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Seasoned Psychotherapists' Experience of Difficult Clinical Moments

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Seasoned Psychotherapists' Experience of Difficult Clinical Moments

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By

Kirk J. Honda

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Seasoned Psychotherapists' Experience of Difficult Clinical Moments

This dissertation, by Kirk J. Honda, has
been approved by the committee members signed below
who recommend that it be accepted by the faculty of the
Antioch University Seattle at Seattle, WA in partial fulfillment
of requirements for the degree of

DOCTOR OF PSYCHOLOGY

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Abstract

Seasoned Psychotherapists' Experience of Difficult Clinical Moments

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This phenomenological study was concerned with the clarification of the experience of

the difficult clinical moment which is defined as a discrete moment in which the

psychotherapist experiences distress as a result of his or her work with a client.

Retrospective descriptions of experience of difficult clinical moments were obtained from

a diverse sample of ten seasoned psychotherapists in the Seattle area. The interviews

were transcribed, analyzed, and summarized, and these summaries were confirmed by

each participant as being an accurate representation of their experience. Thematic

analysis revealed six themes of experience during a difficult clinical moment: 1) Feeling

Fear, 2) Feeling Inadequate, 3) Feeling Anger, 4) Feeling Confused, 5) Feeling an Urge

to Hide Feelings, and 6) Feeling an Urge to Terminate. An essential general structure of

the experience of difficult moments was derived from these themes. Conclusions are

discussed including: 1) the novel findings of feeling fear and feeling an urge to hide one's

feelings during difficulty; and 2) the urge to hide one's feelings during difficulty appears

to be motivated by both therapist shame and an urge to maintain the therapeutic

relationship. Implications are discussed including: 1) the dilemma regarding whether or

not a therapist should entertain the urge to hide his or her feelings; and 2) the culture of

shame within the field of psychotherapy that stigmatizes therapist difficulties which

interferes with consultation. Recommendations for training and research are provided

including a recommendation to disseminate these findings to normalize the experience

and to encourage therapists and supervisors to discuss difficult clinical moments within

consultation, supervision, and training which might reduce the distress of the moment,

improve coping skills, provide treatment strategies, and ultimately improve client

outcomes. The electronic version of this dissertation is at OhioLink ETD Center,

www.ohiolink.edu/etd

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Chapter I: Introduction

Picture the following clinical moments. A patient harshly berates a therapist for being ineffective. A counselor is horrified by a child's account of being tortured by his parents. A patient brings a gun to session. These are but a few examples of difficult clinical moments psychotherapists will experience throughout their career, and without proper guidance, these difficult moments can be destructive to the therapist, the client, and the therapy.

Psychotherapy can be experienced by the therapist as rewarding and positive, but it can also be experienced as difficult–such as having feelings of anger, anxiety, shock, disgust, guilt, and sorrow (Davis et al., 1987; Orlinsky & Rønnestad, 2005; Schröder & Davis, 2004; Smith, Kleijn, & Hutschemaekers, 2007). Although *therapist difficulty* is loosely defined in the literature, it is clear that psychotherapists encounter various difficult moments throughout their career and these moments are an ongoing part of the inner experience of a therapist (Bermak, 1977; Davis et al., 1987; Deutsch, 1984; Iliffe & Steed, 2000; Orlinsky & Rønnestad, 2005; Schröder & Davis, 2004; Smith et al., 2007; Thériault & Gazzola, 2010). In their large-scale study of 4,923 psychotherapists from 14 countries, representing several theoretical orientations and levels of experience, Orlinsky and Rønnestad (2005) found that psychotherapists, on average, experience occasional difficulties at every career stage (see Table 1).

Table 1

Three Dimensions of Experiences of Difficulties in Practice in Successive Career Cohorts
as Reported by Orlinsky & Rønnestad (2005)

	Novice *<1.5 yrs.*	Apprentice *1.5-3.5 yrs.*	Graduate *3.5-7 yrs.*	Established *7-15 yrs.*	Seasoned *15-25 yrs.*	Senior *25-53 yrs.*
Professional self-doubt	2.1	1.9	1.8	1.6	1.6	1.4
Frustrating treatment case	1.6	1.6	1.5	1.4	1.4	1.3
Negative personal reaction	1.1	1.1	1.1	1.0	0.9	0.9

Note. N = 4,923. Items were rated on a scale that ranged from 0 (never) to 5 (very often). Three
Dimensions of Experiences of Difficulties in Practice in Successive Career Cohorts as Reported by
Orlinsky and Rønnestad (2005). Reprinted from "Experiences of Therapeutic Work in Successive Career
Cohorts of Western Therapists," by D. E. Orlinsky, & M. H. Rønnestad, 2005, How Psychotherapists
Develop: A Study of Therapeutic Work and Professional Growth, p. 277. Copyright 2005 by the American
Psychological Association.

As seen in Table 1, psychotherapists, on average, do not experience difficulties very

often, but they experience them nonetheless.

Recognizing hazards of psychotherapeutic practice–such as difficult moments–is

crucial to therapist self-care and ultimately treatment outcomes (Guy, 1987; Norcross,

2000; Polson & McCullom, 1995; Thériault & Gazzola, 2010). Difficulties have been

linked with several negative effects on therapists including stress (Deutsch, 1984),

burnout (Farber & Heifetz, 1982), maladaptive coping behaviors such as alcoholism, drug

abuse, and suicide (Guy, 1987; Kilburg, Thoreson, & Nathan 1986), and potentially

compromised treatment of clients (Gelso & Hayes, 2002; Yourman & Farber, 1996).

Even though difficulties negatively affect therapists and clients, recent research

has found that therapists rate their training regarding difficult therapist feelings as

nonexistent or poor (Pope, Sonne, & Greene, 2006). Researchers have also found

evidence that psychotherapists are only vaguely aware of difficult clinical moments

(Schröder & Davis, 2004).

In addition to a lack of training and awareness, therapists are also likely to hide their experiences of difficulty and not seek consultation or supervision. Research findings indicate when psychotherapists experience higher levels of difficulty, therapists are less likely to disclose their experience for fear of damage to their reputation (Thériault & Gazzola, 2005; 2010). Regarding supervision, research has found that 97% of supervisees admitted to withholding important information from their supervisors (Ladany, Hill, Corbett, & Nutt, 1996), and when a trainee is not honest with their supervisor, patient treatment is compromised (Yourman & Farber, 1996).

As a solution to non-disclosure of difficulties, therapists struggling with a difficulty are more likely to seek help if they consult with someone who normalizes by self-disclosing their own difficult clinical moments (Ladany, Walker, & Melincoff, 2001). In particular, when a *seasoned* psychotherapist self-discloses about difficulties, this helps reduce the anxiety in other therapists by helping to normalize and to lessen his or her unrealistic idealization of therapists as error-free professionals (Brightman, 1984; Glickauf-Hughes, 1994; Ladany, 2004; Ladany & Lehrman-Waterman, 1999; Orlinsky & Rønnestad, 2005). By disseminating seasoned psychotherapists' experience difficult clinical moments, other therapists can be motivated to seek consultation, understand their work, learn how to prepare for difficult moments, and learn how to cope and make use of these moments (Schröder & Davis, 2004).

According to some of the original researchers in the field of therapist difficulties, Schröder and Davis (2004), argue that if we want to provide clients with the best possible care, we must be able to identify difficulties and help therapists cope with them by exploring difficulties which would make them more accessible to consultation,

supervision, and contemplation. Therefore, difficult moments are a worthy topic of research and should be a topic of consultation throughout a therapist's career. Even though difficult moments are often associated with therapist distress and negative outcomes, studies on therapists' subjective experience of difficulties are extremely rare (Gelso & Hayes, 2007; Thériault & Gazzola, 2005). Orlinsky et al. (2005) hypothesize about the causes of the relative paucity of research on psychotherapists: 1) the assumption that psychotherapy is a set of techniques that have been proven to be efficacious in curing psychological disorders; 2) our modernistic and scientific culture that prizes and emphasizes mechanisms conceived as impersonal processes; and 3) the de-emphasis of human experience and relations.

In summary, difficult clinical moments are common throughout a psychotherapist's career. Difficulties are destructive to the therapist and the client. There is a lack of awareness, training, and support. Difficulties provoke therapist shame and non-disclosure in supervision or consultation. Non-disclosure of difficulties compromises patient treatment. The shame and stigma of difficulties can be reduced by seasoned psychotherapists self-disclosing their experiences of difficult moments. Therefore, research that investigates and disseminates seasoned psychotherapists' experience of difficult clinical moments may increase the likelihood of therapists seeking supervision and consultation which may, in turn, improve patient outcomes.

Gap in Research

As will be demonstrated in the literature review in Chapter II, there is an abundance of literature on topics peripheral to the topic of difficulties in therapeutic practice (e.g., countertransference), however, there have been very few studies on

difficult clinical moments and therapists' experiences. Of the scant research on difficulties, and of the scant research on therapists' experiences, there has been no inquiry into therapists' *lived experience*–the immediate experiences prior to reflection, conceptualization, and categorization (Van, 1990)–of difficult clinical moments. Instead, the previous research on difficulties attempted to develop taxonomies–such as transient, paradigmatic, and situational (Schröder & Davis, 2004)–or to discover the prevalence of the different types of difficulty (Davis et al., 1987; Gabel, Oster, & Pfeffer, 1988; Orlinsky & Rønnestad, 2005; Schröder & Davis, 2004; Smith et al., 2007). Although these previous findings are useful to the field, there has been no inquiry into the *meaning of the lived experience* of a difficult moment which happens to be the primary goal of phenomenological research (Creswell, 1998; Heppner, Wampold, & Kivlighan, 2008; Tesch, 1990). Without understanding the meaning of the lived experience of difficult clinical moments, the taxonomies and prevalence numbers provide breadth without depth. As a recommendation to fill this gap in research, noted researchers of countertransference, Gelso and Hayes (2007), recommend future research efforts investigating therapists' subject experiences through a method of in-depth interviews which is the foundation of phenomenological research.

Phenomenological Research

Phenomenological research is concerned with the study of experience from the perspective of the individual while putting aside any taken-for-granted assumptions of the researcher. Through the inductive method of open-ended interviews and participant feedback on data analysis, the meaning of the felt experience of difficult clinical moments can be derived. This can be an effective research method for understanding the

subjective experience of a phenomenon and challenging conventional wisdom. Phenomenological research strives to describe rather than explain, to discover rather than prove.

Phenomenological studies involving in-depth interviews on the experience of psychotherapists can help efforts to increase therapist self-awareness by discovering the common elements of the felt experience of difficult moments and by disseminating those discoveries for other therapists to reflect upon. This reflection upon difficulties is important since therapist self-awareness is considered an important ingredient in quality therapy and a key characteristic for master therapists (Rønnestad & Orlinsky, 2005). Since this study will search for the essence or the central underlying meaning of the experience, a deeper understanding of difficult moments will be discovered for the first time. By gathering and analyzing a number of descriptions from a number of individuals, general or universal essences of the experience of difficult moments can be derived and disseminated (Moustakas, as cited in Creswell, 1998).

Purpose of Study

The purpose of this project is to study seasoned psychotherapists' meaning of the experience of difficult clinical moments. This study is intended to help guide efforts to understand difficult clinical moments as well as improve training, supervision, and support of psychotherapists. The project was guided by the following research question: What are seasoned therapists' experiences regarding difficult clinical moments?

Definition

A difficult clinical moment is a discrete moment in which the psychotherapist experiences distress as a result of his or her work with a client. The moment of difficulty

can occur within a few seconds or several minutes, and it does not necessarily have to occur within a psychotherapy session. A more detailed definition will be provided in the method chapter following an investigation of the construct in the literature review.

Personal Relevance

As a practicing therapist for eighteen years, I have logged an estimated 20,000 sessions. Many of these sessions hold tremendous meaning for me. I can recall at times feeling elated and moved. I can also recall feeling discouraged and distressed. My experience of difficult clinical moments has resulted in shame and sleepless nights. Also, as a clinical supervisor for fourteen years, I have tremendous compassion for other psychotherapists who experience difficulties. I perceive therapists as caring and self-sacrificial people who deserve as much support as we can give them. I am particularly saddened by the suffering of novice therapists, especially given their level of dedication and the suffering they endure. They often have fragile self-esteems and are prone to feeling isolated and incompetent (Thériault & Gazzola, 2010). Novice therapists work long hours for little pay. They are noble in their efforts to make a difference. They deserve our efforts, however small, to reduce their unnecessary suffering. It is my hope for this project to enhance support of therapists, novice and otherwise.

Chapter II: Literature Review

In this chapter, research regarding the topic of therapists' experience of difficult clinical moments will be discussed to demonstrate that the construct of the difficult clinical moment is a unique, distinct, and worthy area of research and to demonstrate the necessity for a phenomenological inquiry into therapists' meaning of the experience of the difficult clinical moment. This chapter will begin with a description of the scant research on difficulties followed by reviews of the peripheral topics of difficult clients, special problems, countertransference, negative therapeutic reaction, failure, stressful moments, feelings of incompetence, relationship ruptures, vicarious trauma, impasses, and others. The chapter will conclude with a discussion of constructs and the gap in research this study intends to address.

Therapist Difficulties

The topic of therapists' experiences of difficult clinical moments has been largely neglected in the clinical and research literature. There have been many descriptions of difficult and challenging clinical case studies (Rachlin & Lev, 2011; Waska, 2011), however writers and researchers usually focus on how patient pathology causes the difficulty rather than focusing on the experience of the therapist. The following review comprises the only published studies, known to this author, that examine therapist difficulties without limiting the difficulties to a specific construct such as countertransference or impasse (Davis et al., 1987; Plutchik, Conte, & Karasu, 1994; Schröder & Davis, 2004; Smith et al., 2007). Two books on difficult moments will also be discussed (Gabel et al., 1988; Orlinsky & Rønnestad, 2005).

Davis, Elliott, Davis, Binns, Francis, Kelman, and Schröder (1987). In 1987, seven clinician-researchers in The United Kingdom, Davis, Elliott, Davis, Binns, Francis, Kelman, and Schröder, developed a taxonomy of nine situations that psychotherapists experience as difficult with the aim of making therapist difficulties accessible to investigation. As the first researchers to examine the construct of therapist difficulties, they claimed this inquiry was overdue because: 1) empirical study of therapists' experience of psychotherapy had been scant, 2) there had been little investigation of therapists' difficulties, and 3) therapists' difficulties were typically discussed under the heading of countertransference (Davis et al., 1987). Each of the researchers contributed their experiences of difficult situations to a pool, which they collectively sorted into categories. Davis and colleagues (1987) defined a difficult moment simply as a therapeutic situation in which the therapist had experienced a difficulty. After analyzing the difficult situations, they collaborated on the following taxonomy of therapist difficulties:

- Incompetent: the therapist feels inadequate about his or her performance as therapist

- Damaging: the therapist feels that he or she may be injuring the patient

- Puzzled: the therapist cannot see how to proceed

- Threatened: the therapist feels a need to protect self against the patient

- Out of rapport: the therapist feels unable to form a relationship with the patient

- Personal issues: the therapist's private concerns are felt to be intruding into the therapy

- Painful reality/ethical dilemma: the therapist is faced with a painful but unavoidable state of affairs and/or therapist cannot decide what action would be most ethical

- Stuck: the therapist feels that the therapy has reached an impasse from which there is no escape

- Thwarted: the therapist feels that the patient is actively blocking his or her therapeutic efforts

The Davis et al. (1987) study has the following limitations. The study's use of researcher-as-participant significantly increased the risk of bias in the study; the essential design of the study was seven colleagues brainstorming and categorizing difficulties without any outside input. There was also an imbalance of men participant-researchers over women. Furthermore, the participants all worked in the U.K. which likely has a distinct culture and understanding of psychotherapy. And in regard to the current study, the Davis et al. (1987) study did not examine the lived experience of the moment of difficulty; the researchers were interested in developing an initial taxonomy instead. The study provided a good overview of therapist difficulties, but it failed to provide depth in understanding.

Gabel et al. (1988). In the book *Difficult Moments in Child Psychotherapy*, Gabel et al. (1988) provide concise clinical vignettes along with strategies to aid child therapists with each difficult moment. The book is concerned with difficult moments that actually occur during sessions with children and with ways of dealing with them. The authors drew from their own and colleagues' accounts of difficult moments. Some of the cases include: when a child will not talk, when a child must be told about abrupt

treatment termination, when a child a sexually provocative in therapy, and several others. The book prescribes concrete and practical skills and coping strategies for each difficult moment in child psychotherapy.

Since the Gabel et al. (1988) book was not a study and the authors did not reference the established literature on therapist difficulties, this book should be considered to be outside the difficult moment research and literature. For example, Gabel et al. (1988) provide the following definition of a difficult moment: "a concrete expression of a disparity between the therapist's and the child's or the parents' expectations of the treatment process" (p. 199). This definition is counter to the established definitions of a difficult clinical moment and instead is similar to the definition of *relationship rupture*–a disagreement about the tasks and goals of treatment (Safran, Muran, Samstag, & Stevens, 2002).

The Gabel et al. (1988) book has additional limitations similar to the Davis et al. (1987) study: 1) it was informed by the authors' personal anecdotes; 2) there was an even larger imbalance of men participants over women; 3) and it did not examine the lived experience of the moment of difficulty; the researchers were instead interested in developing a catalogue of stories and coping strategies.

Schröder and Davis (2004). Seventeen years later, two of the aforementioned seven U.K. clinician-researchers, Schröder and Davis, continued their work in the area of therapist difficulties. In this study, they incorporated previous research findings with reflections on supervisory experiences and a log of session-by-session difficulties kept by one of the authors, Thomas Schröder. They constructed a system for categorizing therapist narratives into three categories, and they attempted to establish reliability and

validity of their system. They distinguished three overarching types of therapists'
experiences of difficulties:

- Transient: impermanent difficulties (e.g., a therapist's lack of skills)

- Paradigmatic: enduring difficulties, idiosyncratic to the therapist (e.g., a
  therapist's intrapsychic conflict)

- Situational: attributed to external factors (e.g., a sad but unchangeable
  situation)

Schröder and Davis (2004) found that as therapists' practice length increased,
transient difficulties decreased. However, therapist age was not a factor in predicting the
amount of transient difficulties. Practice length was not correlated with paradigmatic or
situational difficulties, which suggests that these difficulties do not diminish as a therapist
gains experience.

The Schröder and Davis (2004) study has similar limitations as the Gabel et al.
(1988) book and the Davis et al. (1987) study: 1) the Schröder and Davis (2004) study
analyzed data derived from the researcher himself–again, this use of researcher-as-
participant significantly increased the risk of bias in the study; 2) there was again a lack
of women involvement; and 3) it also did not examine the lived experience of the
moment of difficulty.

Orlinsky and Rønnestad (2005). In their book, *How Psychotherapists Develop:
A Study of Therapeutic Work and Professional Growth,* Orlinsky and Rønnestad (2005)
provided their report on perhaps the largest, most comprehensive study of
psychotherapists. In an attempt to discover the essential characteristics and development
of the psychotherapist, the multi-national researchers analyzed the professional careers of

4,923 psychotherapists from 14 countries, representing several theoretical orientations and levels of experience. The psychotherapist participants included psychologists, psychiatrists, psychosomatic physicians, social workers, counselors, nurses, and pastoral therapists. The design involved a quantitative survey and one qualitative question: "Describe the main factors that have led you to become the therapist you are at present." The survey addressed several aspects of a therapists' life including personal therapy, theoretical orientation, professional development, frequency of difficulties, life satisfaction, stress, and interpersonal style.

Throughout the book, Orlinsky and Rønnestad (2005) occasionally touch upon the topic of therapist difficulties which are framed as being caused by the patient and exacerbated by lack of therapist skill such as the ability to understand what happens moment-by-moment during therapy sessions and the ability to detect and deal with patients' emotional reactions to the therapist. Building upon the previous work by Davis et al. (1987), Orlinsky and Rønnestad decided upon three dimensions of difficulties in practice, each with a number of specific items (see Table 2).

