

DOCTORAL THESIS

Therapeutic Interpretations of Psychodynamic Ideas: A Social Constructionist Grounded Theory

Mabbott, Lucy

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THERAPEUTIC INTERPRETATIONS
OF PSYCHODYNAMIC IDEAS:
A SOCIAL CONSTRUCTIONIST GROUNDED
THEORY

BY
L. A. MABBOTT BSc

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE
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ABSTRACT

The focus of this study is on how counselling psychologists and other therapists interpret psychodynamic ideas. There is a dearth of qualitative work addressing this issue, particularly from the practitioner perspective. This study adopted a social constructionist version of Grounded Theory. Twelve volunteer therapist participants were interviewed (six counselling psychologists and six therapists accredited by the British Association of Counsellors and Psychotherapists (BACP) and the United Kingdom Council for Psychotherapy (UKCP)). Therapists had a wide range of experience but all had at least one year of training in psychodynamic theory.

The analysis produced a grounded theory that suggests a tension between realist and social constructionist epistemological stances to psychodynamic theories. An unquestioning use of psychodynamic ideas persisted whereby these theories remained uncontested and were spoken about as if they were indicative of reality. This alternated with a reflective use of psychodynamic ideas where a theory was seen as one explanation among many. A tension was apparent as therapists spoke from these epistemologically opposed stances. This tension was expressed through the demonstration of being drawn to use psychodynamic ideas unquestioningly as they seem to abate anxiety and provide a sense of professionalism and expertise. The benefits of thinking objectively about psychodynamic ideas draw therapists into speaking of them in this way, even when this approach was not in line with their epistemological stance at other points in time. The tension seems to result from societal demands and contextual pressures as well as the inter-relational discourse with the researcher. It is suggested that practitioners in the field of counselling psychology as well as by practitioners accredited with the UKCP and BACP experience this phenomenon. Length of experience in practice did not play a significant factor in how therapists conceptualise psychodynamic ideas. A discussion of the implication of these findings and the potential for future research is also explored.

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CHAPTER 1: INTRODUCTION

This study addresses how counselling psychologists and other therapists interpret psychodynamic ideas. It opens up the issue of how therapists think about psychodynamic theories of child development and how these theories are viewed as having an impact on practice. This chapter defines the term ‘psychodynamic theories of child development’ (hereon referred to as PTCD) and begins to outline how theory, as a whole, is interpreted within counselling psychology and related therapeutic professions. A rationale is given for the study which highlights its importance to the field of counselling psychology. This chapter is then concluded with a summary of the chapters to follow.

Beginning with Freud (1909) and throughout the last century, psychodynamic theories of child development (PTCD) have had a large influence in psychological therapy. In this study PTCD are referred to as the theories of Sigmund Freud, Anna Freud, Klein, Fairbairn, Winnicott, Mahler, Jacobson, Kernberg, Kohut, and more recently Bion, Bowlby and Fonagy. The theories by these authors have a predictive value for psychopathology in adulthood (Silverman, 1986) and are based on the premise that past influences present, particularly in terms of the development of object relationships early in life (St. Clair, 1986; Gomez, 1997), and identification of stages ‘typical’ to human development.

As a branch of psychology’s study of mind and behaviour, counselling psychology is a discipline which some pursue from a symbolic interactionist perspective (Strawbridge & Woolfe, 2003). This perspective emphasises the importance of social context and self-reflection. Counselling psychology is particularly focused on the prioritisation of the practitioner’s reflexive activity and the abandonment of a fixed notion of ‘truth’ (Strawbridge & Woolfe, 2003). How therapists interpret PTCD is of growing importance in the field of counselling psychology; this is highlighted by the counselling vocation becoming increasingly split between an emphasis on evidence-based, theoretically-driven practice (Fonagy, 2003) or alternatively, on the relationship (Spinelli, 1995; Kahn, 1991) rather than orientation or theoretical viewpoint (Silberschatz et al., 1986; Manthei, 2007). Furthermore, counselling psychology gives more attention to postmodernist and social constructionist perspectives which endorse a plural approach to theoretical ideas.

