Newly Qualified Therapists' Countertransference Experiences when Working with Adult Clients Diagnosed with Eating Disorders - A Thematic Analysis

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Abstract

This is a qualitative study investigating newly qualified therapists' countertransference (CT) experiences when working with adult clients diagnosed with Eating Disorders (EDs). Literature review of this area has revealed that the experiences of newly qualified therapists' CT are understated in the work with this client group. Therefore, to address this gap, eleven participants were recruited and interviewed using semi-structured interviews. Participants' accounts were transcribed verbatim and were analysed using Thematic Analysis (TA). The analysis revealed five superordinate themes as follows: a) 'Doubting Own Identity'; b) 'Safeguarding the Client, the Self and the Work'; c) 'Feeling "Chewed Through and Spat Out'; d) 'It's a Power Struggle!' and e) 'Being Equipped to Manage CT'. Each superordinate theme consisted of three subthemes.

The research findings suggest that new therapists' CT reactions may involve a temporary identification with their clients' views of self and the world, often experiencing mental blocks and extreme anxiety around their own bodies. Findings further indicate CT responses of overprotecting, nurturing and rescuing clients, as well as strong physical reactions to clients' fragile physical appearances. New therapists' CT reactions further included feeling consumed, worn-out and frustrated both during therapy and in their private lives. New therapists participating in this study experienced a battle for power between themselves and their clients. Lastly, findings emphasise the essential role of CT in therapy with this client group.

This study accentuates a need for increased awareness around the importance of CT amongst new therapists working with clients with EDs whilst informing training and NHS services to address potential tensions. The study's limitations, relevance to Counselling Psychology and suggestions for future research are presented.

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Preface

Experiences that contributed to my interest in countertransference and individuals diagnosed with eating disorders

I have always been interested in the processes occurring in relationships, finding myself attracted to what takes place in the communication, beyond words. Many times, my experiences seemed to reveal that spoken words may not be all that takes place between people, but there may be more to it which remains unacknowledged. Ever since I was a child, I have been fascinated by relationships, noticing how my parents' interacted with myself and others, often wondering about what may contribute to how we act and feel towards friends or family members. Later, having studied psychology and embarking on the Counselling Psychology doctoral training, my attention to process and nuanced aspects of this area of interest within the therapeutic setting were further explored. Considering process issues in my clinical work helped me unpack rich and helpful information to the therapy. Moreover, I had begun to notice and wonder about my own reactions working with adults with complex presentations, such as eating disorders.

Prior to beginning my journey as a trainee counselling psychologist, I worked as an assistant psychologist in the NHS. Most of my clinical experience has been with adults presenting to services with severe difficulties, struggling to verbally communicate their emotions and their internal worlds. Working with individuals with eating disorders, I have often found this client group complex and troubling in relating to the rest of the world. Despite having received supervisory support throughout the time, I often sensed hopelessness and frustration, suddenly wondering around my own eating and doubting my clinical skills all within the unique transactions transpiring in the therapeutic setting. I wondered if my reactions were shared by other therapists working with this client group, how to manage these difficulties and if being a novice therapist affected my reactions to the work. Also, my experience of working from a psychodynamic perspective with clients

with eating difficulties in a long-term setting focused my attention even further on countertransference and the potential risks of re-enacting clients' early relating patterns, when one becomes caught-up in the countertransference. Such issues became the foundation of my research topic.

My work with clients and experiences of therapy have helped me understand that although professionals in the caring roles may use labels and categories to refer to specific presentations, knowledge is developed fluidly, subjectively and ideographically. Each individual has unique needs in therapy beyond their labels, requiring a tailored approach. Therefore, in my clinical work I integrate therapeutic models to meet the unique needs of the client.

My clinical experiences as an assistant psychologist and later as a trainee counselling psychologist contributed to how reality can differ from person to person on the basis of their personal experiences and life principles. Reflexivity allowed me to understand to how knowledge, specific situations and relationships are experienced, enabling me to develop professional relationships as well as strengthen my clinical skills in therapy with clients. Consequently, I started exploring with clients with EDs their views of the world and their difficulties, developing an understanding of each of their stories as a continuing fluid ontological journey. My training and clinical practice shaped my view of ourselves and others as a dynamic, diverse and meaningful process rather than an absolute truth. However, I often wondered how other new therapists may experience processes and countertransference in this area and if their ontological stances may differ.

I consider myself fortunate for having worked with people diagnosed with eating difficulties. I had little experience working with issues of process prior to this, which allowed me to expand my reflexive skills around countertransferential responses. Therefore, my decision to conduct the current project has been influenced by my

experiences as a trainee and assistant psychologist. Also, new therapists' stories of countertransference and therapeutic work have impacted on me personally and professionally, inspiring me further. I hope this study adds new findings to the current knowledge within psychotherapy research and in the field of Counselling Psychology.

CHAPTER ONE: INTRODUCTION

Chapter Overview

This chapter represents a review and critical appraisal of the existing literature on countertransference (CT) in relation to the treatment of eating disorders (EDs). It makes available a framework and context for the present study and outlines existing knowledge, pointing towards this thesis' research question. Additionally, this review presents the advances in the use of CT with EDs and dilemmas associated with these notions in the therapeutic frame, alongside with its significance in the context of the therapeutic relationship and current recommended treatments for EDs. Literature on newly qualified therapists and the overlap with CT in the treatment of EDs is presented. The chapter concludes by outlining the research question, aims and relevance to counselling psychology.

1. *Current context and the need for this study*

> *"We wouldn't delay if someone had broken their leg and* ***we mustn't delay in providing high quality therapy to those who need it****" (BEAT Eating Disorders, 2016).*

More than two million individuals of UK's population will develop an eating disorder (ED) (BEAT *Eating Disorders*, 2016) at a certain time within their lives, thus they will require psychological treatment. This means the need to access EDs services is growing, therefore demanding expanding the capacity for EDs treatment. This needs to be expanded without impinging the quality of services provided, such as appropriate number of sessions and suitable training for the professionals in the field (BEAT *Eating Disorders*, 2016). While the number of people diagnosed with EDs was found to be on

the rise in the latest years (NICE, 2017), psychological therapy services in the NHS are placed under pressure to find sufficient resources to match the need for treatment in this area. In addition, Farndon (2016) has found that between 2009 and 2016 there has been a steady number of newly qualified professional psychologists recorded with the Health and Care Professions Council (HCPC). This is relevant because it suggests that there is a substantial and constant number of newly qualified therapists registering yearly, some of which will be working with individuals with EDs considering the raised demands and increased numbers of people with such difficulties. The services also require greater numbers of therapists working with referred clients to address the high risks associated with EDs in relation to the elevated comorbidity with other mental health conditions. It follows that this will need a number of newly qualified therapists, psychologists, psychotherapists to work in individual therapy with clients with EDs.

The National Institute for Health and Care Excellence (NICE) guidelines for EDs have recognised that EDs represent chronic conditions, which, in the absence of adequate treatment, can lead to high psychological and physical harm to the individual or even their death. A vital part of these treatments is the psychological therapy; however, an equally important aspect is the competence and the appropriate training of the mental health professionals who provide such therapy (NICE, 2017). Previous studies point towards the difficulties senior therapists experience in their attempt to establish a robust therapeutic relationship with their clients with EDs. They suggest heavy and complex experiences at personal level in relation to negative bodily perceptions, size, weight and eating behaviours (Colahan, 1995; Costin, 2009; Lowell, & Meader, 2005; Orbach, 2004; Shipton, 2004). These studies also underline the crucial aspect of how therapists manage these experiences to conserve their self-care and clients' best interests. Although there have been many studies considering the therapeutic relationship involving experienced

therapists (Orbach, 1986; Satir, Thompson-Bremmer, Boisseau, et al., 2009), not much attention has been allocated to new therapists. Nor has much consideration been given to how these therapists manage these difficulties in their clinical work.

While existing literature agrees that treatment of EDs can be lengthy, complex and of a difficult nature (APA, 2013; Wildes & Marcus, 2013) qualitative research has also shown that countertransferential (CT) experiences may also at times collude with the therapeutic process (Satir et al., 2009). Generally, working with this client group, therapists were found to experience CT feelings of bodily insecurity, anger, frustration and possible changes in their eating habits (Delucia-Waack, 1999). These feelings are acknowledged as possible barriers to therapy with clients with EDs being linked to overidentification with the client, in the form of taking on their clients' difficulties as their own, being pulled in their clients' presentations. Therapists were found to experience feelings of not being "good enough" as well as high levels of frustration, boredom, fear of calories intake and worries around eating (Hamburg & Herzog, 1990). Left outside of awareness, these CT responses may impact on the ability of the therapist to separate themselves from their clients. This potentially limits the therapists' neutrality, ability to ground themselves and to intervene appropriately. Left unexplored, CT reactions may affect the therapeutic alliance and consequently the therapeutic process.

Furthermore, current literature on the topic has identified that therapists' clinical experience with EDs clients and the therapists' self-esteem are relevant and indirectly proportional with the strength of CT in therapy (Gorman-Ezell, 2009). This study found that therapists who have high self-esteem experience less CT reactions in the clinical work, and therapists with low self-esteem are more likely to experience heavy CT reactions. However, whilst qualitative studies found links between therapists' levels of experience/self-esteem and their CT (Orbach, 1986), the literature appears to lack a clear

understanding of how do novice therapists experience CT and how they manage it. These studies suggest that senior therapists experience CT as heavy and intense (Hughes, 1997; Lowell & Meader, 2005; Thompson-Brenner et al, 2012). It is also necessary to understand how such processes are felt by newly qualified therapists as this is most important as more newly qualified are expected to work with this client group in light of the expansion of EDs services in the NHS (BEAT, 2016).

Subsequently, this study aims to investigate newly qualified therapists' experiences of CT when working with adults with EDs. Adopting a critical realist stance, I aim to explore new therapists' CT experiences using a qualitative design. My epistemological position will be further explained in the following chapter. Previous quantitative findings relate negative CT responses to therapists' low self-esteem and lack of expertise. In contrast, I aim to use a qualitative design to explore the CT experiences of new therapists. For this purpose, I have consulted specialised literature, closely related to the concepts in discussion. The literature reviewed for this study has been obtained by conducting numerous searches of electronic databases such as PsycINFO, PEP (Psychoanalytic Electronic Publishing) and Scopus. The keywords used in the searches were: countertransference, eating disorders, newly/new/novice and qualified therapists. Sources were excluded if they were written in any other languages than English and if the general theoretical model in discussion was any other than integrative or psychodynamic therapy.

Recent developments in psychodynamic therapy focus more on the idea of intersubjectivity and place greater emphasis on client and therapist, welcoming interpersonal issues (Safran & Muran, 1998). This has resulted not only in an interest in the clients' transference, but also the meanings of therapists' CT reactions. Although there seems to be a consensus around therapists' need to make sense of their reactions, Fauth

(2006) has critiqued existing studies for depicting therapists in a passive, reactive position. He argues that CT research frequently undertakes that clients' issues link with parts within the therapist leading to a CT reaction. This study employs a qualitative methodology to allow an investigation of new therapists' subjective experiences of CT to be explored and understood in depth, stepping outside of the static and linear presentation of therapists' reactions.

2. Working with Eating Disorders

2.1 Definition and diagnosis

The relationship between EDs in terms of their diagnostic criteria, complexity, resistance to change, comorbidity, high risk nature and psychological treatment have been widely discussed in literature at a global label (BEAT, 2018; NICE, 2017; APA, 2013). The understanding of the umbrella-term of EDs differs around the world based on geographical areas, cultures and diagnostic manuals. In this current study the concept of EDs is based on the DSM-5 (APA, 2013) and ICD-10 (World Health Organization, 1992). As the current study is conducted in the UK, I considered appropriate that the definition of EDs is best founded on the diagnostic manuals that are most routinely used in the country and Western cultures.

According to BEAT (2018), EDs represent one of the most difficult to treat conditions. DSM-5 (APA, 2013) defines feeding and eating disorders as "characterized by a persistent disturbance of eating or eating-related behaviour that results in the altered consumption or absorption of food and a significant impairment in physical health or psychosocial functioning" (p. 329). Diagnoses such as pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa (AN), bulimia nervosa (BN), and binge-eating disorder (BED) are included under the category of EDs. However, this categorisation system seems to vary across cultures and continents based on a variety of

diagnostic manuals utilised in different geographical area such as the ICD-10 in the UK. Additionally, even within the same regions, diagnostic criteria appear to have changed significantly over time. For example, in the most recent edition of the DSM-5 (APA, 2013), EDs criteria for diagnosis have changed compared to the previous edition, the DSM-4 (APA, 1994). These changes include a lower threshold for the frequency of binging and purging in relation to AN and BN, leading to a broadening of the criteria needed for the diagnosis. A further example of inter addition change sees the introduction of BED diagnosis, resulting in reduced occurrence of the diagnosis of EDNOS (Brewin, Baggott, Dugard, Arcelus, 2014; Fairburn & Cooper, 2011; Keel, Brown, Holm-Denoma, & Bodell, 2011). These changes emphasise the difficult nature of categorising EDs so as to inform further treatment.

Matters are further complicated by clinicians using different systems of categorisation. Wildes & Marcus (2013) have reviewed different models for differentiating amongst EDs based on their comorbidity. They distinguish between multi-impulse versus uni-impulse EDs and incidence or absenteeism of Borderline Personality Disorder (BPD) and OCD (Obsessive Compulsive Disorder). They separated dietary EDs from affect EDs. They distinguished between under controlled, overcontrolled and low psychopathology EDs (Wildes & Marcus, 2013).

Despite the differences in defining and categorising EDs as presented above, the literature is consistent in describing EDs as complex and difficult to treat, often due to their comorbidity with conditions such as anxiety, depression, and personality disorders (APA, 2013).

Psychoneurological studies (Vanderlinden & Vandereycken, 1997) have suggested that EDs are linked to the developmental preverbal stage and the feeding

patterns which activate the "emotional memories" centre in the amygdala. This theory links disordered eating with a psychoanalytic understanding, pointing towards the breast-feeding period and the relationship with the mother. Sometimes, EDs are further linked to schizoid characteristics explained by the "splitting-off" characteristic present in feeding behaviours in individuals with EDs (Fairbairn, 1940; Sella, 2003).

2.2 Co-morbidity with other diagnoses

Literature has largely argued that EDs are highly complex, especially in relation to their high degree of co-morbidity (Brewerton & Dennis, 2014). Recent studies published in Peterson & Pisetsky (2018) found that both adults and adolescents with EDs complied all the criteria of at least another condition such as mood, anxiety, substance misuse, or impulse control disorders. Their study sampled 2,980 adults and 10,123 adolescents. Of these, 56 % were diagnosed with AN, 95 % with BN, and 79 % with BED. Of these respondents, the most common disorders found were specific phobias, social phobia, and PTSD. The same source referenced a study conducted by Hudson et al., (2007) focusing on adult comorbidity, showing that the most prevalent associated conditions were attention-deficit hyperactivity disorder (ADHD) and oppositional-defiant disorder (ODD). Conduct disorder (CD) was more prevalent in BN and BED. In the adolescent sample, Swanson et al. (2011) were able to show a distinct pattern of comorbidity between ODD and AN and BED. They also illustrated a corresponding pattern between BN and CD. However, they found that EDs in general are most often coincided with high rates of substance misuse. They approximated 50% of individuals with EDs misuse alcohol, and/or other drugs.

A comprehensive review of empirical studies by Sansone et al. (2006) found that important associative patterns emerged between EDs and personality disorders. Specially,

in subjects with AN cluster C personality disorders were most common, including obsessive-compulsive personality disorder (OCPD) and avoidant personality disorder. Borderline personality disorder was common in both anorexia and bulimia, but no clear patterns emerged for BED. However, Halmi et al. (2005) found that approximately 30 % of all EDs patients met the diagnostic criteria for OCPD and no significant differences in comorbidities between different EDs. They concluded that OCPD may be a core behavioural feature increasing likelihood of developing an ED.

It has also been recognised (NICE, 2017) that there is a high degree of comorbidity with physical health conditions, such as diabetes, as well as with a number of mental health diagnoses. Both physical and mental aspects add to the complexity of the presentation as well as the treatment. This often requires a multi-disciplinary approach to support the individuals. NICE guidelines (2017) suggest that in cases of comorbidity treatment should be discussed with the patient and their family. That the treatment should be planned on an individual basis taking into account the complexity and difficulties of the ED and the comorbidities. This means that it is essential to consider how therapists work with such individuals, highlighting the need to attend to processes including CT.

3. Defining Countertransference

A construct of the psychoanalytic approach, countertransference (CT) has been highly deliberated throughout the literature beginning with Freud. He referred to it by using the term of "counter- transference which arises in the physician as a result of the patient's influence on his unconscious feelings" (Freud, 1910, p 144). The original psychoanalytical view was that the therapist/analyst should be an objective observer and interpreter of the client's unconscious world, mirroring the patient's projections by remaining a "blank screen" (Freud, 1912). As such, CT was initially regarded as a sign of the analyst's unresolved issues. Such conceptualisation began to shift beginning with

Heimann (1950), who suggested that CT can be seen as a process contributing to the understanding of the client rather than hindering this.

Others tried to define CT by differentiating between "objective CT" (Winnicott, 1949) and CT as the repressed feelings within the analyst, needing further analysis (Stern, 1923; Reich, 1933; Glover, 1927). Ferenczi (1950) considered CT as the loving, positive, affectionate or sexual feelings the therapist experiences about the client, whilst Balint (1950) raises the idea that every relationship is libidinous and that therapists' CT must balance the client's transference to maintain an effective therapeutic relationship. Whilst traditional psychoanalytical theory seems to understand CT as unprocessed responses the analyst experiences towards the analysand, requiring more analysis work for the analyst (Freud, 1910), beginning with 1950's modern psychoanalysis develops a new approach towards the concept of CT. Cohen (1952) argues that the more the therapist increases their awareness in their engagement with the client, both the CT and transference can become manageable and inform the therapeutic work in a precise manner.

In her conceptualisation of CT, Tower (1956) provides as CT examples the following: anxiety in the treatment room, disturbing feelings towards the client, stereotype in feelings or behaviour towards the client, love and hate responses, erotic preoccupations- especially ideas of falling in love with a client, carry-over of affects from the analytic hour, and dreams about clients and acting-out episodes. Furthermore, Little (1951) writes about the criticality of CT especially in the work with severely disturbed patients, explaining that the use of CT is crucial in the mirroring of the client as well as the therapist.

Heinmann (1950) further describes CT as an aid for the therapist. It provides therapists with a deep level consideration of the unconscious reactions through which

they can develop an understanding of the patient's psychological state. The same opinion is shared by Racker (1957), who accentuates the importance CT reactions have in the relation between therapist and client. He brings into attention the use of CT as aiding the continuous transference in the consulting room, opposing the idea that the patient will act out on these reactions if left outside awareness. Therefore, based on the above conceptualisations, CT is a tool used by therapists in helping their clients bring into consciousness feelings/thoughts/memories, through therapists' awareness of their CT responses. Without the facilitation of CT, the patient/client is in danger of repeating his/her difficulties though projection and introjection of "bad objects" Racker (1957).

Whilst traditional psychoanalysts appear to agree on the use of CT as a tool for the analyst/therapist to gain insight in the analysand's/client's internal world, rather than information to be shared with the patient (Grinberg, 1979; Heinmann, 1950; Langs, 1976; Sandler, 1976), modern psychodynamic therapists argue that there are possibilities when CT can be communicated with the client in the room to aid therapeutic movement (Lemma, 2016; Jacobs, 2010). In modern literature, CT is understood as the unconscious feelings and bodily sensations therapists experience as result of their interaction with a client in the treatment process (Delucia-Waack, 1999; Satir et al., 2009; Verbeek, 2016).

Although opinions vary regarding the existence of different types of CT in the post-Freudian approaches (Clarkson, 1997), there is a consensus in the definition of CT as an unconscious type of communication between therapist and client (Curtis, 2015). Contemporary theorists seem to subscribe to the idea that CT incorporates all of the therapist's feelings and attitudes to his/her patient (Gorkin, 1987; Kahn, 1997; Hinshelwood, 1994). Lemma (2016) explains CT as therapists' emotional reactions to clients. She acknowledges the difficulty of differentiating between therapists' emotional reactions to the patients' unconscious communication, from therapists' own "neurotic

reactions". Lemma (2016) introduces the term of somatic CT, understood as therapists' sensory and motor experiences in response to the projective processes coming from clients who cannot verbally articulate their difficulties.

These somatic CT responses, also acknowledged by other authors, are also referred to as "embodied countertransference" (Soth, 2005). This can be experienced during therapy sessions or afterwards, in the form of dreams, pain, or discomfort. If undetected, somatic CT can affect the therapist's wellbeing and undermine the therapeutic process (Costin, 2009). Earlichman (1998) shared his experiences of CT as a male counsellor in therapy with ED clients and how on different occasions these impacted on his therapeutic relationships as well as his own eating habits. This illustrates how therapists can observe variations in their eating patterns as well as their perceptions of their bodies as a result of their work with clients with EDs.

Clarkson and Nuttall (2000) refer to CT distinguishing between 'proactive' and 'reactive' types. They explain proactive CT as the unresolved complexes and past issues of the psychotherapist that could interfere with the therapeutic process. Reactive CT comprises of feelings that are a direct reaction to the patient's material. Rather than seeing CT as an useful tool or an obstacle, they suggest that it can be both. They emphasise the importance for therapists to acknowledge these feelings and consider how they may hinder if they avoid them.

Considering the vast amount of conceptualisations different schools of thought employ in the conceptualisation of CT, an operational definition of CT, informed by contemporary psychodynamic literature (Costin, 2009; Curtis, 2015; Lemma, 2016; Soth, 2005) is necessary. Throughout the current study, the term of CT is therefore being used

to refer to therapists' emotional, behavioural and somatic reactions in response to the unconscious projective processes coming from clients.

Based on the above, it is of great importance to identify and reflect on newly qualified therapists' CT in their therapeutic work. This is critical in understanding the processes in the consulting room with individuals with EDs. This is related to the complexity, treatment resistance and high comorbidity of EDs (Brewerton & Dennis, 2014; Bruch, 1973; Sansone & Fine, 1992; Shipton, 2004), altogether with the advised heavy CT in this clinical area of work (Delucia-Waack, 1999; Lowell & Meader, 2005; Orbach, 2004; Satir, Thompson-Bremmer, Boisseau et al, 2009; Thompson-Brenner et al., 2012; Warren, Crowley, Olivardia, & Schoen, 2009; Zerbe, 2013). Understanding new therapists' CT with clients with EDs becomes essential within a growing clinical area. As Reik (1952) coveys, the therapist should not only trust their theoretical knowledge but also their conscious or unconscious reactions, emphasising therapists' CT in response to the client's material. CT represents an invaluable guide for the therapist to comprehend what the client cannot express verbally, if used considerately and with integrity (Lemma, 2016). She cautions against therapists placing their unresolved conflicts onto clients whenever an overidentification with clients takes place and when therapists' CT responses interfere with the understanding of the client. Therefore, how new therapists experience and manage their CT with this client group is of vital importance for the understanding of their internal processes. It is also critical to the preservation for separation from clients' material/difficulties, preservation of new therapists' self-care and in the avoidance of re-creating previous patterns in therapy.

While CT is a phenomenon generally difficult to bring into the conscious mind, it can become challenging to manage when working with clients who have EDs, where feelings of guilt, anger, frustration and dread can be experienced in

transference/countertransference (Kearns, 2005). As Racker (1953) pointed out, CT has been long under-investigated, perhaps in relation to the analysts' own rejection of their responses of primitive anxiety and guilt. Nevertheless, contemporary models of psychotherapy acknowledge the importance of CT in the therapeutic relationship, as well as its impact on the therapeutic outcome. Especially when working with clients with complex presentations such as EDs, the concept of CT is crucial in the understanding of the unconscious processes and communication to aid therapeutic movement. EDs represent an increasingly common difficulty in the UK and more and more new therapists are employed in specialised EDs services or will come across clients with EDs. As the presented literature describes experienced therapists' strong CT reactions when working with clients with EDs, it becomes crucial to explore the CT responses of newly qualified therapists in their work with this client group as an increasing number of them become exposed to specialist EDs services and their clients. Such experiences are considerably, yet not exclusively critical to the field of counselling psychology which seeks to promote reflexivity and reflective practice in the work with clients and the self-care of therapists.

4. Countertransference – a phenomenon present across a range of presentations

CT has been discussed regarding its importance towards therapeutic progress across different presentations within the literature. It has been described as a crucial phenomenon in the process of making sense of clients' difficulties along with the new, surprising reactions experienced by therapists in their clinical work (Wolstein, 1988). Widely noted both in the consultation room and outside of it (in the therapists' strong feelings prior to or after sessions), CT has been described as a phenomenon raging across clinical presentations by many theorists beginning with Freud (1910) and into more contemporary

writings (Clarkson & Nuttall, 2000; Fonagy & Target, 2003; Hayes, Gelso & Hammel, 2011; Hinshelwood, 2002; Lemma, 2016; Satir et al., 2009; Soth, 2005; Shipton, 2004).