Table 2

Difficulties in Practice as Reported by Orlinsky & Rønnestad (2005)

Currently, how often do you feel…	**M**	**SD**
I. Professional self-doubt	**1.7**	**0.8**
Lacking in confidence that you can have a beneficial effect on a patient	1.9	1.1
Unsure how to best deal effectively with a patient	2.4	1.1
Demoralized by your inability to find ways to help a patient	1.5	1.1
Afraid that you are doing more harm than good in treating a patient	0.9	0.9
Unable to comprehend the essence of a patient's problems	1.4	1.0
Unable to generate sufficient momentum to move therapy with a patient in a constructive direction	1.6	1.1
In danger of losing control of the therapeutic situation to a patient	1.2	0.9
II. Frustrating treatment case	**1.5**	**0.8**
Angered by factors in a patient's life that make a beneficial outcome impossible	1.4	1.2
Distressed by your powerlessness to affect a patient's tragic life situation	2.0	1.3
Conflicted about how to reconcile obligations to patient and equivalent obligations to others	1.2	1.2
Bogged down with a patient in a relationship that seems to go nowhere	1.4	1.0
Irritated with a patient who is actively blocking your efforts	1.6	1.1
Troubled by moral or ethical issues that have arisen in your work with a patient	1.1	1.0
III. Negative personal reaction	**1.1**	**0.7**
Unable to find something to like or respect in a patient	0.8	0.8
Unable to have much real empathy for a patient's experiences	1.2	0.9
Unable to withstand a patient's emotional neediness	1.2	1.0
Uneasy that personal values make it difficult to maintain an appropriate attitude	1.1	1.0
Frustrated with a patient for wasting time	1.0	1.0
Disturbed that circumstances in your personal life are interfering in your work with a patient	1.3	1.1
Guilty about having mishandled a critical situation with a patient	1.2	1.0

Note. N = 4,923. Items were rated on a scale that ranged from 0 (never) to 5 (very often). Difficulties in Practice as Reported by Orlinsky & Rønnestad (2005). Reprinted from "Difficulties in Practice," by D. E. Orlinsky, & M. H. Rønnestad, 2005, How Psychotherapists Develop: A Study of Therapeutic Work and Professional Growth, p. 229. Copyright 2005 by the American Psychological Association.

The Orlinsky and Rønnestad (2005) study did not have many limitations since it was comprehensive, well-designed, and well-authored, and it had a large sample size from around the globe. However, the study failed to examine the subjective lived experience of the difficult clinical moment. In other words, this study provided

prevalence of difficulties rather than a deeper understanding of the way therapists experience difficulties.

     Smith, Kleijn, and Hutschemaekers (2007). In an effort to assist therapist coping and helpfulness, Smith et al., (2007) interviewed 26 Dutch psychotherapists regarding difficult therapeutic situations. The study explored the following questions: 1) Which situations do therapists experience as difficult? 2) How do they react in these situations? 3) Do situation-specific reaction patterns exist, and what is their content? 4) How does personal therapeutic style influence therapists' reactions to clients? The researchers combined and re-analyzed interview data from two previous studies. In the first study (Smith, Kleijn, & Stevens, 2000), 15 trauma-institute therapists (some novices and some experts) were interviewed. In the second study (Smith, Kleijn, & Hutschemaekers, 2006, as cited in Smith et al., 2007), 11 expert psychotherapists (5 trauma-therapists and 6 therapists in regular practice with no special experience with traumatized clients) were interviewed. These two groups of participants were compared: the 15 trauma-institute therapists (both novice and expert) vs. 11 expert psychotherapists (some of whom specialize in trauma and some who do not). This comparison is problematic in that there is considerable overlap making the comparison somewhat meaningless. Aside from this challenge to validity, the findings regarding types of reactions to difficult situations are relevant to this project. Using grounded theory analysis, the researchers found 20 categories of reactions to difficult situations including "anxiety/existential threat felt by the therapist," "being carried away by the intense feelings of the client," and "shock/confusion."

Smith et al., (2007) also found that: 1) both novice and experienced psychotherapists encounter difficult clinical situations; 2) being exposed to clients' traumatic experiences evoke shock, anxiety, somatic reactions, and the need to talk about the experience; 3) difficult situations for the therapist seem to be related to the client's presenting problem (e.g., therapists tend to be traumatized by clients working on trauma); and 4) the recognition of one's personal therapeutic style may help therapists cope with difficulties.

While acknowledging previous typologies of difficult moments (Davis et al., 1987; Schröder & Davis, 2004), Smith et al., (2007) proposed another typology of "difficult clinical situations" by grouping the 20 identified categories into three overall groups:

- Traumatic: feeling shocked, anxious, sympathetic, somatic reactions, and a need to talk about it

- Interactional: feeling helpless, manipulated, and angry, and investing emotionally more than usual

- Existential situations: ruminating, feeling responsible

Although the study by Smith et al., (2007) provides another useful typology, the lived experience and meaning of the difficult moment phenomenon was not explored. Moreover, the researchers, and presumably the participant therapists, all work in the Netherlands, providing a localized view of difficulties. Furthermore, the data were limited since nearly all of the participants were trauma-therapists which is a specific profession within the field of psychotherapy.

Conclusion. Of the scant research on therapist difficulties, the previous research attempted to develop taxonomies or catalogues of difficulties or to discover the prevalence of different the types of difficulty (Davis et al., 1987; Gabel et al., 1988; Orlinsky & Rønnestad, 2005; Plutchik et al., 1994; Schröder & Davis, 2004; Smith et al., 2007). However, there has been no phenomenological inquiry into the therapists' lived experience of the difficult moment. Researching the meaning of the lived experience of difficult clinical moments adds the crucial and neglected component of depth within the literature on difficulties.

Review of Peripheral Constructs

Chapter II will continue with a review of the peripheral constructs (i.e., the concepts that overlap with the topic of the present study) to demonstrate that the construct of the difficult clinical moment is distinct. As will be discussed in more detail later in this chapter, the construct of the difficult clinical moment is defined as a discrete moment in which the psychotherapist experiences distress as a result of his or her work with a client. The list of peripheral and overlapping constructs includes the following:

1. Difficult Clients

2. Life Difficulties

3. Special Emotional Problems

4. Countertransference

5. Critical Incidents

6. Negative Therapeutic Reaction

7. Treatment Failure

8. Stressful Moments

9. Feelings of Incompetence

10. Relationship Ruptures

11. Vicarious Trauma and Burnout

12. Therapeutic Impasses

Difficult Clients. Since this project uses the term "difficult clinical moment," and since the word "difficult" in the clinical and research literature is usually used in reference to difficult patients, the construct of "the difficult patient" should be explored. The psychotherapy literature provides a multitude of descriptions of the difficult patient (see Table 3).

Table 3
The Types of Difficult Patients Within the Clinical and Research Literature

Type of Difficult Patient	Source Literature
The boring client	Cooper, 2011; Yalom, 1995
The suicidal client	McAdams & Foster, 2000
The controlling, challenging and paranoid client	Waska, 2000
The difficult-to-reach client	Cooper, 2011
The frustrating treatment case	Orlinsky & Rønnestad, 2005
The manipulative client	Chitty & Maynard, 1986; Colson et al., 1985; Smith & Steindler, 1983
The psychotic client	Borgogno,2010; Yalom, 1995
The seductive client	Smith & Steindler, 1983
The stubborn client	Smith & Steindler, 1983
The violent and sometimes paranoid client	Smith & Steindler, 1983
The client with borderline personality disorder	Yalom, 1995
The client with narcissistic personality disorder	Yalom, 1995
The client with substance abuse problems	Laskowski, 2001
The client who doesn't show	Waska, 2000
The client who feels dissatisfied with the quality of the therapist	Waska, 2000
The client who seeks help but then fails to listen to advice or rejects it	Waska, 2000; Yalom, 1995

Authors' definitions of difficult clients can be loosely categorized as either: 1) a client who presents behavior that frustrates treatment (Chitty & Maynard, 1986; Colson et al., 1985; Cooper, 2011; McAdams & Foster, 2000; Smith & Steindler, 1983; Waska, 2000; Yalom, 1995), 2) a client with a disorder that does not respond well to treatment (Borgogno, 2010; Laskowski, 2001; Smith & Steindler, 1983; Yalom, 1995), or 3) a client who provokes difficult feelings in the therapist (Orlinsky & Rønnestad, 2005; Waska, 2000; Yalom, 1995). It should be noted that these definitions attribute the difficulty to the client.

Construct comparison. The construct of difficult clients is distinct from the construct of difficult clinical moments in that it would seem many difficult patients would provoke a difficult clinical moment, but not all. For instance, a client who is hostile in session would fit the criteria for a difficult client, but the therapist may or may not experience this as a difficult and distressing moment. Furthermore, the construct of the difficult patient is not concerned with discrete moments for the therapist which is a key defining characteristic of the construct of the difficult clinical moment.

Life Difficulties. Peter Martin (2011), a lecturer and therapist in the U.K., conducted a heuristic exploration of the lives of seventeen therapists and how their own life difficulties affected their work with clients. In his report, Martin briefly described a few conversations he had with therapists about their life difficulties (e.g., a therapist's experience of the death of her child). However, rather than discussing the participants' experiences, the study focused on the author's written responses to the participants. Although this article provides interesting researcher reflections, its focus was on Martin's reaction to the therapists' personal lives, rather than difficult clinical moments.

Construct comparison. The construct of life difficulties is distinct from the construct of the difficult clinical moment in that Martin's (2011) life difficulties occur independent of the therapist's clinical work.

Special Emotional Problems. Gordon Bermak (1977) surveyed seventy-five psychiatrists living in the San Francisco Bay Area on their emotional problems involved in the practice of psychiatry. *Special emotional problems* were defined as emotional difficulties that are special to psychiatrists and their work as contrasted with non-psychiatrists. "Non-psychiatrist" was defined as "other physicians or professional persons," therefore it is unclear who the respondents were thinking of as they discriminated their unique emotional problems. However, after reviewing the findings, it appears the respondents were contrasting their emotional difficulties to those of other medical physicians who did not practice psychotherapy.

The author found that most of the respondents believed that the profession of psychiatry provided several unique emotional problems. The respondents reported the following categories of experience:

- The isolation and being physically alone in one's practice

- The need to control their feelings stimulated by patients

- The need to help and rescue others

- The impossibility of validation of results

- The emotional drain of constantly being empathic

- The physical inactivity

- The struggles with professional identity and being rejected by non-psychiatrists

- The long delay in achieving results in the treatment of patients

- The need to appear psychologically healthy to society

- Patient hostility

- The exposure to depressive people

- Separation anxieties produced by termination with a long-term patient

Construct comparison. Although this construct somewhat overlaps with difficult clinical moments, these two constructs are distinct. Although some special emotion problems of psychotherapists could be included in the difficult moment construct (e.g., separation anxieties produced by termination with a long-term patient), several special emotional problems are general, ongoing characteristics of the profession and not discrete moments (e.g., the physical inactivity, the need to rescue).

Countertransference. In the late 1800s, when Sigmund Freud's mentor, Joseph Breuer, abandoned the treatment of Anna O., a seductive female patient, it was presumably because he felt guilty for responding to the patient's unconscious sexual wishes (Blum & Goodman, 1995). Because he wanted to protect himself from difficult feelings such as these, Breuer took flight from psychoanalysis (Jones, as cited it Blum & Goodman, 1995). Later in 1910, Freud coined the term of *countertransference*: "We have become aware of the 'counter-transference', which arises in him as a result of the patient's influence on his unconscious feelings, and we are almost inclined to insist that he shall recognize this counter-transference in himself and overcome it" (p. 19). From that point forward, the history of countertransference theory has been filled with controversy.

In the book, *Countertransference in Couples Therapy*, Judith Siegel (1997) examined the controversial meanings currently attached to the concept of countertransference. She identified three main categories: classical countertransference, totalist countertransference, and postmodern countertransference. Similarly, in *Countertransference and the Therapist's Inner Experience*, Gelso and Hayes (2007) identified four main disparate definitions of the countertransference construct: classical, totalistic, complementary, and relational. These four definitions will be explored below.

Classical countertransference. In classical analysis, countertransference reactions include cognitive or affective responses to the patient that emerge as a preoccupation, a resurgence of unresolved conflicts that impair the therapist's abilities, or unconscious defenses that prevent the therapist from maintaining the requisite neutrality. Classical theorists consider countertransference to be the largely unconscious, conflict-based reactions to the patient's transference. Countertransference may interfere with the therapist's understanding and interpretations or it may motivate anti-therapeutic behaviors. In this view, countertransference is only destructive and does not benefit therapy. Therefore, it must be eliminated through the therapist's resolution of internal conflict.

Totalistic view. The classical view of countertransference dominated psychoanalysis for many decades. However, as psychoanalysis philosophy evolved, the totalistic view emerged in the 1950s which proposed that all of the therapist's attitudes and feelings toward the patient should be considered countertransference. In this view, the totality of the therapist's reactions is considered useful to the therapeutic process, and it carries important information about the client's psyche. Therefore, countertransference

should be understood and used to further the therapy, not avoided. In this way, the totalistic perspective de-pathologized and normalized therapist's feelings, making them less threatening to admit.

Writing from this point of view, Michael Kahn (1997) asserted that countertransference is commonly considered to encompass all of the therapist's feelings and attitudes toward the client. He identified four forms of countertransference:

- Realistic responses to client behavior (e.g., a client is belligerent, causing a therapist to feel frightened)

- Responses to transference (e.g., the client is critical, and the therapist feels hurt)

- Responses to material troubling to the therapist (e.g., the therapist is going through a divorce and hearing about a client's happy marriage makes the therapist feel envious)

- Characteristic responses of the therapist or therapist personality traits (e.g., a therapist likes to be admired by clients and others).

Regarding these countertransferential responses, he warned against countertransference becoming destructive in the following ways: 1) it can blind therapists to an important area of exploration (e.g., a therapist has unresolved issues with his mother and avoids talking about a client's mother); 2) it can cause therapists to use their clients for vicarious gratification (e.g., a therapist is uncomfortable with his dependency on others and therefore pushes clients toward independence); 3) it can lead therapists to emit subtle cues that greatly influence the client (e.g., a therapist wants her client to like her so when the client criticizes her, she subtly reveals her pain which influences the client to be

less forthcoming about thoughts); 4) it can lead therapists to make interventions that are not in the client's interest (e.g., a therapist is hurt and angry at a client and therefore uses a harsh intervention that harms the client); 5) it can lead a therapist to adopt the roles within the client's transference (e.g., a client frequently accuses a therapist of being uncaring and the therapist might start acting as such).

In their book, *The Therapeutic Process*, Mark Thompson and Candace Cotlove (2005) assert that "every therapist has countertransference reactions. These reactions may be minor or significant, conscious or not conscious, acute or chronic, contained or acted upon, apparent to the patient or not apparent to patient" (p. 217). The authors identify the following ways in which countertransference may manifest:

- Differences in posture or attitude (e.g., a therapist being unusually reserved and conservative with a particular client)

- Dreaming about a client

- Forgetting an appointment, starting late, or extending session

- Intense feelings or an absence of noticeable feelings in the therapist

- Slips of the tongue

- Change in the therapist's usual style of interpretation or excessive use of genetic interpretations

- Difficulty remembering material

- Blind spots or difficulty finding an empathic posture

Complementary view. Epstein and Feiner (1988) conceptualized countertransference as a complement to the client's transference or style of relating. Like

the totalistic perspective, this view considers therapist's reactions are inevitable. However, the complementary perspective is distinct in its consideration of the intertwined nature of both therapist and client psyches. In this view, countertransference occurs when clients consciously or unconsciously influence therapists to think, feel, and behave in accordance with the client's unresolved conflicts. Through the defensive action of projective identification, the client has the primarily unconscious fantasy of ridding himself of unwanted aspects of the self and depositing those unwanted parts in the therapist resulting in complementary countertransferential feelings in the therapist (Ogden, 1982).

Relational and postmodern views. Recent developments in the theories of constructivism, postmodernism, and intersubjectivity have led to a recognition of the subjective reality of the therapist and its influence on the therapy process. The classical, totalistic, and complementary perspectives consider countertransference to derive from client pathology, however the relational and postmodern perspectives assert that therapist interpretations are subjective and should therefore be questioned. The experience of therapy is jointly constructed; therefore, countertransference, or the therapist's emergent feelings, can derive from the therapist without being provoked by the client's material.

Gelso and Hayes' (2007) view. After writing about the four main conceptualizations of countertransference, Gelso and Hayes (2007) propose the following new definition of the countertransference construct based on both their clinical practice and research spanning more than two decades: "Although the therapeutic relationship is co-constructed, and although patient behaviors and characteristics certainly stimulate countertransference, if a therapist reaction is to be considered countertransference, it must

centrally implicate some unresolved issue or vulnerability in the therapist" (pp. 25-26). The authors delineate countertransference from therapist subjectivity–therapist feelings and reactions that are not related to a therapist's inner conflict, vulnerability, or natural responses to the patient.

Example of countertransference research related to the current project. Some researchers have studied the countertransferential reactions of therapists. In one such study, three U.K. researchers, Shevadea, Norris, and Swann (2011) interviewed nine therapists regarding their reactions to children displaying sexually problematic behavior. The authors used the framework of countertransference to understand therapists' reactions. The nine therapists reported feeling powerlessness, unskilled, afraid, shocked, sexual feelings, and feeling like an abuser. They also reported a number of personal changes including becoming less trusting of others. The authors were intending to raise awareness and to normalize the impact of working with sexualized children, so that therapists will be more open to seeking support when needed. This study's value is clear, but it was limited to therapists' negative feelings when working with one type of client. Also, since the interview questions were framed within the countertransference model, phenomena outside that model were not recorded or analyzed.

Construct comparison. Definitions of countertransference can be lumped into three main categories (Gelso & Hayes, 2007; J. Siegel, 1997). "Classical countertransference" reactions include unconscious, destructive, conflict-based cognitive or affective responses to the patient's transference that emerge as a preoccupation, a resurgence of unresolved conflicts that impair the therapist's abilities, or unconscious defenses that prevent the therapist from maintaining the requisite neutrality. Therapist

experiences within this construct can be considered difficult clinical moments, however difficult moments do not necessarily have to be unconscious, destructive, conflict-based, related specifically to transference, or a challenge to neutrality. The concept of "totalistic countertransference" (all therapist reactions as information about the client's psyche) is all-encompassing, hence the moniker "totalistic." Most difficult clinical moments would be subsumed under this broad definition if not for the requisite of being information about the client's psyche. There are perhaps many difficult clinical moments that have nothing to do with the client's inner life. For example, a therapist in the midst of divorcing his wife could have a very bad day which could result in a difficult moment with a client. "Relational" and "postmodern" countertransference is understood as the therapist's feelings toward the client that emerge from the jointly constructed relationship. As with the other countertransference constructs, many difficult moments can be considered to reside within this construct, however many difficult moments would be outside it. For instance, a client, in-between sessions, who dies suddenly from a heart attack might be experienced as a difficult moment for the counselor.

Critical Incidents. Flanagan (1954) developed the concept of "critical incidents" and the "critical incident technique" as a way of identifying behavioral events that have a special relation to some outcome. A critical incident is defined as a human behavioral event that makes a sufficiently definite and observable effect. This concept has been applied to the identification of behaviors that characterize various areas of inquiry: effective vs. ineffective college teachers, favorable vs. unfavorable job applicants, and incidents that precipitate clients to seek outpatient treatment (Plutchik et al., 1994).

Using Flanagan's critical incident technique, three New York psychiatric professors (Plutchik et al., 1994) obtained a list of 52 critical incidents defined by the unusual or infrequent patient behavior that created "special difficulties" or "difficult problems" for the psychotherapist and also resulted in therapist behavior that had an "important effect on the subsequent course of the psychotherapy, for better or for worse" (p. 77). The authors pooled critical incidents from a group of seven experienced psychiatrists and psychologists. The list consists of behavioral descriptions such as "patient threatens suicide" and "patient expresses dissatisfaction with therapist." Plutchik et al. presented this list to 21 experienced psychiatrists who rated each of the 52 critical incidents for importance (defined as potential for affecting the future course of therapy) and frequency (how often an incident had occurred in the practice of the rater). The four most important items identified by mean ratings were "patient threatens therapist physically," "patient threatens suicide," "patient has seen a second therapist and reveals it" and "patient deteriorates (becomes psychotic)." The four most frequently experienced incidents were "patient reports a major trauma in his (her) life (e. g. death of a spouse or parent)," "patient reports physical illness," "patient expresses dissatisfaction with therapy," and "patient expresses suicidal thoughts".

Plutchik et al. (1994) acknowledged that their study's validity is challenged by inconsistent psychiatrist inferences. For example, the item "patient says 'I hate you' to therapist" was taken by one half of the psychiatrist participants to imply criticism of the therapist, whereas the other half understood it to be an attempt to seek friendship. There are some other notable conceptual issues which limit the value of the findings. In the article, the participants' culture and context were not mentioned or considered. If the

context of the participants was specific (e.g., psychiatrists practicing in the inner city), the findings' generalizability might be quite narrow. Additionally, the psychiatrists were asked to rate each of the critical incidents' importance as defined as potential for affecting the future course of therapy. Since a positive or negative value was excluded (i.e., negatively affecting the future course of therapy), the numbers are somewhat meaningless. Furthermore, in relation to the present study, the Plutchik et al. (1994) study did not examine the lived experience of the moment of difficulty.