Differing perspectives on theory and practice have resulted in debate between schools of therapy, counselling, psychotherapy and counselling psychology, regarding the interpretation and use of theory (Williams & Irving, 1995). As a result, it is important for practitioners to develop their own epistemological stance about what informs their therapeutic practice. However, at present the literature offers conflicting epistemological poles. For instance, Wheeler & Elliot (2008) state

therapists should find information from the literature to inform their practice, whilst others challenge this and argue for a state of ‘unknowing’ (Szasz, 1965; Spinelli, 1995) or ‘non-intentionality’ (Levinas, 1989b). While psychology has been based in a positivist epistemology for most of its existence (Hansen, 2004), its theories and practices have come under increasing pressure from postmodern critique. In addition to this, whilst there are a number of meta-analytic studies which argue for the effectiveness of psychodynamic therapy as a treatment for psychological difficulty (Leichsenring, 2005), there is little research that explores how therapists interpret these ideas in relation to their practice. This research aims to address this area of inquiry.

In order to address this area of inquiry, this study proposes to interview counselling psychologists and other therapists to find out how they negotiate the epistemologically incongruent literature. As such, participants were asked the question: ‘What effect, if any, do psychodynamic theories of child development have on your therapeutic work with clients?’ in the context of semi-structured interviews. As a result of this, interviews focused on how practitioners interpret these theories, and partially, but less so, on a practical or concrete explanation of how they apply PTCD in practice. Despite this, these areas are viewed as inextricably linked, for the way one thinks about PTCD is likely to affect the way that they are then used. What the study focuses on, however, are the inherent philosophical and epistemological underpinnings of PTCD and how these are negotiated by practitioners. This study is based within the critical paradigm of social constructionism (Gergen, 1992; Burr, 2003) and symbolic interactionism (Mead, 1932, 1934; Blumer, 1969), and as such, the study proposes a theoretical model as one way in which the collected data can be understood.

A grounded theory was constructed from semi-structured interviews with participants, and this grounded theory describes and explains how these therapists interpret PTCD. Twelve therapists were interviewed, six of whom were counselling psychologists chartered with the British Psychological Society (BPS), three UKCP (United Kingdom Council for Psychotherapy) accredited therapists, two BACP (British Association of Counsellors and Psychotherapists) accredited therapists and one both UKCP and BACP accredited, all of whom were trained for at least one year in psychodynamic therapy. Despite these different accrediting bodies the results remained consistent throughout the analysis. The data collection was conducted between September 2009 and January 2011, in London, England, although the researcher travelled to other cities in the UK to obtain data.

Throughout this work counselling psychology practice is referred to as ‘therapy’ in order to account for the views of the therapists accredited with the UKCP and BACP interviewed in the study. This is to reflect that this research involved the interviews of both counselling psychologists and those who regarded themselves as ‘psychotherapists’, ‘therapists’ or ‘counsellors’, providing they were chartered

or accredited by the British Psychological Society (BPS), BACP and UKCP. A brief overview of each chapter of the study is given below.

Chapter 2: Literature Review

This chapter provides a review of the literature relevant to the research area. It starts by addressing PTCD from a contextual perspective and the general application of theory to practice. It then reviews the implications of PTCD for clinical practice. It aims to offer a critical review of PTCD within social and cultural terms, whilst acknowledging positivist research evidence for PTCD and therapeutic practice. It then locates PTCD in relevant epistemologies in order to highlight the complexities and power games in applying these theories to practice.

Chapter 3: Methodology and Method

This chapter provides a rationale for the choice of research methodology and method. The researcher takes a social constructionist (Gergen, 1992; Burr, 2003) and symbolic interactionist (Mead, 1934; Blumer, 1969) framework to the data and analysis, and contrasts these with positivist inquiry. As qualitative methods tend to focus primarily on processes (Morrow, 2007), these were seen to most appropriately fit this study which looks at the processes of negotiating different epistemologies when speaking about PTCD. A social constructionist grounded theory method (Charmaz, 2006) is used to collect and analyse data, and the choice of this method is discussed and contrasted with other research methods such as discourse analysis and interpretative phenomenological analysis. A description of the method of data collection and analysis makes transparent the process of abstracting data from interviews, formulating this into categories, and the building of a theory.

Chapter 4: Results

The findings are presented in this chapter, supported by participant quotes from the interview transcripts. The resulting focused codes, categories, and core category were organised to construct a theoretical model about how therapists think about PTCD, and the differing epistemological positions they speak about when considering their use of these theories. The findings take into account the participants' length of experience in practice, accrediting body, type of training and demographics. This chapter presents a theory that was generated from and is grounded in the data.

Chapter 5: Discussion

This chapter discusses the findings of the grounded theory in relation to relevant extant literatures. The findings are presented again under the category headings, and linked comparatively with the existing literature. Limitations of the study and the grounded theory method are identified and reflected upon, with suggestions for future research.

