions as time has progressed.

Carol has found that as she has become more experienced she has become more aware of when she is feeling defensive with clients:

> Yeah, I think I've learnt to guard against, I mean I'm not saying that there are never times when I don't feel defensive or even behave defensively but I think I'm much more aware of it now and much less likely to do it.

Perhaps as time has progressed she has become more familiar with the feelings that are a sign of defensiveness and is therefore more aware of them. In response to a question about what else has changed, Carol says that she has become more empathic and tolerant with experience:

> Um and being, I think a lot of it is not about experience but developing personal qualities in terms of how you engage with people and how you

relate to people and how you feel about yourself and think [pause] I don't know maybe as you get older you become more tolerant and more, I don't know, I think maybe I'm just becoming naturally more empathic and naturally, I don't know, it's a good question. I don't really know. I can't answer that question. I've never really thought about how my experience, I think my experience of life and knowing myself is a bigger help than any kind of, anything else really. It's also just getting a feel of worked with different clients.

It seems that it is a difficult question to answer but somehow as time has gone on the way she sees herself in relationships has evolved. As she has got older she has become more accepting, empathic and has developed greater knowledge of herself. It seems that self understanding may have helped her to become more empathic towards herself and her clients.

Simply learning from clients can be very valuable for Mark:

I suppose it's your experience. I've learnt so much from my clients, from the actual people that I've worked with, how they might be and how they might do things.

It seems that he has been impacted a great deal by his clients over the years and has learnt from them what has and has not worked, constantly refining his practice. Clearly, the work affects the participants in different ways and a number of coping strategies have been mentioned. Furthermore, as they have become more experienced they have become better at managing the vicissitudes of their work.

Chapter 4: Discussion

This chapter summarises the findings of the study and then explores the emergent themes, relating them to the existing findings in the field. This chapter also discusses limitations associated with the study, directions for future research, consideration of the contribution to counselling psychology and the implications for practice.

4.1 Summary of findings

The purpose of this study was to explore therapists' reactions to their clients. In particular, it focussed on how these reactions are perceived and when and how they are managed. This was achieved by examining transcripts from the interviews with six therapists using IPA. The therapists interviewed experienced their reactions towards clients in a number of different ways. To begin with, their reactions were a source of understanding their clients' internal world. This included those reactions which are a response to the client's interpersonal pattern so they paid particular attention to the reactions which were evoked in them by their clients. In order to avoid being collusive, they need to stay neutral and a term from Bion (1962) was borrowed to describe the neutral position that the therapist takes in response to their own reactions called "benign indifference". There were also aspects of the participants' internal experience such as feelings of empathy that were neither a response to the client's interpersonal pull nor conflict based.

Secondly, there was a group of reactions that were difficult or painful which included the participants' own conflicts or vulnerabilities. Whether conflicts were triggered seemed to be related to the participants' subjective experience of the relationship with the client rather than the client's material per se. Gelso and Hayes (2007) make a distinction between the therapists own conflicts and vulnerabilities on the one hand and the difficult feelings that would normally be expected of any therapist in response to some client behaviours or characteristics. However, although the source of the reactions may be different, the principles for managing them are the same and they have been included with 'managing reactions'. Various aspects of managing their reactions were revealed by the analysis. This included the importance of self insight or awareness,

empathy, the therapists' own psychological health, theory and specific techniques such as using imagery. Meditation practice such as mindfulness was identified as a way of developing self awareness and helping to get in touch with experience including somatic reactions. This also highlights the importance of therapists' self care activities. They identified the effect their work had on them generally and discussed their coping strategies. This includes supervision and other sources of external support such as colleagues, friends and family as well as alternative therapies such as meditation.

4.2 Making sense of therapists' reactions

This section discusses in detail the participants' reactions in relation to the existing literature. It is hoped that the exploratory nature of this research will reveal a more complete and nuanced picture of the subject of therapists personal reactions.

4.2.1 Self as a "measuring instrument"

Whilst the participants regarded their reactions as crucial to understanding how the client behaves in relationships outside of therapy, there was little discussion about whether or how their own presence in the room affected their clients. For example, at least one participant described himself as a blank slate onto which his clients projected their conflicts. The assumption that the therapist is able to remain unknown to the client may be a result of the pervasiveness of what Strawbridge and Woolfe (2003) refer to as the dominant view of scientific psychology. These elements are based on a model of science which developed after the Enlightenment and originating in the mid eighteenth century. The philosophy of positivism stressed that knowledge claims must be derived from a rational, empirical method of knowledge creation, implying the existence of an objective outside observer. Whilst the discipline of psychology has its origins in the latter half of the nineteenth century when the positivist model of science was prevalent, it still seems to have much intuitive appeal.

Although there is an understanding amongst the participants that they must be aware of when they are responding to the client's interpersonal pull or when they are acting upon their own needs or conflicts, the intersubjective standpoint raises the question of whether therapists can understand the client's interpersonal processes without understanding their own contribution to the relational experience. For example, whilst

it may be true that one participant's client behaved arrogantly towards him, to what extent did the client perceive his arrogance and how did that make her feel? It might be that she felt threatened by him, thus heightening her defensive response. To take another example, one participant was described as being affiliative and we might speculate about the impact that this might have had on the client who managed to elicit personal information. To consider yet another example we might wonder whether one participant's anger was detected by the client and whether that influenced his behaviour towards her.

Farber (2006) states that it is now widely accepted that the therapist cannot remain unknown to the client. He questions the traditional assumption of the therapist's anonymity. Instead the mere presence of the therapist conveys significant amounts of personal information. Appearance, body language, verbalisations, etc necessarily reveal aspects of the therapist's experience, background and personal history. Therefore, all forms of intervention are self revealing. The alternative view to therapist abstinence is that client and therapist continue to influence each other in a reciprocal fashion. Whilst it is perhaps inevitable that the client's perception of the therapist will influence their way of being with the therapist, it could be argued that the therapist's participation in the relational enactment cannot be prevented and should even be welcomed (Safran and Muran, 2000). Nevertheless, it remains that the therapist's attunement to their own reactions is an important source of information for understanding and gaining insight.