Construct comparison. The construct of the critical incident is distinct from difficult clinical moments in that it is strictly concerned with behavior (e.g., patient tries to kiss therapist) and the associated critical outcome (i.e., creates difficult problems for the psychotherapist). Since a critical incident is defined as a human behavioral event that makes a sufficiently definite and observable effect, some critical incidents could be considered difficult clinical moments. For example, a patient threatens suicide resulting in therapist difficulty which, in turn, alters the course of therapy. However, many difficult clinical moments would not be considered a critical incident since many difficult moments do not significantly alter the course of therapy. For example, a child client tells her story about being sexually abused which results in the therapist experiencing difficulty but does not alter the course of treatment.

Negative Therapeutic Reaction. In an attempt to explain difficult moments with clients, Freud (1961) coined the term *negative therapeutic reaction*, whereby the patient gets worse through psychoanalysis. Freud wrote: "every partial solution that ought to result, and in other people does result, in an improvement or a temporary suspension of symptoms produces in them for the time being an exacerbation of their illness" (1961, p,

49). He believed negative therapeutic reactions were most frequently due to oedipal guilt over sexual and aggressive impulses in that they masochistically did not feel they deserved a better life (Mitchell & Black, 1995, p. 100). He also viewed this phenomenon as a result of secondary gain, defiance against the analyst, or narcissism (Hartley, 1993, p. 394).

Horney's contribution. Karen Horney (1936), a German psychoanalyst who is known for questioning Freud's views, was at first skeptical of Freud's concept of the negative therapeutic reaction. But the more experience she gained, the more she came to believe in Freud's observation. She herself experienced patients who showed an increase in symptoms, who then became discouraged, or wished to break off treatment immediately following an encouragement or a real elucidation of some problem, at a time when one might reasonably expect the patient to feel relief.

Karen Horney (1936) diverged from Freud by emphasizing culture and society. She believed patients were taught via culture to compete and have rivalries and would therefore react negatively and competitively to good interpretations by the analyst. Due to this pathological competitiveness, the patient does not want the analyst to feel successful and will therefore sabotage the therapy. She also asserted that patients remain sick because they believe if they attain success they will incur the same sort of rage and envy that they feel toward the success of other persons.

Klein's contribution. Klein (1957) diverged from Freud by contending that the negative therapeutic reaction was rooted not in oedipal guilt but in the envious destruction of the *good breast*. She believed that children are ambivalent of their extreme dependence on the good breast for needed nourishment, safety, and pleasure. Since the

good breast sometimes denies pleasure, children develop oral greed and aggressive resentment toward the good breast. This results in the child projecting hate and humiliation into the good breast which in turn results in the child feeling guilt and worthlessness. Patients stuck in this developmental phase cannot tolerate the possibility that an analyst might be able to help them and sabotage the analysis by hating and humiliating the analyst (Mitchell & Black, 1995).

Newsome's contribution. Faye Newsome (2004), a contemporary analyst and professor, adds to the concept of the negative therapeutic reaction by focusing on the insights of countertransference and what the patient is getting out of the stubborn symptom. She asserts that when an analyst begins to feel judgment about the patient's lack of progress, this is a projection of the patient's belief about himself. She also believes that some patients hold onto their symptoms because they get the gratification of not experiencing their real self and their real desires. Patients stay in the conflict rather than experience what is real in them and their environment at any given moment.

Goodman's contribution. Geoff Goodman (2005) asserts that patients who are prone to having negative therapeutic reactions seem to be increasingly common in clinical practice and these patients pose problems for clinicians who struggle with their feelings of incompetence. As a clinical supervisor, Goodman has seen novice clinicians become demoralized when patients get worse and terminate. He writes about his own sense of inadequacy when one of his first patients failed to show signs of improvement. Goodman proposes that patients are prone to making fledgling clinicians feel unjustifiably demoralized. He asserts that these feelings of incompetence derive from both the patient and the clinician. Goodman is consistent with the classical literature in

that he believes patients who exhibit negative therapeutic reactions experience intense unconscious guilt over their aggression toward their loved internal objects. But he adds that clinicians are also vulnerable to projecting damaged internal representations into the patient.

Construct comparison. Similar to the difficult patient construct, some negative therapeutic reactions may be experienced as a difficult clinical moment while others may not. For example, if a client's depressive symptoms worsen due to client defiance of the treatment, the therapist may or may not experience difficulty or distress. Therefore, the construct of the negative therapeutic reaction is distinct from the construct of the difficult clinical moment.

Treatment Failure. In addition to the concept of the negative therapeutic reaction, other constructs of treatment failure have been investigated. Persons and Mikami (2002) assert that treatment failures are rarely discussed, and therefore therapists are reluctant to disclose their failures, and clinicians lack the skills to handle it. In the clinical literature, there are a variety of terms used to define treatment failure, including:

- Bad therapy (Kottler & Carlson, 2003)

- Deterioration despite treatment (Ogles, Lambert, & Sawyer, 1995)

- Failed to make therapeutic progress (Kendall, Kipnis, & Otto-salaij, 1992)

- Negative therapeutic reaction (Freud, 1961; Goodman, 2005; Horney, 1936; Newsome, 2004)

- Negative therapeutic process (Thériault & Gazzola, 2005)

- Negative outcome (Mohr, 1995)

- Premature termination in long-term psychotherapy (Greenspan & Kulish, 1985)

- Therapeutic failure (Bugental, 1988; Strupp, 1975)

- Treatment failure (Persons & Mikami, 2002)

- Therapeutic impasse (Atwood, Stolorow, & Trop, 1989; Weiner, 1974)

In their book, *Bad Therapy: Master Therapists Share Their Worst Failures*, Jeffry Kottler and Jon Carlson (2003) interviewed 22 prominent practitioners and thinkers in the field to talk about their worst work with clients. They found the following eleven definitions for bad therapy or clinical failure:

- When the therapist does not listen to the client and instead follows his or her own agenda

- Making the same mistake over and over again

- Inflexibility and reluctance to make needed adjustments

- Not knowing where you are going

- Arrogance, overconfidence, therapist's narcissism

- An internal feeling of ineptitude

- Failure to create a solid alliance

- Using obsolete methods

- Negative outcomes of the client

- Losing control of self or countertransference issues

- Making invalid assumptions

Construct comparison. While some moments involving treatment failures might be experienced as difficult clinical moments, others may not. For example, a therapy might fail for reasons out of the therapist's control. However, it seems likely that most failures would be experienced as a difficult moment for the therapist. Therefore, experienced moments that involve treatment failures might be considered a subset of difficult clinical moments.

Stressful Moments. In an attempt to confirm and qualify sources of stress for psychotherapists that originate in client sessions and the professional role and to explore irrational beliefs that contribute to therapist stress, Connie Deutsch (1984) investigated therapists' experience of stress. According to Pakenham and Stafford-Brown (2012), the most widely accepted definition of stress is that of Lazarus and Folkman (as cited in Pakenham and Stafford-Brown, 2012) which defines stress as "a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being" (p. 19).

Deutsch's study (1984) had two purposes: 1) to assess the frequency and relative stressfulness of certain in-session events and professional experiences and 2) to explore the suggestion that certain irrational beliefs are sources of therapist stress. To this end, she compiled a list of self-reported stressful items from 264 psychotherapists in one Midwestern state. The sample consisted of: 38% women and 62% men; 74% master's-level and 26% doctoral-level therapists; 32% had degrees in psychology, 44% social work, 13% counseling, 5% education, and 6% other. The average age was 41 and the average number of years' experience was 10. The therapists reported an average of 75%

work time spent in agencies and 22% in private practice. Their client population was

composed of adults (72%) and minors (25%).

Half or more of the 264 participants reported the following six items as

moderately stressful or higher (see Table 4).

Table 4

Top Six Self-Reported Stressful Events of Therapists as Reported in Deutsch (1984)

Stressful Event	Moderately Stressful or Higher
Clients' suicidal statements	61%
Inability to help an acutely distressed client	59%
Client expressions of anger toward you	58%
Lack of observable progress with client	50%
Severely depressed client	52%
Apparent apathy or lack of motivation in client	51%

Note. N = 264. Expressed as percentage who marked the item as moderately stressful or higher. For example, 61% of therapists identified "clients' suicidal statements" as moderately stressful or higher.

Deutsch (1984) also collected stressor frequency rates in order to determine

overall stress within the profession. The therapist respondents rated "absence of gratitude

from a client" as the most frequent stressful event, occurring in 38% of all client contact

hours, followed by "client expressions of aggression and hostility toward another person"

at 33%, "client agitated anxiety" at 31%, and "apparent apathy or lack of motivation in

client" at 25%.

Deutsch looked at other variables and found that women therapists reported

higher stress than men. Deutsch also found that younger therapists experienced higher

stress ratings than older therapists, and agency therapists experienced higher stress than

private practice therapists.

Construct comparison. As with treatment failures, it seems likely that most

stressful clinical moments (e.g., suicidal statements, client apathy) would also be

considered difficult moments. However, difficult clinical moments include many other

situations that are not necessarily taxing the therapist's resources or endangering therapist well-being. Therefore, stressful moments can be considered another subset of difficult clinical moments.

Feelings of Incompetence. Therapists can experience a variety of negative feelings when they experience a difficult moment. Along these lines, Canadian researchers, Anne Thériault and Nicola Gazzola (2010), examined novice therapists' feelings of incompetence, defined as moments in which therapists' beliefs in their abilities, judgment, and/or effectiveness are diminished, reduced, or challenged internally. They interviewed ten novice therapists and analyzed the data using grounded theory. They found that feelings of insecurity vary in intensity, with lower levels of insecurity experienced as a minor issue versus higher levels of insecurity that affected the therapist's personal identity and were more likely to immobilize the therapist. In level one, the therapist is experiencing self-doubt about the mechanics of therapy: *Where to go from here? What do I say next? I am afraid to do the wrong thing.* In level two, the therapist is experiencing self-doubts about the immediate impact of therapy: *Did this work? Why is the client not engaged with what I said?* In level three, the therapist is experiencing self-doubts about their capacity to be an effective clinician: *Do I have enough training? Am I a competent practitioner?* In level four, the therapist is experiencing preoccupations about their adequacy as a person: *Is it me? What if there is something fundamentally missing in my personality?*

When asked about their feeling of incompetence and self-doubt, respondents reported feeling a wide range of emotions including helplessness, anger, anxiety, discouragement, and powerlessness. The researchers found that the higher the level, the

more difficult it was for therapists to disclose their experience for fear of damage to their reputation. They also found that attempts to cope with and manage feelings of incompetence exacerbated the feelings of incompetence. For example, one therapist's awareness of her feelings of incompetence led to her becoming hyperaware of her insecurities and self-doubts, which in turn, led to further feelings of incompetence.

Construct comparison. As with treatment failures and stressful moments, feelings of incompetence might be best considered a subset of the construct of the difficult clinical moment since many moments that involve feelings of incompetence are likely to be experienced as difficult and distressing for the therapist, but not all difficult clinical moments involve feelings of incompetence.

Relationship Ruptures. A rupture in the therapeutic alliance is defined as a moment of tension or breakdown in the collaborative alliance between therapist and client (Safran & Muran, as cited in Coutinho et al., 2011). Ruptures may also be defined as disagreements about the tasks of treatment, disagreements about the goals of treatment, or strains in the bond (Safran, Muran, Samstag, & Stevens, 2002). During relationship ruptures, clients and therapists can experience negative feelings such as anger, defensiveness, boredom, and failure (Elkind, as cited in Coutinho et al., 2011).

Many authors and researchers have written about the concept of relationship ruptures and how to repair the alliance. One such study by Coutinho et al. (2011) explored therapists' and clients' experiences of alliance rupture events. They examined both therapists' and clients' experiences of the same rupture events. Eight therapists were paired with one client who had a personality disorder. The first 15 sessions were videotaped and rated with the Rupture Resolution Rating System (Eubanks-Carter,

Mitchell, Muran, & Safran, as cited in Coutinho et al., 2011). One week after a rupture, clients and therapists were individually interviewed about the rupture.

The authors found that: 1) relationship rupture events typically involved a repetition of a previous rupture event; 2) the rupture emerged when the client was not prepared to respond to the therapist's intervention; 3) both therapists and clients felt confused and ambivalent; and 4) confrontation events activated intense and negative feelings. The authors recommend that therapists should be better trained to deal with rupture since they found that therapists were aware of the relationship ruptures but not able to resolve them.

Construct comparison. As with treatment failure, moments that involve therapeutic rupture can be considered a potential subset of difficult moments since many ruptures are likely to be experienced as difficult for the therapist but not necessarily as such. For example, a novice therapist makes a mistake resulting in a relationship rupture, and the therapist considers it a welcomed learning experience rather than a difficult clinical moment.

Vicarious Trauma and Burnout. Therapist "vicarious trauma" occurs when a therapist experiences similar trauma symptoms to the primary victim after the therapist has been exposed to client accounts and feelings of the trauma (McCann & Pearlman, 1990; Schauben & Frazier, 1995). As those within the helping professions are exposed to victims' traumatic events, they can experience vicarious trauma, or secondary traumatic stress, in that the therapist experiences similar trauma symptoms to the primary victim (Bride, 2007; McCann & Pearlman, 1990; Schauben & Frazier, 1995). A number of researchers have investigated these effects upon therapists.

In one such study, Iliffe and Steed (2000) interviewed eighteen domestic violence counselors in an effort to explore how therapists are impacted by working with their domestic violence clients. They were particularly interested in vicarious trauma and burnout. They found domestic violence counselors suffered detrimental effects regarding feeling safe, their world view, gender power issues, and burnout. This study provided a general look at the common effects of working with domestic violence clients, but the study design was solely focused on one type of therapist, working with one type of client, at one particular type of clinic.

Construct comparison. As with the construct of special emotional problems, vicarious trauma and burnout are unfortunate potential consequences of the profession and therefore moments within this construct might be experienced as difficult. Therefore, moments that involve vicarious trauma and burnout can be considered a subset of the construct of the difficult clinical moment. However, the overall concepts of vicarious trauma and burnout include ideas outside this current project. For example, a trauma counselor who experiences several moments of non-difficult compassion and caring for hundreds of clients might eventually develop vicarious trauma symptoms without ever necessarily experiencing any notable moments of difficulty.

Therapeutic Impasses. The impasse construct is defined as a deadlock or stalemate that causes therapy to become so difficult or complicated that progress is no longer possible and termination occurs (Atwood et al., 1989; Weiner, 1974). Impasses can be difficult for the therapist in that they can feel anger, boredom, defensiveness, failure, and disappointment (Weiner, 1974).

Hill, Nutt-Williams, Heaton, Thompson, and Rhodes (1996). There has been much written on therapeutic impasses, particularly in the psychoanalytic literature. In one such study, Hill et al. (1996) investigated impasses within therapy from the therapist perspective using questionnaire and interview data. They wanted to know the variables associated with impasses, the manner in which the impasses unfolded, and the consequences of the impasses. The researchers found four variables associated with impasses:

- Therapist mistakes (e.g., being pushy, cautious or biased)

- Triangulation (e.g., making the client feel as though he has to choose between the therapist or their spouse)

- Transference issues (e.g., a client seeing her therapists as being like her disapproving mother)

- Therapist personal issues (e.g., overly sensitive to client emotion)

The researchers found that as a result of the impasse, several of the participants reported feeling frustrated, angry, disappointed, or hurt by their clients. When asked how they cope with these feelings, the therapist participants identified two different strategies for coping with their feelings about the impasses: 1) consultation with colleague or supervisor, and 2) positive self-talk. They also found that therapists use two main strategies to deal with impasses: 1) discuss the impasse with the client, and 2) actively and directly advise the client about what to do.

Moltu, Binder, and Nielsen (2010). Norwegian researchers, Moltu et al. (2010), explored how experienced and esteemed therapists of different theoretical affiliations experience and give meaning to therapeutic impasses–situations where the interaction in

therapy has developed into a stalemate. They interviewed 12 skilled and experienced therapists (six women and six men) about a specific impasse from their experience that resolved successfully. The authors claim that these participants represented the diversity of practice in the field of psychotherapy in Norway. Their analysis indicated that participants, regardless of theoretical orientation, experienced similar phenomena when facing therapeutic impasses and that the way they related to their inner experiences is important to the therapy process. They found the overarching theme common across all participants was the experience of being committed to being helpfully present. This deep commitment set the stage for the following experiences of the impasse: loss of hope, staying helpfully present with an angry patient, and staying helpfully present when the patient withdraws emotionally. Although coming from different theoretical orientations, the participants saw their inner work on sustaining hope and handling their own difficult feeling states as crucial for later successful resolution of an impasse.

Moltu and Binder (2011). Moltu and Binder used the qualitative data from the 2010 study in a second study that focused on the participants' accounts of what they experienced that they needed outside therapy during the difficult phases. They explored the kinds of experiences and activities outside therapy the participants felt they needed when going through a therapeutic impasse and in what ways does having their needs met help them resolve the impasse with the client. They found two therapist needs present in the face of impasse: 1) the need to move from confusion and tension to shared systems of meaning (e.g., a colleague helping the therapist conceptualize the impasse), and 2) the need for a supportive witness. When these two needs are met the therapist experiences beneficial space between self and impasse.

Moltu, Binder, and Stige (2012). Christian Moltu and Per-Einar Binder teamed up with Brynjulf Stige (2012) to again analyze the data from the original 12 interviews to investigate how skilled therapists from various theoretical orientations experience the interaction with the client as an agent of the impasse. They found that participant therapists interpreted the client as contributing relationally to the impasse.

Construct comparison. To review, the "therapeutic impasse" is defined as a deadlock or stalemate that causes therapy to become so difficult or complicated that progress is no longer possible and termination occurs (Atwood et al., 1989; Weiner, 1974). As a subset of treatment failure, some moments of impasse can be experienced as a difficult clinical moment, while others may not. An impasse generated solely by the client might not provoke a therapist difficulty (e.g., feelings of incompetence). For example, if a client suffering from a characterological disorder grinds therapy to a halt, and the therapist is well-trained and well-supported, a difficult clinical moment might not occur even though an impasse has.

Summary of Construct Comparisons. This literature review demonstrates that the peripheral constructs are related to, but distinctly different from, the broader construct of the difficult clinical moment. The following table compares the original Davis et al. (1987) taxonomy of difficult moments with the related constructs (see Table 5).

Table 5

Comparison of Taxonomy of Difficult Moments as Reported by Davis et al. (1987) to Similar Constructs

Taxonomy of Difficult Moments from Davis et al. (1987)	Similar Construct
Therapist feels inadequate about his or her performance as therapist	Feelings of incompetence
Therapist feels that he or she may be injuring the patient	Countertransference, feelings of incompetence, treatment failure
Therapist cannot see how to proceed	Therapeutic impasse, feelings of incompetence
Therapist feels a need to protect self against the patient	Countertransference, difficult client, therapist mental pain, vicarious trauma
Therapist feels unable to form a relationship with the patient	Treatment failure, rupture
Therapist's private concerns are felt to be intruding into the therapy	Countertransference, therapist mental pain, special emotional problem
Therapist is faced with a painful but unavoidable state of affairs and/or therapist cannot decide what action would be most ethical	Therapist mental pain, treatment failure, stressful moment
Therapist feels that the therapy has reached an impasse from which there is no escape	Therapeutic impasse, critical incident
Therapist feels that the patient is actively blocking his or her therapeutic efforts	Difficult client, negative therapeutic reaction

Summary of Literature Review

As was demonstrated in this chapter, of the scant research on therapist difficulties, the previous research developed taxonomies or discovered prevalence of difficulties. However, there has been no phenomenological inquiry into the therapists' lived experience of the difficult moment. Also, there is an abundance of literature on topics peripheral to the topic of therapist difficulties. However, these peripheral constructs are distinct from the construct of difficult clinical moments and therefore separate but related areas of research.

Chapter III: Method

Given that the experience and understanding of difficult clinical moments are inherently subjective, a qualitative design is most appropriate because it provides the opportunity to gain in-depth, context-bound, and subjective information. Qualitative researchers attempt to make sense of phenomena in terms of the meanings people bring to them (Danzin & Lincoln, as cited in Heppner et al., 2008).

Tesch (1990) identified four major categories of qualitative research: 1) research that studies the characteristics of language, 2) research that aims at the discovery of regularities, 3) research that seeks to discern meaning, and 4) research that is based on reflection. This current inquiry of difficult clinical moments belongs to the third category of research that seeks to discern meaning in that it seeks to discern and understand essences and themes of commonalities and uniqueness. Within this branch of qualitative research, the researcher attempts to understand the nature of the text or phenomenon and therefore gain insight.