Cohen (1952) noted that regardless of psychopathology, there are different situations when the therapist may experience uncommon levels of anxiety in clinical work, which was understood as CT. She enumerates these situations as: whenever the therapist feels helpless in shifting the client's presentation; when the therapist is seen as an object of fear/criticism/contempt; when the therapist is treated as the only object of advice for the client; when the therapist is seduced by their client and when the therapist is requested for "other intimacy", as for example being asked to expand the therapeutic relationship to friendships or romanticism. Such situations may become part of the therapy process with clients regardless of their diagnosis; therefore CT becomes a relevant phenomenon across a range of psychopathologies.

Other authors have pointed towards the importance of CT reactions to the work with clients who struggle to identify and communicate intense emotions. For example, Little (1957) wrote about her work with paranoid presentations, emphasising that through CT the therapist becomes aware of their clients' intense and disturbed experiences. She adds that using CT information, the therapist is then able to communicate their own human nature to their clients, which allows for a genuine relationship. Such view was also shared by Epstein (1979), Spotnitz (1969) and Searles (1978) who recommended that therapists communicate their CT reactions to their clients with borderline and schizophrenic presentations.

More recently, Hinshelwood (2002) indicated that CT plays a crucial role in the work with severe presentations, such as psychosis and severe personality disorders. He describes severe personality disorders (SPD) as personality difficulties characterised by

severe lack of care in its core, further defined by heightened suspiciousness to therapeutic help, identification with the abuser and internalisation of the original abuse. Considering these features, he argued that clinical staff's general attitudes towards such clients often involve strong CT in the form of emotional distance and a striking sense of condemnation towards their patients. Consequently, he postulated that such powerful CT often impacts on the clinical interventions with such clients, leading to clinicians becoming more and more detached, basing their practices mainly on 'scientific psychiatry'. This is understood as avoiding the establishment of a therapeutic alliance with the clients by adopting a medical stance where feelings are denied and unwelcomed and treatment becomes reduced to symptoms, labels and medication. Furthermore, he identified that CT reactions are crucial to the work with clients with severe personality disorders, such as clients diagnosed with antisocial, paranoid, borderline and narcissistic personality difficulties. Left undetected, CT can lead to increasingly condemning clients of receiving unworthy help, or barely tolerating and often extruding clients. This could lead to clients potentially being pushed away towards the criminal justice system, ending up in prions or other inpatient mental health services.

On the other hand, Hinshelwood (2002) acknowledged that CT responses can also impact staff in the opposite way, such that clinicians become too indulgent instead, in the attempt to rescue patients. Whilst CT reactions can be very helpful to the understanding of the dynamic between client and therapist, it becomes clear that intense CT responses can also pull therapists into the danger of acting out, possibly re-enacting previous relating patterns of their own or their clients'. Therefore, Hinshelwood (2002) pointed out that most times CT reactions of helplessness or worthlessness, as well as meaninglessness and retribution often represent key responses into what the patient needs help with. He recommends that clinicians receive at least some training and support by their services to

recognise and reflect on their CT reactions towards their clients in a non-judgemental way.

The role of CT has also proven crucial in the therapeutic work with clients diagnosed with antisocial personality disorder (ASPD). Evans (2011) argued that clinicians working in forensic or mental health settings face significant difficulties as the patients' actions within the clinical environment often trigger powerful CT responses that are difficult to contain. He further explained that the forceful and concrete nature of the communications and the feelings evoked can make it difficult for the clinicians to reflect on the symbolic meaning behind the patients' actions. Clients may often target staff complaining that they have been mistreated, or they can also be seductive and charming, 'playing' staff members against each other. Most importantly to this study, Evans (2011) emphasised that new therapists are particularly vulnerable as patients may seduce them into believing that they can be 'rescued' or that they have a special relationship. In the absence of considering their CT responses to the clinical work, mental health professionals often find themselves responding to the magnetic pull of the patient's unconscious as they re-enact scenarios from their history. This can be problematic as it may lead the therapist into becoming stuck together with the client in their early relational patterns, unable to make any therapeutic shift and potentially causing the client further harm in this way.

Similarly, Lucas (2009) stated that therapists working with clients with ASPD presentations may find themselves drawn into the belief that their clients' stories are often plausible, persuasive and effective, frequently considering that the patient's thinking is normal, that they have not committed a crime, or they do not need treatment or care. Therefore, therapists may become caught up in their CT, becoming tempted to collude with the patient's view of their apparent improvement and their denial of their dependence upon the mental health system to maintain their improved mental state.

Both Hinshelwood (2002) and Lucas (2009) emphasised that CT responses often involve feelings of fury, experiencing similar responses to their clients' or interfering with them temporarily , all of which can affect the mental health professional's capacity to accurately assess their clinical state or level of risk. It therefore becomes of high importance that CT responses are considered and reflected on at both individual and institutional levels. This would help ensure that challenging clinical problems are discussed and that clients' tendency towards violent action/ thought/ways of relating, often leaving staff and therapists feeling helpless, ineffective, and frightened, are addressed. This is not only relevant to the work with individuals with severe presentations, but throughout the range of difficulties clients come into therapy to address. This is explained by CT as a phenomenon linked to process and the therapeutic relationship, further addressed in the next sub-section.

5. Countertransference and the Therapeutic Relationship

Throughout the diversity of talking therapies it has been well recognised in the modern literature that the quality of the therapeutic relationship is the vehicle of change (Clarkson, 2003; Jacobs, 2017; Lemma, 2016; Williams, 1997). Described as the relational context between client-therapist, the therapeutic relationship is infused with both individuals' desires and experiences both consciously and unconsciously, which the analytic literature explains through the rich concepts of transference and CT (Lemma, 2016).

A robust therapeutic relationship allows clients to use the therapeutic space to explore any needs and feelings, whilst also permits an exploration and work through any ruptures or disagreements (Jacobs, 2017). The therapeutic relationship becomes the invisible space containing of the processes between the two individuals in the room, one of which is the CT.

In the work with clients with EDs, the importance of CT as an unconscious process within the therapeutic relation has been emphasised by Shipton (2004) in her book. She underlines that therapeutic shift could only be gradually facilitated by the therapist, using CT informed interpretations. The therapist helps the client by guiding them to become aware of their relationship being founded erroneously on previous relationship templates based on unrealistic, infantile ways.

Clients with EDs often challenge such views through frequent denials of desires for an object, or through denying the object's value, replaced by substitutions (Sohn, 1985). Sohn wrote about clients with anorexia who often deny themselves appetite for any food, whilst clients with bulimia lack gratification from any food either seeking more or diversity. Subsequently, in the CT the analyst/therapist feels deskilled, unvalued, unwanted, unrecognised for their individuality, or for their interventions. CT as a process becomes crucial as described by Shipton (2004) as feelings of being "useless" can push the therapist into all sorts of behaviours. It is this aspect of CT that stands out in literature as underpinning the understanding of complex and powerful responses common when working with people with EDs.

Clinical teams may become divided due to the strength of the CT processes involved. Shipton (2004) argues that similar phenomena may take place with a client and their therapist. She explains that patient's relating style to the therapist and the type of object the therapist represents, are founded on the patient's previous kind of experiences which, in principle, are the ones they entered therapy to avoid. Although this unconscious transferential process is understood by psychoanalytic therapists, the constantly challenging therapeutic processes can have an impact on therapists in their CT.

Shipton (2004) further explains that the therapists' reactions to their clients with an ED may be considered differently regarding the object relations which arise. She proposes that the therapist reacts by experiencing the patient's inner world as both subject and object – the depriving and the deprived. Furthermore, some clients, especially women with EDs may sometimes evoke in the therapist a feeling of emotional disconnection from the patient, who appears untouchable. This is difficult for the therapists to tolerate as it becomes a wounding response to therapists' professional and personal wish to be helpful and to succeed in their work. Therefore, it becomes essential for therapists in such dynamics to be aware of their CT responses and to consider their potential effects on the therapy and therapeutic relationship.

In his paper on hate in the CT, Winnicott (1947) encourages therapists to accept hurtful, angry feelings towards clients, and to consider such reactions in relation to their meaning. In the work with individuals with EDs a frequent reaction on therapists' side is struggling to notice any hate (Gorman-Ezell, 2009; Shipton, 2004). This may be linked to the patient's difficulty to feel hate. In the CT, the therapist can feel trapped and confused. Keeping in sight the CT reactions, therapists are able to separate out the unconscious processes and maintain their sensitivity, empathy and individuality fitting with the work.

The psychodynamic literature has also acknowledged the difficult CT around the idea of a 'no-entry' system of defences for patients with anorexia in particular (Williams, 1997), who want to keep out the world. Williams (1997) noticed that initially patients can only cope with "small spoonfuls" of therapy. Shipton (2004) added that in the contemporary approaches, therapists are encouraged to reflect on how their language is received by patients considering the patient's responses to it. Williams (1997) also

described the work with more receptive patients where therapists' projections were received like "foreign bodies".

Lawrence (2002) argued about the intrusiveness of internal objects in clients with anorexia. She highlighted that, for clients with anorexia, the ability to take in or allow anything good to enter the body is affected. This is suggested to be impacting on clients' restricting both food and sexuality. Lawrence (2002) further indicates that the relationship with the mother is used to help disguise anxiety rather than containing and overcoming it. Potentially, such findings may be further extended to explain the quality and struggles in the relationship between therapist and client, in the transference. Lawrence's (2002) suggestions may also offer therapists an indication of the difficulties adult clients with anorexia may encounter in allowing any 'good' (such as the therapy) enter their minds and make any progress. This may be important to consider when trying to make sense of therapists' difficult CT reactions while working with adults who suffer from anorexia, experiencing the therapy as complex and difficult to achieve progress.

Overall, there are many competing perspectives which can affect the therapist's CT when engaging therapeutically with individuals with an ED and gaging the right support to provide them with 'therapeutic food' (Gorman-Ezell, 2009; Lawrence, 2002; Shipton, 2004; Williams, 1997). The therapist frequently faces challenges in the CT as clients often struggle with flexibility in thinking about their experiences, therefore communication involves unconscious splitting and divisive processes often mobilised by clients. The fact that some therapists may also be uncomfortable with their anxieties and their relationship to food and their own bodies may also intervene in the clinical work (Lowell & Meader, 2005). Further anxiety in the therapists' CT reactions may be fuelled by the fear of losing their patients who may act out in dangerous ways (Sella, 2003; Treasure, Schmidt, & Furth, 2003). Therefore, whilst the literature mentions the CT experiences of senior

practitioners and how they manage and work with such reactions, more needs to be known about newly qualified therapists as more and more are being called upon to work with EDs. Thus, the focus of this study is to better understand how they work and manage CT when working with this client group.

6. Therapists' difficulties working with Countertransference

While there is sufficient literature on the topic of CT and EDs, there are very few studies which have explored the impact of CT on newly qualified therapists. Delucia-Waack (1999) indicated that therapists working with EDs should be mindful of their own body images, self-worth and attractiveness in order to avoid overidentifying with their clients, which could possibly hinder the therapy. While this article emphasises the importance of supervision in managing CT, it refers to therapists who have experienced working with clients with ED for a long time in a group setting and not in individual therapy. Consequently, when taking into account the phenomenon of CT in individual therapy and its impact on the new therapist's feelings, body image and eating habits, existent literature appears to lack much in the way of qualitative research.

In her recent study, Verbeek (2016) considered female therapists who had recovered from an eating disorder and explored their experiences of providing therapy to female clients with EDs. She used Interpretative Phenomenological Analysis (IPA) to show therapists' lived experiences of understanding, empathising and resonating with their clients whilst recognising that recovery is a life-long process. She illustrated that they could become stuck and overidentified with the clients' struggles. Whilst Verbeek was successful in providing important findings for the field of Counselling Psychology and treatment of EDs such as the need to become aware of own CT and bracket it, it remains unclear what are the implications or experiences of new therapists who have not

experienced an eating disorder and whether their CT experiences are similar to the experienced therapists'.

Another significant study in this area of the literature was conducted by Gorman-Ezell (2009), who looked at the links between CT, eating attitudes, body image and self-esteem in professionals working with EDs. This study, conducted in the USA, was based on a quantitative methodology and a cross-sectional design which utilised self-report measures. The findings suggest that therapists' CT was found to be less intense and with little impact on the therapeutic work if their self-esteem was high. These findings are perhaps indicative of the importance of therapists' self-development through advanced self-reflective skills and increasing own self-esteem in personal therapy and supervision as ways of managing CT reactions without hindering of the therapeutic process. Nevertheless, the study's positivist stance and social epistemological position limit the provision of personal experiences of new therapists' own lived experiences of CT and possible implications of these due to the restraints of the employed quantitative methods and lack of understanding of participants' experiences and meanings behind these.

Satir et al. (2009) showed that in comparison with trainee psychotherapists, highly specialised psychotherapists working with adolescents with EDs did not generally experience significant levels of negative CT. On the other hand, the study also found that in the case of the small proportion of therapists who did experience negative feelings, the experiences were similar to those of the trainees. These findings showed that negative CT can still emerge even in therapists with significant clinical experience in EDs. It however remains unclear whether these findings are expected to be similar when working with adults with EDs and whether a qualitative methodology focusing on new therapists' experiences would find similar results as this study.

While CT may impact on the therapist's body and eating habits when working with clients with EDs, it is also important to recognise its positive role as a significant source of information that informs the therapy process as suggested by Earlichman (1998):

> *"In the final analysis, countertransference is the unconscious storage chest of our lives, containing all the thoughts, feelings, memories, actions, and reactions that result from contact with each and every patient we face. To deny, ignore, or waste its vitality is to lose a precious gift to our patients and ourselves" (p.294).*

7. Treatment and level of experience when working with EDs in the NHS

Most recent written national guidelines for the psychological treatment of adults diagnosed with EDs in the NHS by the National Institute for Health and Care Excellence (NICE, 2017) recommend eating disorder-focused cognitive behavioural therapy (CBT-ED) for the majority of EDs, either in individual or group settings. The guidelines also suggest another cognitive behavioural based form of therapies such as the Maudsley Anorexia Nervosa Treatment for Adults (MANTRA) and specialist supportive clinical management (SSCM). In cases where the above forms of therapy are not successful, the NICE guidelines recommend eating-disorder-focused focal psychodynamic therapy (FPT).

However, it is important to highlight the observation that the NICE guidelines used in the NHS follow a medicalised model of understanding EDs. These difficulties are viewed as a psychiatric disorder where the patient's presentation is explained through an imbalance of neurotransmitters. Medication and therapy are used to treat the patient alongside eating/feeding plans aided by nurses and dieticians. Whilst these observations

and treatment styles can be helpful to the individuals in difficulties with their feeding, unfortunately little attention is paid to the processes between clients and clinicians in the treatment of EDs.

It is apparent that the biological/medical model appears to omit from consideration the role of the clinician in the therapeutic relationship, and subsequently on the therapy/treatment. This is in line with a positivist view of the model where the therapist is viewed separately from the treatment's outcome and as an outsider, not interfering with the client or the therapy. However, previously mentioned literature supports and acknowledges the presence and impact of the therapists' complex CT reactions. These reactions have the potential of becoming challenging for themselves, the therapeutic relationship, therapy outcome and clients' progress (Lowell & Meader, 2005; Orbach, 2004; Satir, Thompson-Bremmer, Boisseau, et al, 2009; Soth, 2005). It is not within the scope of this study to discuss the most effective therapeutic approaches for clients with EDs. I am bringing to attention the efficacy of the therapy and the necessity and criticality of understanding and managing newly qualified therapists' CT working with individuals with EDs within the therapeutic relationship.

Regardless of the different theoretical models informing the treatment of adults with EDs, the role of the therapist in individual therapy is significant in the created relationship in the consultation room, as in the case of other mental health problems, guiding the client through recovery (Lemma, 2016). Therefore, as a human being who is also exposed to the societal pressure, regardless of the type of therapy used, new therapists are also exposed to the complexity and difficulties of clients presenting with EDs by being present in the therapy room. It follows from the ideas presented in the literature which postulate that therapists can also possibly become vulnerable to unhelpful thoughts and feelings related to body image, weight and eating behaviours in the CT (Delucia-Waack, 1999;

Orbach, 2004; Soth, 2005; Walker & Lloyd, 2011; Zerbe, 2013). Consequently, it is essential that efforts are made towards further understanding of the experiences of new therapists' responses/CT when working with EDs clients across different perspectives.

The idea of therapists' experience in the treatment of EDs has been widely debated in the literature in connection to the therapists' reactions to their clients (Satir, 2013; Satir, Thompson-Bremmer, Boisseau, et al, 2009). Gorman-Ezell's study (2009) which used quantitative methods showed that therapists with high self-esteem have less CT experiences with ED clients. Although this study is insightful in providing an understanding around the relationship between CT and therapists' self-esteem, it does not refer to any further connections with levels of experience and newly qualified therapists' CT. Similarly, other studies seem to describe findings in the same area. One of the earliest studies by Orbach (1986) underlined that clinicians can experience high levels of CT responses when working in areas in which they have limited training regarding that client group. This study began to point towards a possible relationship between strong CT reactions and therapists' limited training/experience with a specific client group, although it remains unclear about specific reports of new therapists' experiences of CT.

A more recent study by Warren, Schafer, Crowley, & Olivardia (2013) argued that therapists experience level in EDs was predictive of burnout. Therefore, they emphasised that years of training and experience are essential in working effectively and safely with individuals seeking treatment for EDs. This opinion was also shared by Satir et al. (2009) in her quantitative study which found that highly specialized therapists have low CT compared to trainees in EDs. In her later paper, Satir (2013), commented on the relationship between therapists' low level of experience and experiencing burnout.

Similarly, Franko & Rolfe (1996) showed that less experienced therapists felt more frustrated around clients with anorexia. They felt more scared, angry and tense in comparison with other therapists with more experience. While this study seems to point towards similar conclusions as the previously reviewed ones, it is imperative to keep in mind that this study used quantitative methods and focused only on working with anorexia. Therefore, no clear accounts were given to any experiences of young or new therapists working with EDs.

Other studies focused on the embodied CT experiences, such as Walker & Lloyd (2011) who addressed the need for health professionals to experience dealing with their bodies being examined by EDs clients. Delucia-Waack (1999) mentioned the need for therapists to have body awareness, self-worth and understanding of their attractiveness as well as clarity in self-exploration and examination. Zerbe (2013) identified the need for therapists to have experience with EDs as a way of avoiding therapists' body image being impacted on by their clients in therapy. While the focus of these studies is on the embodied experiences and the need of the therapists to be experienced in working with EDs, there is little understanding of how this applies to new therapists.

Furthermore, other studies brought to attention the importance of professional competence in working with EDs and identified that new therapists may feel more self-conscious and experience self-doubt (Gurney & Halmi, 2001). Similarly, an earlier paper by Jarman, Smith & Walsh (1997) argued that treating EDs places high demands on mental health services for therapeutic help and emphasized the importance of training in this area due to the difficulty of the conditions. Also, Williams & Haverkamp (2010) mentioned that the demands for therapists in EDs often exceeds availability, which increases the probability of placing young therapists at risk of negative experiences if not having enough clinical experience in the field. Holbrook (2013) in her qualitative study

considered some trainees, but not newly qualified therapists. In keeping with one of the themes of this paper, her findings are related to the level of experience of the therapists, as in the above literature. However, this study only considered clients with anorexia.

Whilst the literature seems to generally acknowledge the criticality of CT in the work with clients with EDs, little exists to describe new therapists' accounts of their CT in this area of clinical work. Lunn, Poulsen & Daniel's (2016) recent study found that strong CT in therapists can affect outcomes in EDs and personality disorders pathology. This follows the findings of Hamburg & Herzog's study (1990) which postulated that it should be expected that therapists will be hurt by their clients with EDs in therapy. Considering the studies presented above which point out the importance of clinical experience in managing CT reactions, it is ever more relevant that new therapists' experiences of CT need to be better understood. The following section addresses in detail the rationale of the current study.

8. Rationale Aims and Relevance to Counselling Psychology

Following on from the critical review of the literature as presented in the above sections, therapists' CT reactions when working with clients with EDs has been recognised as possibly having significant impact on the therapists. Whilst the literature mentions a link between the intensity and type of CT and therapists' levels of experience and self-esteem, little is written about the CT of newly qualified therapists when working with this complex client group. Clearly, there is an identifiable gap in the understanding of how newly qualified therapists may experience such CT reactions in therapy with individuals with EDs.

This study hopes to produce new findings in response to the request for further research that previous studies acknowledged as necessary in forming a more

comprehensive understanding of CT within the modern psychodynamic therapies. The impact of such findings in this field could create additional knowledge about the therapeutic work with clients with EDs, hopefully leading to clearer ideas regarding potential CT reactions and management of these responses in ways that would protect the therapeutic relationship and support clients' progress and wellbeing.

Furthermore, it is possible that the current study's findings may have a potential impact on the review of clinical practice for training therapists and newly qualified therapists' training when heading into working with clients with EDs. The findings may produce information relevant for further developments regarding the supervisory process for newly qualified therapists as well as general guidelines and regulations for treatment of EDs.

The rationale and aims of this study are relevant for the broader field of psychological therapies, as well as for the field of Counselling Psychology. Looking into the value of the CT reactions evoked in therapists to the therapeutic process during work with clients with EDs, I bring to attention the weight of the therapeutic relationship, and intersubjectivity (Diamond & Marrone, 2003; Fonagy & Target, 2003). Developmentally, intersubjectivity proclaims that the self always exists in relation to another, thus meaning 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. This is critical for the field of Counselling Psychology, which focuses deeply on therapists' reflective and reflexive skills, essential in understanding and managing CT (Fauth, 2006; Hayes & Gelso, 2011; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Van Wagoner, Gelso, Hayes & Diemer, 1991). Focused in particular on the counselling processes, counselling psychology places emphasis on distinguishable interventions creating a scrutinised attention around relational aspects and process (Burton & Davey,

2003). Similarly, psychodynamic theories postulate the relationship as central and the catalyst of change, accounting for the required knowledge of psychodynamic theories in supporting therapists reflect on process or what is taking place between therapist and client (Laughton-Brown, 2010).

Counselling psychology is underpinned by phenomenological, existential and humanistic principles. Viewing human beings in a holistic manner and thus accentuating a pursuit for meaning and understanding, large attention is paid to the therapeutic process and subjectivity rather than diagnostic criteria (Strawbridge & Woolfe 2003). The accent on reflexivity is founded on a strong commitment to personal development as an essential part of the training for counselling psychologists through personal therapy and supervision.

Consequently, it is hoped that this study adds to the understanding of process issues in the therapy with clients with EDs. This is in line with the practice of counselling psychologists by its focus on meaning, subjective experience and mutually constructed realities (Strawbridge & Woolfe, 2003). Furthermore, this study employs also a paradigm shift from quantitative research methods to a qualitative approach (Ponterotto, 2005).

Considering the above aims and potential use of findings, the study's research question is:

'How do newly qualified therapists experience countertransference working with clients with EDs?'

I aim to address the above research question by focusing on the understanding of newly qualified therapists' experiences, taking an exploratory stance. Detailed information about the study's design, recruitment of participants, data collection and

epistemology are addressed in the following chapter consisting of the methodology of the study.

CHAPTER TWO: METHODOLOGY

Chapter Overview

This research aims to understand more about the experiences of countertransference (CT) that newly qualified therapists encounter when working with clients with eating disorders (EDs). It seeks to produce a profound perspective and subjective views new therapists attribute to their CT, how they make sense of it and what impact such experiences may have. Thematic Analysis (TA) was employed to address these aims as an appropriate method for exploring individuals' experiences, allowing for epistemological flexibility (Braun & Clarke, 2006) and compatibility with the predefined concepts of CT and EDs. This chapter clarifies the rationale behind the employed methodology in line with philosophical underpinnings, describing the research stages of recruitment, data collection and the process of analysis. It also describes ethical issues and quality requirements related to this study.

1. Rationale for using a Qualitative Methodology

The present study endeavours to respond to a research question which points to a qualitative design considering the nature of an exploratory stance of participants' subjective experiences. Employing a qualitative approach, participants are encouraged to express their views by using their own language (Barker et al, 2002) and share their own personal experiences (Alderfer & Sood, 2016) or as part of a specific group (Carroll & Rothe, 2010). In comparison to quantitative research, qualitative research allows participants more freedom to respond with their own life experiences in describing their own understanding of the researched topic, allowing for a deep understanding of particular areas otherwise difficult to be quantified (Barker et al, 2002) and thus clarifying how people make sense of specific events or experiences (Willig, 2008). Moreover,

qualitative research fits with the philosophical values and underpinnings of Counselling Psychology which places emphasis of the individual and their subjective experiences (British Psychological Society, 2005).