Whilst understanding clients involves a focus on the cognitive and affective aspects of experience, for one participant in particular her somatic responses were an important source of connecting with herself and her clients. However, she was the only participant who focussed on her bodily reactions. As Mace (2008) observes, psychodynamic approaches have traditionally paid little attention to bodily contributions and he states that even today psychoanalytic organisations can professionally penalise practitioners for showing an interest in the bodily contribution to unconscious life. Wahl (2003) suggests that two key developments in Western philosophy are important in understanding the neglect of the body in therapeutic practice. He argues that Western approaches have ascribed an inferior status to the body in relation to the psychological aspects and philosophers have been unable to reconcile the problem of the distinction between mind and body. The conclusion that

71

the soul was separate and immortal led to a devaluing of the body. Counselling and psychotherapy tend towards a psychological understanding, focussing on behaviour, cognition, emotion and relationships. Any focus on the body is often incidental to these main areas. However, bodily expression may be a more reliable source of information than verbal reports (Wahl, 2003). From this perspective, physical sensations are full of information and serve as a basis for meaning and understanding. Body orientated therapeutic work may involve encouraging the client to slow down and experience their bodies as it is experienced in the bodily sensations.

Meditation practice may explain why somatic reactions were so important to one participant. In particular, it seems that mindfulness practice had helped her to become more aware of what is happening in her body from moment-to-moment. As Mace (2008) points out, mindfulness practice helps people to turn inwards and focus on their moment-by-moment experience including bodily sensations, helping them to be more grounded in the present. The body can perhaps reveal to the therapist something about their own experience and how they experience the client. This presents opportunities for exploration, insight and developing new ways of interacting. Helping people to become more aware of their bodies may involve describing what they see or experience and ask questions about physical responses (Wahl, 2003). Noticing and describing somatic changes may lead to a more productive exploration of an individual's experience. Other techniques to enhance the awareness of bodily reactions may involve focussing on eye contact and voice. For example, eye contact could be avoidant, at ease or threatening. The voice can be loud, angry or quiet. As Wahl (2003) points out empirical research into the efficacy of body focussed therapies is sparse, perhaps because research has focussed mainly on particular models of therapy. Nevertheless, this study appears to highlight the potential usefulness of the therapist's attunement to their own bodily reactions.

The findings remind us that therapists' internal experience is more than just their countertransference, defined as their internal conflicts or more broadly as their response to the client's interpersonal pull. There are aspects of their experience that are non-countertransferential. One of the most useful aspects of the inner experience of the therapist is perhaps that of empathy. It is considered an essential ingredient of all forms of therapy (Rogers, 1961; Wosket, 1999). Empathy allows the therapist to put

aspects themselves aside to understand the client's world from their perspective. Psychodynamically, this might be described as a psychological process whereby a person takes in something from another and becomes affected or changed by it (Bateman, Brown and Pedder, 2000). From an experiential perspective, Mearns and Cooper (2005) have used the term 'relational depth' to describe moments of profound contact and engagement between them and their clients in which the client has an opportunity to explore the fundamental aspects of his or her existence. Although the core conditions - empathy, acceptance and congruence - are often thought of as discrete entities, at relational depth it is more appropriate to regard them as a single way of being: a genuine and accepting understanding.

Mearns and Cooper (2005) suggest that a relationally deep encounter might be of value to clients in a number of ways. Firstly, an intimate therapeutic relationship for those who have experienced a lack of connectedness with others in earlier years may serve as a corrective experience that could be rewarding not just in the present but also raising hope for relationships in the future. In this way, a client may learn how to relate more deeply to others through an in-depth relationship with their therapist. If human beings have a basic need to engage with others then these are skills that the client can use to develop more satisfying relationships. Experiencing relational depth may also help clients to relate to themselves in a more helpful way. For many, psychological problems may be exacerbated or maintained by a derogatory or self-critical attitude. Mearns and Cooper (2005) argue that an experience of relational depth can give the client a deep sense of security that enables them to explore the most profound aspects of themselves, aspects perhaps rarely faced and never shared with anyone else. This involves an emphasis on 'being' with clients rather than 'doing'. It also involves letting go of aims or goals as the desire to do something to the client gets in the way of a relational encounter, allowing clients to express themselves more fully whilst creating a safe environment

4.2.2 Managing reactions

The remainder of this section considers the findings of this study in relation to origins, triggers, manifestations, effects and management of therapist conflicts (Hayes et al, 1998). As stated in chapter one, origins refers to the therapists own personal conflicts whilst triggers are the actual events or client characteristics that elicit the therapists'

personal conflicts. Manifestations are those reactions that therapists exhibit when their conflicts are triggered whilst the effect is the impact it has on therapy and management refers to the strategies used to reduce the likelihood of it affecting therapy. From the Freudian perspective, intense emotional reactions were regarded as being a manifestation of the therapist's conflicts (Lemma, 2003). It may be that the client's material is triggering some conflict, vulnerability or unresolved issue in the therapist. For example, at least two participants experienced strong reactions which were reminiscent of reactions towards family members at earlier stages in their lives. Whilst the antecedents of some of the participants' conflicts were rooted in early developmental experiences, this study demonstrates that they need not always be based on the therapist's past. For example, one participant observed that he was more likely to selectively attend to (or ignore) certain client material that touched upon his current life circumstances. This reminds us of Cutler's (1958) study in which therapists tended to either under or overestimate certain aspects of client material that it is related to their own conflicts. Other sources of conflict were perceived threats to self worth, professional competence and values.

Consistent with the intersubjective standpoint, the findings of this study support the contention that the therapist's conflicts will be an interaction between the origins of conflicts in the therapist and the triggers in the client's material (Hayes et al, 1998, Hayes and Gelso, 2001). In other words something that triggers a reaction in one therapist may not do so in another. For example, one problematic reaction for one of the participants was a response to certain client characteristics that reminded her of her mother. For a different therapist with a different maternal relationship, the same client characteristics may have brought up very different feelings. Therefore, it appears that it is participants' subjective experience of their clients that determines whether their conflicts are triggered. When conflicts were triggered the participants reacted either privately in terms of thoughts and feelings or overtly such as working excessively hard in order to compensate for feelings of inadequacy. This demonstrates that therapist conflicts can manifest themselves as more than just the withdrawal and under involvement identified in previous studies (Peabody and Gelso, 1982; Robbins and Jolkovski, 1987).