CHAPTER 2: LITERATURE REVIEW

This chapter provides a critical review of the constructions of child development in historical and contemporary literatures, and addresses how PTCDD are socially and culturally constructed. The aim of this review is to provide an outline and critical appraisal of the literature which addresses how theory is interpreted and integrated into practice, and to demonstrate a gap in the existing literature which this research has started to address.

The chapter begins with an overview of postmodernism, as social constructionism arose in the discipline of psychology from this epistemology. This also provides a context and perspective from which the data of the study is analysed and understood. Psychoanalytic and psychodynamic theories are then introduced and reviewed from a social constructionist perspective in order to deconstruct notions of truth, with particular regard to child development. The chapter then touches on literature which identifies how theory is thought to inform practice, and examines the debate between realist and social constructionist thinkers in the context of psychological theory and therapeutic work. In line with a social constructionist grounded theory method (Charmaz, 2006), this critical review of the literature draws from relevant research and literature which helps to explain and expand upon the findings of the current study.

2.1 Postmodernism

Postmodernism is addressed in this section to provide a contextual background and rationale for the deconstruction of PTCDD and the investigation into how therapists interpret these theories. It informs the analysis of the data and provides an account of the historical underpinnings of social constructionism, a theory on which this study is based.

Postmodernism is the term used to describe an epistemological stance developed in response to modernism and its supposed failures. Modernism attempted to find general laws of knowledge about the world, and through doing so, reduce 'poverty, sickness and class and political servitude,' (Polkinghorne, 1992, p.147). Modernism resulted much from the thinking of Descartes (Loewenthal & Snell, 2003) and his theory that human minds and brains were separate entities. Descartes proposed that outer reality can be understood from an objective standpoint because of this split, and that humans are truly independent from what exists around them. This led to the 'Enlightenment': 'a shared view that, through the application of reason, man... would find himself in productive harmony with tamed nature,' (Loewenthal & Snell, 2003, p. 3).

In terms of the subject of psychology, modernism, which followed this period of Enlightenment, was about making attempts to reveal rules and truth statements about mind and behaviour, through using empirical methods (Gergen, 1992) in an attempt to filter out the 'truth' from subjectivity. This is still commonplace in much of psychology today. Yet despite realist empiricism being a popular view, postmodernist thinkers then began to critically reflect on the idea that knowledge could be gained that accurately represented reality, with an attempt to reveal how modernist thinking was actually limiting and disabling (Lowenthal & Snell, 2003), rather than liberating. The top-down approach of modernism was thought to restrict new material from emerging that did not fit within the context of what was already 'known'. If it could not be scientifically proven with the available methods, new information about the world would not be assimilated with existing theories, beliefs and knowledge.

While PCTD tend to adopt a realist epistemology, a premise of postmodernist theory is that knowledge is socially constructed and is in flux, depending on the social context or interaction. Conversation is the author of the narrative (Hoffman, 1992), and these narratives are constrained by economic, social and cultural circumstances (Lax, 1992). Postmodernism is a stance that produces scepticism of beliefs in relation to truth, knowledge, power, the self and language (Lax, 1992) language being an intersubjective act (Loewenthal & Snell, 2003), rather than a series of truth statements about ourselves or the world. Postmodernist thinkers challenged modernist assumptions with the intention of seeking understanding, but without ascertaining any truth or ultimate knowledge. It brought scepticism to the view that one can perceive the world without the influence of culture, language, ethnicity and learning experiences. Modernism was not seen to be achieving what it set out to do, and hence postmodernism began to deconstruct the ideas of there being a perceivable reality, evidence or certainty. Instead of certainty about the world being increased, it was thought that the number of viewpoints was swelling (Gergen, 1992). Through this deconstruction arose the concept of social constructionism (Polkinghorne, 1992; Burr, 2003), and the idea of 'meaningful interpretations of the real,' (Polkinghorne, 1992, p. 150).

Social constructionism and symbolic interactionism, both themes within postmodernism, are discussed in more depth in chapter 3 (methodology and method), as these are used as the underlying epistemology for the current study. As such, this research does not focus on common laws that can be generalised across time and place, but on differences in perspective and how a person's culture, society, gender, ethnicity and background determine perception.

2.2 *Psychodynamic Theories of Child Development (PTCD)*

This section initially outlines an understanding of the word ‘theory’ and contrasts this to ‘belief’ to distinguish that although often realist, theory does not necessarily constitute belief or dogma, hence escalating the need to determine from therapists how theory is actually interpreted. Following this is an outline of psychological, psychoanalytic and psychodynamic theories of child development that have shaped the practice of psychological therapy throughout the 20th and 21st centuries. This serves to define what is meant by the term ‘psychodynamic theories of child development’ and therefore, what was being asked of the participants when they were posed the question: ‘What effect, if any, do PTCD have on your therapeutic practice?’ in the context of semi-structured interviews. This review of the literature also attempts to break down and deconstruct realist PTCD, aiming to demonstrate how these theories are constructed by society and enforce a powerful social discourse.