2. Epistemological position

When considering different epistemological approaches to research, it is crucial to point out the complexity and diversity of each paradigm and the fact that very often there is no 'clear cut' between them (Madill, et al., 2000, Willig, 2001). While quantitative research tends to adopt positivist paradigms with realist ontology, qualitative research tends to adopt post-positivist paradigms with critical realist or social constructionist ontology (Ponterotto, 2005). Researchers can often move between different positions, however, within each research project it is important to state a position which essentially communicates the underlying assumptions and beliefs guiding the research (Madill, et al., 2000; Hays & Wood, 2011).

The objective of the proposed study is to capture the experiences of countertransference (CT) newly qualified therapists encountered when working in individual therapy with clients with eating disorders (EDs). Therefore, this project is grounded in the critical-realist ideology paradigm while acknowledging aspects of constructivist ontology. The rationale underpinning this stance is that reality may have an aspect of being socially defined, but how we perceive this reality and our personal experiences of the world is different for everyone (Bhaskar, 1975). Additionally, my standpoint that there might be multiple understandings of reality due to everyone's individual experiences explains that in order to understand it, we have to evaluate it critically. Thus, my epistemological beliefs are in line with the position of a critical realist.

Critical realism proclaims that a world independent of human beings exists and there are deep structures in the works that can be represented by scientific theories. This position interprets reality as complex and identifies the role of both agency and structural factors as impacting on human behaviour (Given, 2008).

From a critical realist epistemological position, this study would recognise that an external reality exists, but this would be distinctly perceived by different individuals (Braun & Clarke, 2006). In line with this, my stance would be that whilst that there is some form of reality that can be known, although not universal, I acknowledge that personal experiences shape the way in which we understand it. Therefore, my aim for this study is to explore personal experiences as a way of discovering people's realities, to inform and possibly expand on current concepts and theories. I believe that this stance would enable a deeper understanding of the experiences of new therapists' CT as being 'real', whilst accepting that such experiences cannot be explained by one single reality.

My epistemological position has been shaped both by my training in counselling psychology, as well as my personal and clinical experiences as a trainee working in the NHS. My understanding of CT and EDs has been influenced by the psychodynamic approach and by my own personal experiences of working with adults who have EDs, therefore confronting myself with real concepts which inform treatment.

Critical realism admits that some parts of reality are stable and lasting thus exist autonomously of human conceptualisation. Following this paradigm, individuals attribute different meanings to individual experiences in line with the belief that they perceive different parts of reality. This research takes into consideration the existence of CT in the therapy room as well as the reality of the diagnosis of EDs both as clearly distinguished

concepts in the DSM 5 (APA, 2013) and the psychodynamic understanding of human distress and treatment.

Whilst it is clear that different types of qualitative research share similar characteristics, such as having a focus on finding meaning, on trying to understand subjectivity and experience, there are also fundamental differences among the different methods due to their different epistemological orientations (Willig, 2012). Such positions represent the anchor point of qualitative research, as they are the starting point of any project, defining the researcher's philosophical stance. The current study's epistemological position of critical realism has been considered based on the research question investigated, (Harper, 2012). Furthermore, the stance of a critical-realist has also been evaluated in relation with other main epistemological branches. According to Willig (2012), epistemological positions can be divided into two main categories such as Phenomenological and Social Constructionist stances.

A phenomenological position, together with its variations of interpretative versus descriptive phenomenology, was initially considered for this study. This stance was a potential choice for the current study, as this is recognised as one of the most used positions within the field of counselling psychology. It postulates to understand phenomena based on "the quality and texture of the participant's experience" (Willig, 2012), without questioning it or expecting it to link with other forms of previous knowledge. Phenomenological knowledge claims that a phenomenon can be understood regardless of a theoretical frame previously established but based on the experiential world of the participant. Therefore, on closer examination, it became apparent that this epistemological stance proclaims to produce knowledge about the subjective experience of participants without counting the psychological concepts/processes underpinning such experiences (Harper, 2012; Willig, 2012), which in this case were related to the process

of CT. This concept is central to the current study and has a long-standing origin and understanding clearly shaped by a well-known theoretical model in psychology - the psychodynamic theoretical approach. Therefore, a phenomenological epistemology was deemed unsuitable for the current study as it would have clashed with the theoretical underpinnings of the psychodynamic theory and focus on a specific process such as CT.

A social constructionist stance, including its varieties or radical, moderate or critical realist social constructionism, was also considered and eliminated as a potential epistemological position underpinning the current study. Social constructionist epistemology concentrates on the process by which knowledge is gained, such as studying discourses and the ways in which they are used within particular contexts (Harper, 2012). Furthermore, it assumes that all human experiences are mediated by language, therefore being social constructions. This was found unsuitable for this study, as social constructionism brings into attention the way participants speak about a phenomenon using language to create knowledge (Willig, 2012) and so dismissing the psychological understanding based on the psychodynamic theory of CT. Harper (2012) described social constructionism as closely related to social, historical and cultural context, investigating a phenomenon as a "range of interpersonal and societal functions" (p. 90), all of which are not of interest in the current study. Instead, the current study's focus is exploring the participants' experiences of CT using a predetermined theoretic model, the psychodynamic theory. Therefore, a social constructionism epistemology would have been unfitting with the study's purpose, as CT is discussed from a psychodynamic perspective rather than as a socially constructed phenomenon.

Following the above considerations, it was deemed as most appropriate epistemological position for this study is critical realism. This is congruent with the theoretical underpinnings of the concept of CT, acknowledging some form of reality in

its existence in the therapy room, yet requiring the need to reflect on the subjective realities in order to generate a more comprehensive understanding of the phenomenon in question. Moreover, this stance is also in harmony with the chosen method for the study, thematic analysis (TA), further explained in the following sections.

3. Rationale for using Thematic Analysis as chosen method

Thematic analysis (TA) represents the methodology chosen for conducting this study. This method is widely used in qualitative research to recognise, analyse and account for patterns or themes throughout the data collected (McLeod, 2011; Willig & Stainton-Rogers, 2008). As illustrated in the literature review chapter, previous qualitative research conducted on the experiences of therapists working with EDs have solely used IPA as a qualitative method chosen and have not provided any evidence of the subjective experience of newly qualified therapists.

The current study employed a qualitative method to research newly qualified therapists' experiences of CT with clients presenting with an ED. Considering the need for compatibility between the researched topic and the method used to conduct a research study (Willig & Stainton-Rogers, 2008), TA method was chosen as most adequate for this study. Choosing TA made it possible to accommodate for a compatible relationship between the established reality of the investigated concepts of CT and EDs and the epistemological stance of critical realist adopted in this study. Furthermore, TA also allows for flexibility within the theoretical framework, therefore permitting for the adoption of the critical realist position and locating itself between the two stances of essentialism and constructions (Braun & Clarke, 2006). The mentioned authors have also explained that TA, using a critical realist epistemological position, recognises the manners in which individuals provide an understanding in relation to their experiences,

concurrently taking into consideration the impact of social settings imposed on their perceptions, but nevertheless maintaining an emphasis on the reality and its materialism.

Consequently, TA permits for a social and psychological interpretation of the data set. In comparison to other methods, TA was chosen as opposed to other qualitative approaches due to its element of epistemological flexibility, along with its focus on understanding and interpreting participants' experiences. Although Interpretive Phenomenological Analysis (IPA) brings the attention on the deep meaning making of subjective experiences, it was eliminated as a possible method considering its dissonance with the concept of CT as predefined in the psychodynamic model. This decision can be further explained by the phenomenological nature of IPA, which seeks to capture participants' experiences as they exist in the world regardless of associations with any predetermined theories, relationships or objectivity (Willig, 2012). In contrast with IPA, the current study focuses on the understanding of participants' CT experiences as they are made sense of through the concept's underpinnings within the psychodynamic theoretical model. This implies that the study considers a form of established reality, in this case the psychodynamic understanding of CT, to explore participants' subjective experiences, therefore moving away from IPA's phenomenological nature of exploring individual experiences regardless of any predefined realities. The phenomenon of CT is therefore understood in association with a pre-established theoretical approach, which is in line with a critical realist epistemology by drawing on evidence from theory (Harper, 2012), rather than phenomenology.

Discourse Analysis was deemed unsuitable for the current study as it particularly highlights the function of language in constructing social reality (Willig, 2008). As the current study's aim is to understand new therapists' experiences of CT with clients with EDs, the method needed does not seem to match with Discourse Analysis' aim of

investigating the discursive effects of participants talking about a specific experience from a particular context (Willig, 2008).

Grounded theory was likewise considered unfitting to employ in this study as despite of its similar focus understanding subjective experiences, it appears more disposed towards social phenomena rather than focusing on psychological processes involved in understanding how individuals make sense of a particular experience (Willig, 2001).

Thus, TA was considered most appropriate for the aim of the current study as it allows the investigation of clearly established concepts in the reality as understood by the psychodynamic paradigm whilst investigating participants' experiences in this area. Using TA it is hoped to inform the Counselling Psychology field on specific issues such as the experiences of new therapists in CT with clients with EDs. This would be central to the field of psychological therapies as more therapists are needed in the treatment of EDs and new therapists are often working in this area. Therefore, contribution towards the training of new therapists in EDs is considered highly significant.

4. Thematic Analysis

TA is regarded as a qualitative method in its own right (Braun and Clarke, 2006), making possible the identification and analysis of patterns of meaning within a given data set, allowing for the organisation and detailed description of data. Braun and Clarke (2006) discussed that the employment of TA involves several steps which the researcher must reflect on. First, they underline the subjective aspect in the researcher's decision of identifying themes, highlighting the significance of the researcher's impact and retention of flexibility in this decision. Braun & Clarke (2006) argued that in the process of finding a theme it is appropriate to consider its ability to capture relevant information to the

research question(s). Furthermore, it is vital the researcher decides on the tactic they undertake in the process of patterns or themes finding within the data. Patton (1990) postulates that this can be achieved using an inductive or bottom-up method, meaning the identified themes are strongly linked to the data. However, this approach does not make use of analytical preconceptions in the coding process. Alternatively, a theoretical or deductive or top-down approach can be used, in which the thematic analysis is driven by the researcher's theoretical framework.

Braun and Clarke (2006) also argue that the researcher should clarify the extent of identifying themes. They claim this can be achieved at a semantic level, where the "themes are identified within the explicit or surface meanings of the data and the analyst is not looking for anything beyond what a participant has said or what has been written" (p. 13). On the other hand, TA may also be conducted at a latent level, where the researcher engages in "identifying or examining the underlying ideas, assumptions, and conceptualisations and ideologies that are theorised as shaping or informing the semantic content of the data" (p. 13). For the purpose of the current study analysis was conducted at a latent level.

Braun and Clarke (2006) further explain that thematic analysis represents a respected research method for investigating a gap-area in literature and capturing participants' subjective experiences. TA also pursues to explore the meanings people attribute to their social reality (Schutz, 1962). However, TA further allows for flexibility in identifying constructs (Lawrence, 2012), which explains its suitability for the current project.

Braun and Clarke (2006) provided a clear process of analysis which encompasses six phases in carrying out TA (see Table 1). During the first phase, the researcher engages

with the data to become more and more familiar with it. This is accomplished by transcribing and repeatedly reading the data. Continuous engagement with the data allows the researcher to immerse themselves in the data, becoming progressively more knowledgeable of the content. Following this, phase two can commence by identifying initial codes. Boyatzis (1998) defined codes as "the most basic segment, or element, of the raw data or information that can be accessed in a meaningful way regarding the phenomenon" (p. 63). Following, phase three represents the categorisation of the codes into potential themes. At this point, an initial thematic map may be helpful to sort the codes into themes. Phase four involves refining the themes and subthemes by revisiting the map to check if it reflects the data set. At one level, Braun and Clarke (2006) suggest reviewing the coded extracts by rereading and considering if they appear in a coherent pattern. Level two involves this similar process where the research considers the validity of the themes in relation to the data set. This produces a final idea of the different themes and how they fit together. The final phase involves identifying the 'essence' of each theme and what aspects of the data it captures. Each theme can then be named to give the reader an awareness of what the theme is about.

Table 1: Phases of Thematic Analysis

PHASE	DESCRIPTION OF PROCESS
1. FAMILIARISING SELF WITH THE DATA	Transcribing data; reading and rereading the data and noting ideas
2. GENERATING INITIAL CODES	Coding for interesting features of the data, systematically across the data set
3. SEARCHING FOR PATTERNS AND THEMES	Reviewing codes and beginning to collate these into potential themes across the data set
4. REVIEWING THEMES	Checking whether the data supports the themes i.e. at the level of the coded extracts and across the data set; generating an initial map of themes
5. DEFINING AND NAMING THEMES	Refining the thematic map in relation to specific themes and how these link to tell a story; generating clear definition and names of themes
6. WRITING THE ANALYSIS	Selecting vivid extracts to illustrate themes; analysing these in relation to the research questions

5. Participants

5.1 Inclusion and Exclusion criteria

For this study, a number of eleven participants were recruited and interviewed. The aim of the study was to explore experiences of CT in newly qualified therapists working with clients with EDs. Therefore, the inclusion criteria were:

1. Working with clients with EDs using a psychodynamic or integrative approach

2. Two years or less since qualification

3. Worked with clients with EDs in the last 12 months in individual therapy

As the study aimed to explore therapists' experiences of CT, a variety of qualifications in the field of psychotherapies was used, such as newly qualified psychologists, psychodynamic psychotherapists and counsellors. Furthermore, the rationale behind the model of therapy employed by the participants was directly involved with the understanding and use of the concept of CT in the clinical work with their clients.

Participants were excluded if they did not provide informed consent or if their clinical qualification was awarded more than two years before the time of the interview. The term of "newly qualified" was used in accordance with the British Psychological Society (BPS, 2009) definition of a newly qualified therapist/psychologist, which stipulates a period of time of up to two years post-qualification. Participants were also excluded if they were not actively working with clients with eating problems or if they have not been seeing EDs clients in therapy within the last 12 months using an integrative or psychodynamic model in treatment. The rationale underneath this criterion is explained by the relevance of the gathered data to the proposed area of research, as well as the participants' abilities of understanding, reflecting and recalling their CT experiences in therapy with their clients.

According to Braun & Clarke (2013), approximately 10 participants would be the suggested number of participants when using TA to conduct a research project at doctoral level. It is further explained that the suggested number of participants would allow for the identification of patterns across a data set (Braun & Clarke, 2013). Therefore, the purpose for this number of participants would allow for gathering of sufficient data to investigate and understand the group in depth. Of the eleven participants, two were male and nine

were female. A demographic table with their pseudonyms, training modality and period since qualification can be found below (Table 2).

Table 2: Participants' details

Name	Gender	Age	Training	Period since qualification
Pamela	*Female*	*29*	*Counselling Psychologist*	*1 year*
Peter	*Male*	*31*	*Counselling Psychologist*	*2 years*
Annalise	*Female*	*36*	*Counselling Psychologist*	*8 months*
Sonya	*Female*	*33*	*Clinical Psychologist*	*3 months*
Zara	*Female*	*32*	*Clinical Psychologist*	*1 year*
Ronald	*Male*	*40*	*Relational Counsellor*	*2 years*
Laura	*Female*	*30*	*Integrative Counsellor*	*2 years*
Rose	*Female*	*37*	*Psychoanalytic Psychotherapist*	*1 year*
Faith	*Female*	*34*	*Psychotherapist*	*2 years*
Mia	*Female*	*42*	*Counselling Psychologist*	*1 year*
Julia	*Female*	*34*	*Counselling Psychologist*	*3 months*

5.2 Recruitment

Nine of the participants were recruited from specialist eating disorders and secondary care services within the NHS services in London and around London, whilst two participants worked in primary care in the NHS. Advertisements (Appendix 1) were circulated within the services in printed and electronic forms. Also, emails were sent out to therapists advertising their work with clients with EDs on the British Psychological

Society website. Furthermore, participants were contacted by word-of-mouth also understood as the process of snowballing.

Participants who expressed interest in the study were asked to send an email to the researcher. The researcher then emailed back a consent form and an information sheet (Appendices 2 and 3) which outlined the purpose of the research, the criteria required to take part, information on what the process would entail, confidentiality, and participants' rights. Participants were given time to reflect on the purpose of the research and on their suitability. An opportunity was given to ask any questions before the interviews were arranged.

Issues around recruitment were encountered at the beginning stages of the research. These were related to finding enough participants to take part in the study. Despite numerous contacts made with both NHS and private therapy services offering treatment for EDs in London, only one participant agreed to take part. The rest of the participants were recruited through snowballing, using respondents' recommendations of colleagues who fitted the study's criteria (Atkinson & Flint, 2001). It may be possible that the difficulty around offering to take part in the study could have been influenced by potential concerns of discussing the difficult nature reflection on one's CT reactions, as well as the potential of being judged or viewed in a negative manner in relation to their individual experiences of CT with EDs clients. These difficulties were addressed by a careful consideration of the recruitment advert which emphasised the value of newly qualified therapists working with EDs clients. Furthermore, this was also explained in the supporting information of the study shared with the participants prior to their interviews.

6. Data Collection

6.1 Interview Schedule

The data collection consisted of eleven individual semi-structured interviews as the method of gathering data recommended for TA (Braun & Clarke, 2006). The interview schedule was developed following the appraisal of literature regarding this matter (Braun & Clarke, 2006) and further developed in consultation with the research supervisor. The interview schedule comprised of 10 open-ended, non-directive questions which can be found in the Appendix 5. The questions focused on accessing participants' experiences of the CT when working with clients with EDs. Furthermore, questions were also designed to capture the emotional, physical and therapeutic impact their experiences might have had on them and the work. Therefore, the questions referred to reflections around CT experiences and personal understanding in relations to these. This enabled the ability to collect rich data necessary for further analysis of participants' transcripts. Considering that the interviews could have had the possibility of eliciting strong emotions for the participants, the researcher's role was significant in the gathering of significant data as well as not causing harm to the participants.

Following the exploration of all questions in the interview schedule, each participant was invited to express anything else additionally to the discussed questions, as they considered important and which had not been mentioned during the interview. Also, participants were invited to reflect on their experience of taking part in the study as debriefing from the interview.

6.2 Interview Procedure and Transcribing

Three of the eleven interviews were conducted through Skype video calls, whilst the remaining eight interviews took place face-to-face. Prior to the beginning of each interview, participants were requested to sign a consent form. For the Skype interviews,

consent forms were emailed to the participants and were signed and returned back to the researcher prior to the interviews.

Issues relating to confidentiality were explained thoroughly before the start of the interviews. Also, before the beginning of the interview, participants were reminded that their contribution to the study was voluntary and that they had the right to withdraw at any time.

A digital audio recorder was used to audio record interviews for transcription purposes. Each interview lasted between 40 and 60 minutes. Although throughout the interviews the discussed topics remained centered on the areas covered by the interview schedule, according to guidelines regarding semi-structured interviews, the sequence in the interview schedule was not rigidly followed by the researcher. Some of the questions were asked in a different order than in the interview schedule as this was felt to flow naturally in line to the participants' stories. Furthermore, some of the questions were not asked, as some participants covered these questions prior to them being approached about such matters. On several occasions, the interviews addressed areas which the participants had not been asked about, but which led to the emergence of important data for the research question. This information was considered relevant as it seemed valuable to the participants' experiences, since they voluntarily and unprompted decided to share with the researcher.

Each of the interviews were transcribed verbatim soon after they ended. The process of transcription was completed by the researcher alone and comprised of all the words voiced during the interviews. Pauses, sighs, laughs and other conversational features were also transcribed. Transcripts were edited using generous margins on both sides to allow for notes and comments needed in the process of analysis. This is in line with Langdridge (2008) who postulated that transcription of interviews in data collection

represents an essential aspect of qualitative research.

Subsequent to the interview, participants were given the choice to reflect on their experiences of taking part in the research project. In the debriefing part following interviews, participants were provided information about how to access support if needed within their networks.

7. Ethical considerations

The study was granted ethical approval by the University of East London Ethics Committee in June 2018 (Appendix 10). Minor adjustments, exclusively related to the study's title, were made to reflect findings and were approved in August 2019 (Appendix 11), prior to the submission of this thesis for examination. This study complied strictly to the British Psychological Society Code of Ethics and Conduct (BPS, 2006) and was conducted by the researcher as part of their Professional Doctorate in Counselling Psychology.

In accordance with the Health Research Approval NHS (Health Research Approval, 2016) regulations regarding recruitment of participants in research studies using NHS staff as participants have been consulted and further ethical approval was not required from NHS institutions for this study as long as the interviews were outside of the participants' working time.

With regards to confidentiality and consent, participants were provided with an information page and a consent form (Appendices 2 and 3) prior to taking part in the research. Ahead of their participation they were made aware of the archiving of transcripts at the end of the study for possible publications in the future. Also, participants were reminded that they may decide to withdraw from the study at any time during the interview or withdraw their interview within a specified timeframe afterwards without

having to provide any explanations or reasonings. Issues around confidentiality, data protection and working alone were observed and attended in agreement with the British Psychological Society Code of Ethics and Conduct (British Psychological Society, 2006). All identifiable information was changed, instead the use of pseudonyms was employed. All signed forms and participants detailed information was stored separately from digital recordings, transcribed materials, and demographic details according to the Data Protection Act (1998).

Specific ethical concerns surrounded the investigated concepts of therapists' experiences of CT. For instance, reluctance to open up and discuss due to concerns about disclosing confidential information related to their qualities as therapists. Issues of power imbalances and assessing and minimising the risk of innocuous distress such as potential beliefs of incompetency in their experiences of CT were expected. These issues were addressed by the researcher approaching the topic in a sensitive manner, ensuring that the nature and importance of the research was made sound and that the value of their experiences and understandings of CT was crucial in understanding such an under looked area of the literature.

Detailed consideration was given to the impact on participants' abilities to deliver therapy following participation and also to the potential impact on the therapy process if the therapist/participant becomes distressed. These difficulties were managed during the debriefing part following the interview, where information about the study was disseminated and possible external support for participants (such as supervisors and personal therapists) were identified for participants to reach out if needed.

8. Data Analysis

The analysis followed the six phases of thematic analysis proposed by Braun and Clarke (2006), as presented in Table 1. The first phase of analysis consisted of reading and transcribing each interview; a verbatim account with punctuation was adopted to retain the sense of what the participants conveyed (Braun & Clarke, 2006). It has been argued that this phase was the key stage in becoming familiar with the data (Bird, 2005). The verbatim transcripts included all words, laughter and pauses in the interview (Appendix 6). No specific transcription tool (for example, Jefferson, 2004) was used.

During phase two, I employed an inductive bottom-up approach to code the data. The transcripts were read through in detail and interesting codes were noted at the side of the transcript (Appendix 7). As the transcripts were being coded, key features began to become noticeable, and similarities and differences across the data became apparent. Braun and Clarke's (2013) skill of reading and interpreting the data through the theoretical lens, known as 'analytic sensibility', was held in mind by the researcher throughout the process of thematic analysis. It also refers to the ability to produce insights into the meaning of the data beyond the surface; to recognise patterns or meaning that links to broader psychological, social, or theoretical concerns. Through the process of engagement with the data I have become more and more aware that participants' language at times involved use of figurative speech. Linguistic features, such as metaphors, seemed to have been employed by participants to help express their experiences of CT in the therapy room or outside it. The use of figures of speech allowed participants to communicate their experiences of CT as close to their perceptions. Underpinned by social constructionism ideas, language represents a medium of expression of an argument or particular viewpoint (Billig, 1991). Consequently, some of the codes used in the analysis incorporated linguistic elements and figurative language to capture the intensity of the

participants' CT experiences. Linguistic features such as laughter, pauses, functional aspects of language, tone, repetition, and metaphor were considered as constructive to the participants' perspectives in the analysis. Excerpts from the transcribed interviews were highlighted and clustered together using post-it notes based on their similarity (Appendix 8). This process led to the emergence of themes (Appendix 9) during phase three of analysis. Found themes were named considering the perceived essence of their meaning and significance of the codes. Although described as a linear process, data analysis followed a recursive process, repeatedly engaging with data as part of a back and forth movement throughout all six phases (Braun & Clarke, 2006).

Limitations and consideration of priming in future research are addressed in the discussion chapter.

9. Credibility in the research process

During the process of moving away from quantitative methods and increasingly using more qualitative methods, psychological research has confronted with discussions around quality and validity (Yardley, 2008) in the recent years. Spencer and Ritchie (2012) postulate that ensuring the research process is valid and sound, three principles need to be considered: contribution, credibility and rigour. Yardley (2008) argued that qualitative research can be assessed using four core areas: 'sensitivity to context', 'commitment and rigour', 'transparency and coherence', and 'impact and importance'. All four mentioned principles are recognised and applied in this study. The ability to demonstrate sensitivity to context can be achieved in various ways, such as demonstrating knowledge of the existing literature on the topic, or consulting research that has used a similar methodology. In the current study, this has been addressed through critically evaluating the literature in the introduction chapter as well as through the engagement of

theoretical concepts discussed in relation to the data. Also, throughout this study, I have considered my position as a psychological researcher and my influence on the balance of power in the interviewing process.