Whilst Hayes et al's (1998) conceptualisation of therapist's conflicts has been used to understand those conflictual reactions that originate in the therapist's own life; the findings of this study seem to suggest that any difficult reaction can be understood in terms of their framework. This might include those reactions related to client material such as hearing about distressing life events that any therapist would normally be expected to find difficult. When experiencing any strong emotional reaction the participants sought to understand its origins and in this case the origins lay in their capacity to empathise and to some extent share the feelings of their clients. The trigger remains the client material whilst the reaction can manifest itself, emotionally, somatically, cognitive and behaviourally. The key point is that intense reactions are likely to be an indication that the therapist needs to investigate their source. The accounts remind us that therapists often hear about very painful experiences and therapists ought to be affected, at times quite intensely. It may be that the client's material would elicit that kind of response from any therapist. From this perspective intense emotional reactions can be used to enhance awareness of the dynamics of the relationship. Nevertheless, the therapist will still need to reflect on and understand the source of their reactions.

As stated in chapter one, research on the management of reactions has identified five factors thought to be important to managing reactions (Van Wagoner et al 1991). These are *self insight*, or self awareness; secondly, therapist *self integration*, which includes the possession of a stable identity and an ability to differentiate oneself from others; thirdly, ability to manage a*nxiety* thus preventing it from contaminating their responses to the client; fourthly, *empathy*; and finally, *conceptualising ability* which refers to the therapists' ability to draw on a theoretical framework. It is apparent that the participants attached a great deal of importance to self awareness. This is apparent in the accounts they gave about the origins of their conflicts and occasions when their conflicts were triggered by their clients. The participants self knowledge seemed to help them identify sooner when a particular issue or conflict was being triggered thus helping them to manage their responses. Nevertheless, an additional finding is that the participants generally developed feelings of greater competence and self acceptance as they became more experienced.

The self reflective nature of the work highlights the value in what was described as "self supervision" by one of the participants. Todd and Storm (2002) observe that very little has been written on the topic or guidelines produced on how this may be achieved. In defining a model of self supervision, Todd and Storm (2002) have identified three elements: self monitoring, comparison with an ideal model of therapy and the intent to develop practice. The process of self monitoring includes paying attention to some form of data. One source of data attended to by the participants was their own internal reactions. They had developed an awareness of when certain aspects of themselves had been triggered such as their own issues or conflicts. Experiencing uncomfortable reactions would be a signal that the therapist needs to attend to something. The purpose of self monitoring is that it will hopefully lead to a change in practice and a movement towards some norm which will depend on the therapist's therapeutic approach. Todd and Storm (2002) suggest that the goal of supervision should be self-supervision and offer guidelines on how this can be achieved. It is clear from this study that self supervision need not be a solitary process. It can include peers, group supervision and more informal networks assuming that confidentiality is ensured.

It appears that the participants who described fewer conflicts had fewer problematic reactions during therapy. This indicates that more secure therapists will have less conflictual responses to manage in the first place. It seems that occasions when the participants' professional competence is at stake have the potential to be particularly difficult. This seems to be more likely for participants who described a less secure sense of self. A couple of the participants were aware of some unhelpful beliefs that were triggered by some client behaviours leading to feelings of inadequacy. This contrasts with another participant who openly acknowledged his arrogance which posed different challenges. As a result they have had to work on their personal development in supervision and their own therapy. Developing self awareness has helped them to cultivate their capacity for self observation.

The importance of personal development was reflected in the participants' accounts of their own personal therapy. Studies have shown that therapists consider it to be a crucial part of their ongoing development and it has been strongly endorsed by training institutions (Bike, Norcross, Schatz, 2009). Bike et al (2009) replicated a study conducted in 1987 into therapists' experience of personal therapy. They sampled 727

therapists, including counsellors, psychologists and social workers. Nevertheless, the findings of this study were consistent with Bike et al's (2009) findings and other studies confirming that therapists undergoing personal therapy experienced much improvement in their psychological health. Rizq and Target (2009) have identified a number of prominent themes from a review of the literature including the ability to distinguish self from other, personal development and ability to use self and the development of empathy. In relation to this study, it seems that personal therapy helped the participants to distinguish between reactions that are a response to the client's interpersonal style and reactions that emanate from their own conflicts. It is also apparent that the opportunity to identify and work on conflicts was an important part of personal development and growth as an effective therapist. Rizq and Target (2009) suggest that the experience of being in personal therapy and seen by another allows therapists to develop the capacity to tolerate aspects of themselves, helping them to be more empathic and effective. Whilst the participants were clear about the value of personal therapy, the research into the effect of therapist's personal therapy on treatment outcomes remains ambivalent with some showing no correlation, others showing a positive correlation and two showing a negative correlation (Bike et al, 2009).

The importance of dealing with sometimes intense and uncomfortable feelings was underlined by the analysis, particularly when being challenged by a client. This study draws attention to the fact that whilst anxiety has been considered at length in the existing literature (Fauth, 2006), emotional reactions may take on a number of different forms. Participants experienced the full range of emotions including sadness, anger, and despair. They managed these reactions in different ways. An unhelpful strategy for managing difficult feelings led one participant to become passive and work extra hard to compensate for feelings of anger. Safran and Muran (2000) argue for the importance of being able to fully experience and contain such feelings but point out that relatively little attention has been devoted to describing how therapists achieve this. Another participant went into detail about how he would respond to a confrontation by the client. He would first ask himself if he has done something wrong for which he needs to apologise. If not the incident would be used as an opportunity to explore what was possibly being enacted. Participants' reports suggest that when therapists stay with and fully experience their uncomfortable reactions without acting upon them, the intensity of the feelings gradually reduces. There seems to be some parallels between the state of

77

mind they are describing when staying with an experience and the state of acceptance that is aimed for with mindfulness practice.

The use of imagery by one participant proved to be a useful cognitive strategy to manage difficult feelings which was an unexpected finding. This was combined with a theoretical knowledge or understanding of why the client was behaving in that way. When participants felt criticised for example, it might be important to understand that it was often directed less at them and more at who they represented. For example, one client described his experiences as a professional musician before becoming a therapist and the animosity that used to be felt by his colleagues towards the person occupying the position of lead violin. Even concepts from TA emerged as an unexpected but potentially useful way for conceptualising communication between client and therapist and for responding appropriately. Whilst Peabody and Gelso (1982) suggest that therapists who are very empathic are also attuned to their own internal experience, more accepting towards themselves and others, one participant used her empathy to manage her client's anger. This helped the client to feel understood thus reducing the intensity of the client's anger and strengthening the relationship.