Phenomenological Research

Phenomenology began as a school of philosophy that much later was adopted by scholars in the development of the explicit investigative method of phenomenological research (Tesch, 1990). Phenomenology is more of an attitude than a method. It is a way of approaching the world through wonder and curiosity. Phenomenological researchers attempt to describe the meaning of the lived experiences for several individuals about the phenomenon (Creswell, 1998). They are interested in the way people experience their world (Tesch, 1990). Phenomenological researchers search for the essence or the central underlying meaning of the experience (Creswell, 1998). The main goal is to determine

and describe the individual's meaning of the experience. From an understanding of a number of descriptions from a number of individuals, general or universal essences of experience are derived (Moustakas, as cited in Creswell, 1998).

Phenomenological research is concerned with the study of experience from the perspective of the individual while putting aside any taken-for-granted assumptions and presuppositions of the researcher. The researcher attempts to suspend all judgments about with is "real" until they are founded on a more certain basis. The researcher is to remain open to themes that emerge (Tesch, 1990). This strategy of suspension of prejudice is called epoché by Husserl (Creswell, 1998; Heppner et al., 2008). Through in-depth dialogue and reflection, the phenomenological researcher attempts to understand and describe, with an open mind and without preconceived ideas. Although, researchers realize that it is inevitable that their personal notions will affect the research process and this must always be kept in mind from inception to completion of the study (Protinsky & Coward, 2001). This process is difficult, and perhaps impossible to achieve fully, but the goal of pure curiosity and open-mindedness is strived for as a way to derive the structure of essential elements within a phenomenon.

Through the inductive method of open-ended interviews and participant feedback on data analysis, the meaning of the felt experience of difficult clinical moments can be derived. This can be an effective research method for understanding the subjective experience of a phenomenon and challenging conventional wisdom. In this project, the phenomenon of interest is defined as *the psychotherapist's experience of difficult clinical moments*. The meaning and experience of difficult clinical moments can be best understood and conveyed by paying close attention to the participant's phenomenological

experience. By analyzing units of meaning and compiling a list of shared meanings across the participants, an unencumbered understanding can be discovered.

Defining Difficult Clinical Moments

Before moving forward, a clear definition of a difficult clinical moment must be established. As was demonstrated in the literature review, the construct of the difficult clinical moment is an abstract and subjective concept that a small number of researchers and authors have attempted to comprehend. The seminal article *Development of a Taxonomy of Therapist Difficulties: Initial Report* by Davis et al. (1987) is considered to be the first investigation into therapist difficulties (Orlinsky & Rønnestad, 2005; Schröder & Davis, 2004). These researchers merely described therapist difficulties as situations "in which we had experienced a difficulty" (Davis et al.,1987, p. 111).

In the book *Difficult Moments in Child Psychotherapy*, Gabel et al. (1988) provide the following definition of a difficult moment: "a concrete expression of a disparity between the therapist's and the child's or the parents' expectations of the treatment process" (p. 199). Since the Gabel et al. (1988) book was not a study and the authors did not reference the established literature on therapist difficulties, this book should be considered to be outside the difficult moment research and literature. Furthermore, their definition is counter to the established definition of a difficult clinical moment and instead is similar to the definition of *relationship rupture*–a disagreement about the tasks and goals of treatment (Safran, Muran, Samstag, & Stevens, 2002).

Schröder and Davis (2004) provided descriptive definitions of three types of therapist difficulties: 1) *transient difficulties* in which the therapist experiences a difficulty involving "deficits in the knowledge or technical repertoire" (p. 331); 2)

paradigmatic difficulties in which the therapist experiences a difficulty involving "stable, distinctive personal attributes of the therapist" (p. 331) that contribute to the difficult situation; and 3) *situational difficulties* in which the therapist experiences a difficulty involving external factors (e.g., difficult patient) that would cause difficulties for any therapist.

Although the sparse literature on therapist difficulties provides some useful taxonomies (Orlinsky & Rønnestad, 2005; Schröder & Davis, 2004; Smith et al., 2007), there has been no attempt to provide a more detailed definition of a "therapist difficulty" or a "difficult clinical moment" aside from the original Davis et al. (1987) definition: "situations… in which we had experienced a difficulty" (p. 111). Since no established comprehensive definition of a difficult clinical moment exists within the research literature, the following working definition was developed by this author based upon a compilation of the research findings regarding difficult moments by Davis et al. (1987), Orlinsky and Rønnestad (2005), and Smith et al. (2007).

Definition. A difficult clinical moment is a discrete moment in which the psychotherapist experiences distress as a result of his or her clinical work with a client. The moment of difficulty can occur within a few seconds or several minutes, and it does not necessarily have to occur within a psychotherapy session. The therapist distress can take the following forms: feeling demoralized, inadequate, self-doubt, or unconfident; feeling overly confused or out of control of the therapeutic situation; feeling overly responsible, guilty, remorseful, or injurious of the client; surmising that his or her private concerns are intruding into the therapy; feeling afraid, intimidated, manipulated, or emotionally hurt by the client; feeling shocked, anxious, overwhelmed, destabilized,

hopeless, helpless, or sorrow; feeling irritated, angry, aggressive, or frustrated; feeling disgust, nausea, tenseness, unrest, or avoidant of the client; ruminating on the client or feeling unable to let go; feeling distant, unable to empathize, or unable to form a relationship with the client; or experiencing intrusive images, nightmares or disturbing dreams.

Participant Selection

The study was designed for ten participants. Efforts were made to provide as diverse a sample as possible. Samples for phenomenological inquiries are generally much smaller than those used in quantitative studies, because more data from more participants does not necessarily lead to more information (Mason, 2010). Also, qualitative research is concerned with the discovery of meaning rather than making generalized numerical statements about a population (Creswell, 1998; Mason, 2010; Tesch, 1990). Furthermore, because the analysis of phenomenological research data is time consuming, a large sample is simply impractical (Mason, 2010). Recruitment of this convenience sample ceased when the investigator, in consultation with the dissertation committee, determined that theoretical saturation of each category was reached.

Recruitment. Participants were recruited for this study using word of mouth, flyers, phone calls to agencies and universities, emails on listserv, and emails to known seasoned therapists. Within the clinical literature, many professions are often considered when researching psychotherapists (Orlinsky & Rønnestad, 2005). Similarly, in this study, several professions were considered eligible including psychologists, psychiatrists, marriage and family therapists, mental health counselors, social workers, and pastoral therapists. Notable community members, university faculty, students, and others were

asked to recommend seasoned psychotherapists for this project. The investigator reached out to clinicians in the Greater Seattle Area via written correspondence to recruit private practitioners and those working at agencies. Colleagues were asked to provide lists of potential participants, and the candidates were approached as voluntary participants in the study. The flyer and correspondence included the following information in accordance with the Institutional Review Board guidelines of Antioch University Seattle: researcher's affiliation, description of the procedures, statement of voluntary involvement, and procedures to maintain participant privacy and confidentiality of data (Appendix A).

Screening. Potential participants were provided with a phone number and email for the investigator and were asked for consent for a phone or email screening to determine eligibility for the study. To be eligible for participation, participants must a) have had at least fifteen years' experience as a practicing psychotherapist (in accordance with the Orlinsky et al. (2005) criteria for a seasoned psychotherapist), b) have been trained in a graduate program, and c) have been able to meet with the investigator in Seattle for both the initial interview and a potential follow-up conversation. Efforts were made to provide as diverse a sample as possible regarding ethnicity, gender identification, sexual orientation, etc.

Upon being screened, the seasoned psychotherapists were asked by the researcher to participate in a qualitative study regarding difficult moments with clients and invited to participate in a two-hour interview and a potential follow-up conversation. The participants were not offered payment or any other sort of reward for their participation.

Informed Consent

Before the initial interview, each participant received a Consent to Participate in Research form via email (Appendix B). This form included the voluntary participation, researcher affiliation, study purpose, study procedures, anonymity and confidentiality, anticipated risks and benefits, contact information, and statement of participant receipt of document. The participant was encouraged to review the informed consent prior to the interview. There was time at the beginning of each interview to review the informed consent during which the participants had opportunities to ask questions and obtain clarification. Once the participants agree to proceed, the participant and investigator signed two copies of the consent form with one kept on file by the researcher and one provided to the participant.

Participant Risk

Unearthed emotions. Since the participants were discussing difficult clinical moments, there was a possibility of a therapist unearthing some difficult emotional material during the interview. This was accounted for by informing them of the possibility, by monitoring their experience during the interview, by allowing the participant to direct the interview depth, by suggesting they have the time and space after the interview to decompress, and by encouraging them to utilize their own therapeutic and/or consultative support.

Confidentiality. This project involved a small number of participants within a small professional community, so assigning numbers would have been ineffective in masking identities. Therefore, participants were given the opportunity to omit any of their identifying details in the final report. Furthermore, since the participants and the

audience are within the same field, the participants were informed that this particular study might be read by some of their colleagues which allowed them to make an informed decision as to whether or not to participate in the study.

Benefits versus risk. The benefits of this research outweigh the risks in several important ways. Knowledge of the phenomenon of difficult moments in therapy can be used to enhance therapist training. Students, interns, and practicing therapists can better prepare for potential difficult moments if they are given a summary of the events and their meaning. Supervisors may use the results of this study to guide their supervision of novice therapists. Also, researchers may use the qualitative findings for the basis of future research.

Procedures for Collecting Data

Recording and location. The interview was video and audio recorded for later review. A notebook computer recorded the audio and a video camera recorded the video. To assure a quality audio recording, the participant and interviewer each had a microphone and each interview took place in a quiet room located in the researcher's office or the participant's office. Eight of the ten interviews took place in the participant's clinical office and two took place in the researcher's office. The audio and video files were stored on the researcher's password-protected desktop computer.

Consent and demographic questionnaire. At the beginning of the interview, the consent was reviewed. Confidentiality was discussed in detail to help the participant feel freer to share their experience. Participants also completed a demographic form which included questions about such topics as the participant's gender identification, ethnicity, theoretical orientation, professional identity, years of experience, and any other identities

of diversity they wished to share. Furthermore, verbal permission was obtained for the interviewer to ask clarification questions.

Interview questions. The interviews followed an unstructured format to allow the participants to speak spontaneously and openly about their experience of difficult clinical moments. The main prompt was: *Please tell me your experience of one or more difficult clinical moments.* I asked other questions throughout the interview in an attempt to elucidate the participants' experience of the difficult clinical moment. However, special care was taken to allow the interviewees to direct the interview in a way that felt comfortable to them and allowed them to describe their experience without interference from the interviewer. The participant was allowed to describe as many difficult clinical moments as he or she wished. The interview ended when the participant felt the moments were sufficiently described.

Post-interview memos. In his article titled *Qualitative Interviewing as an Embodied Emotional Performance*, Douglas Ezzy (2010) argues that emotions are central to the conduct of qualitative research interviews. He points out that qualitative researchers often make the mistake of purposefully omitting the significance of the emotional aspects of interviews. They do this by: 1) conducting interviews that typically focus on the cognitive statements, 2) asking only cognitively articulated questions, 3) recording only the audible spoken parts of the interview while ignoring non-verbal, visual information denoting emotional content, 4) and analyzing only textual transcriptions of interviews. Ezzy argues it is the *emotional structure* of the researcher-participant relationship, as much as a well thought out *cognitive approach* to questions that underlines good interviewing practice.

To capture the emotional experience of the interview, Groenewald (2004) asserts that memo-ing is an important data source in qualitative research. It is the researcher's field notes recording what the researcher hears, sees, feels, experiences and thinks in the course of collecting the interview data and reflecting on the process. Researchers are easily absorbed in the data-collection process and may fail to notice and record important details that are otherwise unrecorded. Since emotional content is often a felt experience while in the presence of the participant, the researcher wrote a post-interview memo after each interview, reflecting upon his emotional response and observations. These memos provided insights into the experience of the seasoned therapists. These memos were later analyzed with the understanding that my feelings were not purely a reflection of the participant's experience, but rather a co-constructed (or even a self-constructed) phenomenon. Other details were also mentioned in the post-interview memo. For example, methodological notes were recorded and reflected upon to enhance the process and procedure of subsequent interviews.

Follow-up. After each interview was analyzed, I conducted a validity check by returning to the participant to determine if the essence of the interview has been correctly captured. The participant was given the choice to provide written feedback or participate in a face-to-face or phone conversation. All ten participants chose to provide feedback via email. Their feedback was incorporated into the final analysis of each individual interview. In general, the participants found the initial write-up of their interview to accurately represent their experience of the difficult clinical moments they described, and of the participants who provided feedback, they only provided minimal edits to their interview's summary.

Ethical critique of qualitative research. In their article titled *Confronting the Ethics of Qualitative Research,* Brinkmann and Kvale (2005) identify what they call *qualitative ethicism*: a tendency among qualitative researchers to portray qualitative inquiry as inherently more ethical than quantitative research simply due to the nature of qualitative research design. This biased thinking can lead to researchers being blind to the inevitable power plays and cultural context inherent in the research.

They also characterize qualitative research as saturated with more concealed forms of power than quantitative research. Qualitative researchers possess a particular privilege because: 1) they define the interview situation, 2) the interview is often a one-way dialogue (it is considered bad taste if participants break with the ascribed role by asking questions), 3) the research interview is not a mutual conversation, but a means serving the researcher's ends, and 4) the interviewer often has a monopoly on the interpretation of the data. Brinkmann and Kvale (2005) accuse qualitative researchers of using their privilege and faking warm relationships to manipulate and potentially harm participants. This project incorporated Brinkmann and Kvale's advice regarding ethical research in the following ways.

Interview flexibility. My privilege and power as a researcher might have made the participants feel uncomfortable and therefore unlikely to share their experience or unlikely to assert their needs. Privilege might have also prevented me from being open to their experience–I was at-risk of interpreting the interviews through my preconceived notions rather than really listening to them. Therefore, reducing or managing my privilege was ethical, moral, and useful to the project. Rather than exerting my privilege by defining the interview situation, I strove to remain flexible and adjust to their

preferred style of being interviewed. Also, before the interview began, I emphasized their freedom to break from the typical interview format if they choose to do so. Furthermore, I allowed each participant to determine when the interview ended.

Participant feedback to analysis. Researchers often retain a monopoly on the interpretation of the data. This monopoly was dismantled by allowing the participants to influence the data analysis. After each interview was analyzed and summarized, the participants were given a draft of the findings and their reflections and feedback were incorporated into the analysis and final report. Since the purpose of this project was to convey the participants' experience, this necessary and valuable step in the analysis increased accuracy and reduced researcher bias.

Data storage. Data was stored in a password-protected file on a password-protected computer located in a locked office. The names of the participants were deleted from any records; numbers on participant data corresponded to participant names; the coding for the names files was securely locked in a different storage device in a separate locked room. No persons except for the researchers named herein were ever granted access to this data. Each participant electronic file contained the following:

- A scan of the signed informed consent agreement (the hard copy was shredded)

- A scan of the pre-interview demographic survey (the hard copy was shredded)

- The post-interview memo and any other memos related to that interview

- The draft analysis of the interview that was presented to the participant for validation

- The final approved analysis of the individual interview

Data Analysis Method

Even though phenomenologists are reluctant to focus too much on steps since methodological rigidity might interfere with the discovery of the essence of the phenomenon, this study followed a modified version of Hycner's (1999) model:

1) Bracket

2) Listen for the whole

3) Delineate meaning units

4) Cluster units of relevant meaning

5) Ask the participant to validate the themes

6) Modify the themes based on participant feedback

7) Extract themes from all the interviews

Bracket. Fischer (2009) describes bracketing typically refers to an investigator's identification of vested interests, personal experience, cultural factors, and assumptions that could influence how he or she views the study's data, and these influences are placed in ''brackets'' and ''shelved'' for the duration of the study. She argues that instead of treating bracketing as a perfunctory initial phase, bracketing should continue throughout the research process. This is easier said than done. During this study, I attempted to continually remind myself to remain open to the experience of the interviewees and attempted to shed my assumptions as much as possible. As an integrated phenomenological psychotherapist, this is a philosophical position I have practiced for many years with my clients and am therefore quite comfortable with. I also consulted to assure I was not losing my ability to remain open to the participants' described experience.

Listen for the whole. I then listened repeatedly to the audio recording of each interview to become familiar with the words of the interviewee in order to develop a holistic sense of the interview. I attempted to get a general sense of the experience of research participants.

Delineate meaning units. This is a critical phase in data analysis, in that those statements that are seen to illuminate the researched phenomenon are extracted and isolated (Creswell, 1998; Groenewald, 2004). I made judgment calls while consciously bracketing my presuppositions in order to avoid inappropriate subjective judgments. To do this, I considered the literal content, as well as the number of times a meaning was mentioned, and also how they were stated.

Cluster meaning units into themes. I then examined the list of meaning units and tried to elicit the essence of meaning of units within the holistic context (Groenewald, 2004). I went back and forth between the audio recording of the interview and the list of meaning units to derive clusters of appropriate meaning. Central themes of the phenomenon emerged during this phase.

Ask the participant to validate the themes and modify the themes. Groenewald (2004) recommends the researcher conduct a validity check by returning to the participant to determine if the essence of the interview has been correctly captured. The participants' feedback was documented and incorporated into the final analysis of each individual interview. This process was a rather simple process since the participants generally accepted the initial draft of the interview summary and analysis.

Extract themes from all the interviews. I then looked for the themes common to most or all of the interviews. Groenewald (2004) points out that the minority voices are

also important counterpoints to highlight. Again, the original interviews and post-interview memos were reviewed, along with each list of meaning units to validate broader conclusions. This step culminated in the synthesis and integration of insights contained in the participant-confirmed themes into a consistent description of the structure of the phenomenon or the *essential general structure* (Giorgi, 1985). This essential general structure was presented to a number of participants who positively confirmed its accuracy.

Chapter IV: Results

The purpose of this project is to study seasoned psychotherapists' meaning of the experience of difficult clinical moments. This chapter will present findings from the interviews with the ten seasoned psychotherapists. The first section will provide the demographic information of those who were interviewed. The second section will present the types of difficulties described by the participants. The third section will comprise of an analysis of themes along with a number of quotes from the participants. The fourth and final section will provide the essential general structure of the phenomenon. Pseudonyms will be used to mask the identities of the participants.

Participant Demographics

Upon completing a short demographic survey, the participants provided the following demographic data. Five of the participants identified as female and five identified as male (see Table 6). Ages ranged from 42 to 71 with an average of 60.4 years (see Table 6). Most were between the ages of 58 and 71.

Table 6
Participant Age and Gender Identification

Age	Gender Identification
42	Female
43	Male
58	Male
58	Male
60	Female
62	Female
69	Female
70	Male
71	Female
71	Male

Six participants identified as White or Caucasian, three identified as mixed

(White/Native, Jewish/Puerto Rican, White/Jewish), and one identified as Jewish (see

Table 7). When asked to provide any other identities of diversity they wished to share,

five participants identified as gay (see Table 7).

Table 7
Participant Ethnicity and Self-Chosen Identity of Diversity

Ethnicity	Self-Chosen Identity of Diversity*
White	
White, Swedish-American	
White, Northern European Background	Gay
White	Gay
Caucasian	Gay
Caucasian	
Mixed: White and Native	
Mixed: White and Jewish	Gay
Mixed: Jewish and Puerto Rican	
Jewish	Gay

Note. *Participants were asked to provide any other identities of diversity they wished to share.

In light of these demographic data, the sample could be considered as somewhat

diverse since seven out of the ten participants endorsed at least one identity of diversity

such as being gay or of an ethnic minority. When asked regarding their license, three of

the participants indicated they were licensed psychologists, three were licensed mental

health counselors, two were licensed social workers, and two held dual licenses in

marriage and family therapy and mental health counseling (see Table 8).

Table 8

Participant Graduate Degree and License

Graduate Degree	License
MA, MApStat, PhD	Psychology
PhD	Psychology
PsyD	Psychology
MPS, Masters in Art Therapy	LMHC
MS	LMHC
MA	LMHC
MSW	LICSW
MSW	LICSW
MA	LMFT, LMHC
Mdiv, MA	LMFT, LMHC

The participants indicated membership in several professional organizations including the American Counseling Association, American Psychological Association, American Art Therapy Association, American Dance Therapy Association, American Association of Marriage and Family Therapy, Association for Behavioral and Cognitive Therapies, C.G. Jung Society, Northwest Alliance for Psychoanalytic Study, National Association for Poetry Therapy, Women's Therapy Referral Service, Washington Mental Health Counselors Association, Washington State Psychological Association, and Washington State Society for Clinical Social Work (see Table 9). When asked to identify their theoretical orientation, the participants indicated a wide variety of approaches including cognitive-behavioral therapy, dance/movement therapy, depth psychology, feminism, humanistic psychology, integrative, interpersonal, Jungian, object relations, psychodynamic, relational psychodynamic, and reality therapy (see Table 9).