Commitment and rigor have been upheld throughout the analysis process by remaining attentive and sensitive towards the data. Transparency and coherence have been addressed through a comprehensive description of the research process at all stages, as well as careful presentation of each decision made where arguments are offered. Moreover, careful consideration was given to the fitting between the research question of the study and the underlying epistemological and ontological assumptions of the approach implemented.

The use of reflexivity at a conscious level throughout the research process demonstrates transparency. Reflexivity during research is understood as a fundamental component to the validity of qualitative research by providing transparency regarding the researcher's personal views and experiences (Lawrence, 2012; Willig, 2008). Lastly, this study's impact and importance are demonstrated through whether this research revealed interesting, useful, or relevant findings. These are discussed in detail in the following chapter, the analysis.

CHAPTER THREE: ANALYSIS

Chapter Overview

This chapter presents the findings produced by the analysis, highlighting how participants understand and talk about their experiences of countertransference (CT) in their work with clients with eating disorders (EDs). The analysis suggests that there are five distinct superordinate themes that seem to reflect the participants' experiences. These are: 'Doubting Own Identity', 'Safeguarding the client, the self and the work', 'Feeling "Chewed though and spat out", 'It's a Power Struggle!' and 'Being Equipped to Manage CT'. Each theme and their subordinate themes are subsequently described using quotes from across the interviews with the participants in the following sections of this chapter.

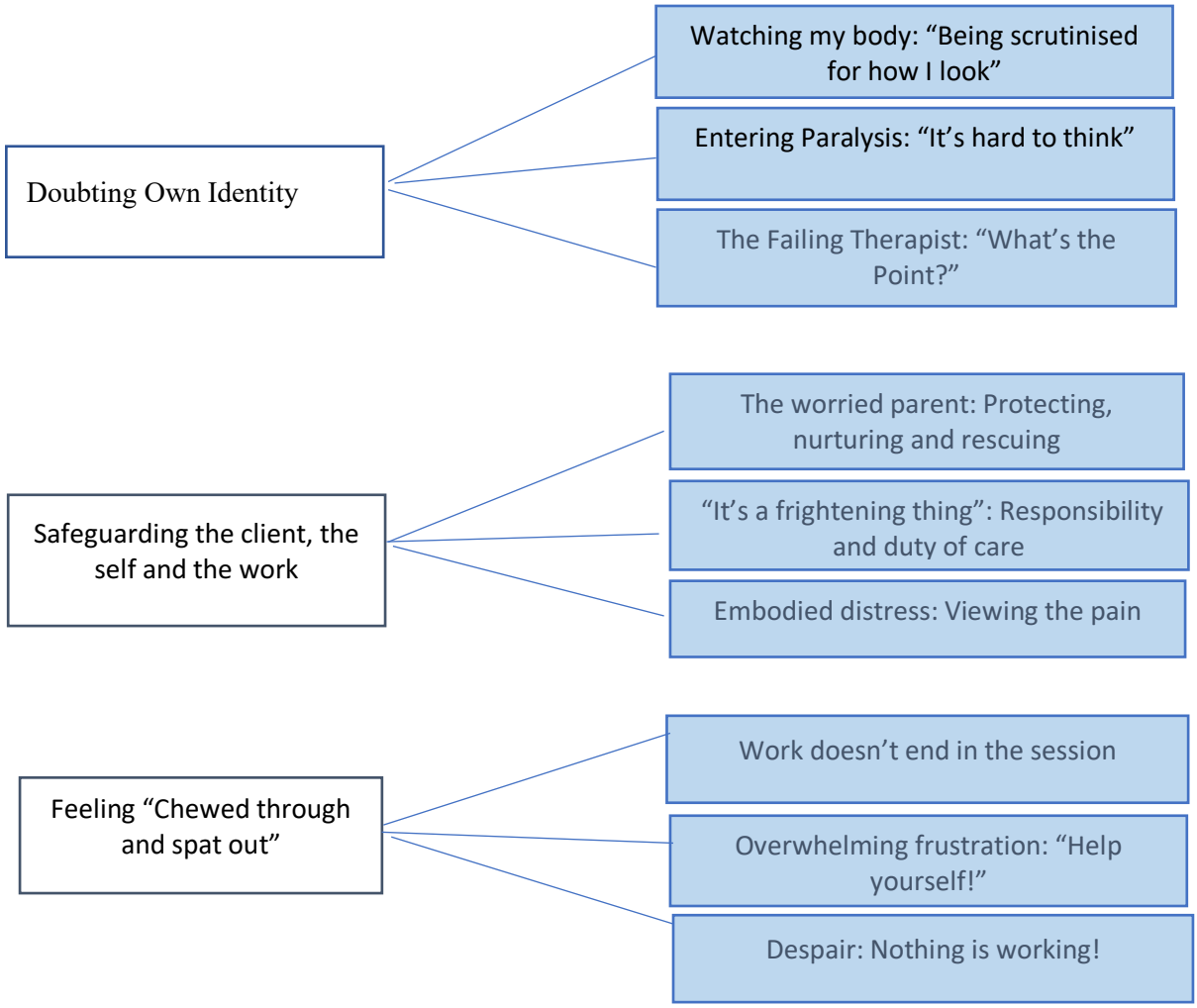
1. Themes overview

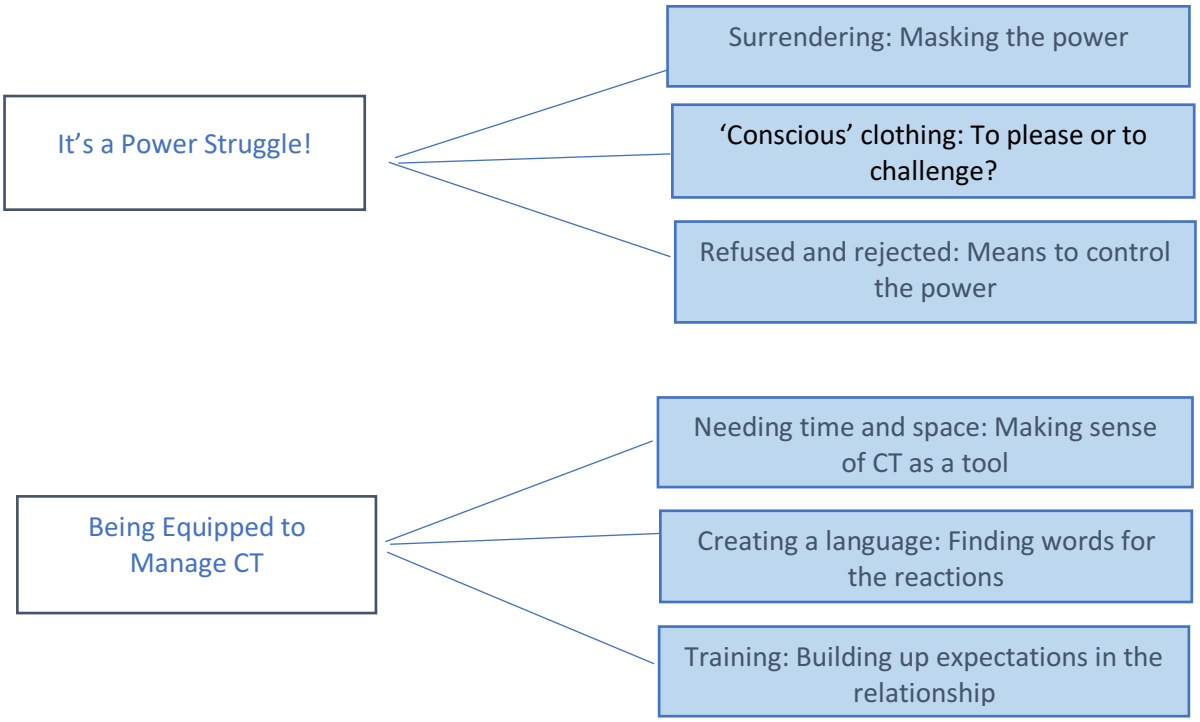
In general, analysis suggests that new therapists working with clients with EDs found it difficult to talk about their CT experiences, especially about the impact it had on their own professional and private lives. On closer investigation, it emerged that as part of their CT responses, new therapists adopted a fragmented view of themselves and the therapy work, similarly to their clients. That is, they seemed to identify with their clients' feelings, behaviours and ways of seeing the world. This may have impacted on their ability to remain grounded in their roles as therapists, struggling to retain their professional identities following CT responses of intense anxiety, frustration, worries about their bodies/size/weight, feelings of inadequacy, inability to help clients and, subsequently hopelessness. Furthermore, new therapists' experiences of CT were spoken about as necessitating time and space to be understood in the therapy process. This was linked to tensions around strained resources and limited therapy timeframes within NHS services, potentially causing CT to be overlooked and 'invisible' in the therapy setting.

Subsequently, new therapists found themselves overwhelmed and, at times, re-enacting clients' past experiences in their therapeutic relationship. Nevertheless, despite the difficult CT experiences, new therapists maintained a reflective stance and focus on ways of improving general knowledge and training in the use of CT as a critical tool in the work with clients with EDs.

The following thematic map (Figure 1) presents the superordinate themes and their subthemes found during the analysis of the transcripts.

Figure 1. Final thematic map





2. **Superordinate Theme 1: Doubting Own Identity**

All participants discussed at length their emotional reactions, emphasising that in their work with clients with EDs, they often had a sense that they were temporarily losing their own professional identities, taking on their clients' distressing presentations in their doubted identities as therapists and identification with their clients. New therapists appear to make sense of their confused identity by reflecting on their initially unconscious CT reactions and by talking about their felt discomfort at all levels: emotional, somatic and behavioural. Such reactions appear to be similar to their clients' reactions. Participants also referred to their CT as a tool in understanding what was happening for the clients, through their overidentification with them.

Whilst this theme was discussed as an opportunity to experience the client's inner world, it also brought up new therapists' uncommon levels of uneasiness in the form of elevated anxiety in their abilities to help clients, amplified attention to their own bodies

and experiences of mental blocks during their therapies with clients. Participants' accounts of their CT show their experiences of uncommon unease, almost as they became their own clients through their felt levels of anxiety and discomfort. Such experiences were talked about as new and unmet before in their previous clinical work with other client groups.

Subtheme 1.1. Watching my body: "Being scrutinised for how I look"

Throughout the interviews, participants often mentioned becoming increasingly more aware of their own body shapes and weight, focusing on specific body parts throughout their therapeutic work with their clients with EDs. For example, Julia discusses her observation of a completely new felt sense of insecurity suddenly emerging during her work with her client who saw herself as 'fat and ugly', as captured in the following quote:

> *Julia: ...I never, I've never really had any serious issues about the way I looked, and it was never really an insecurity that I had. Uhm...but then I started to become more like self-conscious, so I would pick an item that I would put on to wear it, but then I would look in the mirror and think hmmm… I don't know if I should wear this or does this make me look too slim? Does this make me look too ...something? I don't even know, it was definitely just there, I was always like, before, before her particular session I remember, cause it was on a Monday, so I remember having to think twice about what I was wearing and about how I would ...look! […] I would spend ages like picking out like if this outfit would have been okay, you know… She would say things like, like from her perspective she would say I've got tree trunks for legs and uhm... And I can't re-member exactly at what point but I then started to then… I wasn't able to then wear trousers ...*
>
> *(Lines 191-197)*

Julia's intense CT reactions of identifying with her client's embodied emotions seem distressing and foreign to her usual perception of her own body. The overidentification with her client's way of seeing herself - as completely faulty, ugly and

insecure - becomes so realistic and intense that appears to begin to affect Julia's way of perceiving her own body, worrying about her own body image and size. The above excerpt points towards Julia's high anxiety related to her own body, so much so that she stops wearing trousers to her therapy sessions. This becomes a new and real difficulty, very similar to her client's presented difficulties, apparently causing Julia to act out on the client's worries by having identified with them. The repeated use of the adverbs "never", "always" and "ever" seems to emphasise both the novelty and shocking nature of the experienced CT reactions during the mentioned therapy sessions.

Similarly, Mia's CT experiences describe her emerging worries, also related to her own body image:

> *Mia: Now, I don't have weight issues, I don't really worry about that too much, yet I instantly start thinking how does the client perceive me, because I am an average size, but I know obviously people with EDs have got perhaps, you know, different perceptions of how you look, how they look, so on and so forth. […] sometimes I worry that they feel I am this perfect looking therapist and they may feel maybe under some kind of criticism from me. […] I'm aware of how I'm perceived, I am conscious of how I sit, I am conscious of them thinking of how I look, and I feel I am almost being scrutinized for how I look.*
> *(Lines 152-163)*

Although Mia had not felt insecure about her body or weight prior to the therapy with this client group, she seems to become somewhat concerned about her appearance in front of her client, considering variances in body sizes, her position in the chair, and fearing scrutiny. Similarly to Julia, Mia also appears to doubt her previous personal and professional identities, taking on the client's difficulties in relation to feeling overly-conscious about how she looks and sits in her therapy chair, fearing scrutiny from the client. Her use of the word "instantly" suggests a sudden increase in her level of anxiety

throughout the sessions, fearing judgement from her client around body shape, in a similar manner as her client fears in her relationship with herself and others.

The following excerpt accentuates another participant's similar experiences during the therapeutic work with a client with EDs:

> Zara*: I never had this before, but I sort of go through periods when I sort of catch myself when I sort of say to my partner or my friends, Oh, do you think I am fat? like it makes me very conscious of that, but this isn't helpful I am thinking because these are people who I work with, it isn't helpful for them to listen to that, of course I don't say that when I meet with them, but obviously people in the public say that all the time […]. And there are periods of time when I think well, actually you know, I shouldn't be worrying about being fat, I should not worry about putting on weight or having to exercise excessively because at the end of the day I am healthy.*
> *(Lines 131-136)*

Zara describes how she also becomes anxious around her size, in similar way to her clients. She demonstrates a fear of gaining weight during the therapy work with clients with anorexia. Her increased attention to body shape, weight and thoughts of excessive exercise to stay slim suggest an extreme anxiety and the adoption of new possible behaviours related to this, identical to her clients' behaviors. Zara's use of the words "I catch myself" seems to suggest an unconscious reaction of elevated anxiety about gaining weight and a need to receive reassurance from friends about this. Whilst she appears to be aware of her CT reaction in her use of the word "conscious", Zara's quote denotes an internal conflict and perhaps internal distress triggered by two contrasting parts: the CT response of fear linked to putting on weight and her identity of a therapist reminding herself of staying healthy as a main goal.

Participants' felt distress, spoken about as part of the process of temporary identification with their clients' difficulties around eating and body sizes, appears to have

taken place regardless of therapists' gender. Male therapists seem to have experienced similar CT reactions to their female colleagues. For example, Peter reported his eating changed in the period of time he was seeing clients with EDs. Although he notices these changes from a reflective perspective, he appears to identify with his clients in the possible anxiety around gaining weight around his stomach.

> *Peter: Like, every Friday I would basically binge although that wouldn't be considered clinical binge. So, in summary, inadequacy, reflecting on my stuff how am I with eating, how do I feel about getting older and maybe a bit bigger in the middle.*
>
> *(Lines 142-145)*

Overall, participants' accounts seem to indicate uncertainties about their bodies and appearances, all of which in some way reflected those of their clients'. New therapists' CT experiences with clients with EDs seem to have replaced previous experiences of identifying as stable, grounded, secure therapists in clinical work with other client groups. Therefore, as part of their CT, all participants describe a sense of questioning their own identities by becoming overly identified with the concerns and the unease of their own clients regarding their bodies. Also, therapists' eating was noticed to have become modified by borrowing some of their clients' examples, consequently experiencing themselves and the world in the same way their clients did. Participants spoke about CT as having a strong impact on their therapeutic work, keeping them stuck in one place together with their clients, at times finding it difficult to think and feel in sessions. The impact on therapeutic work is further discussed in the following subtheme.

2.2 Subtheme 1.2. Entering Paralysis: "It's hard to think"

This subtheme was found following participants' repeated reports of experiencing uneasy CT reactions in the room with their clients, as well as after sessions. Such CT was described as blocks in therapists' abilities to help their clients. Participants mentioned feeling "stuck" in the work with their clients, struggling to think or make sense of their emotions, consequently feeling temporarily trapped, similarly to their clients' difficulties.

In the below excerpt, Julia provides her experience of feeling unable to move on with her client in therapy, feeling stuck in helping her client.

> *Julia: We get into this profession because we want to help people and the majority of the time we are able to do that, but when you come up against something that is, that you feel like …why can't I just do that? It's hard to think! Then you forget about the 90% that you have helped and you focus on maybe the difficult ones, the ones that you're struggling with, and then that just becomes like the general so I can't help anyone and if this is what it's going to be like then there's no point because I can't, I can't help people and that's why I'm getting into this, so what does that then mean to me?*
>
> *(Lines 168-175)*

Julia appears to emphasise the extent of "feeling stuck" impacting on her professional identity as a therapist. She suggests this affected her self-confidence, doubting her professional skills and questioning her general ability as a therapist. Julia's strong CT appears to be very similar to how her client felt, unable to help herself and doubtful of all the parts which formed her sense of self. Her rhetorical questions appear to indicate the paradoxical element of her felt CT of inadequacy in the provided clinical example, underlining the fact that such reactions may be specific to the work with people with EDs, as well as the difficulty of such reactions affecting therapists' capacity to maintain their own professional roles.

Another participant, Pamela, also speaks about feeling as if nothing was shifting in her work with her clients. She refers to this not only as frustrating, but through her use of

the term "futility" she captures a sense of vainness. Pamela accentuates the felt sense of her CT as feeling paralysed in the lack of progress with her client. Furthermore, she appears to experience this as a painful reaction in her association of this with "running and hitting your head on an invisible glass". She describes feeling stuck as a challenge in the therapy with this client group, seeing it as her "buttons" being pushed by the clients. Pamela's interpretation of her CT feeling of "not getting anywhere" followed by the terms of "certification" and "humility" point towards her acceptance that there may be nothing to do to help the clients at times, giving up hope. This becomes striking in its similarity with clients' views of themselves and the world often feeling despair and complete lack of hope.

> *Pamela: Uhm....yes, with some clients, in terms of ...not being able to think, stopping, that stopped in the session. Really hard to move forward, almost a paralysis uhm.... The other thing that comes to mind as the stuff is coming back flowing back, is this idea of despair, running very hard to way too much effort and getting absolutely nowhere, like you hit your head on an invisible glass wall and nothing ever changes. Futility. That sort of thing. I think it taught me where my buttons were, because they kept pressing them, uhm... it has to do with emotional responses to folks and also certain amount, amount of patience and tolerance, endurance of knowing or feeling that you are not getting anywhere, but this is something that is part of my personality trying to fix stuff, but that kind of gets thrown under the water particularly with this client group as you are soon taught, that sometimes you feel like you are not getting anywhere. There's only so much you can do no matter how hard you try, it just doesn't happen, this is certification and a little bit of humility.*
>
> *(Lines 159- 171)*

Interviewed new therapists spoke about their CT responses by relating these to a sense of being trapped in the therapy, unable to find again the motivation for helping their clients. This can be understood as an overidentification with clients' emotional distress and inability to think or reflect, possibly unconsciously adopted by new

therapists in the process of losing their own identities as therapists and, in the CT, taking on their clients' identities. This finding shows the complexity of effects new therapists' CT reactions may have in the process of overidentification with clients, underlining intense distress, changes in body perceptions and worries around weight, size and eating.

2.3 Subtheme 1.3. The Failing Therapist: "What's the Point?"

Participants' unconscious process of doubting their identity temporarily seems to be linked with their CT reactions of seeing themselves as failing in their roles of therapists. This new perceived way of identifying as therapists appears to resemble their clients' split views of themselves, in that clients are either a perfect weight/body shape or they perceive themselves in a complete negative manner. Such negative self-perceptions appear to have been experienced by the participants to this study in their CT reactions. For example, Sonya mentions her emotional CT response in the work with her client with AN:

> *Sonya: I had just been feeling I hadn't been good enough or hadn't done the right thing or…I think it's all unheard at times, a real sense of hopelessness… uhm…like there's not point, it doesn't make any difference. That's probably the most often CT feeling I'd experience that kind of I haven't done good enough… What's the point?*
>
> *(Lines 144-146)*

Sonya's CT experience denotes her own identity as therapist becoming amalgamated with her client's views of the world, herself and the therapy. Whilst Sonya's self-confidence as therapist may be challenged by the client's resistance to treatment, she also appears to become drawn in by her client's presentation, seeming to lose sight of all her professional abilities, skills and all previous experiences of helping individuals in therapy. This seems to raise intense anxiety in Sonya's views of herself as therapist and her practice. Her used words of "unheard", "hopelessness" and "there's no point"

accentuate the difficulty of her felt CT, suggesting a sense of professional failure and therefore despair in her assumed identity of a failing therapist.

Such strong reactions were noticed by all participants to the study in their felt sense of not being good enough, seeming to indicate towards therapy as becoming pointless. A similar experience was provided by Rose, who described an intense feeling of failing in helping her client, seeing herself in a completely negative manner:

> *Rose: Very often with one particular client I worked with I'd often think what's the point? what's the point of everything? I'm useless, I'm not helping this person in fact quite the opposite. I had emotions where I felt I wanted to break down and cry, I did not, but I felt distressed.*
>
> *(Lines 162-165).*

Rose's CT reactions depict an extreme way of seeing herself as a therapist in the work with her client with BED, so negative that she doesn't just feel distressed in the overidentification with her client, but she suggests her therapeutic interventions are causing harm to her client. Rose's assumed identity of a failing therapist appears to be similar to her client's presentation, borrowing her client's primitive defences in the CT. Rose's view of herself as a failing therapist seems to cause her an enormous level of anxiety and self-doubt in her role as newly qualified and in the therapy, emphasising the importance of raising awareness and increasing reflexivity around such processes in the work with clients with EDs.

In line with the above-mentioned theme and its three subthemes, analysis suggests that participants' experiences of their CT reactions denote a possible temporary lost sense of their professional identities as a product of the unconscious processes arising from the therapy. Therapists' identities become momentarily covered up by their clients' identities and difficulties. However, participants also talked about other CT responses they

experienced, such as wanting to care for their vulnerable clients, as presented in the following superordinate theme.

3. Superordinate Theme 2: Safeguarding the client, the self and the work

This superordinate theme was developed following participants' widespread descriptions of their CT experiences of elevated anxiety around their clients' wellbeing , themselves in their roles as professionals holding a duty of care, and the outcome of the therapeutic work. Therapists frequently described being drawn into adopting the stance of a protective mother/parent as they felt overwhelmed by concerns regarding their clients' presented difficulties, emotional pain and physical appearance. They noticed themselves becoming overprotective, needing to nurture and rescue clients. They also spoke about becoming overly concerned by their client's risk to die or become very unwell as a result of their EDs, fearing becoming responsible for their potential lack of improvement and being blamed by the authorities and their own clients. Furthermore, participants often reported a deep sense of anxiety and need to protect their vulnerable clients as a strong reaction to their clients' fragile physical appearance. These reactions are understood as therapists' CT and are presented in detail in the following three subthemes.

3.1 Subtheme 2.1. The worried parent: Protecting, Nurturing and Rescuing

Throughout the interviews, participants' accounts suggest a strong CT reaction of anxiety felt in response to their client's vulnerability. Therapists often felt overly maternal/paternal towards their clients. This CT emotional response appears to be understood as a need to nurture, protect and rescue the clients perceived in the transference

as vulnerable children. In the quote below, Annalise refers to her CT response of wanting to become 'the maternal object' for her client with an ED:

> *Annalise: They often really find it difficult to speak with their parents or families because they don't have that relationship with them where they can they feel, sometimes have an environment at home where they can't talk about feelings, they can't express negative feelings or anger. I think a lot of the time I am wanting to be that good object for them and especially if there's a lack of good objects in their life, to be that almost parental figure for them to provide that containing space where they can feel they can talk about their feelings, about themselves, uhm... […] I am really glad to have the flexibility to do that.*
>
> *(Lines 91-98)*

Annalise's experience of CT seems to be triggered by a perceived neediness from the clients' part which she reacts to through a parental stance. As part of her CT, Annalise seems to want to provide her client with a re-parenting experience in therapy by becoming the "good object" for the client. This appears to not only provide the client with the safe space essential for the therapeutic work, but also help the client with an ED experience an emotional nurturing and care needed to allow for the anger and other negative feelings to be safely explored, named, accepted and experienced in a tolerable, soothing manner. Annalise seems to indicate that some clients with EDs require such experiences in therapy explaining her maternal CT reaction, in line with general expectations from parents who provide nurturing and care for their children when they become distressed.