Whilst the discussion so far has focussed on how to manage conflicts the notion that an individual's vulnerabilities can be helpful to others is found in one of the participants' accounts. She talked about her experiences of being an emotional caretaker for her mother when she was young and has consequently become attuned to the feelings of others. Perhaps an understanding of one's own vulnerabilities turns them into a strength which can be used in the service of therapy. As the discussion about the management of therapists' reactions shows, for one's suffering to be of benefit to others the therapist must have some perspective on their problems and for them to be sufficiently resolved. Therapists who are unaware of their vulnerabilities and conflicts "are at risk of projecting onto clients the persona of the 'wounded one' and seeing themselves as 'the one who is healed' " (Gelso and Hayes, 2007, p. 107). When this happens this will limit therapists' use of their own experiences to understand their clients. Nevertheless, it is also important for the therapist not to over identify and assume that they know how it is for the client resulting in empathic failure (Gelso and Hayes, 2007). Although some such as Jung (1963) have written about their own difficulties, as Gelso and Hayes (2007) note, there is little research on the notion of the wounded healer and how it

helps. Nevertheless, the findings here suggest that working through of painful experiences can help therapists to better understand their clients.

4.2.3 Therapist self care

Although the participants were not specifically asked about the wider impact of their work, they talked about the effect that the work has on their general level of wellbeing. The exploratory nature of IPA allows for the emergence of unexpected findings as the researcher attempts to set aside any pre-existing assumptions about what they expect to find. Nevertheless, the finding that therapists experience stress should not be surprising considering the fact that they are confronted with a range of intense emotions on a daily basis. Therapists are often confronted with the difficult problems of other people and sometimes this can include aggression and hostility. Therapists can experience stress related psychological problems such as anxiety, emotional exhaustion, decline in job satisfaction etc (Deutsch, 1984). There is also the potential for burnout reflecting the high output of time, energy and attention demanded by clients, adversely affecting therapeutic effectiveness.

Whilst there was a clear acknowledgement of the impact that the work had on the participants, the focus was on strategies for maintaining their wellbeing. Supervision was one of the most frequently cited strategies for maintaining wellbeing. Supervision seems to offer a safe environment in which the supervisee can reflect on any aspect of their work, whilst enhancing their own wellbeing. It seems to be particularly important for identifying and understanding the dynamics of the relationship. Sarnat (2010) shows how experiences with the supervisor can be used to address similar dynamics arising between the supervisee and the client using a psychodynamic understanding of supervision. The supervisees' experience of emotional containment leads to the development of self reflection and relationship skills, such as the ability to tolerate the intense emotional experience with the client.

A number of other strategies for maintaining wellbeing were discussed by the participants such as meditation and exercise. This supports the findings of at least one previous study which examined the effects of Mindfulness Based Stress Reduction for therapists in training (Shapiro et al, 2007). The study reported significant reductions in levels of stress, negative affect, rumination and anxiety. As the authors point out, the

increased ability to regulate emotional states, leads to increases in compassion for self leading to more compassion for clients. They point out that therapists who lack self compassion are more controlling and demanding towards themselves and their clients. Furthermore, Shapiro et al (2007) found increased levels of mindfulness amongst the trainees and this could be important for therapeutic practice. It involves directing attention to become aware of our experience as it takes place in the moment allowing us to deautomate our reactions. The findings suggest that the introduction of mindfulness based components to training is worth considering as an addition to training programmes. Nevertheless, this study reminds us that there are a range of recreational activities that promote therapist wellbeing.

Finally, the participants discussed the relationship between the level of experience and their levels of stress. This is consistent with the findings of Hellman, et al, (1987) that older therapists experienced less stress. More experienced clinicians apparently respond more flexibly in stressful work related situations whereas inexperienced clinicians responded in more rigid or stereotyped ways. However, there seemed to be no relationship between stress factors associated with client behaviour and therapist experience. Previous findings have found that the behaviours by clients that therapists found most stressful were suicidal intent, aggression or hostility directed at the therapist, severe depression, apathy and termination (Deutsch, 1984). At least one participant linked her stress levels to high expectations of herself, with client criticism triggering beliefs about inadequacy or vulnerability. Failure to live up to expectations was seen as evidence of inadequacy or incompetence. Nevertheless, with greater experience there was a re-evaluation of such beliefs leading to the development of greater self acceptance.

4.3 Limitations

This study was designed to be limited to therapists who worked from a psychodynamic orientation. These therapists tended to see the therapeutic relationship as central to the process of therapy, whilst paying particular attention to their own reactions towards their clients. On the whole it seems that there was little discussion by the participants about the intersubjective aspect of therapy and the co-construction of the relationship. It could be argued that for some of the participants there seemed to be an implicit

assumption that the therapist is able to remain an impartial and detached observer which is typical of traditional psychodynamic approaches. Nevertheless, it might have been useful to have invited the participants to consider the impact of their own reactions on the client. It is also interesting to speculate about whether or how the findings might have been different in this regard if counselling psychologists had been interviewed. With counselling psychology's roots in phenomenological and existential philosophy, we might speculate about whether this would have featured more in the participants' accounts.

Whilst negative reactions were considered at length by the participants such as anger, sadness, despair, and arrogance, Hayes and Gelso, (2001) remind us that difficult emotional reactions may take on different forms including positive emotions.   This can lead to behaviours which could be described as excessively supporting the client, agreeing too much or engaging in too much self disclosure. For example, one participant talked about becoming uncharacteristically disclosive which seemed to be linked to his own interpersonal style as well as the client's presenting material. This demonstrates how positive reactions, whether arising from therapists' conflicts or not, have the potential to damage the relationship, as they may serve the therapist's interests rather than the client's. The participants' focus on negative emotions may have been a reflection of the way in which the term countertransference is viewed amongst therapists more generally. Furthermore, whilst the interview guide provided flexibility for in depth exploration of issues arising from the interview, with hindsight, perhaps the schedule was weighted too much towards a focus on eliciting therapists' experience of negative reactions. For example, the participants were asked how they would define a problem in the relationship and how they would deal with it. A future consideration would be to reduce the number of questions, possibly using only one question and then following up any interesting leads. This would hopefully reduce the chances of the researcher influencing too much which aspects of their experience the participants described.

An important part of the focus of this study has been on the potentially harmful aspects of therapist conflicts and the need to manage them. However, Gelso and Hayes (2007) point out that the idea that therapists vulnerabilities might be helpful to others is a theme that can be found in cultures since ancient times and is often referred to as the 'wounded

healer'. In facing their own problems, therapists can use their experiences of suffering to help others. Nevertheless, it is important that the therapist's own difficulties have been resolved to such an extent that they can be of use to the therapeutic process. Limited research exists on the usefulness of the therapist's own suffering. Whilst studies have been unable to find a link between therapists in recovery and outcomes in drug and alcohol treatment these findings may be confounded by educational and training attainment (Culbreth, 2000). Although one participant spoke about being an emotional caretaker as a child it would be interesting to learn more about the relationship between therapist's own suffering and the characteristics that enable them to use their own vulnerabilities in the service of therapy.