Table 9

Participant Professional Organization and Theoretical Orientation

Professional Organizations	Theoretical Orientation
American Psychological Association (APA), Washington State Psychological Association	Dynamic, Interpersonal, Modern Analytic
CG Jung Society, Sandplay Therapists of America	Jungian
American Association of Marriage and Family Therapy	Marriage and Family Therapy
Northwest Alliance for Psychoanalytic Study, Washington State Society for Clinical Social Work, National Association for Poetry Therapy	Psychodynamic
American Art Therapy Association, Women's Therapy Referral Service	Feminist
American Counseling Association, Supporting Emotional Needs of the Gifted	Object Relations
Jungian Psychotherapists Association, Jung Society	Depth Psychology, Humanistic, Developmental and Mindfulness
Alliance Psychoanalytic Studies, American Dance Therapy Association, Washington Mental Health Counselors Association, SCA	Relational Psychodynamic, Dance/Movement Therapy
APA, Washington State Psychological Association	Integrative: Humanistic/Reality/Cognitive
APA, Washington State Psychological Association, Association for Behavioral and Cognitive Therapies	Cognitive-Behavioral Therapy

Years of experience ranged from 15 to 36 with an average of 28.7 years. Most of the

participants had between 30 and 36 years of experience (see Table 10).

Table 10
Participant Years of Experience

Years of experience
15
15
27
30
30
32
33
33
36
36
Mean: 28.7

Specific Difficult Clinical Moments Described

Prior to the interview, the participants had time to think about which difficult clinical moment they wished to describe for the study. Since the research design was phenomenological and therefore open to the participant's meaning-world, a definition of difficult clinical moments was not provided prior to the interview. If the participant asked for a definition, I provided the following statement: a difficult clinical moment is a discrete moment in which the psychotherapist experiences distress as a result of his or her work with a client.

During the interview, each participant was allowed to describe as many difficult moments as they wished. The participants chose to describe one, two, or three difficult clinical moments. The following list provides some general examples of the described difficult clinical moments:

- A client is repeatedly aggressive with the therapist

- A child client tells a story of severe abuse

- A client feels deeply rejected by the therapist

- A client brings a gun to session

- A client touches upon a fresh emotional wound in the therapist

- A client sexually exploits the therapist

- A client decompensates in session

- A client becomes inappropriately sexual in session

- A client demonstrates his male privilege

- A client threatens the therapist's safety

- A client humiliates the therapist in front of others

- A client accuses the therapist of being non-therapeutic

Thematic Analysis

The primary source of data for this project was the transcribed interviews with the seasoned psychotherapists. Following a modified version of Hycner's (1999) model of phenomenological analysis, I first attempted to bracket and shelve any assumptions regarding the topic of inquiry. I continually reminded myself to remain open to the experience of the interviewees. To this end, I periodically reflected upon my thoughts and assumptions–in the form of written memos–throughout the interview process and the data analysis process.

Upon completing and transcribing the ten interviews, I dedicated a number of consecutive days to the task of interview analysis and summarization. Each interview was analyzed separately and I did not move on to the next interview transcript until the summary was written. First, I listened for the whole of the interview by repeatedly listening to the audio recording and watching the video recording–to become familiar

with the words of the interviewee and to develop a holistic sense of the interview. Second, I delineated meaning units within the interview. For example, when I analyzed Brad's transcript, I delineated the following quote as a meaning unit: "I felt like I didn't particularly know what to do." Each interview presented several of these meaning units and associated quotes. Third, meaning units were clustered into themes. Fourth, I wrote a summary of each interview and allowed each participant to provide feedback on their interview's summary. After incorporating their feedback, all ten participants approved of their interview's summary. Fifth, all ten summaries were analyzed together and all meaning units and themes were clustered into overall themes. Sixth, an essential general structure of the phenomenon was formulated. Seventh, each participant endorsed the essential general structure as accurate. The following themes were identified as central and relevant to the phenomenon of the difficult clinical moment since they each were identified by at least half of the participants during the interview:

1) Feeling Fear

2) Feeling Inadequate

3) Feeling Anger

4) Feeling Confused

5) Feeling an Urge to Hide Feelings

6) Feeling an Urge to Terminate

Theme One: Feeling Fear. All ten participants reported feeling fear during at least one of their described difficult clinical moments. This was the only theme reported by all ten of the participants. The following words and phrases were used by the participants to describe this feeling of fear: afraid; anxious; scared; frightened; panicked;

nervous; worried; tense; terrified; horrified; freaked; traumatized; intimidated; a fearful urge to run; alarmed; frozen with fear; unsafe; fight-or-flight; a sense of danger; and like a deer-in-headlights. The following quotes exemplify their described feeling of fear.

The horror was amazing.

I just remember being really freaked by it.

In that moment, I was frightened…

I was so nervous and so anxious.

I was worried…

I just also remember that sense of being on guard and fearful…

My internal experience was of feeling really afraid. I was feeling scared…
I felt very frightened.

In light of these quotes, it might appear the difficult clinical moments involved the client threatening the therapists' safety. Indeed, some of the difficult moments that provoked a fear response did involve threats to physical safety. For example, when a client was being verbally aggressive with Harry, and Harry was alone in the building, he was terrified by the client's anger and physically frightened.

What did I feel? I think like a lot of us, I'm not good with anger, and I don't like to be yelled at, and I don't like somebody around me to be yelled at… certainly felt some sense of panic. At that point, I was a guy in a room in a building, so there wasn't an immediate support system. Here, I can open my door, scream and 10 other doors will open. There, I could open my door, scream and probably no other doors would open… It's a moment, a difficult moment, of being confronted with that level of anger, probably more anger that I've ever been confronted with in 31 plus years now. That's why it stands out to me, and it would just simply be my own terror, my own discomfort with conflict, with verbal abusiveness, with being misunderstood...

However, in contrast to the above example, most of the described difficult clinical moments involved situations that did not threaten the participants' physical safety.

During the interviews, the seasoned psychotherapists described feeling afraid while

hearing a child recount the abuse they suffered or having a client criticize them. For

example, Brad described his fear as "just in my own head."

> There was nothing particularly threatening happening–I thought–between
> us. So the problem was just in my own head–the fear.

As another example, when Isaac was experiencing a difficult clinical moment, he

became worried about the client complaining to the licensing board and he consequently

worried about losing his ability to make a living as a therapist.

> It did worry me. That was one of the worries that I didn't mention to you
> before, that if I say the wrong thing, if I do the wrong thing, then he's
> going to say something about this to the licensing board or somebody
> else… I'm very leery of having something bad happen to me and my
> license, that's how I make a living.

Feeling physical symptoms. Five of the participants reported they felt physical

symptoms of fear during the difficult clinical moment including:

- Adrenalin surge

- Breathless

- Butterflies in the stomach

- Central nervous system activation

- Dry mouth

- Face flush

- Heart pounding

- Sweating

- Tightness in the chest

For example, when remembering a difficult moment, in addition to feeling shame

and like a deer-in-headlights, George recalled feeling the following physical symptoms of

fear: 1) central nervous system activation, 2) an adrenalin surge, and 3) flushed in the

face.

> I think that I felt a little activated. It was the kind of thing that I wouldn't
> have been surprised if I woke up in the middle of night thinking about or
> wondering about or worrying about… More like CNS activation… Yeah,
> more adrenalin, not a lot, but just a little… Maybe a little face flush…
> which I think is deer-in-the-headlights… I should know. I should know
> what I ought to do here. I think there was some shame mixed in there,
> something like that or shame around: "Why don't I know?" I think I felt
> that. I felt something in my face around that.

Some participants felt the physical symptoms of fear not only during the difficult

moment but also during the interview. For example, Isaac felt butterflies in his stomach

and a dry mouth while telling his story of a difficult clinical moment during the

interview. This fear response during the interview helped him remember how anxious he

was during the difficult moment. However, he does not remember noticing or

acknowledging his anxiety in the moment.

> As I think about it now I have a little bit of butterflies in my stomach in a
> sort of recollected reaction to it which I think might talk a little bit about
> how difficult it was for me at the time… Like being anxious. Like
> nervousness. Well, it produced a lot of anxiety in talking about it. If I talk
> about it right now, my experience right now is a little bit of butterflies in
> my stomach and a dry mouth slightly. Clearly it makes me anxious to talk
> about it and this is something I did not expect to happen. It makes me
> anxious to talk about it which retrospectively tells me how anxious I was
> in the moment and I might not have described myself as feeling anxious
> then. I clearly had to be very anxious about what's going on. There's so
> many implications, so many things that could have happened.

Theme Two: Feeling Inadequate. Eight out of ten of the participants reporting

feeling inadequate during at least one of the difficult clinical moments they recalled

during the interview. During the interviews, the seasoned psychotherapists described

feelings of insecurity, uselessness, incompetence, lack of confidence, embarrassment, and

shame for failing as a therapist.

Some of the seasoned therapists recalled feeling particularly inadequate and insecure as a consequence of being new to the field, several years ago. For example, during one particular difficult clinical moment that occurred at the beginning of his career, Frank thought of himself as being young, inexperienced and insecure. He even felt silly at times. He thought his clients would detect his inadequacy and be skeptical of him. He also felt alone, isolated, and a lack of support from his workplace which added to his sense of insecurity. In a nutshell, he felt like an inadequate novice who was likely to fail as a therapist.

> In those early days… I had so many insecurities and there wasn't a
> lot to hold on to.

Some of the seasoned psychotherapists reported feeling shameful about their perceived inadequacy and did not want to admit they felt incompetent or insecure about failing. For example, upon reflecting during the interview, Brad discovered he had hidden his insecure feelings from his awareness until he explored his experience during the interview. He recalled coping with this hidden feeling of inadequacy by adopting an "academic" stance.

> It was a level of insecurity… Maybe I deal with it more academic–the way
> I thought about it–and the feelings hide there. Maybe I couldn't face my
> sense of insecurity well.

A common precipitant to the feeling of inadequacy was a self-realization of not knowing what to do during the difficult moment. Some of the participants reported they thought they ought to know what to do and therefore felt inadequate as a clinician. For example, during a difficult clinical moment, George felt embarrassed, insecure and ashamed for not knowing how to proceed with the client. He ruminated on his inability

to figure out what to do during the difficult moment. He felt pressure to quickly come up with a response that met everyone's needs and wants. He became self-critical.

> I think my ruminating might have been something around, "What am I going to do? I've got to decide something." I think I called it a pressure to hurry up, to figure this out… "Why the hell don't you know what to do here?" … I should know. I should know what I ought to do here. I think there was some shame mixed in there, something like that or shame around: "Why don't I know?" I think I felt that. I felt something in my face around that.

Feelings of inadequacy were also precipitated by perceived failure. For example, Carol reported feeling guilty for making her client feel abandoned. She felt inadequate as a therapist, as though she was failing in her duty to help the client. She thought it was her job to help him not feel abandoned, and in the difficult moment, she felt misery for failing at this job.

> It's like, "Oh God." That was awful. That was just awful. I think sitting with his despair was awful, was almost worse than when you're with a client who has been abandoned… That was awful, compounded by my guilt and abandoning. It felt like I was abandoning him in his moment of need. I would say that that's one of the worst feelings… I just made a joke about something else to someone recently about how even after 37 years of practice, I guess I still have rescue fantasies. I want to help. There was a period of time when I moved here to Seattle where I wasn't doing therapy. I just realized how much this was not just a job but like a calling. And that I really missed it. I was still in a somewhat clinical position but I wasn't actually doing one-to-one therapy. The value of helping or offering myself, my understanding, my ability to sit with pain, all those things, that's a major value for me… I think that's where the sensitivity to abandonment comes in, that it just feels like, "How can you leave me now?" I'm particularly susceptible to guilty feelings… around that.

As another example, in one particular difficult moment, Dorothy had a profound realization that she might not be helping the client. She described a moment in which her therapy was not helping the client reduce her dissociation in the session. She felt a disconnect between what she thought was happening with the client and what was

actually happening. She wondered if the client was benefiting at all from the therapy and she felt insecure about her ability to help the client. Even though she had consulted many times about this client and even though she had worked hard for many years, she thought the therapy she provided would never be good enough.

> It was really profound for me, because I felt like even when we do the simplest exercise–that for anyone else would just be the simplest kind of attunement to the environment–she's not even there, even after eight years of working together… "What is she getting out of being here? Should she come? Should I take her money?" … I thought, "Even though I've gotten endless consultations on this woman, it will never be enough. I still can't read her after all these years. I can't…" It made me feel like... "What do I have to offer her? Is this helping? Why does she come?"

Theme Three: Feeling Anger. Seven out of the ten participants reported feeling anger during at least one of their recalled difficult clinical moments. During the interviews, the seasoned psychotherapists talked about feeling frustration, fury, outrage, aggression, hatred, rage, disapproval, judgment, an urge to be firm, and an urge to get revenge.

One of the reported forms of anger was visceral rage. As a particularly poignant example of this rageful feeling, Carol felt rage, fury, and adrenalin during a recalled difficult clinical moment. Carol's child died previous to the session, and when the client became emotionally rejecting of the client's daughter, Carol felt rage toward the client.

> I had actually lost my [child]... [The client] was so rejecting of her daughter… Just rejecting her so grossly… I just had this rage inside. It was like this wave of fury of just wanting to say, "You are so damn lucky to even have your children!" That's probably one of the most dramatic moments that I've ever had with a client… I had probably gripped my chair, but I had to sit for a moment before I made the next response and really try to think about how to say something that still felt true in a sense of not lying to this woman about what I thought was going on. I remember that… I think I just stomped around the room when she left. I think I did something physical, or just let out a big… or maybe I cursed her in the room. I don't know. I do know that I had a need for some kind of release.

Another reported form of anger was judgmental anger. For example, in two difficult moments with two different clients, Dorothy felt judgmental and embattled with each client. She privately questioned the clients' honesty and character. She wanted the clients to take responsibility for their choices and she felt frustrated with them. She had an urge to shove one client up against the wall and confront him, even though, of course, she would never act on such an impulse.

> What woman out there doesn't want to shove a man up against the wall and say, "Hey! You male-privileged-pain-in-the-ass, here's what you're doing! Take some responsibility for it!"

Upon reflecting on the feeling of anger, some of the seasoned psychotherapists deemed their anger and angry behaviors as unwanted and not helpful. For example, during one particular difficult clinical moment, Harry felt anger and an urge to fight with the client and defend himself against the client's angry, unfair accusations. He felt the flight-or-flight response, and rather than flee in fear, he chose to fight. Later, he evaluated his behavior as being not helpful.

> That sense of fight-or-flight… I verbally fought with him… I shouldn't have bought into it, but it was the fight part of that fight-or-flight… That was ridiculous… I know better than that, but that was maybe a moment where I was totally not a psychologist and just a human being where this random person said I'm at fault for something I wasn't at fault for.

In contrast to the previous example, some of the participants evaluated their anger as being helpful for the client. For example, in several difficult clinical moments involving hostility from two clients, Brad described a number of moments in which he felt competitive, an urge to be firm, and an urge to fight. During the interview he explained his belief that therapists, to be helpful, have to fight with their clients at times. He also admitted he is a "fighter" and a "competitive person." During his described

difficult moments, he remembered feeling angry and having an urge to be firm and

somewhat aggressive. He had an urge to "go with her into her craziness" and become

"big with her." He considered his anger and firm behavior to be a therapeutic act. He

used his anger to help the client understand how she was affecting other people.

However, he reported also feeling hatred which he did not consider helpful.

> And you had to get big with her… You had to love and care about her in a
> way that allowed you to go with her into her craziness, you know, those
> times, they are really difficult. And then some part of you does hate too.
> You know it's very difficult… It brought out a fighter in me too. I'm a
> fighter–a competitive person. And so it would bring that side out of me…
> As a therapist, you're a fighter and you're not a fighter. But you have to
> fight… You have to come back strongly and firmly and convinced even if
> you're not okay in the moment. So even within the context of being
> embarrassed or… when someone's screaming at you, it affects me… You
> have to come back with some degree of firmness… I had to shut her up at
> some level, because I became aware of what it was doing to other people.
> I had to figure out how to deal with that. But I would be very firm back
> with her. And I would be firm in a way that was: "Okay, that's what
> happened!" That always seemed to help her… I would respond with
> people quite strongly if it was necessary… right or wrong… The
> firmness… it was helping her reduce it, but it was generally not by "Shut
> the fuck up!" But by trying to affirm her in a very firm way so I could get
> through her reaction to me–which is what I was trying to do. But I
> suppose that's the professional part you're talking about because I was
> doing it that way instead of "Shut the fuck up!"

Theme Four: Feeling Confused. Five out of the ten participants reported feeling

confused, unprepared, and did not know what to do during at least one of their described

difficult clinical moments. This theme of feeling confused overlaps with the second

theme of feeling inadequate since some of the inadequate feelings derived from a

realization of not knowing what to do and feeling confused. However, these two themes–

Feeling Inadequate and Feeling Confused–are distinguished by the participants

describing their confusion as sometimes being independent of feeling inadequate,

insecure or self-critical. In other words, these feelings of confusion contributed to the

distress of the difficult moments described by the seasoned psychotherapists whether they felt inadequate or not.

Descriptions of their confusion were relatively uniform. The following is a list of quotations which demonstrates similarity in the felt experience of confusion during different difficult clinical moments. The quotes are from Brad, George, Isaac, and Julie, respectively.

I felt like I didn't particularly know what to do.

I felt like, "I don't know what to do here."

The difficulty of the moment was to know what to do with this material. Should it be integrated into the way we do therapy with her? Should I ignore it?

I also felt like I didn't know what to do.

Some of the seasoned psychotherapists said the difficult moment occurred because they were unprepared or untrained for that particular situation. For example, early in Harry's career, he encountered a clinical situation he had not previously experienced, nor had he heard any other therapist talk about in consultation group, classes or workshops. He felt pressured by the perceived lack of time to carefully consider his options.

It was so brief and so unexpected… I was about seven years in practice, and never having confronted something like that, I wasn't prepared for it, and again, it was just the banging on the door, so I didn't see it coming. I don't think I had heard enough even in consultation groups or classes or workshops that really prepared me for, "If this happens, consider doing the following." Truly, I was making it up as I went along. I mostly just tried to I think, unsuccessfully. I tried to maintain it. It was unsuccessful… I don't have a bag of tricks here, so I got to make it up as I go along, and there wasn't enough time.

Some of the participants reported feeling confused within a dilemma. For example, as George recalled one particular difficult clinical moment, he remembered he was trying to balance several opposing forces. He was conflicted about what to do. He had an acute sense of not knowing what to do. He felt boxed in. It was therefore distressful for him. He was frustrated because he could not see into the future.

> I felt like, "I don't know what to do here." … I felt like I got boxed into a yes/no, all-or-none, concrete way of thinking… It was distressful to me… It was really, "Oh man. There is no win-win here." … There is still some distress in it for me… "Shit, what do I do?" I think for me an important part of the moment is that having to use a crystal ball that I don't have…

Theme Five: Feeling an Urge to Hide Feelings. Five out of the ten participants reported feeling an urge to hide their feelings from their clients during the difficult clinical moments they recalled in the interview. When describing this experience, the seasoned psychotherapists described this feeling in the following ways: controlling my feelings; hiding fear; giving the impression of not having the hidden feelings; my inside not matching my outside; not letting on; and working hard at not reacting visibly.

For example, during a difficult clinical moment, Erica felt an urge to hide her fear. She had an urge to remain professional rather than showing her fear. During the interview, she reported believing that hiding her feelings of fear was helpful to the task at hand.

> I'm on high alert… But I'm not showing it because that's just the other thing about being a therapist… The other thing is, with some people, if you let them know you're afraid, that's not going to be a good thing. I probably gave him a clue when I didn't shut the door.

As another example of the urge to hide fear during a difficult clinical moment, when Julie's client started hyperventilating, Julie reported being aware of a split between

her inner anxiety and her outward appearance of being in control and competent. She

remembered her inside did not match her outside.

> I think if you could see a film of this moment, you would have seen me
> being very calm and keeping my equanimity. And I moved over to the
> couch to sit near her. And I let her feel my presence really there. And I
> really wanted her to feel my steady presence. But inside, it was like, "Shit.
> I don't know what to do." … My inside was not matching my outside. My
> outside was being a good therapist, doing, I think, just what I should have
> done. And my inside was not in that place at all. I was really aware of
> that… Then another part of me coming in and saying, "Well…" It's like
> the more mature, developed, experienced therapist coming in and saying,
> "Go. Go sit. Close your door. She needs to feel comforted. Stay calm." …
> There was a part of that was staying connected to that calm therapist
> voice. It's kind of that split.