Similarly, Ronald seems to have a similar CT experience:

> *Ronald: Yeah, yeah, but I felt intensively responsible because it felt no one else was looking after them, so I felt I needed to rescue them. And even though it is not within my training I found I was having conversations about their weight and their diet and even actively encouraging them to stand on some scales in the corner of the room because I did not believe them when*

> *they told me they weigh 12 stone, some of these people looked as they would snap, so you would doubt that.*
>
> *(Lines 66-72)*

Whilst Ronald's account denotes a clear sense of responsibility in his instinctual reaction of looking after the client, it also suggests a sense of concern and need to protect the client. Ronald's use of the words "encouraging", and "rescue" suggest he is adopting a parental role in his relationship with his client, as a parent may often do in looking after their child/children who may be vulnerable and may avoid the truth or reality as an immature response to difficulties. Although interviewed therapists saw adult clients with EDs, such as the client Ronald refers to in the above quote, the temptation to become maternal/paternal towards them in the therapists' CT is revealed in all participants' accounts.

3.2 Subtheme 2.2. "It's a frightening thing": Responsibility and duty of care

Many participants in the current study described a continuous sense of fear related to their client's poor resilience and possibility of harming themselves, potentially ending with their deaths. For example, Pamela's experience of her felt anxiety is expressed in the following quote:

> *Pamela: It's definitely a frightening thing. What I found is that after one in terms of the self-harm I stopped reacting almost to it. Uhm, almost not quite, so there still was a concern, but immediately my thoughts go to self-harm - precursor to potential suicide, rather than...you almost get used to it, it is so prevalent, at least in my view. […] Uhm...but what it is in the back of the mind is this idea of suicide cause EDs and suicide are very close and we are very aware of that, so that is something that is a fear that sometimes sticks with you.*
>
> *(Lines 78-86)*

Pamela's expression "in the back of the mind" highlights a sense of constant, elevated anxiety experienced in relation to her client's diagnosis of ED, a fragile ego and potential to end his/her life. Pamela's CT reaction seems to be maintained throughout her work with the clients, without any breaks. This suggests that her CT response may be linked not only to her client's projected vulnerabilities, but also to her perceived responsibility held towards her employment, professional body and career as a therapist. Pamela's use of the phrase "a fear that sometimes sticks with you" appears to reinforce a sense that although she may have become "used" to the fear about risk of self-harm and suicide, the fear remains present and alive throughout the therapeutic process, carried by her as therapist in her mind and body.

A similar view and CT experience is shared by Sonya in the following extract:

> *Sonya: It does stay with you the element of risk, it's something that stayed with me. When someone took their own life on a ward I was working on and I had to go to court […] it was really, really difficult experience and they did not have an ED but it reminds me that people do die and the risk EDs come with and the process of being accountable and the whole service makes you realise gosh that can happen! And then I remember a girl in that service being bulimic and with a colostomy bag […] she went to bed, and I got myself into such worry should I have done that, said that, will she wake up in the morning? And it really got to me and actually that lady did die a few years later, so in her 20s. So it's a really, really risky client group to work with. So I am over-conscientious about that and then you take it home and when you realise you think uh, I need to find a way to leave that at work.*
>
> *(Lines 201-213)*

Although Sonya recalls a tragic experience about a client without an ED, her association of death with the presentation of her clients with EDs seems to bring up intense anxiety and fear of being investigated as a professional for her duty of care. Sonya highlights the reality of death within health care services and within the population of

clients with EDs, as she links this to her client with bulimia. This accentuates the felt sense of anxiety as a CT reaction not only in response to the clients' vulnerabilities, but in the larger system around the client- the service and the justice systems. Sonya's use of repetitions such as "really, really difficult experience" and "really, really risky client group" denote the unusual anxiety she experiences in her role as a new therapist working with individuals with EDs not only in the workplace but carrying the worries at home. Sonya's anxiety seems reinforced by the superlative "over-conscious" which may suggest her use of reflexivity in managing CT, but nevertheless appears to point towards extreme levels of extra-care needed for herself and her clients in the therapeutic work.

3.3 Subtheme 2.3. Embodied distress: viewing the pain

This subtheme reflects participants' powerful CT reactions to the visible pain of their clients. The embodied distress expressed by clients through the medium of their appearances in front of their therapists was frequently captured throughout the analysed interviews. Overall, participants described powerful CT responses of anxiety, physical pain, emotional distress and an intense need to protect their clients. One of the most expressive experiences of such CT experiences was provided by Faith in her interview:

> *Faith: [...] it's that thing about looking physically unwell and often very childlike, which again brings up 'I want to protect you' because see, for example, I am working with a lady at the moment she did not hit puberty, so she looks like a child, she talks like a child ...uhm...I think the impact it has on their lives is so visible, so it's a bit like seeing somebody's distress sat in front of you, visibly I can see what they feel, and I am a very image-based person, so I can hear the distress for people and I can feel sad for them, I feel emotions for them but it's so visible, visibly with EDs that can be incredibly hard...*
>
> *(Lines 45-53).*

Faith's CT temptation of rescuing and protecting her client in the above extract appears to be linked to her attunement to the client's embodied emotional pain. Faith's

quote suggests the impact her client's appearance has on herself as therapist. Faith seems to connect with the client's distress brought in the room in the most direct manner- by wearing the pain. Her use of phrases such as 'so visible', 'image', 'seeing somebody's distress' followed by the phrase 'incredibly hard' emphasise the intense CT response of sadness and hurt experienced by Faith in the therapeutic work. This evidences the emotional impact CT reactions may pose on newly qualified in their interactions with clients whose distress is visible, potentially increasing therapists' emotional discomfort and distress. Faith develops further her felt CT in the form of her bodily sensations:

> *Faith: I think my body responds...I think particularly with this client, perhaps because she's so unwell, it was actually when I went to get her from the waiting area my heart just sank, I felt a very physical response, my chest felt very cold and I felt a bit sick, not with disgust but with shock. She is just so unwell, and I think sadness came with that, I get sadness as I go through this. Actually, my body is responding in a nice way, so I can do something about that, but I felt so sad for her as she hates herself so much I felt a very strong sense of… Oh Gosh, this is ...horrible, it's definitely in my body that's why I'm putting my hand on my chest, that's where I feel it it's in my chest!*
>
> *Lines (71-80)*

Faith's CT experience in the above extract highlights the powerful emotional response of sadness translated at a deep embodied, visceral level. Her embodied reactions described as "heart sinking" and the physical sensation of sickness appear to indicate strong bodily responses to the visual distress observed in the client. Moreover, Faith's CT reactions may be also suggesting an involuntary reaction of defensive repulsion by feeling sick towards the noticeable pain seen in the client. Faith's felt sensation of cold in her chest points towards an intensified sense of distress, similar to freezing or paralysing to seeing her client's pain, thus accentuating the strength and difficulty of her experience. The vivid and intense CT appears to be so powerful, not just in the actual meeting with her client, but during our interview as well. By placing her hand on her chest whilst

sharing her experiences with myself, Faith shows a re-activation of the embodied distress re-lived during her interview. Therefore, it becomes apparent that such intense CT appear to have a strong impact on new therapists' distress both at emotional and embodied levels, potentially suggesting more attention being required around new therapists' self-care conservation and reflexive practice to ensure their wellbeing and proficient practice.

Most participants in the study spoke about the difficulty to ignore the physical appearance of their clients with different EDs diagnoses. They described a variety of intense CT reactions of fear, need to protect and rescue, speaking in softer tones of voice compared to other clients and feeling a strong need to hold their clients in their arms.

4. Superordinate Theme 3: Feeling "Chewed through and spat out"

This superordinate theme was identified following many participants' descriptions of their felt sense of being consumed by their clients and the therapeutic work. They seemed to describe the impact of CT experiences on their self-care in sessions and outside sessions, in their own private lives. New therapists mentioned feeling overwhelmed with negative emotions, worn-out and frustrated with their clients as part of their therapeutic dynamics. These CT reactions are explored in the following subthemes.

4.1 Subtheme 3.1. Work doesn't end in the session

Most participants expressed CT experiences of depletion following therapy sessions with their clients with EDs. Whilst these reactions may be understood as therapists' efforts towards therapeutic shifts regarding clients' rigidity as a recognised characteristic of individuals with EDs (Shipton, 2004), they also emphasise therapists' exhaustion and consumption of themselves. For example, Pamela speaks about her difficult CT responses below:

> *Pamela: Uhm....exhaustion, exhaustion after the session and emptiness, like they've eaten me, with some clients particularly than others, more so with emotionally hungry clients that you felt chewed through and then spat out, uhm... to use again a food metaphor. And that was prevalent with a couple of clients uhm....yeah...just exhausting, empty and very low energy.*
>
> *(Lines 155-159)*

Pamela's excerpt identifies her CT after the session with one client, naming the feeling of 'emptiness'. Her powerful CT is conveyed through her use of metaphors as aids in depicting the complexity and felt sense of her subjective experience. The phrases 'they've eaten me', 'emotionally hungry' and 'felt chewed through and spat out' bring to surface the uncommon intensity of her CT and the complete use of self in the therapeutic work. The felt sense of emptiness appears so great that she perhaps felt almost as disposable following the session, as there was nothing left within herself after her client's consumption of Pamela's emotions and energy. Pamela's CT experiences point towards the difficulty of such reactions and the crucial aspect of time to make sense of CT by reflecting on the session after it ends. They also seem to suggest a potential need to new therapists to devote time addressing their self-care between sessions and after work.

In the following quote, Mia describes similar CT reactions of tiredness and depletion. However, Mia's CT experiences suggest further effects on her behaviours outside the clinical work with her clients with EDs.

> *Mia: Outside of the room, like I say, it's something I do at a subconscious level- eating loads, sometimes sleeping loads- because I'm so exhausted after those sessions, you know...drinking more coffee, uhm...I wonder whether the criticism after having a binge… I'll be thinking about my client: like now it's the time when she would throw up. Of course, I'm not going to throw up because I couldn't, even though I don't want all that rubbish in my stomach, but there I am on a Friday evening thinking about my clients at home! And again, you see, this is where the effect is that I am working after work, so it affects my private life!*

> *[…] If I'm binge eating on an afternoon I'm thinking about my client, that's me taking the client to my house in commas. […] Is it that she wants me to keep her in my mind even outside of sessions, which tells me that at this point in time and in her childhood she did not have enough care, affection, attention, and she desperately needs it. And there's me, through CT, looking after her, but at my own expense.*
>
> *(Lines 241- 255)*

Mia's felt need to eat, sleep more and drink more coffee appears linked to her lack of energy following her sessions with her clients with EDs. These appear to be prevalent not just at work, but also in her personal life outside the clinical hours. Mia's personal life becomes impinged on by her work with her clients, suggesting a sense of anger towards the effects the clinical work has on her private life almost as this becomes outside of the therapist's control. Her CT reactions suggest a multitude of powerful emotional responses such as self-criticism, disappointment with herself and perhaps frustration towards herself following the described behaviours. Mia's account shows that the use of self and her CT reactions are not solely limited the therapy room but continue to unfold in all aspects of her personal life as she describes herself 'thinking about her clients at home on a Friday night'. This is further unpacked later in the interview with Mia, highlighting intense feelings of anger within the CT. Whilst Mia recognises the importance of CT in making sense of her client's difficulties by considering what is being communicated within the non-verbal processes in therapy, she also highlights the powerful impact of the CT on her personal life 'at her own expense'. Mia's experiences appear to indicate her complete use/consumption of self in the work with her clients. This emphasises the raised impact of CT on newly qualified therapists, bringing into attention ways of addressing and managing such heavy, negative reactions at personal development levels, as well as in supervision and at continuous professional development levels.

4.2 Subtheme 3.2. Overwhelming frustration: "Help yourself!"

This subtheme highlights participants' powerful CT reactions of frustration to the clinical work emerging through their experiences of being completely consumed by their clients. Analysis suggests that new therapists' efforts invested in the therapy with their clients are unilateral, only from the therapists' side. This is understood as leading to the therapists' overinvolvement in their role, further linked to frustration and exhaustion. The following extract from Mia's interview captures her strong frustration with her client in the CT:

> *Mia: .... I can't, like I feel that I can't...like I'm banging my head against a brick wall sometimes, and especially with this particular lady the progress is so slow, it's frustrating. So, my frustration is around I'm here, I'm trying to help you, I'm giving you everything I can, and I've pulled everything out of my bag, yet I'm thinking about yet another way to help you, almost as if it was my responsibility 110% to make you feel better[...] I'm not good enough, no one is good enough, uhm...you know, my life is complete shambles, I can't help myself, but no one can, and you're another one who can't help me and doesn't know how to help me and can't rescue me. [...] Yes, I am a therapist and I will, well, but it's so strong and frustrating because I'm thinking you're not, to be honest, you're not doing enough to help yourself! I've done everything I can, and you still play a role, sorry to say, I'm the victim here, help me, and I understand why she's feeling this way obviously because past experiences, so on and so forth, but for me she's saying I'm so vulnerable, I'm such a victim, I need lots of help and lots of support, yet you're not good enough, you can't help me.*
> *(Lines 117-136)*

Mia's CT reaction as described in the quote above seems to reveal a strong felt sense of being pulled into doing more than her role would usually entail as therapist, giving her client '110%' in response to her projected vulnerability. Mia's frustration expressed by the use of the words 'banging my head against a brick wall' is perhaps not only directed

to her client in her attempt to 'prove her wrong' and by trying hard to rescue the client, but also towards herself as therapist completely becoming 'pulled in' by her ego as therapist. In this excerpt Mia identifies her becoming consumed by the work with her client. Her frustration seems to be also linked to the client's passive stance in the therapy, although similarly experienced as rejecting of the offered help. This appears to have an impact on the therapeutic relationship and the balance in the collaborative effort in the room, where the therapists' frustration becomes a reaction to the client's lack of motivation and ownership in improving their difficulties. Mia's employment of the phrase 'you're not doing enough to help yourself' seems to highlight this, perhaps bringing to surface the unspoken wish her client became more involved in the therapy. Mia's account appears to denote the impact CT responses of elevated frustration may have on new therapists, therapy sessions, therapy outcome and on the therapists themselves in their abilities to confront themselves with such uncommon reactions. Left unexplored and in the unconscious mind as suggested by Mia's account, such findings highlight the potential for new therapists to experience burnout or to act out on their CT reactions in the therapeutic process as suggested by previous studies (Colahan, 1995; Costin, 2009; Hughes, 1997; Lawrence, 2002; Lowell & Meader, 2005).

4.3 Subtheme 3.3. Despair: Nothing is working!

This subtheme captures participants' shared CT reactions of despair towards the lack of progress in the therapeutic work with their clients with EDs. This response appears to be exacerbated by contrast between the immense efforts new therapists offered their clients in therapy and the perceived responses of rejection from the clients. It appears that therapists' efforts are directly proportional with their felt sense of frustration and lack of progress by the clients, therefore acting as catalysts to new therapists' difficult CT

reactions. This subtheme emphasises the unusual CT response of desolation participants reported despite their hardest attempts to rescue and help their clients. The following excerpt depicts Peter's powerful CT reaction:

> *Peter: Why are you not eating, eat more! it's like becoming the mother I can begin to hear in my mind. So, no matter how sophisticated I thought I was, it has now just boiled down to that why are you not eating?*
>
> *(Lines 120-122)*

Peter's CT points out an elevated sense of despair experienced in his role as therapist having tried everything within his professional power to help his client, yet without results. Peter's reaction can be interpreted as an ultimate and obviously simplistic response to the lack of improvement in the client's eating pattern. His use of rhetoric questioning and comparison between his professional role of a therapist and the role of 'the mother' underlines his hopelessness in the ability to help the client and seems to suggest therapy as ineffective by becoming reduced to just eating. This excerpt highlights the intensity of new therapists' reactions of despair, putting into perspective the importance and possible impact of CT responses in the work with clients with EDs as well as the start of conversations around ways of managing such reactions by therapists.

Taking a different perspective in relation to the lack of progress with her clients, Mia's CT response of despair appears to be associated with her supervisory support. She describes the difficult feeling of helplessness not only experienced by herself as therapist, but also suggesting to be affecting her supervisor, as part of a parallel process between the therapeutic process and supervision:

> *Mia: Well again, the projections, the transference from the client doesn't just stop at me, it stops at my supervisor, and it's then my CT that my supervisor's guidance even it's not good enough. It's like a .... not double CT, but it's more than just from me...I wonder if my supervisor may feel like he's not good enough*

> *when I'm talking about this client, because I wonder if sometimes he feels helpless, because the client is not improving, the scores are not improving, the client is stuck and it's almost the same every week. Does he feel the same as I feel? He may take this to his supervision, but I wonder how far does this go then?*
>
> *(Lines 173-181)*

Mia's lost sense of hope seems also linked to her thoughts about her supervisor's CT reactions. She appears to wonder if her supervisor may also be affected by the potential feeling of "not being good enough", perhaps causing her elevated anxiety. This may be understood as potentially causing Mia to feel worried in the CT, considering her hypothesized view of the levels of support around herself and her client. Furthermore, her reaction accentuates the idea that nothing or nobody may be able to help the client, not herself as therapist, neither her own supervisor nor the next level supervisor. Similarly to Peter, Mia's CT response also denotes frustration and exasperation perhaps linked to the client's poor sense of owning their improvement in therapy, suggesting endless hopelessness in her used phrase 'how far does it go then?'. Such an elevated reaction of hopelessness in the CT emphasises the importance and powerful impact such responses may have on new therapists, therapy and the professional support around newly qualified whenever CT may not be discussed as part of the therapeutic processes.

The three presented subthemes and superordinate theme suggest that newly qualified therapists may potentially experience unusually elevated reactions of exhaustion, depletion and hopelessness in response to their use of self in sessions and outside of them and in response to the lack of progress in the therapy.

5. Superordinate Theme 4: It's a Power Struggle!

This superordinate theme emerged as many participants revealed their experiences of acknowledging the strong power dynamic in therapy with their clients with EDs. Participants spoke about a felt sense of needing to reconsider this aspect and lower their perceived power as therapists to allow clients to feel safer in therapy and make progress. All interviewed therapists referred to an unspoken struggle in this dynamic, underlining their experienced CT reactions of either giving into the struggle, defending against the client's attacks or rejecting the client. Such reactions are presented in detail in the following subthemes.

5.1 Subtheme 4.1. Surrendering: Masking the power

Interviewed participants spoke about their clients' preoccupations around their body image in comparison with other people's bodies. Inevitably, this matter was also mirrored in the therapy room in the relationship between new therapists and their clients with EDs. New therapists spoke about feeling scrutinised by their clients regarding their own bodies, often feeling that clients felt unsafe when new therapists' bodies were perceived as 'good-looking'. This subtheme captures the idea of an unspoken battle for power in the therapy between the therapists and their clients, where only one of them can be victorious to allow for therapeutic progress. This subtheme emphasises the need for therapists to surrender their power by masking their physical features through their nonverbal communication of their body appearance in sessions.

Julia's experience below evidences the intensity of such battle for power through her felt CT reactions. These appear to have a clear and strong impact on Julia's self-care, as she reports in the below excerpt not looking after her appearance as she normally would during her sessions with a client with EDs:

> *Julia: And then not really, not really making an effort I remember, so like not maybe spending much time sort of looking, I don't know what the word is, but not really taking time to do my makeup, my hair like I usually would so that she wouldn't feel ...uhm...intimidated, no, threatened...so I guess I couldn't be too good looking in the sessions, like my hair and how I dressed because that would make her feel so uncomfortable, yeah, I remember that!*
>
> *(Lines 226-231)*

The above extract highlights Julia's powerful CT reaction revealed through her need to minimise her 'effort' invested in her appearance prior to the sessions with her client. Julia's felt need for her to 'not to be too good looking in the sessions' can be understood as a way of surrendering the power to her client, perhaps in order for the client to feel more comfortable in the perceived comparison of the two bodies in the therapy room. In her interview, Julia seems to consider her CT and reflect on her reaction at the time rather than during the therapy process with her client. This accentuates the deep unconscious nature of the CT reactions she experienced at the time of the therapy. Although CT reactions appear to have had an obvious effect on Julia's appearance and stance in the therapy room within the therapeutic relationship, it appears to have remained unspoken about at that time yet communicated nonverbally by Julia to her client through the means of her bodily appearance. This may be seen as a mirroring process where Julia as therapist embodies her CT reactions of surrendering the power to her client through obvious changes in her appearance, using her body as a familiar language to communicate this to her client, therefore mirroring her client's communication of distress through her body's appearance. In the interview, Julia's voice tone is noticeably lower and sadder as she shares her CT experience with me, revealing the saddening effect of such powerful dynamic in the work with her client, as well as potential feelings of shame or inadequacy Julia may have experienced in her interview. Once again, this seems to emphasise the

need for new therapists to reflect on their CT throughout the therapeutic process with their clients, in supervision, CPD and on their own after sessions.

5.2 Subtheme 4.2. 'Conscious' clothing: To please or to challenge?

The embodied communication and the power battle between new therapists and their clients with EDs seem to point towards the complexity of the processes taking place in the therapeutic relationship. Participants' CT reactions of modifying their appearances in order to soften their perceived power described as intimidating for their clients, as mentioned in the previous subtheme, appear to be taken a step further in therapists' felt need of either challenging or pleasing their clients by choosing which clothes to wear in sessions and in front of their clients. New therapists' CT responses during therapy sessions and prior to sessions can be potentially suggestive of a conscious process of carefully choosing their clothes, which may be interpreted as a need to please clients or to challenge them in the power struggle.

Zara's quote captures her CT reaction of heightened anxiety prior to her sessions with one client with EDs in the search for her body to become invisible to her client's eyes or to be pleasing her client:

> *Zara: […] I started seeing her for individual sessions and whenever she sees me she always comments on my clothes, so she always says 'Oh, I like that, Oh you look really good in that dress today! Oh, I really like that!' and that just makes me sort of conscious of it. And then I started to realise that before I see her I always have a look at my clothes just to kind of …and I don't even know why I do that!...I don't know if I am trying to find something that she would like to look at or whether I want to find something dull and boring that she wouldn't comment on …so, yeah...so I suppose that's a type of CT cause I am reacting in a way to what she is saying.*
>
> *(Lines 160-168)*

Zara's use of present tense as well as her unclarity making sense of her reactions to her client's comments suggests that she tries to understand her CT response at the time of the interview, perhaps without having reflected on this before. This may, once again, emphasise the unconscious and difficult nature of CT reactions, which may have been missed at the time of therapy. Regardless, Zara points out her wish to possibly finding 'something dull and boring' as a way of becoming invisible to her client, perhaps to avoid scrutiny and causing her intense anxiety. Her CT reaction appears to communicate a need to either please her client by wearing something she would like or to defend her appearance and her body from the uncomfortable comments made by her client, who may in this way hold the power in the therapeutic relationship through the appraisal of Zara's looks.

Similarly, Julia's below excerpt denotes strong CT experiences at an emotional and behavioural level during sessions with her client:

> *Julia: And I only noticed that afterwards, that this was something that was happening, that there was somehow something being played out, that yeah…, I was picking up I guess her difficulty, her process, yeah that was really affecting me! And I do remember even when I was getting ready I would think does this show off my body? cause I wouldn't want her to see that, so I would be wearing quite baggy clothes, quite loose fitting clothes so that she couldn't see my body, uhm...I think yeah…, cause then I started to wear just long skirts so that you can't see the outline of my legs and uhm...and then just really like loose fit clothes I remember...uhm...*
>
> *Lines (109-115)*

Julia's reflections of her CT experiences appear to have been facilitated by the interview, allowing her to make sense of her projected difficulties of her client onto herself and the extent of the impact it had on her. Julia's intense CT responses to the power struggle with her client mirror a need to hide her body in front of her client by

'wearing quite baggy clothes, quite loose-fitting clothes'. This may be understood as surrendering to her client's power by hiding the outline of her own body. Although Julia is able to reflect on her reactions at the time of therapy in her interview, she appears to have been acting out on her CT of needing to become invisible to her client at the time of therapy, having been pulled in by the unconscious processes in the therapy. This is suggestive not only of the difficult nature and elevated intensity of her felt CT at the time, but also of the negative effects it had on Julia's self-confidence as a young woman and newly qualified therapist. As both Zara's and Julia's accounts suggests elevated distress, reduced self-care and need to succumb power to the client during the therapy, new therapists' CT becomes crucial to consider in the work with individuals with EDs as a way of attending to therapists' and clients' wellbeing in the unravelling of complex therapeutic processes.