4.4 Contribution to counselling psychology

Since the therapeutic relationship is central to the theory and practice of counselling psychology, the findings of this study are particularly relevant. It reminds us that the therapeutic endeavour takes place within an intersubjective context in which client and therapist mutually influence each other. This is entirely consistent with the counselling psychology's philosophical roots in phenomenological and existential thinking. Since it is also clear that the way in which therapists deal with their own conflicts and vulnerabilities can impact the therapeutic relationship, it is important to understand those aspects of the internal experience of therapists that allow them to deal with the uncomfortable and difficult feelings that arise. The participants' accounts have shed further light on the ways that therapists can understand and manage their reactions, thus facilitating a deeper relationship with their clients. As discussed, the therapist characteristics that seem to facilitate the use of painful or conflictual reactions in the service of therapy are self insight, conceptualising ability and self integration. The field of mindfulness seems to offer further insight into the management of difficult reactions. For one participant in particular, he described a state of mind in which he was able to fully experience and understand his pain which reduced its intensity. This presents an interesting link with the particular importance of bodily felt experience identified by another participant. Wahl (2003) has noted the commonly held Western view of the mind as separate from the body. The alternative view is of experience as an embodied process so that we have knowledge not just through our minds but also our bodily experiences. Thus acquiring knowledge through our bodily-felt experiences as well as

cognitively gives us the experience of emotion. The next section explores how to develop this awareness in ourselves and our clients.

4.5 Implications for practice

One area in which the study of therapist reactions is valuable is in regard to training. Given the importance of therapists' reactions, training programmes need to teach counselling psychologists how to identify, understand, manage and make use of their responses. We also need to consider the kind of developmental work that the therapist needs to engage in to be able to understand and make use of their inner experiences. The therapist's willingness to encounter themselves is achieved by creating an environment in which the therapist has an opportunity to experience the self in encounter with other people. As Mearns and Cooper (2005) point out, many of the negative beliefs about meeting others are challenged by the experience of an encounter with others. The therapist's own personal therapy is one way of raising awareness of self in relationship with another although encounter groups are likely to offer a more powerful way of raising awareness. The purpose of such groups is to create an environment in which people can learn about themselves through their interactions with others. Another direction may involve integrating some form of mindfulness practice into the training of counselling psychologists in order to help cultivate the capacity for self observation and promote therapists' own wellbeing.

4.6 Future research

The findings of this research project have pointed to the importance of understanding therapists' reactions as embedded in a relational context. More research emphasising therapists' subjective experiences and emotion, including positive emotions would deepen our understanding of the therapeutic process. Insight into the internal processes of both therapist and client would require in depth descriptions of their experiences along with a detailed account of changes in their internal experience. This might include further in depth qualitative research conducted immediately following a videotaped session with a client. As an example of potentially useful research, it might be interesting to review therapy sessions with therapists and perhaps also clients. This would provide an opportunity to obtain therapists' and clients' subjective experiences of

the relationship in order to illuminate the internal experiences of both parties. There needs to be more research into how therapists can make use of their own sufficiently resolved vulnerabilities and conflicts to help their clients. Further research is also required in the area of therapist self disclosure to help guide therapists on whether and when to discuss their reactions with clients.

4.7 Concluding remarks

I embarked on a journey to investigate how therapists make sense of their reactions towards their clients. This research provided an in depth snapshot of a small number of therapists working from a similar theoretical orientation. The benefits gained from this study include insights into how therapists make sense of and manage their reactions. Using IPA has hopefully enabled the development of a greater richness and clearer theme development. The results from this thesis highlight the value of qualitative research methods using in depth interviewing techniques. The conclusions drawn from the research support the premise that therapists' reactions are a complex process. The participants understood their reactions in a number of different ways but they all seemed to agree that their feelings required careful understanding and management. The research has generated new questions and provided directions for future research.

References

Ashworth, P. (2003). The origins of qualitative psychology. In J. Smith, (Ed.) *Qualitative Psychology: A Practical Guide to Research Methods.* London: Sage.

Bateman, A.; Brown, D.; Pedder, J. (2000). *Introduction to Psychotherapy: An Outline of Psychodynamic Principles and Practice*. London: Routledge.

Berne, E. (1961). *Transactional Analysis in Psychotherapy.* New York: Grove Press.

Bike, D.; Norcross, J.; Schatz, D. (2009). Process and outcomes of psychotherapists' personal therapy: replication and extension 20 years later. *Psychotherapy Theory, Research, Practice, Training,* **46**(1): 19-31.

Bion, W. (1962). *Learning from Experience*. London: William Heinemann.

Bretherton, I.; Munholland, K. A. (1999). Internal working models in attachment: A construct revisited. In J. Cassidy and P. Shaver (Eds.) *Handbook of Attachment: Theory, Research and Clinical Application.* New York: Guilford.

Bruce, N.; Shapiro, S.; Constantino, M.; Manber, R. (2010). Psychotherapist mindfulness and the psychotherapy process. *Psychotherapy Theory Research, Practice, Training,* **47**(1): 83-97.

Burton, M.; Davey, T. (2003). The psychodynamic paradigm. In R. Woolfe; W. Dryden; S. Strawbridge (Eds.) *Handbook of Counselling Psychology* (2nd ed.) London: Sage.

Culbreth, J. (2000). Substance abuse counselors with and without a personal history of clinical dependency: a review of the literature. *Alcoholism Treatment Quarterly,* **18**(2): 67-82.

Cutler, R. (1958). Countertransference effects in psychotherapy. In *Journal of Consulting Psychology,* **22**(5): 349-356.

Deutsch, C. (1984). Self reported sources of stress among psychotherapists. *Professional Psychology: Research and Practice,* **15**(6): 833-845.

Diamond, N.; Marrone, M. (2003). *Attachment and Intersubjectivity.* London: Whurr Publishers.

Fairfax, H. (2008). CBT or Not CBT, is that really the question? *Counselling Psychology Review,* **23**(4): 27-35.

Farber, B. (2006). *Self Disclosure in Psychotherapy.* New York: Guilford Press.