In addition to feeling an urge to hide feelings of fear, other participants reported

feeling an urge to hide other feelings. For example, Carol felt an urge to control her rage

and disapproval. She tried to focus on the intellectual challenge, to maintain the

therapeutic alliance with the client.

> As quickly as I felt it, I knew I had to control it. It was just too extreme. I
> probably was trying to focus on formulating something I could say. I think
> the intellectual challenge of the moment is where I went… Sometimes I
> think about people abusing their children or people not appreciating the
> people in their lives who could be gone tomorrow. It was the conflict
> between just feeling that she was so wrong and yet that I had to maintain
> some kind of therapeutic alliance with her. That's the conflict, is that I
> couldn't just say, "You are so off" or "You're going to regret this."

Additionally, Frank had an immediate response to hide his vulnerability and his

feeling of being exposed to the client. He felt insecure and afraid, and he did not want his

group therapy clients to notice his feelings of inadequacy. When one of the group

members verbalized the participant's insecurity, Frank had an urge to deny it and defend

against it.

> My immediate response was sort of a belief that my vulnerability must not
> be seen. I needed to defend against what he was saying and deny it. I think

I actually probably immediately said something like, "No, I'm not. I'm fine. It's going okay. This all right," but inside, I could even hear it now in my voice going up and, "It's all good, everything's fine. Everybody, we're fine. Look, why don't we just end early. Bye."

Not only did the participants report feeling an urge to hide a particular feeling– such as tension or rage–but some reported feeling an urge to hide the lack of a feeling. During one particular difficult clinical moment, Dorothy tried to hide her lack of compassion. She wanted to give the client therapeutic compassion, however, her compassion fatigue became a barrier. Consequently, she had an urge to act as if she had compassion, to hide her lack of compassion and her true feelings, in an attempt to maintain the therapeutic alliance.

So I rely on a lot of the stuff I've learned about like: head tilt, smile, nod. So I pull out a lot of the physical attributes that I have heard helps these people, because I don't trust that my voice is maybe or that I even know what to say anymore so it's that social engagement system…

Theme Six: Feeling an Urge to Terminate. Five out of ten of the participants reported feeling an urge to stop working with the client when they experienced their described difficult clinical moment. In response to the distress of the difficult moment, these seasoned psychotherapists reported an urge to refer, to terminate with the client, never work again with that population, or to resign from the profession.

Some of the seasoned psychotherapists reported feeling an urge to refer the client to a different clinician during the difficult clinical moments they recalled. For example, during one of the difficult moments Erica described in the interview, she felt an urge to not work with the client and to refer him. She did not want to work with a client who "creeped her out" and crossed boundaries.

I rarely refer out once I've started working with a client. He was a compulsive masturbator, and about five or six sessions in, he commented

what I was wearing, and he said, "Oh, that's what you wore the first time I met you." I thought, "Oh dear, I'm not going to keep on working with you. You need to work with a man." I found somebody for him to work with and I made a referral… I just felt like I didn't want to work with him in that moment… I just didn't feel like doing it.

Some of the participants reported an urge to terminate with the client. Their distress during the difficult clinical moment prompted them to seek a solution by no longer working with the source of their distress. For example, when a client arrived in his office with a gun, Brad felt fear and consequently wanted to terminate and never work with the client again.

> I wanted to terminate… I felt uncomfortable with him carrying the gun… I probably would have said… "I want to stop working together because I'm scared…" I probably did a lot of verbal garbage about it. But I know I didn't want to work with somebody who was carrying a gun.

In addition to feeling an urge to refer and an urge to terminate, some of the seasoned psychotherapists reported feeling an urge to resign from the profession all together. For example, upon hearing children tell their stories of severe abuse, and since her own children were in the same community as the abused children, Amy was worried about her kids being abused. She was overwhelmed with emotion and responsibility, and she had an urge to not work as a therapist any longer.

> I stopped working at that point and I was never going to work again as a therapist because I hadn't done my own healing… It was real loss of innocence for me. I hadn't experienced man's inhumanity to man in such a vivid way. And so I had to stretch and make room for that too… And so it touched the "oh my god" in me. "Have my kids been touched?" So it was very involving. I was never going to work again… I said, "I can't do this work anymore…" I said, "I can't do this work anymore…" I said, "I am not going to do this anymore." And then someone said, "You don't have to work with kids." And I thought, "Oh, good point." Part of what was hard about the kids was I didn't know if they'd make it. After they left therapy, what's going to happen with their life? How will they carry this? Because it's not like it's over. It has to be metabolized. It's part of

their story at that point. And they need to figure out a way to wear it so they can go on with their life.

Essential General Structure of the Phenomenon

The final step in the data analysis is the formulation of the *essential general structure* of the phenomenon of seasoned psychotherapists' experience of difficult clinical moments (Giorgi, 1985). Put simply, this essential general structure is a compilation and a distillation of all ten participants' experiences of difficult moments. This composite description is an explication–or making sense–of the meaning-structures provided by the participants. The aim of this section is for the researcher to synthesize the results into a general description and to reveal the essential elements of the meaning-structure of the experience of difficult moments.

The following essential general structure emerged late in the data analysis process. Before conducting the interviews and throughout the planning phase of this project, I purposefully refrained from predicting the results. I enjoyed the freedom of not knowing and the excitement of curiosity. During the interview phase of this project, I was quite occupied with the logistics of scheduling and conducting the interviews and therefore did not notice any themes. Even after I transcribed the interviews and watched the video recordings, no essences were realized. Only after weeks of dedicated emersion in the data did the themes emerge. And finally, after repeatedly refining the themes and writing several rough drafts of this chapter, the following synthesis suddenly emerged without much effort. As a final measure of data analysis, a number of the participants confirmed the accuracy of the following essential general structure.

A difficult clinical moment is a discrete moment in which the psychotherapist experiences distress as a result of his or her work with a client. When a seasoned

psychotherapist encounters a difficult clinical moment, he or she feels anxiety. The therapist might feel physical sensations of anxiety such as a pounding heart or a surge of adrenalin. The therapist might feel physically threatened, as if his or her life is in danger. Or the psychotherapist might feel emotionally threatened, as if the client is judging the therapist unfairly or as if the client's emotional presentation is overwhelming the therapist. Or the therapist might feel professionally threatened, as if the client will submit a complaint to the licensing board. In response, the therapist is likely to feel vulnerable, nervous, and perhaps panicked. This will engage the fight-flight-or-freeze response, resulting in the therapist either having urges to fight, urges to run out of the office, or an autonomic response of freezing like a deer-in-headlights. All of this fear might result in future trauma effects.

Since the difficult clinical moment seems to emerge suddenly and without warning, the therapist is likely to feel confused. *What do I do?* The therapist is likely to feel unprepared or untrained for this particular clinical situation. This feeling of not knowing what to do is likely to be followed with a deep sense of inadequacy. *Why don't I know what to do?* The therapist might also feel guilt and shame, and have self-critical thoughts. *What's wrong with me?* The therapist might begin to question his or her abilities as a clinician. The therapist might feel embarrassed as he or she flounders or fumbles in front of the client. Feelings of betrayal and defensiveness might follow. *Why is the client doing this to me?*

The therapist's professional stance is deteriorating under the pressure of their intense feelings of fear, confusion, and inadequacy. This is when the anger begins. The anger might manifest as judgmental and disapproving thoughts about the client. *What's*

wrong with this client? The therapist might have urges to lash out at the client. However, the seasoned psychotherapist is likely to restrain him or herself from acting on those aggressive urges.

All of these feelings–fear, confusion, inadequacy, anger–are followed by an urge to hide the feelings from the client. The feelings are seen as shameful or unhelpful. The therapist does not feel able to reveal these emotions to the client. *My true feelings must not be seen.* The therapist quickly attempts to give the impression that he or she is calm, cool, collected, composed, and compassionate. The therapist might even deny, to him or herself, that the feelings exist at all. This denial might result in intellectualization or an urge to attend to the duties of the job.

All of this distress during the difficult clinical moment might result in the seasoned psychotherapist feeling an urge to somehow terminate with the client. The therapist might feel an urge to refer the client to someone "more suited" for the client. *I can't help this client.* The therapist might even have an urge to resign from the profession altogether. *I can't do this anymore!* However, this urge is merely a temporary, soothing fantasy since the therapist is not likely to actually terminate or resign. And lastly, for many therapists, the final feeling is an urge to consult and a feeling of hope for future help from colleagues.

Chapter V: Discussion

This final chapter will provide a discussion of the results presented in previous chapter. First, a brief review of the project purpose will be presented. Second, the findings from the previous chapter will be summarized. Third, a comparison to the previous literature on difficulties will be discussed. Fourth, in light of this comparison, a discussion of Theme Five: Feeling an Urge to Hide Feelings will be provided including a discussion of the dilemma of self-disclosure. Fifth, recommendations for training and supervision will be offered along with a discussion of contributing factors to trainee non-disclosure and solutions to non-disclosure of difficulties. Sixth, the limitations of the present study will be detailed. Seventh, recommendations for future research will be given. And eighth, a summary of the entire report will be provided.

Review of Project Purpose and Method

The purpose of this project was to study seasoned psychotherapists' meaning of the experience of difficult clinical moments. This report is intended to help guide efforts to understand difficult clinical moments as well as improve training, supervision, and support of psychotherapists. A phenomenological design was used to examine the lived experience of ten seasoned psychotherapists. The participants–with an average of 29 years of experience–were interviewed for approximately one hour using an unstructured interview protocol.

Review of Findings

Regarding seasoned psychotherapists' experience of difficult clinical moments, six themes were found that: 1) Feeling Fear, 2) Feeling Inadequate, 3) Feeling Anger, 4) Feeling Confused, 5) Feeling an Urge to Hide Feelings, and 6) Feeling an Urge to

Terminate. Also, an essential general structure of the experience of difficult moments was derived from these themes (see Chapter IV).

Comparison to Previous Research

The two dominant studies in the field of difficulties–Davis et al. (1987) and Schröder and Davis (2004)–overlapped to some degree with the present study's findings in that two themes of experience–confusion and inadequacy–were highlighted in their findings. However, the themes of Feeling Fear and Feeling Anger were only minimally mentioned in these studies, and the themes of Feeling an Urge to Hide Feelings and Feeling an Urge to Terminate were not reported at all by the researchers.

Even though the methodology and reporting styles were different, the results of the comprehensive Orlinsky and Rønnestad (2005) study and the results of this present study are mutually confirming in that therapists in both studies reported feeling some form of confusion, inadequacy, anger, the urge hide feelings, and the urge to terminate. However, Theme One: Feeling Fear was not represented in the Orlinsky and Rønnestad (2005) study. The Smith et al. (2007) findings also concurred with five of the six themes except for Theme Five: Feeling an Urge to Hide Feelings.

Analysis of comparison to previous literature. It is curious that even though all ten of the participants in the present study reported feeling fear during at least one of their described difficult moments, and even though Smith et al. (2007) found anxiety to be the most prevalent reaction to difficulty, the experience of fear and anxiety has not been a focus within the established literature on difficulties. Perhaps the experience of fear is not as prevalent as the results from the present study suggest. Or perhaps therapists are less shameful of their feelings of confusion and inadequacy than their feelings of fear and

were less likely to disclose their feelings of fear in the previous studies. These questions are worthy of further inquiry.

Furthermore, it is also curious that aside from one of the many items on the comprehensive survey by Orlinsky and Rønnestad (2005), Theme Five: Feeling an Urge to Hide Feelings is not mentioned anywhere in the previous literature on difficulties. The simplest explanation is that the findings of the present study are not representative of the larger population of psychotherapists and therefore it was not found as a meaningful reaction to difficulty or a common type of difficulty. However, this simple explanation is challenged by the Orlinsky and Rønnestad (2005) empirical finding that therapists often "attempt to contain troublesome feelings" (p. 230).

There are other possible factors in the novelty of this finding. Most of the previous research focused on developing taxonomies of difficulties. When therapists were asked about the *types* of difficulties, the therapists might have focused on client elements such as difficult or suicidal clients. Since the urge to hide one's feelings is independent of a particular type of difficult client and more related to the therapist's inner experience, the present study's design may have captured a previously unknown element of difficulty.

Discussion of Theme Five: Feeling an Urge to Hide Feelings

Due to the present study's phenomenological design, a previously hidden element of therapist difficulties may have been discovered: therapists feeling the urge to hide their feelings during difficulty. In this section, a discussion of this urge will be presented followed by recommendations for training and supervision. First, a return to the interview transcripts will ground the discussion in participant data.

Hiding to manage shame. Some therapists may feel an urge to hide their feelings in an attempt to manage their shame. For example, since the participant, Frank, was ashamed of his feelings of fear and inadequacy during a difficult clinical moment in a group therapy session, he felt an urge to hide his feelings from the group members in an attempt to convince himself that he was not feeling those painful feelings and to preserve his self-esteem and the respect of the clients. Put generally, this is a non-disclosure of feelings by the therapist in reaction to internal shame and not necessarily an attempt to improve treatment outcomes. It is solely a reaction to protect the self of the therapist from a painful and shameful perceived reality.

Hiding to maintain relationship. The other participants who reported feeling an urge to hide their feelings did so in an attempt to maintain the therapeutic alliance with the client. They thought if they revealed their feelings of disapproval, anger, or fear, the therapeutic relationship would suffer, and subsequently, the care of the client would be compromised. Generally speaking, this could be considered a non-disclosure of feelings in an attempt to maintain empathy, positive regard, and the therapeutic alliance. This is a conscious decision to hide one's feelings for the betterment or preservation of client outcomes.

Hiding to maintaining homeostasis. According to systems theory, the therapist's urge to hide their feelings could also be explained by the concept of homeostasis or the tendency of imbalanced systems to seek a return to balance through the employment of negative feedback mechanisms which act to minimize change (Watzlawick, Bavelas, & Jackson, 1967). The concept of homeostasis is most often applied to family systems, particularly when families resist change and movement toward goals of therapy.

However, this concept could also be applied to the system of the therapist and the client who, over time, develop a set of routines and rules that govern how the system reacts to perturbations. When the system is introduced to new and novel input–e.g., a client yelling angrily at the therapist–the system attempts to return to balance by employing a negative feedback mechanism–e.g., the therapist behaving as if he or she is calm rather than the therapist expressing fear, confusion, inadequacy, and anger which would likely result in a positive feedback loop and would threaten the integrity and perceived safety of the current system structure. In other words, the unspoken rules of the system might dictate the therapist remain calm to return the system to the security of the original homeostasis.

The dilemma of self-disclosing feelings. The decision to either override or entertain the urge to hide one's feelings during a difficult clinical moment can be explored within the constructs of therapist self-disclosure and immediacy. Since the dawn of psychotherapy, therapists have grappled with the question of whether, when, and how to self-disclose (Wolitzky, 2011). In the literature, self-disclosure is commonly defined as anything that reveals personal information of the therapist, including a therapist's verbal or non-verbal indication of an emotion (Hill & Knox, 2002). Immediacy is defined as feedback provided by the therapist in response to what is currently happening in the session (Egan, 2001; Hackney & Cormier, 2013). When a therapist has a feeling in reaction to a difficult clinical moment, the therapist might use the technique of immediacy by self-disclosing his or her feelings in an attempt to help the client understand how the client affects others.

Prevalence of self-disclosure. According to research cited in Henretty and Levitt (2010), self-disclosure is a common therapist behavior with over 90% of therapists reporting they disclose personal information to their clients. Furthermore, according to meta-research conducted by Hill and Knox (2002), an average of 3.5% of all therapist interventions in individual therapy are self-disclosures by the therapist. Even though self-disclosure is a common practice, it has been a controversial topic within psychotherapy literature, particularly between the various schools of thought. In an attempt to alleviate the confusion of this controversy, some authors have developed guidelines for self-disclosure.

Guidelines for self-disclosure. According to the ethical codes of the various psychotherapeutic professions, therapists have an obligation to strive to do good and to avoid doing harm to their clients. Specifically, within the American Psychological Association (APA) Ethical Principles of Psychologists and Code of Conduct (2002), Principle A: Beneficence and Nonmaleficence articulates the obligation that counseling psychologists competently establish a therapeutic alliance with the client while at the same time avoiding potentially harmful boundary violations (e.g., harmful self-disclosure) and multiple relationships (e.g., fostering a friendship-like relationship rather than a therapeutic relationship with appropriate boundaries).

Along these lines, according to an extensive review of previous empirical research on self-disclosure outcomes, Hill and Knox (2002) developed the following guidelines for self-disclosure: 1) therapists should generally disclose infrequently; 2) the most appropriate topic of disclosure involves professional background and the less appropriate involve sexual practices and beliefs; 3) therapists should generally self-disclose to

normalize, model, strengthen the alliance, or offer alternative ways to think or act; 4) therapists should avoid using disclosures that harm the therapy or the client; 5) therapist self-disclosure might be particularly useful when it is in response to similar client self-disclosure; 6) therapists should observe carefully how clients respond to their disclosures; and 7) it is important to tailor self-disclosure to the particular needs of the clients.

Based on a different set of empirical studies on the effects of self-disclosure, Chang, Scott, and Decker (2013) provide the following guidelines to consider prior to using self-disclosure: 1) the goal of any disclosure should be to enhance or preserve the relationship; 2) the clinician's personal needs should not take precedence over the client's needs; and 3) the disclosure must be for the benefit of the client. Also, regarding immediacy, Chang et al. (2013) recommend only using this technique when the self-disclosure of feelings is relevant to the immediate tasks or goals of the therapy. These guidelines will inform the following discussions on the case for hiding therapist feelings and the case for not hiding feelings.

The case for hiding. In this section, the case will be made for entertaining the therapist urge to hide their feelings during difficult clinical moments. The guidelines put forth by Hill and Knox (2002) and Chang et al. (2013), along with additional relevant research and ethical codes, can be used to evaluate this ethical and clinical dilemma. Specifically, Hill and Knox suggest therapists should generally disclose infrequently, and the most appropriate topics of disclosure involve professional background. Also, Chang et al. recommend the clinician's personal needs should not take precedence over the client's needs. Also, an interpretation of the APA ethical code obligates the therapist to only self-disclose if the disclosure will help further the goals of therapy while avoiding a

harmful boundary violation and a harmful dual relationship. These considerations bolster the case for therapists to not reveal their immediate emotional reaction during difficult clinical moments. In other words, these guidelines and ethical codes suggest the therapist should entertain their urge to hide their feelings during a difficult moment. The following is a discussion of research in further support of hiding one's feelings.

Hiding to maintain the relationship. The aforementioned guidelines and codes in support of hiding one's feelings mirror the participants' report that they felt an urge to hide their emotions for the sake of the therapeutic relationship which is dependent upon positive regard, empathy, and a therapeutic alliance. Along these lines, according to their exhaustive review of the empirical research on positive regard (defined as the therapist having a "warm acceptance of each aspect of the client's experience" (Rogers, 1957, p. 101)), Farber and Lane (2002) found a positive association between therapist positive regard for clients and treatment outcomes. Additionally, Bohart, Elliott, Greenberg, and Watson (2002) reviewed the empirical research on empathy and found a positive association between therapist empathy and client outcomes, even if the empathy was merely communicated and not necessarily felt by the therapist. They also found that empathy accounts for 7-10% of outcome variance which is more variance than the specific intervention used which has been found to be between 1% and 8%. Furthermore, Horvath and Bedi (2002) conducted a thorough analysis of the empirical research on the therapeutic alliance (defined as the positive affective bonds and goal consensus between therapist and client) and found the quality of the alliance is an important element in successful, effective therapy.

Research suggests that therapists should not reveal their immediate feelings unless the therapist can reasonably conclude the feelings are "resolved." For example, research by Yeh and Hayes (2011) showed that when therapists disclose unresolved issues, clients rated the therapists as less attractive, less trustworthy, and worse at instilling hope than when therapists disclosed resolved issues. Along these lines, after an extensive review of the literature on countertransference, Gelso and Hayes (2002) underscore the importance of therapists resolving their personal issues by engaging in supervision, consultation, and personal therapy rather than exposing clients to therapists' personal issues. Another meta-analysis conducted by Hayes, Gelso, and Hummel in 2011 revealed that managing countertransference successfully is related to better therapy outcomes. During an acute difficult clinical moment, the ability to quickly and accurately evaluate whether one's feelings are resolved or not is likely compromised. For example, when the participant, Julie, felt intense anxiety in response to an in-session crisis, she did not have time to evaluate whether or not her feelings were related to a "resolved issue," and therefore, in accordance with the research findings, Julie's concealment of her feelings might have helped the client trust Julie and have more hope during the difficult moment.