5.3 Subtheme 4.3. Refused and rejected: Means to control the power

Linked with the idea of a robust, tacit power struggle as one of the dynamics entwined in the therapeutic relationship, interviewed participants revealed strong CT reactions of wishing to push their clients away as a response to such processes. Caught up in the struggle for power with their clients, therapists frequently reported experiencing the temptation to reject their clients, perhaps as ultimate means to claim power in the relationship. Mia reveals her CT experience of wishing to 'push her client away' in the excerpt below:

> *Mia: Well, my response is: one, the need to rescue which she needs and wants from me, but two, at the same time it's almost like sabotaging the work by me saying almost like wanting to push her away. Like if you don't feel like I am good enough, then obviously go somewhere else, […], so yeah, it's difficult, but then I ...yeah...*

(Lines 138-143)

Mia's experienced sense of 'not being good enough' as a therapist seems to be understood as rejection by her client's refusal of the offered help. Mia's mentioned CT response of wishing to reject the client back by 'sabotaging the work' highlights the intensity of her CT reaction, as well as the struggle for power in the therapy. Although Mia acknowledges her client's difficulties, linking these with previous attempts by other therapists to address the clients' bulimia and trying to empathise with her client's difficulties, her CT reaction indicates an intense and powerful negative response. This may suggest that Mia's reaction overtakes her conscious, logical reasoning, pointing towards a potential egotistic injury regarding her therapist role, indicated by the words 'if you don't feel like I am good enough, then obviously go somewhere else'. Mia's emotional response can be interpreted as anger/hate in her CT response to the experienced rejection by her client, crucial to consider in the resolution of the power battle. Mia's quote emphasises once again the intensity and power of the CT experiences of the participants to this study and the importance of such processes in the therapeutic work with clients with EDs.

Equally, Zara's excerpt below appears to reveal similar CT experiences of anger and wish to reject the client:

> *Zara: She is not getting much out of this therapy she's resisting quite a lot, she's not even engaging in the therapeutic work, and physically her BMI is fine, is not significantly low, but unconsciously I think there is a part that is sort of rejecting her because I don't feel that she is working with me and to yeah...perhaps there is a part of me that is feeling quite angry and wanting to reject as well.*
>
> *(Lines 234-239)*

Zara appears to provide a rationale for the possibility of ending her work with her client, pointing out the fact that she is 'resisting the therapy'. Using tentative language

such as 'perhaps' and 'sort of', Zara may suggest that although her built rationale is realistic and plausible of discharging her client from therapy, the underlying motivation for such reaction could be linked to her feeling angry and rejecting to the client in the process of CT. It may be possible that Zara's use of tentative language suggests a fear of being judged in the interview by myself as researcher and therapist. Furthermore, Zara's quote may indicate, similarly to Mia's CT experience, a sense of anger in the CT in response to her frustration with the client's lack of progress and struggle for power in the room as suggested by the phrase 'I don't feel she is working with me', followed by Zara's acknowledged anger and wish to reject back her client. Both Zara's and Mia's shared CT experiences could be understood as ways of punishing their clients in a phantasy realm, thus claiming back power in their attempt to restore themselves after suffering an egotistic injury as therapists.

Considering the power struggle in the dynamic between new therapists and their clients with EDs, the found subthemes appear to convey the difficult nature and uncommon intensity of the CT reactions participants experienced in their work. Analysis suggests that these reactions may possibly affect new therapists by potentially causing them to feel vulnerable in their bodies and in the relationships with their clients. Participants have spoken about feeling the need to please their clients by masking their appearance, carefully chose their clothes prior to sessions or end the therapy following painful emotional CT reactions of rejection. As mentioned by the participants to the current study, such responses may be important to the therapeutic work in order to conserve and reinforce new therapists' self-care, therapeutic relationship and therapy outcome from possibly acting out.

6. Superordinate Theme 5: Being Equipped to Manage CT

This superordinate theme was found in relation to participants' accounts trying to make sense of CT in their work with clients with EDs. Analysis suggests that participants' retrospective reflections around their CT reactions may possibly highlight not only the importance of CT as an essential tool in the therapy, but may also point out the potential need for further awareness and the creation of a common language for CT as an unspoken unconscious process. These ideas are captured in the following subthemes.

6.1 Subtheme 5.1. Needing time and space: Making sense of CT as a tool

Throughout the interviews participants recognised the value of their CT experiences in the therapy outcome. They identified the use of CT as a treasured tool in understanding their clients' internal worlds through their own experienced changes at emotional, cognitive and behavioural levels. This subtheme emerged from participants' views on CT as supporting tools only if successful in unpacking and making sense of them before using their CT experiences in therapy.

In the extract below, Julia captures her ability to reflect on her CT experiences resulting from her work with her clients with EDs:

> *Julia: I think was my own ability to reflect on what was going on because it was something I never had an issue with and it didn't come up in other areas of my life so that was one way of managing it, so being quite reflective all the time about what was going on uhm....and I think at that time I had ...like when I was writing my notes after session I had my own, my own book for notes and the notes I wrote for the service were separate. So I would use that a lot, writing everything that was happening in the room with her and the processes, and I remember having lots of questions okay, what does this mean? what is happening? So I guess I would also use my process notes to make sense and mange my CT.*
>
> *(Lines 257-266)*

Prior to this excerpt, Julia had shared her experienced CT reactions in the work with a client with anorexia, underlining the negative impact of the CT on herself as a new therapist. The above extract presents Julia's efforts to make sense of her CT following sessions with her client. Julia stresses the extent of the labour she devoted to reflecting on her reactions and feelings related to the therapeutic work with her client, pointing towards time needed to reflect on sessions after they take place to give meaning to CT. Julia's use of process notes following sessions suggests the complexity of CT reactions in the work with clients with EDs, deeply rooted in therapists' own experiences and views of themselves. This appears to be suggested by Julia's reflections on her previous work with other clients and the lack of such strong CT reactions before, compared to her shaken self-esteem as therapist and body-image concerns she refers to in her interview. Julia's excerpt seems to point out the need to slow down the CT experiences by recording them in writing, emphasising the crucial aspect of time resources in the work with clients with EDs. Repeatedly referring to her written notes, Julia's quote denotes the significance of time and space required to allow new therapists to reflect on their CT responses to the work. Once these conditions are met, CT becomes an invaluable tool to the therapy.

Similarly to Julia, Pamela's experience of her CT is understood as a process which would have benefited from additional time and space to think about at the time:

> *Pamela: It would have been really nice to have had the space to discuss how it would affect you, and also to discuss the CT and just space to actually talk about it than rather just be this treatment machine that really talks factual […] there was very little space to discuss personal reactions and the meaning that draws out of this.*
>
> *(Lines 242-247)*

Pamela's quote appears to reveal an important aspect in the stretched NHS services. She appears to bring into focus an identified dilemma in the management of her CT reactions in connection with the service where she worked. Pamela's use of the phrase 'treatment machine that really talks factual' when referring to herself, may suggest an increased sense of pressure as a new professional within an NHS service to conduct clinical work without pausing to reflect, but instead positioning herself at a 'factual' level as a therapist. Pamela's quote may also point towards a system around herself as a new therapist, described by the term 'machine', seeming to suggest her experience of a cold-hearted environment, continuously working mechanically, without allowing for space to think or reflect at deeper-level around issues arising in the therapeutic relationship. Pamela's account may possibly indicate her experience of her role as therapist becoming reduced to solely facts and doing through the imposed attitude of a machine-therapist in her service, rather than thinking and reflecting.

Both Julia's and Pamela's excerpts appear to underline a felt need to use CT reactions as invaluable tools in the therapeutic process through time and space to make sense of them. Therefore, this subtheme attempts to convey participants' lived experiences, wishes and reflections regarding the importance of CT reactions, emphasising that such processes can be used appropriately when services resources create opportunities for reflective time. Such findings are important for the current NHS services where clients with EDs are treated in therapy by new therapists in order to manage and make sense of CT reactions.

6.2 Subtheme 5.2. Creating a language: Finding words for the reactions

In addition to the previously identified subtheme and the process of understanding and making use of the CT as an essential tool in the therapeutic relationship, new

therapists also referred to a need to create a language for their CT reactions. This is considered as an essential aspect in the use of CT in helping both the client and therapist, as captured by Julia in the extract below:

> *Julia: I don't think I did use myself in the… in what I was picking up in the room, so there was almost like a lack of language...So I didn't have the language at the time, I did not have the vocabulary at the time to say this is what it may be happening between us, or this may be what you are feeling when you're coming here and when you see me, and I think that would have been helpful for both of us.*
>
> *(Lines 161-166)*

Julia's quote indicates a felt need for encountering suitable words or language as part of the process of managing and understanding of the complex, unconscious dynamic of CT responses. Julia's CT experiences in response to the work with her clients highlight the lack of training and, subsequently, of language in her own understanding of the process. This is seen by Julia as a barrier in her ability to better support her client at the time, as a result of the missing communication around the occurring processes within the therapeutic relationship. Julia further suggests that having been able to use appropriate language around her CT could have improved the quality of the therapy process and its outcome. This could be understood as perhaps an attempt to communicate Julia's belief in further progress in the client's presentation and Julia's own development as newly qualified given the existence of suitable language around CT reactions. This finding may be relevant in the clinical work new therapists overtake with clients with EDs, conveying a potential need for further support in reflective practice, personal therapy, supervision and/or CPD around CT reactions.

This subtheme appears to bring to attention a potential requirement for new therapists to be provided all needed support, training, time and space alongside

encouragement from their supervisors to discuss and find suitable language for their CT in the clinical work.

6.3 Subtheme 5.3. Training: Building up expectations in the relationship

Subsequent to participants' experiences of their CT, making sense of it and using it as a tool to the therapy, participants also made many references throughout their interviews to a perceived wish of having had expected such CT responses to the client's materials. These views allowed for the emergence of this subtheme.

Some participants referred to having had brief training around the psychodynamic understanding of process and implicitly CT. Laura's below quote gives voice to her experience of CT as a difficult process unspoken about in her training:

> *Laura: I think I would have wished that I'd known more about that CT, the transference, how to look out for it, what to look out for, because as I said sometimes you can come out of any session feeling quite down, especially feeling quite depressed uhm...but this was on top, it was extra… So I wish I'd known how to notice that in the room as a warning sign to say: Okay, just pause for a moment and think are you acting on your emotions, are you throwing all of these things at this person because you're feeling anxious or are you doing what you'd normally would?*
>
> *(Lines 287-293)*

Laura seems to point out the importance of CT and processes in the clinical practice, linking this to her work with clients. She appears to emphasise that detailed training and increased awareness of the potential CT responses that may be expected with this client group, could have allowed her and her client to make more progress in therapy. Equally important, Laura appears to raise the idea that having relevant training increases therapists' knowledge in the area, which allows them to avoid the likelihood of acting out on their CT which would lead to colluding in this way with the client. Laura's reflections

during the interview appear to give way to a sense of sadness she may have experienced subsequently to having identified gaps in her training prior to the work with clients with EDs. Laura's low tone of voice and use of the words 'feeling quite down […] quite depressed' can be understood as possible sadness towards the missed opportunity to better therapy outcome and the appropriation of her expectations of CT as a new therapist.

Similarly, Pamela expresses a wish she had training preparing her to expect difficult CT reactions in the work with clients with EDs:

> *Pamela: Oh God, a lot of stuff (laughing). Um....just knowing ahead of the sort of emotions that could be involved and that this is normal, and the anxiety, and that actually, as I picked up after a while working in the service, my colleagues experienced that sometimes as well, even the experienced ones. That this is sometimes okay and normal.*
>
> *(Lines 220-224)*

Pamela appears to allude to the idea of CT reactions being 'normal' and expected. Her account may be indicative of a brief training around new therapists' expectations in the work with this clinical group of clients, perhaps in a satirical and angry manner suggested by Pamela's laughter at the beginning of her quote. She seems to contrast new therapists' inferred feelings of shame and low self-esteem caused by the difficulty of their experienced CT with the normality of such reactions in the work with clients with EDs. Furthermore, Pamela's nonverbal cues such as her laughter reveal the ridicule extent of the impact professional training had on her CT experiences, as well as on the clients and the therapy. She seems to allude that the normalisation and validation of difficult CT experiences in the work with clients with EDs should have been expected and taught in the training programmes.

Other participants also referred to the need for detailed training around CT. Although Mia's below view recognises the need for normalisation and expectation of

difficult CT, she also accentuates the ideas of collaboration, motivation and responsibility required from both therapist and client for a positive therapeutic outcome. Mia's emphasis on training on the above-mentioned areas appears to be associated with her experiences of intense CT and poor self-care:

> *Mia: I wish I knew back then that actually it's not just me in this relationship, it's two people, and both of us have to work equally on this particular issue and I pull back and I don't necessarily give it 110%. And the self-care, it's not been that long that I've had weekends to myself without working, but I wish work was work and home was home[…] To start with I very much struggled with understanding the whole concept of transference and CT, I struggled to put in practice, to see what effect it has on me […] which meant then that I was investing too much, I know for a fact, in my clients, I know I was doing too much for them, I felt like I need to take on the whole responsibility in the session, outside the session.*
>
> *(Lines 349-356).*

Mia's account seems to point towards the idea of creating appropriate expectations during professional training, as a potential way of helping therapists manage their CT reactions in the clinical work with this client group. Mia's quote suggests possible bitterness around the missed opportunities to feel more at ease as a new therapist working with people with EDs. She refers to her prolonged overuse of herself in therapy by being caught-up in the CT reaction of rescuing her clients, therefore impinging on her self-care. Mia's mentioning of her weekends and evenings spent as working from home in the attempt to rescue clients suggests an intense sadness regarding the missed chances if she had expected such CT reactions, and in doing so possibly avoiding her overuse of herself in the clinical work. Mia's clear examples of her affected self-care highlights the idea that her 'doing too much' and 'taking on the responsibility' may have been avoided if she had specific support with regards to managing CT responses in therapy with clients with EDs. This finding may underline the importance of adequate awareness and support for new

therapists, expressed as necessary in the creation of realistic expectations of CT reactions to support new therapists' self-care, self-esteem and to protect both therapists and their clients from potentially acting out in the therapeutic work.

This chapter uncovered that all participants recognise their difficult yet helpful experiences of CT in the therapy with clients with EDs. It also underlined new therapists' awareness of the impact and importance CT responses may have on themselves, their clients and the therapy outcome. The importance of reflection and making sense of CT is present in most accounts, seeming to emphasise the use of CT as a precious tool in the therapy work. Despite all discussed experiences of CT difficulties, new therapists recognise the role of appropriate training in understanding CT and creating expectations in the work with this client group. These ideas and possible implications to the field of therapeutic practice are discussed in the following chapter.

CHAPTER FOUR: DISCUSSION

Chapter Overview

The current chapter aims to discuss the key findings of the study by contextualising them within current literature and by pointing to the ways that current findings could extend the understanding of newly qualified therapists' experiences of CT when working with clients with EDs. It also illustrates the limitations and implications of the study related to the field of Counselling Psychology. Suggestions regarding future research and enhancement to the training of new therapists and services providing therapy for individuals with eating disorders are outlined at the same time as the role of clinicians in future clinical practice is explored.

1. Discussing New Findings

This section highlights new and significant findings in relation to existent literature on topic. Whilst this section makes some references to the implications of new findings to psychological therapy, these will be further explicated in the 'Implications' subsection.

Five superordinate themes and 15 subordinate themes were found following analysis of the transcribed interviews. The main themes were: a) 'Doubting Own Identity'; b) 'Safeguarding the client, the self and the work'; c) 'Feeling "Chewed through and spat out"; d) 'It's a power struggle!' and e) 'Being Equipped to Manage CT'. Below, I discuss the themes that I consider providing new contributions to the field, answering the study's research question: *'How do newly qualified therapists experience countertransference working with clients with EDs?'*.

Firstly, the findings of this study appear to confirm existing knowledge regarding the ways that therapists generally work with EDs, whilst also extending this to a new area of newly qualified therapists. Previous literature established that experienced therapists working with individuals with EDs should be mindful of their own body images, self-worth and attractiveness in order to avoid overidentifying with their clients, possibly hindering in this way the therapy (Delucia-Waack, 1999). Although there has been recognition about the importance of an unconscious overidentification with clients with EDs, especially written about in the context of supervision (Delucia-Waack, 1999), this has only been linked with senior therapists' CT. The current study indicates that similar CT processes could take place for newly qualified therapists, as suggested by the emerged superordinate theme 'Doubting Own Identity'.

Such findings reveal the importance of CT reactions and their potential impact on new therapists' work and their self-care preservation. As part of their CT, new therapists often spoke about temporarily experiencing an uncommon anxiety related to their own bodies, sizes and shapes, similarly to their clients. Not only did they worry about their bodies, but new therapists' CT experiences also seem to be linked with modified behaviours around eating and around different types of foods, in similar ways to their clients. This finding confirms Warren et al (2009) quantitative study in the USA, which showed that most therapists will experience changes in their bodies perceptions, weight, size and eating behaviours, becoming more vigilant around these than before the work with ED clients.

Another key finding is the idea that when considering CT reactions, the body becomes critical in the process of preserving new therapists' wellbeing and self-care. Sella (2003), Orbach (2004) and Soth (2004) argued about the importance of considering

the therapists' embodied CT reactions in treating individuals with EDs, pointing to the need for the therapist to be conscious and in-tune with their bodily sensations in order to become aware of somatic CT reactions. This seems to be experienced first-hand by clients in their own bodies and projected onto the therapist by the communication of pre-verbal raw, intense and difficult emotions. These projections are experienced by therapists in different ways in their CT (Colahan, 1995; Hayes, Gelso, & Hummel, 2011; Hughes, 1997; Lanyado & Horne, 2009; Lowell & Meader, 2005). Current findings are suggestive of new therapists' potential temporary overidentification with clients at an embodied level. This was found in participants' unusual worries around body shape, physical pain in different body parts, hunger, extreme exhaustion and weight, as captured by the superordinate theme 'Doubting Own Identity'.

Furthermore, the current study suggests additional levels of identification with clients in the CT: the emotional and cognitive identification. Therefore, it extends existent knowledge, adding to Sella (2003), Soth (2004) and Delucia-Waack (1999) writings on embodied CT. New therapists spoke about becoming temporarily "stuck" in their ability to think or feel within sessions, mirroring in a way their client's 'stuckness'. They found themselves employing primitive defences such as splitting in their views of themselves. Elements of the embodied CT reactions were also found in another theme related to power and control in the therapy, 'It's a Power Struggle!'. New therapists spoke about their need to defend themselves and hide their power as therapists by hiding their bodies in their desire to almost become invisible in front of their clients. This emphasises the potential impact CT reactions may pose on new therapists' grounding in the clinical work, self-care after sessions and outcome of therapy.

The current study also provides new insights in the understanding of newly

qualified therapists' reactions of CT and the potential burnout related to overidentification with their clients. Although Satir (2013) and Warren et al (2013) have identified in their quantitative studies that younger and less experienced therapists are more likely to experience burnout in the work with EDs, understanding this in connection to new therapists' overidentification with their clients (Satir, 2013), new therapists' lived experiences remained unexplored prior to the current study. The current study found that therapists' CT responses may be explained as reactions to the clients' neediness and their desire to be rescued. Interviewed participants spoke about the perceived vulnerability of clients as seeming younger than their actual age and in need of having a good object/maternal figure. In the current study, therapists reported elevated fear of the responsibility and duty of care to their clients with EDs in keeping with previous studies (Bruch, 1973; Costin, 2009; Green, 1974; Shipton, 2004). These findings are similar to Hamburg &Herzog (1990), who looked at therapists' CT in supervision. Whilst the current study's findings are similar to the above mentioned in regard to therapists' CT tendencies of wanting to 'do it all for the client' and fearing about their clients' potential death or deterioration, there are also noted differences and further contributions by the current research. Hamburg &Herzog (1999) discuss therapists' CT response of 'doing it all for the client' as an unconscious reaction to therapists' narcissistic injury' towards the clients' refusal to improve in therapy. Although these findings are similar, it is important to acknowledge that all previous studies referred to long-term qualified professionals. Therefore, the current study confirms that similar CT reactions can be experienced by newly qualified therapists, giving voice to their experiences in and out the consultation room.

The present study also revealed the potential for an impingement on newly qualified therapists' self-care and wellbeing in the absence of reflecting and making sense

of CT responses. As described by the superordinate theme 'Feeling chewed through and spat out', findings exposed the intense and difficult nature of CT reactions new therapists may have experienced throughout the therapy sessions with their clients with EDs. The interpreted lack of boundaries in the felt experience of CT responses may suggest an elevated degree of use of self by therapists in their therapeutic work. They spoke about experiencing extreme exhaustion, depletion and complete emptiness following sessions with this client group, more than with other groups of clients.

The dual and conflicting aspect of newly qualified therapists' CT in their work with clients with EDs offers new insights on how strong CT responses may potentially become harmful to the therapeutic outcome. This was linked to cases where new therapists' may have experienced limitations in reflecting on their CT reactions, either in supervision or on their own. This process was understood as preventing the potential for acting out or letting their CT reactions collude in the therapy. On the other side, new therapists also recognised the immensely significant meaning to the therapy CT experiences hold, representing essential tools in understanding their clients' inner world, relationships patterns and pre-verbal feelings that they are unable to communicate otherwise.

In line with previous literature recognising the CT reactions of rage, frustration, despair and need to cut-off from the client (Satir et al, 2009), this study shines light on the potential that therapists could possibly end up acting out on their felt CT responses by possibly rejecting clients, sabotaging or prematurely ending the therapeutic work. Adding to the therapists' CT reactions of frustration and rage is the ultimate power of refusing the client through ending therapy or discharging them (Shipton, 2004; Hamburg &Herzog, 1999; Satir, 2013). Although the present findings confirm the above-mentioned CT responses, it also extends this knowledge to newly qualified therapists by

evidencing the possibilities of new therapists acting out on their strong CT reactions. Participants often spoke about the felt need to discharge their clients with EDs and refer them to other therapists or services. They also reported the desire of almost sabotaging the therapy by ending it prematurely in order to claiming back their power in the battle between therapist and client. Such findings may be important in considering the clients' wellbeing, therapy outcome, and accessing appropriate services and treatment. This links to Hinshelwood's (2002) writing about clinical staff's CT reactions of "distancing" themselves from clients as a way of repeating their patterns of being neglected, abused and not receiving the needed help. Current findings suggest based on Hinshelwood's studies (2002) that becoming aware of the CT reactions to clients with severe presentations, such as EDs, is of primordial importance in the therapeutic work.

Another area of contribution relates to participants' feelings that only by surrendering to their clients' holding power were they able to mask their own power as provided in their roles as the therapists. This was understood by participants as a mean to allow the therapeutic relationship to become stronger and sustain the therapy. New therapists also spoke about their CT experiences as a power struggle in the work with their clients with EDs. This theme has been widely found throughout the literature of EDs, revolving around the idea of control and power in the therapy room. This is supported by Shipton (2004), who wrote about the client, as both the "depriving and the deprived" in the therapeutic relationship, controlling the power in the therapy room. The current study found that participants felt that only by surrendering to their clients' holding power were they able to mask their own power as provided in their roles as the therapists.

New findings emphasise newly qualified therapists' potential of experiencing the need to hide their bodies as a reaction to the intense discomfort in the room with their clients with EDs. Findings convey new therapists' CT reactions as a need to defend

themselves and their bodies, in the power battle, by hiding their bodies from the attacks and scrutiny of their clients. This study confirms previous literature's understanding of experienced therapists' CT reactions to become unseen in the room, wearing baggy, boring and dull clothing as a way of minimising the battle for power in the therapy room (Delucia-Waack, 1999; Gelso & Hayes, 2007; Thompson-Brenner et al., 2012; Warren et al.,2009; Williams, 1997). Current findings show that such reactions may also be present in new therapists, whilst adding a qualitative perspective to the CT experiences new therapists voiced during their interviews. This could be used to preparing new therapists for managing such CT experiences by developing further their awareness, reflexivity and attention to processes.

The current research restates the need for understanding and reflecting on CT as a tool for the therapy of individuals with EDs within the present-day context of the NHS. As a result of participants being recruited in the NHS, one of the themes found by the study suggests the need for time and appropriate supervision resources to allow the management of CT in the work with EDs. This study brings to light not only the crucial information contained by newly qualified therapists' CT responses, but promotes the need for these reactions to be understood and reflected on in order to be decoded and become useful as tools. Participants mentioned the need for post session time and space to reflect on their CT reactions rather than immediately having to head into another session with the next client. This was discussed by participants by placing it in contrast to NHS services described as "machines" where new therapists are often expected to provide sessions without time to reflect in between. The literature clearly supports this finding and emphasises the useful and vital aspects of CT in therapy as described by different psychoanalytic and psychodynamic schools of thought (Burton & Davey, 2003; Colahan, 1995; Earlichman, 1998; Fauth, 2006; Fonagy & Target, 2003; Gelso & Hayes, 2007;

Hayes et al, 2011; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Shipton, 2004; Van Wagoner et al, 1991).