Fauth, J. (2006). Toward more (and better) countertransference research. *Psychotherapy: Theory Research, Practice, Training,* **43**(1): 16-31.

Finlay, L. (2003). Through the looking glass: intersubjectivity and hermeneutic reflection. In L. Finlay & B. Gough (Eds.) *Reflexivity: A Practical Guide for Researchers in Health and Social Sciences.* Blackwell: Oxford.

Fonagy, P.; Target, M. (2003). *Psychoanalytic Theories: Perspectives from Developmental Psychopathology.* Abingdon: Routledge.

Frankl, V. (2004). *Man's Search for Meaning.* London: Random House.

Gelso, C.; Hayes, J. (2001). Countertransference management. *Psychotherapy,* **38**(4): 418-422.

Gelso, C.; Hayes, J. (2007). *Countertransference and the Therapist's Inner Experience.* New Jersey: Lawrence Erlbaum Associates.

Gravell, L. (2010). The counselling psychologist as therapeutic container. *Counselling Psychology Review,* **24**(2): 28-33.

Hayes, J.; Gelso, C. (2001). Clinical implications of research on countertransference: science informing practice. *Journal of Clinical Psychology: In Session, Psychotherapy in Practice,* **57**: 1041-1051.

Hayes, J; McCraken, J.; Hill, C.; McClanahan, M. (1998). Therapist perspectives on countertransference. *Journal of Counseling Psychology,* **45**(4): 468-482.

Hellman, I; Morrison, T.; Abramowitz, S. (1987) Therapist experience and the stresses of psychotherapeutic work. *Psychotherapy*, **24**(2): 171-176.

Horvath, A.; Symonds, D. (1991). Relation between working alliance and outcome in psychotherapy: a meta analysis. *Journal of Counseling Psychology,* **38**(2): 139-149.

Jung, C. (1963). *Memories, Dreams, Reflections.* New York: Random House

Kvale, S. (1996). *InterViews: An Introduction to Qualitative Research Interviewing.* California: Sage.

Laing, R. (1960). *The Divided Self.* London: Tavistock.

Latts, M.; Gelso, C. (1995). Countertransference behaviour and management with survivors of sexual assault. *Psychotherapy,* **32**(3): 405-415.

Laughton-Brown, H. (2010). Trust in the therapeutic relationship: psychodynamic contributions to counselling psychology practice. *Counselling Psychology Review,* **25**(2): 6-12.

Lemma, A. (2003). *Introduction to the Practice of Psychoanalytic Psychotherapy.* Chichester : John Wiley and Sons.

Mace, C. (2008). *Mindfulness and Mental Health.* London: Routledge.

Madill, A.; Jordan, A.; Shirley, C. (2000). Objectivity and reliability in qualitative analysis: realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, **91**: 1-20.

Martin, D.; Garske, J.; Davis, K. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta analytic review. *Journal of Consulting and Clinical Psychology*, **68**(3): 438-450.

McLeod, J. (2001). *Qualitative Research in Counselling and Psychotherapy*. London: Sage.

McLeod, J. (2003). Qualitative research methods in counselling psychology. In R. Woolfe; W. Dryden; S. Strawbridge (Eds.) *Handbook of Counselling Psychology* (2nd ed.) London: Sage.

Mearns, D.; Cooper, M. (2005). *Working at Relational Depth,* Sage: London.

O'Driscoll, A. (2009). The growing influence of mindfulness on the work of the counselling psychologist: A review. *Counselling Psychology Review*, **24**(3&4): 16-23.

Peabody, S.; Gelso, C. (1982). Countertransference and empathy: the complex relationship between two divergent concepts in counseling. *Journal of Counseling Psychology,* **29**(3): 240-245.

Ponterotto, J. (2005). Qualitative research in counseling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology,* **52**(2): 126-136.

Reid, K.; Flowers, P.; Larkin, M. (2005). Exploring lived experience. *The Psychologist,* **18**: 20-23.

Robbins, S.; Jolkovski, M. (1987). Managing countertransference feelings: an interactional model using awareness of feeling and theoretical framework. *Journal of Counseling Psychology,* **34**(3): 276-282.

Rogers, C. (1961). *On Becoming a Person,* London: Constable & Robinson.

Rizq, R.; Target, M. (2009). The power of being seen: an interpretative phenomenological analysis of how experienced counselling psychologists describe the meaning and significance of personal therapy in clinical practice. *Counselling Psychology Review,* **24**(3&4): 66-83.

Ryle A.; Kerr, B. (2002). *Introducing Cognitive Analytic Therapy,* Chichester: John Wiley and Sons.

Safran, J. (1990a). Towards a refinement of cognitive therapy in light of interpersonal theory: 1. Theory. *Clinical Psychology Review,* **10**: 87-105.

Safran, J. (1990b). Towards a refinement of cognitive therapy in light of interpersonal theory: II. Practice. *Clinical Psychology Review,* **10**: 107 –121.

Safran, J.; Muran, J. (2000). *Negotiating the Therapeutic Alliance,* New York: Guilford Press.

Sarnat, J. (2010). Key competencies of the psychodynamic psychotherapist and how to teach them in supervision. *Psychotherapy Theory, Research, Practice, Training,* **47**(1): 20–27.

Shapiro, S.; Brown, K.; Biegel, G. (2007). Teaching self care to caregivers: Effects of mindfulness-based stress reduction on the mental health of therapists in training. *Training and Education in Professional Psychology,* **1**(2): 105-115.

Smith, J.; Flowers, P; Larkin, M. (2009). *Interpretative Phenomenological Analysis.* London: Sage.

Smith, J.; Jarman, M.; Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray and K. Chamberlain (Eds.) *Qualitative Health Psychology: Theories & Methods*. London: Sage.

Strawbridge, S.; Woolfe, R. (2003). Counselling psychology in context. In R. Woolfe; W. Dryden; S. Strawbridge (Eds.) *Handbook of Counselling Psychology* (2nd ed.) London: Sage.

Todd, T.; Storm, C. (2002). *The Complete Systemic Supervisor: Context, Philosophy and Pragmatics.* Lincoln: Authors Choice Press.

Van Wagoner, S.; Gelso, C.; Hayes, J.; Diemer, R., (1991). Countertransference and the reputedly excellent therapist. *Psychotherapy: Theory, Research, Practice, Training,* **28**(3): 411- 421.