Hiding to model emotional regulation. Hiding one's feelings from a client could also be considered a way of modeling healthy emotional regulation. According to Thompson (1991), emotional regulation is defined as "the extrinsic and intrinsic processes responsible for monitoring, evaluating, and modifying emotional reactions, especially their intensive and temporal features" (p. 271). When an emotion is initiated, the emotion organizes and coordinates a multi-system response to particularly significant events, and emotional regulatory processes are necessary to provide behavioral flexibility

and also to enable individuals to respond quickly and efficiently (Thompson, 1991). The brain evolved processes of emotional regulation to appraise the event and to determine what the individual should do (D. Siegel, 2012). This ability to regulate one's emotions and to act harmoniously within a society (e.g., learning to repress violent urges) is critical for an individual's development and is seen as a sign of emotional maturity and competence. Therefore, when an emotion is evoked (e.g., fear or anger) during a difficult clinical moment, regulating that emotion through suppression or concealment is a sign of prosocial emotional regulation which can benefit the client through modeling or preserving the therapeutic relationship.

The case for not hiding. Even though there are several convincing reasons for entertaining the urge to hide one's feelings during a difficult clinical moment, there are also a number of compelling arguments in favor of self-disclosure. Although some of the guidelines outlined above by Hill and Knox (2002) suggest entertaining the urge to hide one's feelings, other guidelines support self-disclosing if the disclosure: 1) normalizes the client's experience, 2) models healthy emotional expression, 3) strengthens the therapeutic alliance, or 4) offers alternative an way to think or act. Also, some of the Chang et al. (2013) guidelines promote the use of therapist self-disclosure of feelings if the disclosure will enhance or preserve the relationship. Furthermore, an interpretation of the APA ethical code allows for the therapist to self-disclose their feelings during a difficult moment if the disclosure will help further the goals of therapy while minimizing the risk of harm.

Empirical research supports these particular guidelines. For example, according to a meta-analysis conducted by Henretty and Levitt (2010) on the effects of self-

disclosure found that self-disclosing therapists elicited more positive responses and perceptions from clients than therapists who did not disclose. They also found that *self-involving statements* (i.e., the therapist's immediate feelings about the client) elicited more positive responses from clients in ratings of their perceptions of the therapist than *self-disclosing statements* (i.e., a therapist's personal experience outside the therapeutic relationship). In support of this, Chang et al. (2013) assert that self-disclosure of immediate therapist reactions has a greater impact than reporting on experiences from the past.

Research on negative effects of hiding. In addition to research showing positive effects of therapist self-disclosure, there are also empirical findings within cognitive psychology showing negative effects on the individual and the relationship when emotion is suppressed. For example, Butler et al. (2003) found the following effects when an individual suppresses their emotion while discussing an upsetting topic with another person: 1) disrupts communication between the individual and the other person, 2) magnifies blood pressure responses in the other person, 3) has a negative impact on the individual's emotional experience, 4) increases blood pressure in both the individual and the other person, 5) reduces rapport, and 6) inhibits relationship formation. In other words, when a therapist suppresses or conceals their emotional reaction during a difficult clinical moment, the therapist risks disrupting the relationship and increasing stress for both therapist and client.

Feminist critique of hiding. From a feminist viewpoint, we might conceptualize the therapist's urge to hide his or her feelings as a result of historical oppression of women and the devaluing of emotional experiences associated with women. According

to Johnson (2014), in the United States, we live in a patriarchal society that is male-dominated, male-identified, and male-centered. Men dominate positions of authority within politics, the law, religion, education, the military, the police, the economy, the household, medicine, business, etc.

Johnson (2014) asserts that patriarchal, male-identified societies consider masculine traits to be good, desirable, preferable, and normal–traits such as control, strength, toughness, logic, decisiveness, autonomy, rationality, and coolness under pressure. In contrast, feminine qualities such as vulnerability and emotional expressiveness are devalued. Since the field of psychotherapy has existed since its inception within a patriarchal culture, psychotherapists naturally possess attitudes that value masculine traits and devalue feminine traits. During a difficult clinical moment, as a therapist experiences fear, inadequacy, and confusion, the patriarchal regard for strength, toughness, decisiveness, and coolness under pressure might motivate the therapist to hide his or her feelings for fear of appearing vulnerable and emotionally expressive which are female-associated traits.

In accordance with this viewpoint, Mahalik, VanOrmer, and Simi (as cited in Hill & Knox, 2002) point out that feminists support therapist self-disclosure in that it equalizes the power in the therapy relationship and facilitates the departure from the typical patriarchal style of therapeutic relationships. Since therapist disclosure of feelings promotes the feminist notion that coolness under pressure and non-emotionality should not necessarily be valued, feminists also support self-disclosure to help clients view their own feelings with less shame. In support of this position, two large meta-studies conducted by Hill and Knox (2002) and Henretty and Levitt (2010) showed that therapist

self-disclosure, in general, has positive effects on clients including improving the therapeutic alliance, increasing client self-disclosure, and reducing client drop out.

Hiding harms the therapy. According to Kottler (2003), when self-disclosure is used in a timely and restrained manner, it can build a more authentic, congruent, transparent, genuine, and open relationship. More specifically, according to the tenets of person-centered therapy (Rogers, 1961), when a therapist entertains the urge to hide their feelings, there is incongruence between what is being experienced and what the therapist believes to be an ideal reaction to the difficulty. Incongruences between one's real experience and one's "ideal self" result in psychopathology and relationship strain. Through childhood socialization, the therapist develops an ideal vision of the self, and if a difficult clinical moment provokes a feeling that resides outside that ideal vision of the self, the therapist defends against that feeling by hiding it from the client and possibly from themselves. This is called incongruence. The therapist's ideal self is being threatened and the therapist allows him or herself to be only part of who they actually are. According to the perspective of the person-centered therapist, when a therapist is genuine, congruent, and self-discloses immediate feelings, this encourages authentic disclosure from the client as well. Conversely, when a therapist conceals their feelings, the person-centered therapist views this as antithetical to the core therapeutic principles of fidelity and beneficence and is therefore harmful to the therapy.

Hiding harms the therapist. Many prominent authors and theorists in the field of psychotherapy consider the hiding of one's feelings to be harmful to the individual. As far back as 1895, Breuer and Freud (1957) argued that emotional inhibition results in psychological illness. After searching for a cause of emotional inhibition, Freud (1929)

argued that individuals long for the freedom to realize their instinctual urges but society demands conformity and instinctual repression, and this conflict produces internal strife and psychopathology. This notion has remained as a central tenet of psychodynamic psychotherapy. As a contemporary example, in *The Therapeutic Process: A Clinical Introduction to Psychodynamic Psychotherapy*, Thompson and Cotlove (2005, p. 13) provide the following quote exemplifying this contemporary psychodynamic view:

> The ability to be comfortable with a potentially conflicted emotion… correlates with the ability to enjoy life, have greater emotional energy, and to experience intensely other (positive) emotions. Holding back feelings requires effort. That is, repression requires energy.

In addition to psychodynamic theory, within the field of cognitive psychology, the hiding of emotions has been shown to have several potential ill-effects on the therapist. For example, a study by Gross and Levenson (1997) found that emotional suppression 1) interfered with successful adjustment, 2) impaired the efficiency of cognitive processing, 3) blocked adaptive action, and 4) limited the ability of others to accurately track (and thus respond appropriately to) the individual's needs and plans. As another example, Gross (1998) found empirical evidence that emotional suppression increases the sympathetic arousal associated with the concealed emotion. In other words, as a therapist attempts to hide a feeling, the feeling becomes more intense and potentially more distressful for the therapist. Furthermore, after reviewing previous research on this topic, Campbell-Sills, Barlow, Brown, and Hofmann (2006) concluded that emotional suppression is ineffective for reducing negative emotions in the short-term and may be related to ongoing difficulties with emotion and interpersonal functioning. These and several other studies in cognitive psychology bolster the case for the therapist to not hide

their emotions during difficult clinical moments since concealing the emotion might lead to impairment, distress, and interpersonal difficulties.

Authors and theorists within Gestalt and experiential therapy regard the urge to hide one's feelings as pathogenic (Prochaska & Norcross, 2010). According to Perls (as cited in Prochaska & Norcross, 2010), two of the five layers of psychopathology are the phony layer and the phobic layer. Therapists who exist at these levels of existence by hiding their feelings are behaving as inauthentic, fearful "phonies" who are "playing games," acting as "big shots," and acting as a therapist who would never feel fear. They are attempting to live up to a concept that they and others have created as the ideal therapist. According to gestalt thinkers, this not only models pathological, self-harming behavior to the client, but it also results in neuroses and suffering for the therapist.

Conclusion. In conclusion, the dilemma regarding whether or not to entertain the urge to hide therapist feelings needs to be addressed on a case-by-case basis, and each therapist is responsible for integrating the research and reasoning discussed above. During a difficult clinical moment, when a therapist experiences a feeling of fear, confusion, anger, inadequacy, or an urge to terminate, the therapist is forced to suddenly evaluate several factors and choose between a myriad of possible behaviors. On one hand, perhaps it would be in the client's best interest for the therapist to hide their feelings in an attempt to model emotional regulation and to maintain the therapeutic relationship. On the other hand, perhaps the self-disclosure would benefit the client by normalizing emotionality, equalizing the power in the therapeutic relationship, deepening the therapeutic relationship, providing therapeutic authenticity and congruence, and avoiding the harmful psychological effects of emotional suppression such as those

posited by psychoanalytic, psychodynamic, cognitive psychology, and Gestalt thinkers. This decision needs to be made quickly amidst feelings of confusion and potentially paralyzing anxiety. The manifest complexity of the decision calls for adequate training, support, and supervision in the areas of difficult clinical moments, therapist self-awareness, and self-disclosure.

Recommendations for Training and Supervision

As mentioned in Chapter I, research has shown that even though difficult moments are associated with therapist distress and negative client outcomes, there has been little attention given to difficulties in research and training (Deutsch, 1984; Farber & Heifetz, 1982; Gelso & Hayes, 2007; Guy, 1987; Kilburg et al., 1986; Schröder & Davis, 2004; Thériault & Gazzola, 2005; Yourman & Farber, 1996). Even though difficulties negatively affect therapists and clients, recent research has found that therapists rate their training regarding difficult therapist feelings as nonexistent or poor (Pope et al. 2006).

Illustrating this point, some of the participants in the present study identified this lack of training as being a factor in determining whether a moment became difficult and whether the therapist dealt with it effectively and healthily. One of the participants in the present study, Harry (a psychologist), described a moment in which he experienced a difficult clinical moment he had not been trained to deal with.

> It was so brief and so unexpected… I was about seven years in practice, and never having confronted something like that, I wasn't prepared for it, and again, it was just the banging on the door, so I didn't see it coming. I don't think I had heard enough even in consultation groups or classes or workshops that really prepared me for, "If this happens, consider doing the following." Truly, I was making it up as I went along. I mostly just tried to I think, unsuccessfully. I tried to maintain it. It was unsuccessful… I don't have a bag of tricks here, so I got to make it up as I go along, and there wasn't enough time.

Another participant, George (also a psychologist), felt embarrassed, insecure and ashamed for not knowing how to proceed during a difficult clinical moment. He ruminated on his inability to figure out what to do during the difficult moment. He felt pressure to quickly come up with a response that met everyone's needs and wants.

> I think my ruminating might have been something around, "What am I going to do? I've got to decide something." I think I called it a pressure to hurry up, to figure this out… "Why the hell don't you know what to do here?" … I should know. I should know what I ought to do here. I think there was some shame mixed in there, something like that or shame around: "Why don't I know?" I think I felt that. I felt something in my face around that.

These two accounts reveal an alarming lack of training in our field on the topic of difficulties.

Therapists hide difficulties. If we are to improve training and supervision regarding difficult clinical moments, we must first understand why trainees tend to not talk about difficult clinical moments in supervision. According to the comprehensive study by Orlinsky and Rønnestad (2005) that involved surveying 4,923 psychotherapists from around the world, when asked to rate how often they seek consultation as a coping strategy after experiencing a difficulty, respondents indicated an average of 2.79 with 0 meaning *never* and 5 meaning *very often*. On one hand, this figure is encouraging in that it indicates many seek consultation regarding difficulties, but on the other hand, 2.79 could be considered much lower than optimal. As discussed in Chapter I, research has shown when psychotherapists experience higher levels of difficulty, they tend to not disclose their experience for fear of damage to their reputation (Thériault & Gazzola, 2005). Therefore, the 2.79 average rating found by Orlinsky and Rønnestad (2005) is

perhaps much lower when it comes to therapists seeking consultation for particularly difficult clinical moments.

Alarmingly, research by Yourman and Farber (1996) found that 91% of the supervisees in their sample of mostly doctoral trainees admitted to at least occasionally withholding information (e.g., perceived clinical errors) from their supervisors. They also found that 30-40% of supervisees withhold information at moderate to high levels of frequency, and 48% of supervisees indicated they are only sometimes honest with their supervisors when the supervisee has interacted with a client in a way the supervisee thought the supervisor would disapprove of. Perhaps even more troubling, research by Ladany et al. (1996) found that 97% of supervisees admitted to withholding important information from their supervisors. When a trainee is not honest with their supervisor, a less than optimal learning experience is established, and, in a worst case scenario, patient treatment is compromised (Yourman & Farber; 1996).

In their book, *Bad Therapy: Master Therapists Share Their Worst Failures*, Jeffrey Kottler and Jon Carlson (2003) interviewed 22 renowned therapists–such as John Norcross and Susan Johnson–about their failures and were struck by the shame the master therapists exhibited. Kottler and Carlson observed that these master therapists did not disclose fresh failures and instead disclosed older, less shameful incidents. The authors suspected the therapists did not disclose recent and raw failures for fear of harming their reputations. Kottler and Carlson surmised that even the masters in our field are not comfortable disclosing their vulnerable difficulties. Even though the masters of psychotherapy receive abundant affirmations of their ability, even they shy away from

self-disclosures that might seem shameful. This points to an overall culture of shame within the field of psychotherapy. Therefore, it can be asserted that therapist non-disclosure of difficulty is prevalent, and therefore, it is crucial to understand the contributing factors to this non-disclosure.

Trainees hide due to shame. According to an extensive review of supervisee disclosure by Farber (2006), shame is the most significant contributory factor underlying supervisee non-disclosure of difficulties. It could be hypothesized that trainees are socialized to be ashamed and secretive early in their career and this socialization becomes habitual later in their career and also contributes to an overall culture of shame within the field of psychotherapy. Because psychotherapy trainees are new to the field and they are excessively exposed to the scrutiny of others (instructors, supervisors, peer-trainees, and critical patients), they are particularly susceptible to feeling shame and feeling anxiety about others seeing their shame (Buechler, 1992). Also, when intern therapists see their first clients, they often learn it is better to hide their feelings of anxiety and inadequacy, and this shame and suppression of emotion might persist throughout one's career and might influence the way they later supervise newcomers to the field of psychotherapy thus continuing the cycle and culture of shame.

According to Millon, Millon, and Antoni (1986), psychotherapy trainees are often infantilized by the experience of graduate school. Students are implicitly required to subjugate their views to those of their faculty and supervisors. There is an ever-present fear of being seen as incompetent or worse yet, being dismissed from the field altogether. This experience can even be extended beyond graduation as the therapist seeks licensure through post-graduate supervision. For years, the therapist is considered a trainee or

supervisee which continually challenges the therapist's professional self-esteem and self-confidence. Millon et al. (1986) go on to point out that therapist self-confidence is further challenged by the field's lack of clear indices of success and the "soft" nature of the science.

Along these lines, in *The Personal Life of the Psychotherapist*, Guy (1987) points out it typically takes a long period of time for a psychotherapist to develop a sense of mastery and competency. Plus, success in therapy is difficult to obtain or notice due to lack of clear measures. Furthermore, trainees often engage in subtle competition with one another, each vying for the ambiguous accolades from their superiors, such as compliments on their work, letters of reference, job offers, client referrals, etc. In the book, *What Therapists Don't Talk About and Why* (Pope et al., 2006), Gerald Koocher mirrors this when he writes in the introduction about his observations as a supervisor. He noticed that his supervisees are sometimes less inclined to disclose their feelings for fear of negative judgment or negative professional consequences. Later in the book, the authors discuss how therapists are enculturated to believe they should be invulnerable to difficulties and how this is reflected within training practices.

According to Alonso and Ruttan (1988), in order to develop as adult learners, psychotherapy trainees must be willing and able to tolerate the inherent confusion and ignorance of being new to the complicated field of psychotherapy. Trainee self-esteem must be able to withstand the regular reminders that they have a long way to go before they will consider themselves competent in the field of psychotherapy. Alonso and Ruttan also describe the dilemma of a trainee: in order to be seen as competent, their mistakes must be exposed, "dumb" questions must be asked, and personal flaws must be

focused on. At the same time, this necessary exposure to their shortcomings results in trainees becoming sensitive to the gap between their ideal professional (the supervisor) and their own self-image as a professional. And since the supervisor has power over the trainee's professional advancement, the occasional feeling of shame may motivate the non-disclosure of therapist difficulties. However, in order to become competent, the trainee must disclose difficult moments even though this disclosure might result in supervisor disapproval or professional setbacks.

In summary, there is compelling and logical evidence of an epidemic of non-disclosure of difficulties from trainees to supervisors due to trainee shame. Therefore, if we can reduce the shame surrounding difficulties, we might be able to increase trainee disclosure, which will hopefully lead to enhanced training and ultimately improved client outcomes.

The solution: Self-disclosure by seasoned psychotherapists. If seasoned psychotherapists and supervisors are to help trainees with their difficult clinical moments, the shame of difficulties must be lessened to facilitate trainee disclosure of difficulties to their supervisors, and this shame could be alleviated by the normalization of psychotherapists' experience of difficult clinical moments (e.g., the findings of the present study).

According to research discussed above, when trainees hear stories of esteemed therapists struggling with difficult clinical moments, the trainees are likely to feel relieved they are not alone and therefore more likely to discuss their own difficulties with others. In *What Therapists Don't Talk About and Why*, Pope et al. (2006) recommend supervisors create a relationship with their supervisee that will enable trainees to explore

difficulties by creating an environment of safety and trust that encourages honesty and self-examination. Trainees must believe that what they say will not be used against them. Along these lines, in his chapter titled *Supervisee and Supervisor Disclosure*, Farber (2006) asserts that when supervisors self-disclose, this builds the supervision relationship and encourages the supervisee to disclose their own difficulties. Additionally, research has shown that therapists struggling with a difficulty are more likely to seek help if they consult with someone who normalizes by self-disclosing their own difficult clinical moments thereby challenging the cognition that difficulties are an indication of incompetence (Ladany et al., 2001). Also along these lines, to study supervisor self-disclosure, Knox, Edwards, Hess, and Hill (2011) interviewed 12 graduate-level trainees regarding their experiences of supervisor self-disclosure and found that when trainees experienced a difficult clinical situation and the supervisor self-disclosed about a related clinical experience, there were several positive effects, such as normalization, improved supervisory relationship, improved clinical work with clients, and increased honesty by the trainee. In particular, when *seasoned* psychotherapists self-disclose about difficulties, research has found this helps reduce the anxiety in less-experienced psychotherapists by helping to normalize and to lessen the unrealistic idealization of therapists as error-free professionals (Brightman, 1984; Glickauf-Hughes, 1994; Ladany, 2004; Ladany & Lehrman-Waterman, 1999; Orlinsky & Rønnestad, 2005). Even though there is a robust range of research demonstrating the utility of supervisor disclosures of past difficulties with clients, research conducted by Ladany and Lehrman-Waterman found that only half (51%) of supervisees reported that their supervisors had shared experiences related to their own struggles with clients.

However, it should be noted that not all supervisor self-disclosure was experienced as having a positive effect on the trainee. For example, supervisor self-disclosure runs the risk of impeding the trainee's need to idealize the supervisor as a defense against the trainee's anxiety. In other words, some anxious trainees may need to see supervisors as a strong, confident foundation upon which to stand. Along these lines, in the Knox et al. (2011) study, one participant described feeling shocked and uncomfortable with her supervisor's self-disclosure regarding his family difficulties and his Axis II-related personality traits. These considerations regarding supervisor self-disclosure should be kept in mind when supervisors are contemplating disclosure of a personal experience of difficulty.

Personal story. Since I am, in all likelihood, the person most affected by this project, a reflection upon this project's personal effect is warranted. One disclosure in particular is worthy of discussion and demonstrates the value and applicability of the present study's findings.