Findings also suggest a potential need for new therapists to find a suitable language for their CT reactions in order to decipher them and interpret them in the consultation room for their clients. This stresses the importance for new therapists to reflect individually and in supervision around such difficult processes in order to develop language to contain and understand CT within current NHS settings. Previous psychodynamic writings support the idea of use of language to verbalise internal processes as a way of containing anxieties and managing overwhelming difficult feelings (Lemma, 2016). However, this study brings new contributions to the area of EDs by emphasising the potential need for increasing awareness of CT processes for new therapists' prior to commencing work with this client group. All participants spoke about a need for specialised psychodynamic thinking to support this field of work in order to help new therapists build up more knowledge and realistic expectations around the concept of CT in therapy with clients with EDs. The idea of communication or suitable language for the CT reactions has also been discussed with regards to other psychopathologies, such as clients with paranoid presentations, borderline and schizophrenic difficulties. Little (1957), Epstein (1979), Spotnitz (1969) and Searles (1978) showed that through the use of CT the therapist becomes aware of their clients' intense and disturbed experiences, further using this information to communicate their own CT reactions to their clients. This process strengthens the therapeutic relationship and helps therapeutic movement, similarly as in the work with clients with EDs. This finding has direct implications at training levels for new therapists working with clients with EDs.

Lastly, the current study accentuates the importance of training in managing CT for new therapists working in EDs services. Whilst existent literature has made clear the importance of CT in therapeutic work (Lemma, 2016; Peabody & Gelso, 1982; Robbins & Jolkovski, 1987; Shipton, 2004), the current study adds the potential need for further development in newly qualified therapists' training. These areas may include encouragement of focused attention to the CT reactions new therapists may experience, specific training focusing on process issues in the treatment of individuals with EDs, as well as the need for reflexivity and management of difficult CT reactions during therapy. This may be of importance for NHS services specialising in EDs by reconsidering the impact of CT reactions new therapists experience at several levels (embodied, cognitive, behavioural), as well on the therapy and client, all of which ultimately affect services outcome, resources and efficiency. Addressing these areas may lead a reduction in the number of cases referred back to services, a better management of CT reactions, thus reducing the possibility of professional burnout and increasing the possibility of better outcome in therapy.

2. Limitations and future directions

This study was designed to explore newly qualified therapists' experiences of CT in their work with clients with EDs. Therefore, individuals recruited for the study were only selected to participate in the study bearing in mind their theoretical orientation in therapy. This means that only a self-selecting group of psychodynamic and integrative practitioners, who were familiar with the concept of CT, were considered for participation. The most used theoretical model currently utilised in the NHS EDs services is the Cognitive Behavioural Model (NICE, 2017), which meant that the process of recruitment was long and difficult to complete. The restricted use of the psychodynamic

framework within the present-day NHS services could therefore prove to be a possible limitation of this current study. Although National Institute for Health and Care Excellence guidelines (NICE, 2017) recommend psychodynamic therapy for the for treatment of EDs, this is considered only for clients whose treatment was not successful following CBT as an initial intervention. On the whole, it appears that although there is recognition for psychodynamic therapy in the field of EDs, services remain limited in the provision of this model. Further research may be necessary to explore the importance and impact of process issues in the psychological treatment of EDs within NHS services. New further studies may decide to investigate therapists' wellbeing and experiences of burnout in this clinical field in relation to the capacity to reflect and discuss process issues at individual or supervisory levels. Such studies may be expanding on current understandings around supervisory models, therapy approaches, training needs and therapists self-care in the work with EDs.

Whilst this study aimed to capture CT experiences new therapists have in the work with all types of EDs, some of the interviewed therapists seemed to have focused their CT responses reflecting on clinical examples with clients with AN. This matter can be understood in the context of AN being one of the most severe and prevalent presentations within the EDs services across the NHS (BEAT, 2019). Whilst this may also be potentially understood in relation to the high eligibility criteria for accessing services, it may also represent a limitation of the study. As participants to this study reported during interviews, clients are often eligible for treatment within EDs services only when their presentations are assessed as moderate to severe, therefore new therapists are most likely to be offering therapy to clients with complex difficulties such as AN, based on the high risks for physical health, suicide risk and high comorbidity (BEAT, 2019; Breweton &Dennis, 2014). Although participants also spoke about other EDs

diagnoses such as BED and BN, six of the total number of 11 newly qualified therapists interviewed for the study referred to their CT reactions in relation to their work with clients who were diagnosed with AN. This may also be further linked to intense and difficult CT reactions in newly qualified therapists. The connection with serious physical health problems and even death, may impact on the therapists' held responsibility and increased pressure to help clients with AN.

Another limitation of the study could be that most newly qualified therapists who took part in the study were women. This may be related to the general gender demographic within the broad field of psychotherapy where women seem to be more numerous than men. The current study comprised of a total of nine female participants, while the remaining two were male. Previous literature found that in the treatment of EDs the gender of therapists may be important to consider as it could lead to differences in CT and therapeutic relationship. Zunino et. al (1990) pointed out that in the treatment of individuals with BN the therapist's gender is important to consider, explaining that CT reactions could be significantly different based on the therapist's gender. This may be an area for further research involving EDs in general.

Furthermore, the use of TA in the current study has its own limitations, similarly to any other research method. Whilst TA has been recently described as a method in its own right (Boyatzis, 1998; Braun & Clarke, 2009), possible limitations need to be acknowledged and potentially addressed in further research. TA has been criticised in the literature for its generic, superficial and descriptive nature of finding themes (Holloway& Todres, 2003). Whilst TA has been shown to provide a systematic and transparent way of high-quality research by using inductive analysis of a phenomenon, one possible limitation of the current study may be that the level of interpretation is not as deep and

specific as in other methods such as IPA, for example. TA captures the main ideas in the data, reflecting a balanced view of it, rather than emphasising the frequency of the codes within their context (Harper, 2012). Also, it is acknowledged that although careful attention has been attributed to the demarcation of themes by restricting this as much as possible to the data collected from participants, it may be possible that through the use of subjectivity themes may have been influenced by theoretical ideas within the processes of analysis and interpretation.

Lastly, another limitation of this study is the difficult nature of identifying and differentiating between the different CT reactions new therapists experienced. Although for the purpose of this study, an operationalised definition of CT was used to clarify the meaning of this concept within the study and during the interview schedule, it is acknowledged that CT can be difficult to pin down in sessions, during clinical work, as well as on reflection. This may be due to the difficulty to determine with certitude between 'proactive' and 'reactive' CT (Clarkson & Nuttall, 2000). Although this was not a focus point during the interviews, participants may have found it challenging to separate their unresolved complexes and past issues that could interfere with the therapeutic process from the reactive CT, such as feelings that are a direct reaction to the patient's material.

In relation to the above-mentioned limitations of the study, future research in the field may be conducted to address the differences in CT reactions looking at how new male therapists' CT may be different from that of new female therapists'. Also, further research considering newly qualified CT in the private sector of working with clients with EDs may be needed to determine that if a lack of tension linked to limited resource problems and work without pre-determinate therapeutic models as specific to NHS services may result in different CT experiences in new therapists.

Further research may also be needed to look at other possible types of CT newly qualified therapists may experience outside of the reactions or responses therapists had to the client material. As Clarkson and Nuttall (2000) argued in their work, CT can be differentiated into proactive and reactive CT. Whilst the current study looked at new therapists' reactive type of CT, new research may want to pursue therapists' proactive CT. This would include experiences of their own unresolved complexes and past issues which could interfere with the therapeutic process.

Lastly, another potential area for future research to investigate may be related to how new therapists using the CBT model experience and make sense of their reactions to process issues in the work with their clients with EDs. Although the CBT model does not recognise the concept of CT, it admits the importance of the therapeutic alliance in the outcome of the therapy (Fairburn, 2008). Therefore, new research in this area may help therapists using the CBT framework develop further ideas related to their own self-care and reflect on the possible impact their reactions may have on the therapy when working with clients with EDs.

3. Implications

The Economic and Social Research Council (ESRC, 2019) has identified the following five areas of impact when discussing implications of new research studies: academic impact; economic and societal impact; instrumental impact; conceptual impact and capacity building impact. Each of these defined areas can be referred to and expanded in view of the findings of the current study and its implications.

At an academic level, current findings may potentially help influence the content of EDs training courses for new therapists, by raising awareness of the expected difficult and complex CT responses new therapists may face with this client group. This may be

achieved by engaging new therapists/trainees in discussions around the importance of CT in the dynamic process occurring in the therapy with this client group, using a multidimensional theoretical approach rather than a single one. At a professional level, this may help expand new therapists' abilities to reflect, normalise and encourage attention to processes and CT reactions for new therapists heading into this clinical field of work. Similarly to the views of the interviewed participants in this study, teachings about employing different theories (including psychodynamic theory) and facilitation of focused discussions on CT reactions could help trainees and new therapists further develop their awareness and improve their understanding of such complex reactions. Doing so could support new therapists to better manage their CT reactions by reducing the potential impact on their self-care, avoid becoming stuck in possible re-enactments with their clients, and therefore allow for therapeutic progress. These areas are crucial in the ability to achieve a positive therapeutic outcome, helping clients to overcome their difficulties. Furthermore, it is important for new therapists continuation of their professional development, avoiding potential burnout.

At training level, the current study may also aid new therapists form possible expectations regarding their performance with this client group. As the study found, new therapists can become exhausted in the work with clients, 'stuck' in a power struggle or doubting their identities, similarly to their clients. Therefore, current findings may highlight a potential need for new therapists to develop personal robustness during their professional training to manage potential heavy CT responses in clinical work. More specifically to the different training programmes for psychologists, counsellors and psychotherapist, robustness can be developed by raised awareness about possible CT experiences to aid recognising, processing and working with such experiences in the clinical work. This can be achieved through the use of personal therapy and the use of

reflective groups during training. Both these could help in further developing awareness about CT reactions and how to best manage them.

Moreover, supervisors may also benefit from the current findings by considering and exploring possible parallel processes between supervisors and supervisees, bringing these into discussion during supervision (Hamburg & Herzog, 1990). Regardless of the core therapeutic orientations, training targeting raising awareness about CT reactions could support new therapists to reflect and improve their self-care, the therapeutic relationship and therefore the outcome of therapy. The idea of despair and overuse of self in the therapy as suggested by the superordinate theme "Feeling chewed through and spat out" becomes crucial when considering new therapists' self-care in this clinical area, the possibility of experiencing burnout in their profession and any potential negative impact on the therapeutic relationship and therapy outcome. New therapists' awareness and ability to make sense of their CT responses, regardless of their therapeutic approach, could support new therapists' understanding of the dynamic processes arising between themselves and clients, limiting the possibility of acting out on such strong reactions. This is important to ensuring therapists remain grounded and attending to their self-care as a way to counterbalance strong CT, which further enhances therapy outcome.

Furthermore, there are possible implications for the therapeutic relationship and therapy outcome. Professionally, findings reported by this study are not only limited to the field of counselling psychology but refer to the broad domain of psychotherapy. This includes many different training courses preparing therapists to work with this client group. This determines that not only psychologists may be impacted on by this study, but also counsellors, psychotherapists and other therapists trained in different schools of thought may benefit from the findings of this study which may potentially be seen as a CPD event. CPD is essential to the professional roles of

therapists/psychologists/psychotherapists/counsellors, potentially being used as a stage to normalise CT experiences and provide therapists with an environment that is open to discussion, support and enhancement of reflective practice. This could allow addressing any specific potential insecurities around therapists' bodies, raising awareness of possible physical reactions, and management of physical discomfort in sessions. This is important to help new therapists pre-empty any chances of acting out following potential CT reactions of such nature and attend to their self-care preservation when looking after their own bodies and self-image for the duration of therapy. Also, it may be used to emphasise the centrality of the power balance in the room, considering multiple ways of empowering clients in the interaction between new therapists and clients. This may be achieved by increased awareness around the importance of the therapists' bodies and attire in sessions, which can be normalised and discussed further in supervision.

At a societal and economic level, this study may contribute to the improvement of newly qualified therapists' relationships with their clients and a better efficiency of NHS services. This may have a positive impact at the general level of the profession, considering the significance of CT reactions for the therapeutic relationship and the criticality of both in the outcome of therapy (Burton & Davey, 2003; Clarkson, 2003; Colahan, 1995; Costin, 2009; Earlichman, 1998; Gilbert & Leahy, 2007). This study may contribute to improving reflexivity in the internal processes of new therapists. New therapists' reflexivity regarding their CT responses has a strengthening effect on the therapeutic relationship, seen as a vehicle of change within therapy, which potentially increases the chances for positives outcomes of the therapy (Lemma, 2016). This can reduce the likelihood CT reactions interfere with the therapy and clients' brought material. Furthermore, a successful and robust therapeutic relationship can have broader implications on the wider systems around clients and their wellbeing, such as by

improving interpersonal relationships with family and friends. Moreover, NHS services may also possibly be impacted on by a reduction in the "revolving door" effect for clients with EDs. Therefore, by improving awareness and greater reflexivity of CT responses new therapists may experience, regardless of therapeutic orientation, could help inform the quality of service delivery.

At an instrumental level, this study may also have implications on the improvement of existing policies regarding the current psychological treatment of EDs. Updated and reviewed clinical policies are crucial for the professional roles in broad area of psychotherapy and NHS. Closer attention to the area of the processes taking place between new therapists and clients can help inform the recommendations made by the NICE guidelines for the treatment of adults with EDs. This may include references to modalities for therapy as well as theoretical models suitable for supervision (Hawkins & Shohet, 2006) and the frequency of supervision for newly qualified therapists. This study may be helpful in the process of setting out policies regarding supervisory support for new therapists within NHS services for clients with EDs, perhaps by considering different therapeutic approaches in therapy and supervision, as well as by creating space for exploring and normalising new therapists' CT responses. This would help new therapists by providing them with space to reflect, make sense and find appropriate language for their CT responses related to the therapy with clients with EDs, therefore safeguarding them from potentially acting out. This would help new therapists build up their robustness, attending to their self-care and prevent possible burnout in their roles.

Current findings emerging from this study could also have implications at a conceptual and capacity building level, considering new professionals' and trainers' theoretically enhanced knowledge about CT reactions in this line of work. This project's

findings may impact on how new therapists, trainers and supervisors could alter their thinking about the complexity of CT reactions experienced by new therapists in their work with EDs. This may inform services about re-consideration of resources needed by new therapists and supervisors to make use of the CT. Likewise, it could impact on encouraging the newly qualified to talk and reflect on these responses rather than to feel as 'not good enough' therapists. This would further help newly qualified therapists build further robustness and normalise the experience of CT reactions with clients with EDs and across diagnoses.

Overall, it is trusted that the findings of this study may help raise further awareness around the uncommon and strong reactions of CT in the work with clients with EDs. Also, the study suggests a potential for further attention and reflexivity on the CT of new therapists working with clients with EDs. As more and more newly qualified are joining this clinical area of work in the NHS following increased numbers of individuals with eating problems (BEAT, 2019), advanced knowledge regarding CT reactions is required to improve the new therapists' wellbeing, self-care, clinical work and services efficiency. Whilst acknowledging current limitations of this study, it is possible that this research adds to the knowledge already provided by professional therapeutic training, skills, processes and resources by having given a voice to newly qualified therapists' experiences of CT. It is hoped that this study opens new possible pathways for the completion of further quality research in this area.

4. Relevance to Counselling Psychology

Investigating new therapists' experiences of CT when working with clients with EDs is an area that merits attention as it affects professionals, clients, services, policy makers, thus making it crucial to consider the views and experiences of this group of

therapists. Following the study's general implications as presented above, this research could also impact significantly the field of Counselling Psychology.

Counselling Psychology places a great emphasis on the concepts and values of reflexivity and intersubjectivity in the therapeutic work (Laughton-Brown, 2010; Strawbridge & Woolfe, 2003). Counselling Psychology's humanistic ethos comes forward in the detailed attention paid to the relationship between client and therapist, focusing on the importance of reflexivity linked to processes and their impact on both individuals in the room as well as on the therapy. Furthermore, Counselling Psychology is interested in the deeper-situated area of the therapists' impact on the co-constructed therapy, which involve the processes of transference and countertransference. Therefore, this study's findings are relevant to the field of Counselling Psychology in that they draw attention to the experiences of newly qualified therapists of CT and their effect on the therapy and therapeutic relationship. Both are aspects of critical importance for counselling psychologists.

These findings may also be of importance to the professional training in counselling psychology. As Counselling Psychology has been expanding more and more as a self-standing science and branch of psychology, it has also become more and more accepted and acknowledged for its training and its practitioners. Therefore more and more new counselling psychologists work in the NHS, in schools, in academia and in the private sector, often coming across individuals with EDs in therapy. Preaching an integrative therapeutic approach, professional training in Counselling Psychology accords significant attention to psychodynamic theories and thus CT reactions. This study's findings are thus aligned with the importance of the preparedness of counselling psychologists working with clients with EDs. This study's findings are not dismissing the

quality and validity of accredited training programmes but hopes to further raise awareness of the complexity and importance of CT reactions when working with clients with EDs.

Furthermore, the professional training of counselling psychologists' is not only limited to prepare individuals to become therapists, but also supervisors, services managers and policy contributors. Therefore, CT experiences of new therapists working in EDs are important to consider at all the above-mentioned levels of practical work. These findings may also be vital in the consideration of potential reactions and tensions in services related to resources, therapy and theoretical models for supervision for both roles of new therapists or supervisors/trainers. As counselling psychologists often play important roles in the national guidelines for care and practice, new therapists' CT can be of relevance when reviewing such standards of practice for EDs. The government has highlighted the crucial role of raising awareness and improving knowledge regarding mental health matters towards living a healthier life and promoting wellbeing (Department of Education, 2016). Psychologists are encouraged to raise awareness and provide education about mental health (HCPC, 2015). Therefore, it becomes part of counselling psychologists' skills and proficiencies to provide psychoeducation, psychotherapy and supervision to all parties involved around the matters of EDs treatment.

Lastly, this study is applicable to the field of Counselling Psychology by its direct links to the implications of CT as a therapeutic process on the communities of new therapists and clients with EDs. Consequently, considering the ethical duty held towards the participants of this study and to my area of training as a counselling psychologist and researcher, I plan to disseminate this study in various modalities. I plan to transform this

study into an article for publishing in relevant journals, such as the Counselling Psychology Journal, as well as Eating Disorders Journals. Also, considering the theoretical orientation adopted by this study, another potential place to disseminate findings could be in the Psychotherapy Journals. Furthermore, this study may be of interest to the communities mentioned above which are reachable in academic conferences and CPD training within different NHS Trusts providing EDs services. The study can be disseminated on the main charities' websites for EDs, such as BEAT. Additionally, this study can be of interest for the attention of general psychology magazines which may reach a broader level of population interested in this clinical practice area.

Furthermore to the study's demonstrated relevance to Counselling Psychology, the following section will discuss my reflexivity as a researcher, another essential process to the field of Counselling Psychology.

5. Reflexivity

My experience of emerging myself in this research study has been rich, satisfying and insightful. My engagement with the collected data and relevant literature search has been conducted to the best of my ability by consulting and adhering to qualitative research guidelines and reading relevant materials. I have been guided by my research supervisor throughout the study, enabling me to follow these guidelines in the correct manner.

Aiming to collect meaningful and appropriate data for this study, I considered carefully the criteria for participants' inclusion, the found themes and the meaning they covered. Whilst I initially intended to interview therapists working only within specialised EDs services in the NHS, I reconsidered this aspect. I was confronted with

many difficulties recruiting newly qualified therapists, as it proved much more difficult than I had expected to find participants for the study willing to respond to inviting emails or adverts posted in work places. Often, there was no communication from the contacted therapists invited to participate in the study. However, on one occasion I was surprised to receive a confrontational response from a therapist explaining that psychodynamic therapy is not evidenced to work for the treatment of EDs. All participants interested in the study were recruited using a snowballing process.

My engagement with the data throughout the process of the analysis followed a carefully and rigorously approach. I frequently linked the data with the research question, adhering closely to the TA methodology. Findings were connected to the existing literature. Furthermore, I explained the findings by considering the literature on the topic to support the found themes in a coherent manner. I attempted to ensure the relevance of the study's findings through the acquisition of knowledge in order to enhance the current understanding of findings.

I consolidated the process of data analysis by providing evidence for the interpretations made for each research claim and pointing out their significance to clinical practice, services and clients. Samples of data transcription, coding and themes development have been provided in the appendices. I tried my best in being explicit about the nature and focus of the study in explaining to participants the nature of the research project.

I have found supervision most valuable during the review of the analysis process. Discussing this area with my supervisor allowed me to understand and clarify the content of the material from a researcher's point of view and to further develop the initially identified themes. I was also able to discuss the drafts of each chapter with my supervisor,

receiving extremely helpful feedback. Receiving supervision throughout the completion of this study has been reassuring and has offered me expert guidance in relation to explored topic.

Although I started this research project very consciously aware of my stance as a novice researcher, with time, engaging more and more with the study allowed me to break free from my fears. Being aware of my subjectivity in analysing the data, the co-creation of the findings and taking ownership of my role allowed me to reach a deeper layer, beyond the descriptive analysis and progress into more in-depth analysis. I found it helpful to keep a log of my reflections throughout the duration of the research journey.

I tried to remain reflexive during all stages of the study, helping me engage with the whole project. I found that supervision facilitated my ability to remain focused and grounded in the researched topic without diverting.

I acknowledge that having employed qualitative methodology, the findings of the study represent my understanding of the experiences participants shared with me during the interviews, and that my interpretations may not reflect participants' intended meanings. I also recognise that engaging with my subjectivity throughout the reading of the data set is my own way of explaining participants' experiences and that the same data may have been otherwise interpreted by another researcher.

I further recognise that my previous clinical experiences working with clients with EDs and disordered eating has stirred my interest for the study and influenced my interpretations in the analysis. Also, my direct therapeutic relationship and work with this client group has inclined me to research this topic. I am fascinated about working with this particular client group from a psychodynamic core perspective, considering the impact this sometimes has on me as the therapist and on the therapy. My own experiences

in the therapy with this client group as well as of readings of relevant literature throughout my working career have motivated me in trying to contribute to this clinical area by conducting this study.

Regardless of my awareness of my own personal experiences, which I have tried to bracket off in the interpretation of the data, I am conscious that such an attempt would not be completely successful, recognising that my personal experiences have undoubtedly impacted on the study.

I accept my role and clinical work as a trainee counselling psychologist employed in the NHS for the duration of my training may have influenced the negative concepts in the findings perhaps in relation to the concept of 'difficult client group' and negativity associated with the diagnosis of EDs. Throughout my clinical experiences on placements, I have found that amongst both therapists and trainees there is a prevalence of difficult experiences compared to positive ones in their work with this client group. Therefore, I may have felt more inclined to focus more on participants' shared heavy and difficult CT experiences.

Although engaging with my reflexivity gave way to recognising my subjectivity, I remain aware that my own experiences of CT with this client group may be limited. Therefore, considering a broader understanding of the CT process in this area, I intend to maintain a more balanced attitude regarding participants' experiences of CT. Whilst engaging in this study has added to my previous knowledge regarding the importance of CT to the therapy and to therapists' self-care, it has also highlighted the use of psychodynamic theory in clients' conceptualisation and therapeutic relationship. CT, in all its forms, serves the therapy process by becoming an essential tool in considering the limitations of the therapy work within the relationship. CT is a complex process where

different factors interact together, such as each person's individual experiences and expectations, ability to reflect, relational templates and their use of language to communicate embodied feelings. Clients with EDs encompass both the limitations of physical, embodied difficulties and the effects of rigidity at a cognitive level. Consideration and reflection on CT in the training and clinical work of new therapists treating people with EDs may lead to increased self-esteem and self-care for new therapists, preventing and pre-emptying intense negative reactions and improving treatment, all of which should be a priority for any policy.

6. Conclusion

This study has aimed to understand the CT experiences of newly qualified therapists' in their work with adults with EDs. The analysis and discussion chapters have highlighted important aspects regarding CT that new therapists could face on a daily basis in this clinical field by engaging in the therapy with clients with EDs. They also discussed the extent of the potential implications regarding newly qualified therapists' CT reactions and what role it plays for them, their clients and the therapy. Current findings may be especially relevant to the arena of counselling psychology, which places great accent of therapeutic processes and the relationship. Findings in this study validate previous studies which acknowledged therapists' overidentification with clients, the power battle between therapist and client, difficult CT evoked in therapists, difficult presentations to treat and the need for a robust therapeutic relationship.

Furthermore, this study has identified that in this field research on new therapists' CT experiences has been limited. Following on from preceding studies, current research has acknowledged a potential need for further development of awareness of CT reactions for newly qualified therapists within services for EDs within the NHS. Although this

study has provided new findings about the CT experiences of these particular newly qualified therapists by giving voices to their felt CT, further research is required for a more comprehensive understanding of this subject.

The current project has emphasised a possible need for resources and further accent in training to support new therapists in their abilities to become more aware of their CT reactions when working with clients with EDs. It has also considered the possible contribution of counselling psychology to this topic, considering its humanistic values and emphasis on process within the therapeutic relationship. The study has demonstrated the importance of dynamic processes beyond mechanical interventions, attention to reflexivity, self-care and their impact on therapy. Furthermore, it highlights a need for ethical consideration in offering clients the most useful therapeutic approaches regarding treatment.