Wahl, B. (2003). Counselling psychology and the body. In R. Woolfe; W. Dryden; S. Strawbridge (Eds.) *Handbook of Counselling Psychology* (2nd ed.) London: Sage.

Willig, C. (2001). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method.* Buckingham: Open University Press.

Willig, C. (2008). *Introducing Qualitative Research in Psychology: Adventures in Theory and Method* (2nd ed.) Buckingham: Open University Press.

Wosket, V. (1999) *The Therapeutic Use of Self,* London: Routledge.

List of Appendices

Appendix 1   Interview schedule

Appendix 2   NHS Ethical Approval

Appendix 3   University of East London Ethical
                                    Approval

Appendix 4   Participant information sheet

Appendix 5   Participant consent form

Appendix 6   Master table of themes

Appendix 1

Interview Questions

1. What part do you think the therapeutic relationship plays in the process of therapy?
    Prompt: what kind of things do you attend to when developing a therapeutic relationship

2. How would you define a problem in the relationship?
    Prompt: for example, a client might confront you with an issue or you might become aware of a form of compliance.

3. How would you deal with a problem in the relationship? Can you give an example from your own practice?
    Prompt: My client who expected to be let down by men

5. How were you affected in the session? How might this affect you (if no example)?
    Prompt: physically, emotionally, mentally. Were you feeling anxious, annoyed, worried, defensive?
    Prompt: What did you do to manage these feelings at the time?
    Prompt: What effect did this have on the therapeutic relationship?

6. How were you affected after the session? How might you be affected after the session (if no example)?
    Prompt: When I made a mistake I felt like a failure: all or nothing thinking
    Prompt: What effect did this have on your approach to the client/feelings about the client?

7. What helped (would help) you to deal with these feelings? What was (would be) unhelpful?
    Prompt: e.g. awareness of own feelings and experience as well as of client, a collaborative focus, focus on here and now, and an emphasis on understanding

8. What if anything prevents you or might have prevented you from resolving the situation?
    Prompt: e.g. experiencing negative feelings, imposing values, techniques when not accepted by client

Appendix 2

25 June 2008

Mr Jacob Maunders
West London Mental Health Trust
Uxbridge Road
Middlesex
UB1 3EU

Dear Mr Maunders

Full title of study:	**A phenomenological analysis of therapeutic relationship: How do therapists deal with difficult counter transference reactions?**
REC reference number:	**08/H0604/71**

Thank you for your letter of 08 June 2008, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered at the meeting of the Sub-Committee of the REC held on 20 June 2008. A list of the members who were present at the meeting is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised.

Ethical review of research sites

The Committee has designated this study as exempt from site-specific assessment (SSA). There is no requirement for other Local Research Ethics Committees to be informed or for site-specific assessment to be carried out at each site.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission at NHS sites ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Application	Parts A&B	
Investigator CV	Jacob Maunders	27 March 2008
Protocol	1	27 March 2008
Compensation Arrangements	University of East London	27 March 2008
Interview Schedules/Topic Guides	2	06 June 2008
Letter of invitation to participant	2	06 June 2008
Participant Information Sheet	2	06 June 2008
Participant Consent Form	2	06 June 2008
Response to Request for Further Information		08 June 2008
Supervisor's CV	1	27 March 2008

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

08/H0604/71	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project

Yours sincerely

Appendix 3

UEL
University of
East London

Jane Lawrence
School of Psychology
Stratford

ETH/08/47

19 February 2012

Dear Jane,

Application to the Research Ethics Committee: A Phenomenological analysis of the therapeutic alliance (J Maunders)

I advise that Members of the Research Ethics Committee have now approved the above application on the terms previously advised to you. The Research Ethics Committee should be informed of any significant changes that take place after approval has been given. Examples of such changes include any change to the scope, methodology or composition of investigative team. These examples are not exclusive and the person responsible for the programme must exercise proper judgement in determining what should be brought to the attention of the Committee.

In accepting the terms previously advised to you I would be grateful if you could return the declaration form below, duly signed and dated, confirming that you will inform the committee of any changes to your approved programme.

Yours sincerely

Debbie Dada
Admissions and Ethics Officer
Direct Line: 0208 223 2976
Email: d.dada@uel.ac.uk

_____

Research Ethics Committee: ETH/08/47

I hereby agree to inform the Research Ethics Committee of any changes to be made to the above approved programme and any adverse incidents that arise during the conduct of the programme.

Signed:..Date: ....

Please Print Name:

Appendix 4

Participant Information Sheet

Title of project: **How do therapists make sense of their reactions towards clients?**

Name of researcher: **Jacob Maunders**

I would like to invite you to take part in a research study. This study is about the therapeutic relationship and the working alliance.

Before you decide whether to participate you need to understand why the research is being done and what it would involve for you. Please take time to read the information carefully. Part 1 tells you the purpose of the study and what will happen if you participate. Part 2 gives you more information about the conduct of the study. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you would like to take part.

PART 1

What is the purpose of the study

I am a doctoral trainee on the counselling psychology programme at the University of East London. This letter is an invitation to consider participating in a study I am conducting as part of my doctorate. I would like to provide you with more information about this project and what your involvement would entail if you decide to take part.

Why have I been invited?

The aim of the study is to develop an understanding of how therapists make sense of their reactions. Therefore, I intend to interview eight to ten therapists about their experiences in this area. You have been identified as a potential participant because of your background and experience in this area.

Do I have to take part?

It is up to you to decide whether you want to take part. If you decide you want to take part, you will be asked to sign a consent form which will show that you have consented. You are free to withdraw at anytime without giving a reason.

What will happen to me if I take part?

This study will involve semi-structured interviews. This type of interview involves open ended questions that are few in number. The interviews will be conducted face-to-face and on a one-to-one basis. The interview will last for approximately one hour. The aim is to enable you to describe the processes through which you work with

uncomfortable or difficult feelings in a helpful way that could otherwise impinge on the therapy.

The interviews will be audio recorded and later transcribed for analysis. Handwritten notes will also be made. For reasons of client confidentiality, you will be asked not to reveal any personal details about your clients. To protect your anonymity, aliases or pseudonyms will be used for individuals and places. The interviews will be audio recorded and transferred to computer. It is envisaged that the recordings will be kept for no more than two years after which time they will be destroyed.

Expenses and payments
It is not anticipated that you will incur any expenses and there is no plan to make payments.

What are the possible benefits of taking part?
I cannot promise that the study will help you directly, but the information gathered from this study will help to shed light on the process that maintain an effective therapeutic relationship.