During a session a few years ago, a hostile client was berating me for being ineffective in her treatment. On that particular day, my personal life was not going well, and perhaps as a consequence, I did not have the fortitude to withstand her criticism. I tried to remain professional by calmly repeating phrases like "Well, perhaps I'm not the best therapist for you." But inside, I was panicking. She continued to harshly castigate me. This client had a knack for getting under my skin. I could feel my heart beating fast and my forehead was beading with sweat. I wanted to run away. I could not think straight. I had trouble breathing. I doubled over, put my head in my hands, and asked

her to let me catch my breath. Even though this session occurred years ago, I can remember that moment like it was yesterday.

Before my work on this project, I admit I felt ashamed of my feelings in that session. Those painful feelings drove me to criticize the client, as a way of defending myself from the pain of having to acknowledge my perceived inadequacy in that moment. Upon hearing the stories of difficulties from the seasoned psychotherapists of this study, a new meaning of that difficult clinical moment emerged for me, and I began to tell my story to trainees and consultants. When the trainees reacted with compassion and appreciation rather than judgment and disappointment, I experienced, first-hand, the power of a seasoned psychotherapist's self-disclosure of difficulties. In light of these experiences, from this point forward, I will forever view the consultation of difficult moments with increased clarity and purpose.

Conclusion of training recommendations. In summary, the decision regarding whether or not to entertain the urge to hide therapist feelings is a complex dilemma that requires the therapist to suddenly evaluate how the self-disclosure of therapist feelings will affect 1) the therapeutic relationship, 2) the therapist's modeling, 3) the client view of emotionality, 4) the power in the therapeutic relationship, 5) therapist authenticity and congruence, and 6) the therapist's emotional and psychological well-being. This decision needs to be made quickly amidst feelings of confusion and anxiety. Therefore, therapists need adequate training, support, and supervision in this area. However, there is an epidemic of non-disclosure of difficulties among therapists which interferes with the development of training and the supervision process. Therefore, we need to reduce the shame and stigma surrounding difficulties.

In the effort of helping therapists seek training and consultation on difficulties, the results of the present study and other studies on difficulties should be disseminated among the population of therapists to normalize difficulties and to create a new cultural understanding within the field of psychotherapy that difficulties are not an indication of incompetence but instead a normal part of practice and worthy of consultation and acceptance from supervisors and peers. This training would encourage supervisors and instructors to self-disclose their own difficulties and provide guidance on how to cope and how to be as helpful as possible during a difficult clinical moment. This could be specifically accomplished by including the topic of difficulties in counseling coursework, continuing education, supervision of therapists, and supervision training.

We need to disseminate this research on difficult clinical moments 1) to reduce stigma, 2) to increase training and research, 3) to increase self-compassion, 4) to reduce the shock of experiencing difficulties, 5) to reduce the harmful notion that therapists are invincible, 6) to facilitate healing from the trauma of difficulties, 7) to increase understanding of difficulties within the field, 8) to empower therapists to speak up and seek help, 9) to increase awareness, and 10) to reduce harmful therapist in-session reactions such as anger or judgment.

To achieve this task, the development of a training module is justified. The module could focus on 1) types of difficulties, 2) specific difficulties likely to be encountered at some point in one's career, 3) therapist experience during difficult clinical moments, 4) coping skills, 5) self-disclosure of feelings, 6) therapeutic strategies,

7) self-care techniques, and 8) expectations that supervision should allow for the discussion of difficulties. Such a training module could be included in graduate training programs and continuing education for therapists and supervisors.

Limitations of the Study

The small sample size–inherent in many qualitative designs–was a limitation to the study in that the results cannot be confidently generalized to the broader population of seasoned psychotherapists. Sample sizes of phenomenological research are customarily determined by redundancy, meaning that the sample size is increased until the data gathered from participants becomes redundant (Mason, 2010). As can be seen in Chapter IV, after a thorough familiarity of the transcript data was established, several statements made by the participants became redundant and themes were easily identified therefore negating the need for additional participants. Also, the sample sizes within phenomenological research are small since it is concerned with the discovery of meaning rather than making generalized numerical statements about a population (Creswell, 1998; Mason, 2010; Tesch, 1990). Furthermore, because the analysis of phenomenological research data is time consuming, a large sample is simply impractical (Mason, 2010). Lastly, including only seasoned psychotherapists and only psychotherapists practicing in Seattle in the sample were other limitations also affecting external validity.

Colleagues sometimes ask why I did not limit the population to one type of psychotherapist (e.g., psychologists). It is common for those in the psychotherapy field to feel great distance between the professional affiliations. Since I am a professional with ties to various professional organizations (i.e., marriage and family therapy, psychology, mental health counseling, chemical dependency, and social work), I find that we all

experience psychotherapy similarly. When I state this opinion, some of my colleagues express shock and disapproval of the notion that those "others" are similar to themselves. I contend we are all in relationship to our clients and therefore the phenomenon of the difficult clinical moment is more or less universal within the field, although there is no empirical support for this claim.

Since some of the described difficult clinical moments occurred several years prior to the interview, the potentially compromised accuracy of the memories was another limitation of the study. Also, asking participants to describe their experience of difficult clinical moments without specifying one type of difficult moment was another limitation to the study since it is possible the experience of difficulties varies between types of difficulty.

Common to many qualitative designs, I was the only researcher to interview the participants and analyze the data. It is possible–and probable–that another researcher would have interviewed the participants differently and interpreted the data differently. Along these lines, it is also probable that the interviews and data analysis were influenced by researcher bias. A more robust–and resource consuming–research design would have involved multiple researchers, more participants, and multiple methods to triangulate and confirm findings.

Also common to qualitative research, this study offers no reliable quantitative data and no cause-and-effect conclusions. However, as mentioned in previous chapters, this study was designed to provide new knowledge on the meaning of the lived experience of difficult clinical moments rather than determining causal relationships between variables.

Recommendations for Future Research

Since recognizing the hazards of difficult moments is crucial to therapist self-care and ultimately treatment outcomes (Guy, 1987; Norcross, 2000; Polson & McCullom, 1995; Thériault & Gazzola, 2010), it is important to continue examining difficult clinical moments. Without a robust understanding of this phenomenon, we run the risk of increasing therapist suffering and degrading patient outcomes. Additional qualitative and quantitative research could further explicate the confidence of the results of the present study.

Specific types of difficulties could also be examined. This study asked participants to describe their experience of *any* difficult clinical moment he or she wished to share. However, future research could focus on psychotherapists' experience of specific difficulties such as therapeutic impasse or treatment failure (e.g., the Thériault and Gazzola (2010) study on feelings of incompetence). This focused research could begin to compare and contrast the experience among each type of difficulty.

If resources were abundant, it would be beneficial to evaluate how different training and supervision techniques affect therapist distress and therapeutic outcomes during and after a difficult clinical moment. Perhaps there are therapist and supervisor practices that result in better client outcomes and less negative effects on the therapist such as stress and burnout. Manualized training and supervision protocols could be evaluated against therapist distress measures and client outcome measures. More specifically, training and supervision protocols that involve instructor and supervisor self-disclosure of difficulty would be a worthy independent variable of inquiry.

Future research could also study how therapist personality and how particular therapist family-of-origin experiences interact with types of difficulties. Perhaps individual personality traits increase a therapist's vulnerability to a particular type of difficult clinical moment. And perhaps these factors also play a role in how a therapist responds and copes with the difficulty. The results of such research could tailor training and supervision to the individual therapist.

Since a comparison with previous research found the present study's theme regarding the urge to hide one's feelings during a difficult clinical moment to be a mostly novel finding, additional research on the topic of this urge to hide one's feelings should be conducted to determine its prevalence, its precipitants, and its effect on various outcomes. A better understanding of the urge to hide one's feelings could result in improved awareness and training regarding difficult clinical moments.

Report Summary

The purpose of this study was to examine seasoned psychotherapists' experience of difficult clinical moments with the hope of helping guide therapists' and researchers' efforts to understand difficult clinical moments as well as improve training, supervision and support of psychotherapists. Research on difficulties is important since difficult moments occur through a therapist's career and the awareness of difficult moments is crucial to self-care and treatment outcomes. Yet, many therapists rate training on difficulties as poor or nonexistent and therefore are only vaguely aware of difficulties. And even if they are aware, they are not likely to consult for fear of stigma and potential damage to their reputation.

Previous research has mostly focused on constructs peripheral to the construct of difficult clinical moments such as countertransference and difficult patients, and of the scant literature on difficult moments, researchers have focused on developing typologies and prevalence rates of difficulties rather than investigating the lived experience of difficulties. To fill this gap in the research, a phenomenological design was used to examine the lived experience of ten seasoned psychotherapists in the Seattle area. The participants–with an average of 29 years of experience–were interviewed for approximately one hour using an unstructured interview protocol. The therapist interviews were transcribed and analyzed. The participants were consulted and each confirmed the analysis of their interview as accurately summarizing their experience of difficult clinical moments.

Thematic analysis revealed six themes of experience during a difficult clinical moment: 1) Feeling Fear, 2) Feeling Inadequate, 3) Feeling Anger, 4) Feeling Confused, 5) Feeling an Urge to Hide Feelings, and 6) Feeling an Urge to Terminate. An essential general structure of the experience of difficult moments was derived from these themes which provided an easy-to-understand narrative of the experience of difficult clinical moments.

Several conclusions can be drawn from this study. First, it is curious that even though all ten of the participants in the present study reported feeling fear during at least one of their described difficult moments, the experience of fear has been overshadowed by the feelings of confusion and inadequacy within the literature on difficulties. Second, it is also curious that aside from one minor exception, the Theme Five: Feeling an Urge to Hide Feelings is not mentioned anywhere in the previous literature on difficulties.

Third, the urge to hide one's feelings during difficulty appears to be motivated by therapist shame and an urge to maintain the therapeutic relationship. Fourth, the dilemma regarding whether or not a therapist should entertain the urge to hide his or her feelings during a difficult clinical moment is a sophisticated and intricate decision, and this sudden and crucial decision regarding self-disclosure needs to involved careful consideration of the therapeutic relationship along with modeling emotional regulation and expression, equalizing the power in the therapeutic relationship, providing therapeutic authenticity and congruence, and avoiding the harmful psychological effects of emotional suppression.

Fifth, due to a culture of shame within the field of psychotherapy, there is an epidemic of non-disclosure of difficulties among therapists which interferes with the development of training and the supervision process. Sixth, in the effort of helping therapists seek training and consultation on difficulties, the results of the present study and other studies on difficulties should be disseminated to create a new cultural understanding within the field of psychotherapy that difficulties are not an indication of incompetence but instead a normal part of practice and worthy of consultation and acceptance from supervisors and peers. Seventh, supervisors and instructors should be encouraged to self-disclose their own difficulties to normalize, to provide guidance on how to cope, and to demonstrate how to be as helpful as possible during a difficult clinical moment despite the associated feelings of anxiety and inadequacy. Eighth, since worthy research projects contribute new knowledge to the field, the present study's worth can be touted by 1) the added depth to our understanding of difficulties, 2) the mostly novel findings regarding feeling fear and the urge to hide therapist feelings during

difficulty, and 3) the contribution of a descriptive essential general structure of the experience of difficult clinical moments rather than another taxonomy of difficulties.

The dissemination of these findings on difficulties may help normalize the experience and encourage therapists and supervisors to discuss difficult clinical moments within consultation, supervision, and training which might reduce the distress of the moment, improve coping skills, provide treatment strategies, and ultimately improve client outcomes.

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Appendix A

Flyer for Recruitment

FLYER FOR RECRUITMENT

OPPORTUNITY TO PARTICIPATE IN A RESEARCH PROJECT

Researcher seeking seasoned psychotherapists to participate in a study exploring
experiences of difficult clinical moments

Who can participate?

Clinicians with a graduate degree and 15+ years' experience practicing psychotherapy–
psychologists, marriage and family therapists, mental health counselors, clinical social
workers, psychiatrists, and pastoral counselors.

Who is doing this project?

This project is being undertaken by Kirk Honda, MA, LMFT in partial fulfillment for
requirements for a Doctorate in Psychology, in the School of Applied Psychology,
Counseling, and Family Therapy at Antioch University Seattle.

Why is this study being done?

The purpose of this project is to study seasoned psychotherapists' meaning of the
experience of difficult clinical moments. This study will help guide efforts to understand
this phenomenon as well as improve training and supervision of psychotherapists.

What will be involved in my participation?

All data will be gathered via in-person, individual interviews with the primary researcher,
Kirk Honda. Arrangements will be made for interviews to be conducted at the primary
researcher's office in Seattle or at a mutually agreed upon location, i.e. your office, a
quiet space in a public library, or an office located at Antioch University Seattle. You
will be asked to complete a brief demographic information form which will include
questions about such topics as the participant's gender, ethnicity, theoretical orientation,
and years of experience.

How long will my involvement take?

The interview will take approximately 1-2 hours depending on the length of your
answers. You will also review transcripts of the interview and have an opportunity to
discuss these with the researcher to ensure that your experiences are accurately portrayed
in the transcript and analysis. Once the primary researcher has reviewed the transcripts
with you, along with any changes you wish to make as determined through requests to the
researcher, you will receive a final notification to acknowledge completion of your
involvement in the study.

Do I have to participate?

No. Participation will be completely voluntary, and you are under no pressure to respond to the request to be involved in the study.

How will my anonymity and confidentiality be ensured?

In this study, any information provided through your interview and the Demographic Questionnaire will be kept in confidence. Your identity will not be revealed to anyone other than the principle researcher, Kirk Honda, throughout the study, and all identifying information will be changed to protect your privacy. Audio of your interview will be labeled with a numerical code, and any names (yours or others) or other identifying information will be deleted from the transcript.

How will this information be stored?

Transcribed records of interviews will be kept in a locked cabinet to which only the researcher has access. The audio file will be stored on the researcher's password-protected desktop computer.

If you are interested in participating, please contact Kirk Honda at khonda@antioch.edu or 206-841-8151.

Appendix B

Consent to Participate in Research

CONSENT TO PARTICIPATE IN RESEARCH

Study on Seasoned Therapists' Experience of Difficult Clinical Moments

You are invited to participate in a research study that will help identify common themes experienced by psychotherapists of difficult clinical moments conducted by Kirk Honda, a psychology doctoral student at Antioch University Seattle.

Voluntary Participation

The following information is provided so that you can decide whether you wish to participate in this study. You should be aware that even if you agree to participate, you are free to withdraw at any time, and that if you withdraw from the study, you will not be subjected to reprimand or any other negative consequences.

Researcher Affiliation

Kirk Honda is the primary researcher. He is conducting this research in partial fulfillment for requirements for a Doctorate in Psychology, in the School of Applied Psychology, Counseling, and Family Therapy at Antioch University Seattle. Dr. Mark Russell is the faculty sponsor for this project. This study is funded by Antioch University Seattle.

Purpose of the Study

The purpose of this project is to study seasoned psychotherapists' meaning of the experience of difficult clinical moments. This study will help guide efforts to understand this phenomenon as well as improve training and supervision of psychotherapists.

Procedure for Participants

All data will be gathered via in-person, individual interview with the primary researcher, Kirk Honda. The interview will audio and video recorded using a microphone and video camera on a tripod. Interviews may take place at Kirk Honda's office in Belltown, Seattle or at a mutually agreed upon location, i.e. your office, a quiet space in a public library, or an office located at Antioch University Seattle. You will be asked to complete a brief demographic information form which will include questions about such topics as the participant's gender, ethnicity, theoretical orientation, and years of experience.

The interview will be semi-structured therefore allowing for elaboration of answers and addition of information that you feel may be useful. The interview is anticipated to last between one and two hours. This interview may be emotionally challenging. If at any time you wish to end and to reschedule the interview or to terminate your involvement with the study, there will be no negative consequences.

After Kirk Honda analyzes the interview, you will also be asked to review a transcript of your interview and have an opportunity to provide feedback to the researcher to ensure that your experiences are accurately portrayed and understood. Once the primary researcher has reviewed the transcripts with you, along with any changes you wish to make as determined through requests to the researcher, you will receive a final notification to acknowledge completion of your involvement in the study.

Records

As noted above, during the interview, you will be audio and video recorded. Each completed audio and video file will be coded with a number to protect your confidentiality. Transcribed records of interviews will be kept in a locked cabinet to which only the researcher has access. The audio and video files will be stored on the researcher's password-protected computer. Access is available to the primary researcher only. You will retain the right to review your audio and video, and you may request that the file be destroyed at any time.

Anonymity and Confidentiality

Any information that is obtained in connection with this study and that can be identified with you will remain confidential and will be disclosed only with your permission or as required by law.

Your identity will not be revealed to anyone other than the principle researcher, Kirk Honda, throughout the study.

We will not use your name in any of the information we get from this study or in any of the research reports. When the study is finished, we will destroy the list that shows which code numbers goes with your name.

Information that can identify you individually will not be released to anyone outside the study. Mr. Honda will, however, use the information collected in his dissertation and other publications. Also, we may use any information that we get from this study in any way we think is best for publication or education. However, any information we use for publication will not identify you individually.

If you provide information that might identify you (e.g., where you work), the primary researcher will alter or omit that information to protect your identity. Also, you be given an opportunity to review the transcript of the interview and omit information that might identify you.

Potential Risks

Because of the sensitive nature of the topics under discussion, you may experience feelings of discomfort. If this becomes a problem, you may discontinue your participation. We expect that any risks, discomforts or inconveniences will be minor and we believe that they are not likely to happen. Here are three potential risks:

1. This process may involve examining and talking about some provocative feelings and personal experiences, which involves the risk of refreshing those painful reactions.
2. This project will involve a small number of participants, so in the effort to protect participants' identities, assigning numbers or compiling composites will be ineffective in masking identities. Therefore, you will be given the opportunity to omit any of their identifying details in the final report. If

needed, the written study will interweave fictitious descriptive information that is similar to the truth.

3. Since you and the eventual readers are potentially within the same field, you should be aware that this particular study might be read by some of your colleagues. However, if you provide information that might identify you (e.g., where you work), the primary researcher will alter or omit that information to protect your identity.

Benefits

There is no monetary compensation for being in this project. However, your involvement may ultimately assist in clarifying the experiences of psychotherapists, which will hopefully, in turn, encourage therapists to seek help with difficult moments and assist training and supervision.

Contact Information

If you have any further questions or concerns about the study or would like to learn about the results of the research, you can write to: Kirk Honda, School of Applied Psychology, Counseling, and Family Therapy, Antioch University Seattle, 2326 Sixth Avenue, Seattle, WA 98121, or by calling 206-841-8151. You may also contact Dr. Mark Russell, Dissertation Chair, at 206-441-5352.

Copy of Consent Form

You are asked to sign two (2) copies of this form. I will keep one on file but will keep it separately from audio and records to protect your privacy. One of the signed copies will be for you to keep in case you have any questions about the study.

With your assistance, I believe professionals may be able to get a better understanding of how psychotherapists experience difficult clinical moments. This exploration will hopefully yield themes that will ultimately guide efforts to reduce therapist suffering.

Identification of Researchers

Kirk Honda, M.A.	Mark Russell, Ph.D.
Principal Researcher	Core Faculty
School of Psychology	School of Psychology
Antioch University Seattle	Antioch University Seattle
2326 Sixth Avenue	2326 Sixth Avenue
Seattle, WA 98121	Seattle, WA 98121
206-841-8151	206-268-4837
khonda@antioch.edu	mrussell@antioch.edu

Rights of Research Subjects

The Antioch University Seattle Review Board has reviewed and approved my request to conduct this project. It was approved on 8/19/13 and expires on 12/31/13. If you have any concerns about our rights in the study, please contact Mark Russell at Antioch University Seattle at 206-268-4837 or his email at mrussell@antioch.edu.

I have read the above statement and have been fully advised of the procedures to be used in this project. I have been given sufficient opportunity to ask any questions I had concerning the procedures and possible risks involved, and I assume them voluntarily. I likewise understand that I can withdraw from the study at any time.

_____

Participant Name   Participant Signature   Date

_____

Researcher Name   Researcher Signature   Date

Please do not fill out

Participant ID#: _____

Date: _____

Appendix C

Demographic Questionnaire

DEMOGRAPHIC QUESTIONNAIRE

1. How old are you? _____

2. How do identify your gender? _____

3. How do you describe you ethnicity?
   _____

4. Please provide any other identities of diversity you wish to
   share:_____

5. What graduate degree(s) have you obtained?
   _____

6. What, if any, licenses do you hold?
   _____

7. What, if any, professional organizations are you a member of?
   _____

8. How many years of experience do you have as a psychotherapist?
   _____

9. How would you describe your theoretical orientation?
   _____

Please do not fill out

Participant ID#: _____

Date: _____

Appendix D

Permissions

Permission Letter Table 1

APA hereby grants permission at no charge for the following material to be reused according to your request, subject to a required credit line. Author permission is not required in this instance.

Permission Letter Table 2

APA hereby grants permission at no charge for the following material to be reused according to your request, subject to a required credit line. Author permission is not required in this instance.