Overall, considering current limitations, future research in this field is hoped to further support new therapists' clinical experiences with this client group as well as help improve care for therapists within the NHS services offered to clients with EDs. Hopefully the present study will add to the vast amount of literature on EDs, particularly in connection with issues of intersubjectivity in the therapeutic relationship and treatment outcome.

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APPENDICES

Appendix 1: Recruitment Advert/Poster

Are you a therapist working integratively or psychodynamically in individual sessions with clients with eating disorders for a period of less than 2 years since qualification?

If so, why not participating in a study looking at new therapists experiences of countertransference in this field?

This study will involve taking part in an individual interview with the researcher about your experiences as a therapist working with this client group. The interview will take approximately 60 minutes and can be arranged on Skype or in person.

If you would like to participate in this study you can sign up by email at either the following email addresses:

Berta.Sandu@nhs.net or u1153387@uel.ac.uk

Thank you!

Appendix 2: Invitation Letter for Participants

Newly Qualified Therapists' Countertransference Experiences when Working with Clients Diagnosed with Eating Disorders

PARTICIPANT INVITATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

My name is Berta Sandu and I am a postgraduate student at the School of Psychology at the University of East London. I am currently studying for a Professional Doctorate in Counselling Psychology and as part of my doctoral studies I am conducting the research you are being invited to participate in.

What is the research?

I am conducting research to find out more about how newly qualified therapists working in services for eating disorders for a period of less than three years are experiencing working with this population. More specifically, I am interested in hearing about your countertransference or your feelings throughout therapy sessions with this client group. I would like to find out about any experienced/potential difficulties in your work with clients with eating disorders. This includes your experiences of any strong reactions, how you felt emotionally and your embodied reactions to the clinical work. I am also interested in how you might have dealt with any difficulties during the course of therapy with this client group.

My research has been approved by the School of Psychology Research Ethics Committee at the University of East London. This means that my research follows the standard of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate in this study as a newly qualified therapist working in the field of eating disorders for less than 3 years. I am looking to find out about your personal experiences and any potential difficulties encountered when working with clients with eating disorders.

I emphasise that I am not looking for 'experts' on the topic I am studying. You will not be judged in any way and you will be treated with respect, anonymity and confidentiality throughout your participation in this study.

You are free to decide whether or not to participate and should not feel coerced to participate in this study.

What will your participation involve?

If you agree to participate you will be asked to:

- Meet with me for an interview that will focus on your experience of working with individuals with eating disorders.
- The interview will last approximately 60 minutes.
- If you consent to the study and agree to participate, you will be contacted by email/telephone to set up a date and time for the interview. This will take place at your practice location or at the UEL campus in Stratford.
- The interview will be like having an informal chat about your experience as a therapist.
- I will be audio recording in the interview in order to allow for transcription and analysis of the information.

Your participation would be very valuable in further developing knowledge and understanding of my research topic. New findings in this field could impact on addressing and normalising difficult experiences working with clients with eating disorders, aiding newly qualified therapists to discuss these in supervision. Also, the study could possibly help reviewing clinical practice for training courses and informing guidelines/regulations for treatment of eating disorders. This is essential when working with clients with complex presentations, such as eating disorders.

Your taking part will be safe and confidential

Your privacy and safety will be respected at all times.

Your personal details and all provided information will be anonymised in all written material resulting from your participation in the study, or in any write-up of the research.

You will not have to answer all questions asked and can stop your participation at any time in the interview without any consequences.

Access to the personal data provided by your participation to the study will be solely made available to myself as the researcher of this project.

What will happen to the information that you provide?

The personal material provided by your participation in the study will be securely stored in a locked cabinet. All personal contact details will be anonymised by using different names in the study and by omitting/changing all identifiable information before presenting it in supervision or to other examiners.

Only your anonymised data will be seen by the supervisors and examiners at University of East London. The finalised research thesis will be made available in the institutional repository of open access publications (ROAR) at the University of East London where you can find a copy if you wish to read it.

In accordance with the University of East London's Code of Practice for Research, the material provided by your participation will be kept intact for any legally specified period and otherwise

for at least five years, subject to any legal, ethical or other requirements, from the end of the project.

What if you want to withdraw?

You are free to withdraw from the research study without explanation, disadvantage or consequence at any point before the analysis of data has begun (January 2019). If you withdraw before that date all the data collected from you will be destroyed. If you withdraw after that date your anonymised data will remain in the analysis and presented in the final report.

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me. My contact details are:

Berta Sandu (Counselling Psychologist in Training)

University of East London; Email: U1153387@uel.ac.uk

If you have any questions or concerns about how the research has been conducted please contact the research supervisor Dr Stelios Gkouskos, School of Psychology, University of East London, Water Lane, London E15 4LZ, (Email: s.gkouskos@uel.ac.uk)

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.

(Email: m.finn@uel.ac.uk)

Appendix 3: Participant Consent Form

Consent to participate in a research study

Newly Qualified Therapists' Countertransference Experiences when Working with Clients Diagnosed with Eating Disorders

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

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I am free to withdraw from the research study without explanation, disadvantage or consequence before the analysis has begun (January 2019).

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

……..

Researcher's Name (BLOCK CAPITALS)

BERTA SANDU……..

Researcher's Signature

BERTA SANDU ……

Date: ……..…….

Appendix 4: Debrief Form

Newly Qualified Therapists' Countertransference Experiences when Working with Clients Diagnosed with Eating Disorders

Thank you very much for taking part in this research, and for your time and effort. Your participation is greatly valued.

As stated in your invitation letter to the study, the purpose of this research is to explore your experiences of working with clients being treated for eating disorders in individual therapy. Your participation will contribute to a greater understanding of therapy with this client group.

Your anonymity will be ensured. The audio, the transcript, the informed consent form and this debrief will all be stored separately in accordance with the Data Protection Act 1998, during the time of analysis.

If your participation has raised any discomfort or if you feel concerned about some of the information you have disclosed with the researcher and would like to discuss this with me, I have included my contact details, below, for your convenience. You may also want to discuss some aspects of the interview with your personal therapist or your supervisor. You are welcome to discuss with me about other sources of support, should you require them.

Please be aware that you have the right to withdraw from the study at any time before analysis commences in January 2019. If you would like to see a copy of the final thesis it will be located in University of East London library from January 2020.

Thank you for your valued support in this study!

I agree that this study was conducted in a professional and ethical manner.

Participants Name..... Participants Signature.....
Researchers Name..... Researchers Signature.....

Researcher: Berta Sandu; u1153387@uel.ac.uk
Research Supervisor: Dr Stelios Gkouskos; s.gkouskos@uel.ac.uk
Department of Psychology, University of East London, Water Lane, London E15 4LZ.

BPS Find a therapist:
Website: https://www.bps.org.uk/lists/DIR

Appendix 5: Interview Schedule

Interview Schedule/Guide

Opening

- Greeting participant; thanking them for taking part.
- Explaining the purpose of the research and why I am conducting this study.
- Opportunity to ask me any questions.
- Reviewing consent/confidentiality, participation letter, demographic information form, any questions?

Guiding Questions

1. Now that we have gone over all the forms, tell me a bit about your choice to work as a therapist in the Eating Disorders Clinic.

Prompt: What attracted you to this field?
What are the reasons you decided to work in EDs?

2. What is it like, in your experience, to work with clients with EDs in individual therapy?

Prompt: How is it different than working with other client groups?
How does the work impact on you as a person in the room and outside of it?

3. Tell me in your words how do you understand Countertransference or the process, reactions and feelings you have noticed you have as a result from your work with clients?

Prompt: How important is this in your work and how you use it?
How did you know this was your CT?

4. Based on what you have described, what are some of the strong CT reactions/feelings/embodied feelings you may have noticed in/after sessions?

Prompt: If difficult, think of a particular client you have worked with and your reactions in response to this.
How did you manage your CT?

5. I am wondering how you might think your CT reactions impacted on you as a person?

Prompt: Positive and negative impact
How are you seeing yourself in your future career?

6. How do you manage difficult CT evoked in sessions or after sessions?

Prompt: What has helped you managing your CT experiences?
How do you manage your CT until supervision?

7. Looking back at these CT reactions, do you think that being a new therapist might have affected your reactions? How?

Prompt: What role does experience have on the CT and therapy when working with a client with an ED?

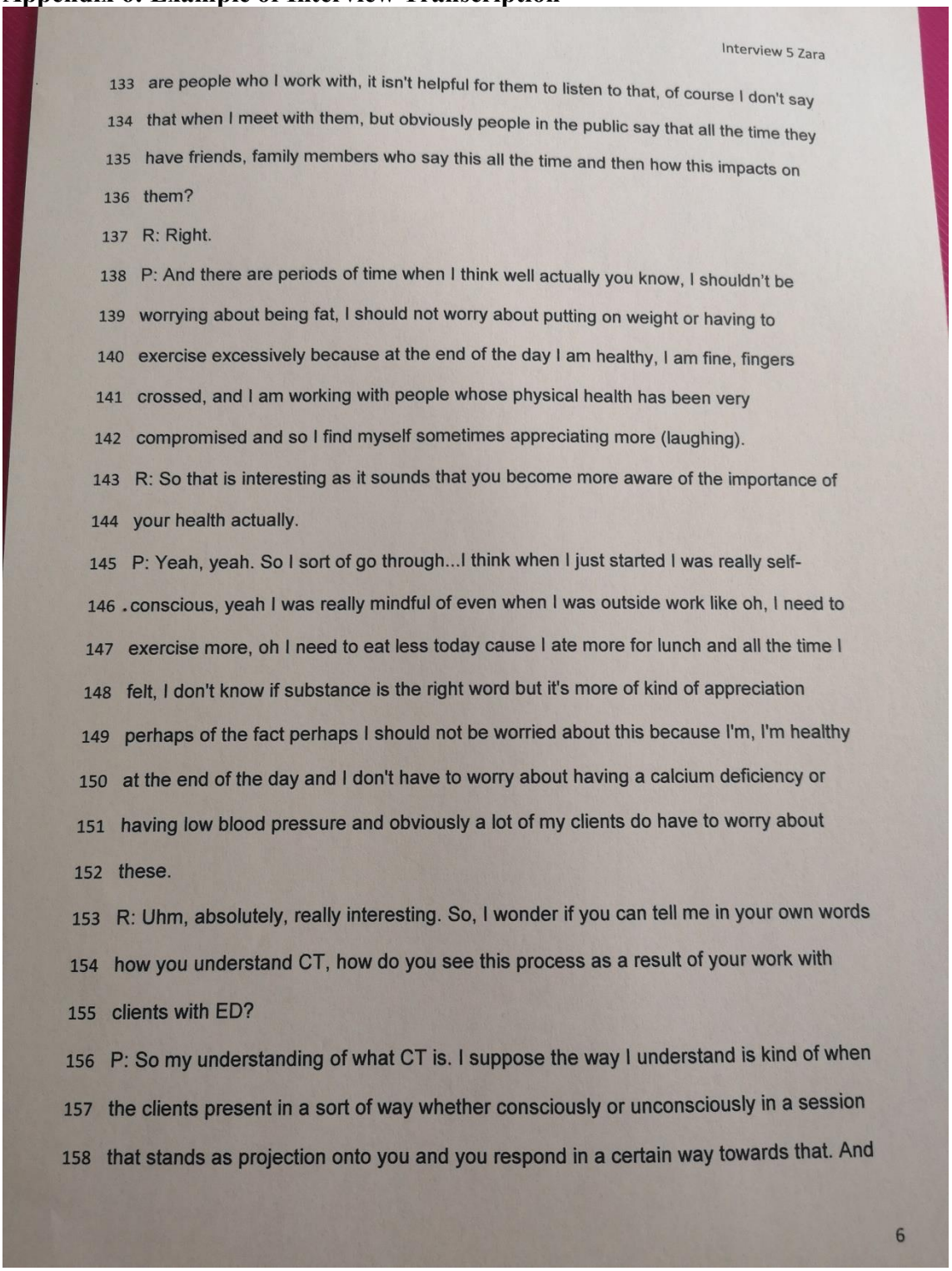
8. Based on the CT described earlier, what do you wish you knew before you started your job to help you be more effective or deal with these differently?

Prompt: What would have helped improve your CT experiences with clients with EDs?

Closing

- Is there anything else you might like to add?
- Are you happy for us to end the interview here?
- Thanking the participant and offer chance to ask any questions.
- Debriefing – discuss the issues on the debriefing form.

Appendix 6: Example of Interview Transcription



Interview 5 Zara

are people who I work with, it isn't helpful for them to listen to that, of course I don't say that when I meet with them, but obviously people in the public say that all the time they have friends, family members who say this all the time and then how this impacts on them?

R: Right.

P: And there are periods of time when I think well actually you know, I shouldn't be worrying about being fat, I should not worry about putting on weight or having to exercise excessively because at the end of the day I am healthy, I am fine, fingers crossed, and I am working with people whose physical health has been very compromised and so I find myself sometimes appreciating more (laughing).

R: So that is interesting as it sounds that you become more aware of the importance of your health actually.

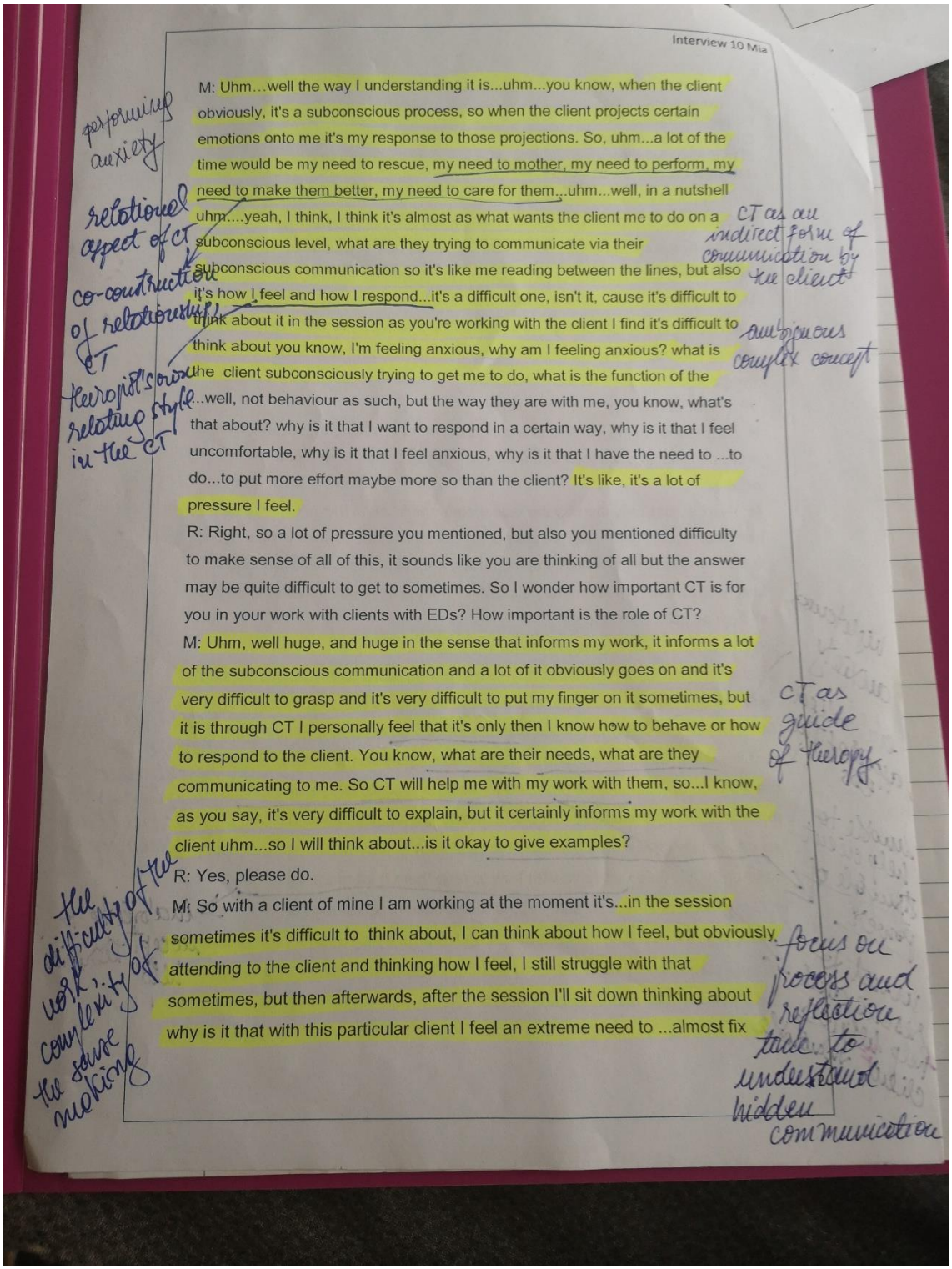
P: Yeah, yeah. So I sort of go through...I think when I just started I was really self-conscious, yeah I was really mindful of even when I was outside work like oh, I need to exercise more, oh I need to eat less today cause I ate more for lunch and all the time I felt, I don't know if substance is the right word but it's more of kind of appreciation perhaps of the fact perhaps I should not be worried about this because I'm, I'm healthy at the end of the day and I don't have to worry about having a calcium deficiency or having low blood pressure and obviously a lot of my clients do have to worry about these.

R: Uhm, absolutely, really interesting. So, I wonder if you can tell me in your own words how you understand CT, how do you see this process as a result of your work with clients with ED?

P: So my understanding of what CT is. I suppose the way I understand is kind of when the clients present in a sort of way whether consciously or unconsciously in a session that stands as projection onto you and you respond in a certain way towards that. And

6

Appendix 7: Example of Transcript with Emerging Codes



Interview 10 Mia

M: Uhm…well the way I understanding it is...uhm...you know, when the client obviously, it's a subconscious process, so when the client projects certain emotions onto me it's my response to those projections. So, uhm...a lot of the time would be my need to rescue, my need to mother, my need to perform, my need to make them better, my need to care for them...uhm...well, in a nutshell uhm....yeah, I think, I think it's almost as what wants the client me to do on a subconscious level, what are they trying to communicate via their subconscious communication so it's like me reading between the lines, but also it's how I feel and how I respond...it's a difficult one, isn't it, cause it's difficult to think about it in the session as you're working with the client I find it's difficult to think about you know, I'm feeling anxious, why am I feeling anxious? what is the client subconsciously trying to get me to do, what is the function of the ...well, not behaviour as such, but the way they are with me, you know, what's that about? why is it that I want to respond in a certain way, why is it that I feel uncomfortable, why is it that I feel anxious, why is it that I have the need to ...to do...to put more effort maybe more so than the client? It's like, it's a lot of pressure I feel.

R: Right, so a lot of pressure you mentioned, but also you mentioned difficulty to make sense of all of this, it sounds like you are thinking of all but the answer may be quite difficult to get to sometimes. So I wonder how important CT is for you in your work with clients with EDs? How important is the role of CT?

M: Uhm, well huge, and huge in the sense that informs my work, it informs a lot of the subconscious communication and a lot of it obviously goes on and it's very difficult to grasp and it's very difficult to put my finger on it sometimes, but it is through CT I personally feel that it's only then I know how to behave or how to respond to the client. You know, what are their needs, what are they communicating to me. So CT will help me with my work with them, so...I know, as you say, it's very difficult to explain, but it certainly informs my work with the client uhm...so I will think about...is it okay to give examples?

R: Yes, please do.

M: So with a client of mine I am working at the moment it's...in the session sometimes it's difficult to think about, I can think about how I feel, but obviously attending to the client and thinking how I feel, I still struggle with that sometimes, but then afterwards, after the session I'll sit down thinking about why is it that with this particular client I feel an extreme need to ...almost fix

performing anxiety

relational aspect of CT

co-construction of relationship

CT

therapist's own relating style in the CT

CT as an indirect form of communication by the client

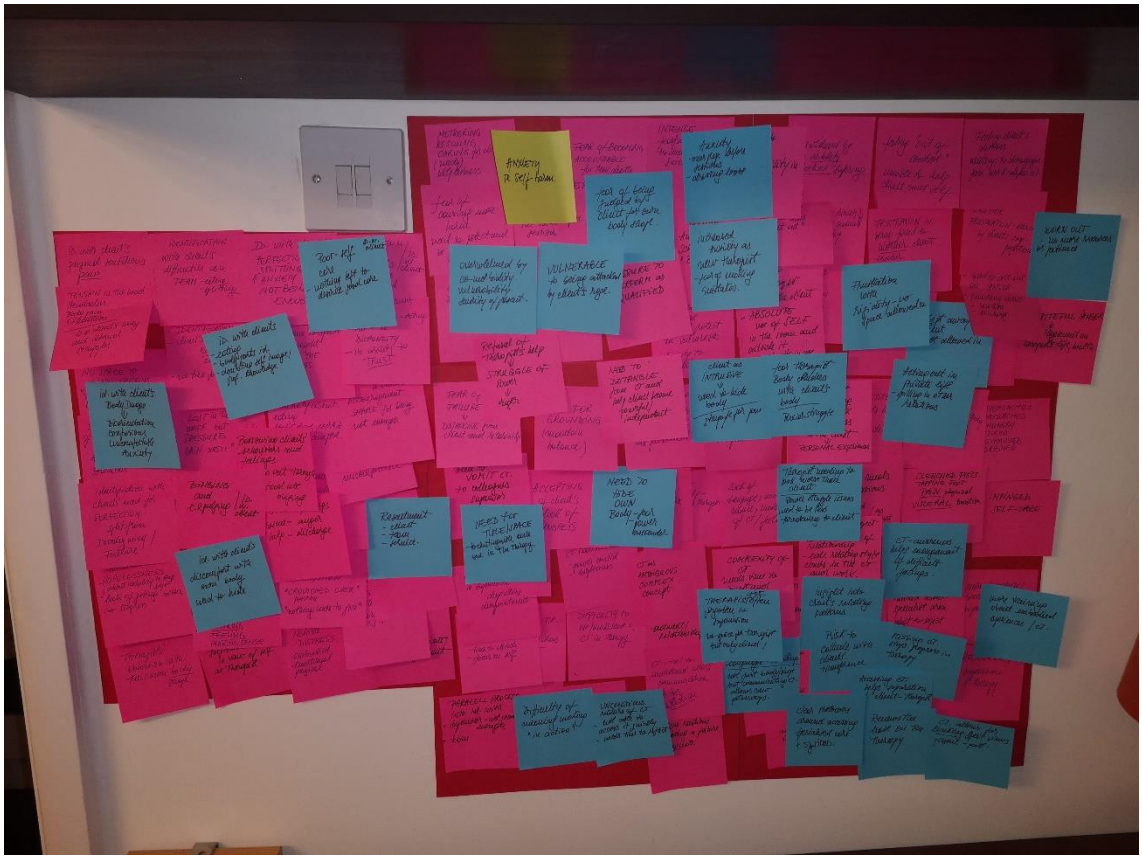
subconscious complex concept

CT as guide of therapy

the difficulty of the work, the complexity of the sense making

focus on process and reflection tools to understand hidden communication

Appendix 8: Example of Coding



Appendix 9: Example of Emerging Themes

Appendix 10: UEL Ethics Committee Approval Form

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Maria Castro

SUPERVISOR: **Stelios Gkouskos**

STUDENT: Berta Sandu

Course: Professional Doctorate in Counselling Psychology

Title of proposed study: Newly qualified therapists experiences of countertransference working with clients with EDs

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY

(Please indicate the decision according to one of the 3 options above)

2. APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES

Minor amendments required *(for reviewer)*:

Title to have minor adjustments, not involving any changes to the approved process of research. No changes were made to the data collection, recruitment or the interview schedule used to collect data. Final title of project is:

Newly Qualified Therapists' Countertransference Experiences when Working with Clients Diagnosed with Eating Disorders – A Thematic Analysis

Major amendments required *(for reviewer):*

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

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

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

Student number: u1153387

Date: 13/06/2018

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

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

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

☐ HIGH

Please do not approve a high risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure please refer to the Chair of Ethics.

☐ MEDIUM (Please approve but with appropriate recommendations)

☒ LOW

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

Reviewer *(Typed name to act as signature)*: Dr Maria Castro Romero

Date: 05/06/18

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

RESEARCHER PLEASE NOTE:

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

Appendix 11: Title Adjustment Approval

Change project title - Ms Berta Sandu

The Psychology Research Degrees Sub-Committee on behalf of the Impact and Innovation Committee has considered your request. The decision is:

Approved

Your new thesis title is confirmed as follows:

Old thesis title: New Therapists' Countertransference Experiences with Clients with Eating Disorders- A Thematic Analysis

New thesis title: Newly Qualified Therapists' Countertransference Experiences when Working with Clients Diagnosed with Eating Disorders - A Thematic Analysis

Your registration period remains unchanged.

Appendix 12: Electronic Data File - Interview Transcriptions

See attached memory stick with data files.