What are the possible disadvantages or risks of taking part?
Because of the personal nature of the interviews, there is a small possibility that you might find the interview distressing. Your needs as a participant take priority over the needs of the research and if you can decline to answer any of the questions. If you wish, the interview can be stopped at any point and you can withdraw from the study.

What if there is a problem?
Any complaint about the way you have been dealt with during this study and any possible harm you might suffer will be addressed. Detailed information on this is given in part 2.

Will my taking part in the study be kept confidential?
Yes. Ethical and legal practice will be followed and all information about you will be handled in confidence. The details are included in part 2.

If the information in part 1 has interested you and you are considering participating, please read additional information in part 2 before making any decision.

PART 2

What will happen if I do not want to carry on with the study?
You may withdraw from the study at any point and the data will be destroyed.

Complaints
If you have a complaint about any aspect of the research you should speak to me and I will do my best to answer your questions (tel. 07884 351342). If you remain unhappy and wish to complain formally, you can do this through the NHS complaints procedure.

Harm

In the event that something does go wrong in the research, and this is due to someone's negligence, then you may have grounds for a legal action for compensation against the University of East London but you may have to pay your legal costs. The normal NHS complaints mechanisms will be open to you.

Will my taking part in the study be kept confidential?

If you join the study, information might be seen by authorised persons from the university. They may also be looked at by authorised people to check that the research is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

If evidence of bad or illegal practice becomes apparent, it would in the first instance be discussed with my research supervisor. It may also be reported to the relevant regulatory authorities. I would discuss this with you first if possible.

What will happen to the results of the research?

The results will be presented in my doctoral thesis which will be made available in the university library.

Who is sponsoring the research?

The research is being sponsored by the University of East London.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, well being and dignity. This study has been reviewed and given ethical approval by the Oxfordshire Research Ethics Committee. It has also been approved by the University of East London's Ethics Committee.

You will be given a copy of this information sheet and a copy of the consent form to keep.

Further information and contact details

If you have any questions or concerns about this study, you are encouraged to call: Jacob Maunders. Email: jacobmaunders@hotmail.com Tel.: 07884 351342

If you are unhappy about the study you should contact Jane Lawrence, Senior Lecturer (Research Supervisor), University of East London, Stratford Campus, Romford Road, London, E15 4LZ.

If you would like general information about ethics you might find the following website useful: http://www.bps.org.uk/downloadfile.cfm?file_uuid=5084A882-1143-DFD0-7E6C-F1938A65C242&ext=pdf

Thank you very much for your participation.

Appendix 5

Consent form

Title of project: **A phenomenological analysis of the therapeutic alliance: How do therapists make sense of their reactions towards clients?**

Name of researcher: **Jacob Maunders**

Please tick the box

1. I confirm that I have read and understand the information sheet dated
    2 June 2008 (version 2) for the above study. I have had the opportunity
    to consider the information, ask questions and have had these answered
    satisfactorily.

2. I understand that my participation is voluntary and that I am free to
    withdraw at any time without giving any reason.

3. I understand that relevant sections of my data collected during the study
    may be looked at by the researcher's educational supervisor or the university
    in the event of malpractice. I give permission for these individuals
    to have access to my records.

4. I consent to the storage and use of my personal data.

5. I consent to the audio recording of the interviews

6. I agree to take part in the above study.

Participant's Signature:

Date:

Print name:

Researcher's Signature:

Date:

Print name

Master table of themes for the group

Master theme 1: self as a "measuring instrument"

Subtheme 1: Reciprocation

Sarah: Listening, it's hard work, listening to yourself, listening to the client	399-400
Simon: the self, that's the measuring instrument by which you gauge the nature of the relationship	26-28
Carol: how I feel about them gives me important clues about how other people might feel about them or respond to them.	85-87
Richard: You know, it's easy to see that this particular habit, if you wish, set up in the first five years of life is still operating thirty years later	546-547
Mark: He, he managed to get all sorts of things out of me. I equated the two situations and actually talked to him about it.	462-463

Subtheme 2: Self disclosure

Sarah: There is something else. So I may have to say: "It feels as if you're trying to please me. Can we look at this?"	76-78
Carol: It might be quite helpful to just be able to let them know the impact that they're having on me because that might give them clues about how other people might be responding to them.	85-87

Subtheme 3: Empathy

Katharina: sometimes I represent the mother to my clients	13
Mark: you just get to a different level	324

Master theme 2: Managing reactions

Subtheme 1: Managing responses to client material

Sarah: I had to do visualisation techniques as in I was wearing a suit of armour	521-523
Simon: although this is open to being misheard, it's water off a ducks back	149-150
Richard: They are seeing what you represent in the chair	344-345
Katharina: so it's about taking care of that and bringing it back to either my adult or my professional relationship with the client	158-160
Carol: trying to understand what it is that they want that you're not giving to them	251-254

Richard: I use from Bion which is benign indifference   187-188

Subtheme 2: Managing conflicts or vulnerabilities

Sarah: So obviously I knew what my own reciprocal roles were   506-507
Simon: Now I am reasonably arrogant, it's my own right and I therefore
particularly don't like being patronised   540-543
Katharina: It's more likely to happen to therapists that um as kids were the
emotional caretakers of their own parents   331-332
Mark: I suppose I feel quite impotent at times   358
Carol: I suppose maybe that rung bells for me in terms of my own,
[pause] you know I find dealing with people who are very stuck   442-445

Master theme 3: Therapist self care

Subtheme 1: Impact on self

Simon: in my unconscious meeting their unconscious, I can be left
feeling very unsettled and unhappy, cross   198-200
Katharina: You cannot ignore that huge part of how vulnerable you could
become   347-348
Carol: listening to people talk about things that happened to them in
the past and that can be quite distressing   428-430

Subtheme 2: Coping strategies

Katharina: So in the swimming pool I tried to stay as calm as possible and
say okay I can cope with this   466-468
Mark: So in my experience we talk to each other about those thoughts,
those feelings, the feelings that we have   375-377
Carol: You know it's a kind of safety valve thing.   563-564

Subtheme 3: Time period

Sarah: You're not a failure as a therapist if you say that "I cannot help
you anymore"   375-377
Katharina: I like more into taking it easy, stretches, breathing, focussing
on my body   525-526
Mark: I've learnt so much from my clients   534
Carol: I don't know, I think maybe I'm just becoming naturally more
empathic   364-366