The Oxford Dictionary (2007) describes theory as ‘an idea or system of ideas used to explain something; a set of principles on which an activity is based,’ (Hawker & Waite, 2007, p. 948). This is distinguished from belief to highlight that a theory can be believed as true of the world, or not. A theory can be a principle which guides but doesn’t necessarily require a belief that this is true of the world. Belief is described as ‘a feeling that something exists or is true; a firmly held opinion; trust or confidence in or religious faith,’ (Hawker & Waite, 2007, p. 77). Belief is a form of dogma (Burr, 2003), and can rule out the possibility of other theories and viewpoints. Whether the following theoretical constructs are theory or dogma becomes blurred in the way that they are written. The discourses that constitute them often exude certainty and appear to reflect belief rather than theoretical possibilities.

It seems necessary to return to the roots of psychological thought, to elucidate how PTCD have developed and changed over time. Modern psychological theories of child development were informed by the theorist John Locke (1699), who proposed that the child is born with a mind that is a ‘tabula rasa’ or blank slate, and although having innate ‘temperaments and propensities’, he emphasised the importance of the social environment in shaping and creating differences between individuals. Due to the advancement of biological research, more modern descriptions of development highlight that humans are born with highly structured brains. Locke’s (1699) view has been appreciated yet updated, as the current view is that the idea of a ‘tabula rasa’ downplays the ‘nature’ or ‘innate’ influences on child development. This gives just one example of how psychological theory has changed over time, whereas in the 17th century it was most likely regarded as truth.

‘Childhood development’ is now a term which psychologists Cole & Cole (2001) describe as ‘a process involving the whole child in a dynamically changing set of cultural contexts,’ (p. xvi-xvii). However, it is still often implied that there is a correct developmental path for children to take, and if not given adequate or appropriate social interaction certain milestones are not fulfilled. This presupposes a developmental path which can be deviated from rather than allowing for a number of alternate paths. Children are socialised to develop according to the context in which they live, although some regard developmental ‘stages’ as innate and progressed through naturally, developmentally (Cole & Cole, 2001). The idea of ‘stages’ assumes that periods of time in childhood are negotiated in a particular order of progressive capacity (for instance, see Piaget, 1926), which suggests developmental determinism.

Looking back to the origin of psychoanalytic thought, Freud and Klein’s psychoanalytic theories are based on the concept of internal and innate drives and instincts, almost completely independent of social context and culture. In addition to this, theoretical ideas within psychoanalysis were often derived from case studies and observations of single patients (St. Clair, 1986), and were thought to be generalisable to whole populations. Later theorists such as Bowlby (1969) and Winnicott (1965) acknowledged the influence of both innate features and social interaction and environment on the development of the child. Despite this, optimum development was still emphasised, whether this is to develop more of a ‘true’ as opposed to more of a ‘false’ self (Winnicott, 1965), whether the child successfully achieves a ‘secure attachment’ with the caregiver (Bowlby, 1969), or whether the infant successfully masters and surpasses the ‘oral stage’ (Freud, 1938), for example.

Psychoanalytic principles developed from Freud and Klein with later theorists such as Kohut (1977), who constructed a theory of the self and narcissism. Following Winnicott and Mahler, Kohut’s theories began to deviate from the Freudian model of instinctual drives and directed psychoanalysis into a different and new direction which began to incorporate the possibility of maternal care having an influence on the development of the ego (St. Clair, 1986). For instance, he believed that narcissism resulted from a lack of empathically responding ‘selfobjects’ (‘the person used in the service of the self or experienced as part of the self’ (St. Clair, 1986, p. 190)) in order to function (Kohut, 1980). This was opposed to Freud’s idea that the narcissistic personality is devoid of attachments with no emotional investment in others (St. Clair, 1986). Again it is clear that since its origination psychoanalysis has been a fluid and changing collection of theoretical ideas, but despite that they have been continually written from a realist perspective.

PTCD are based on particular paradigms, and are heavily rooted in western culture. For instance Freud’s (1938) instinctual drive theory, whereby a person’s innermost drives require gratification, was

devised in a time following the industrial revolution but preceding the digital era. His theories revolve around pressure and expulsion through cathartic release, and engender a language which could be seen to represent mechanical movement and locomotion, gas cylinders and such. The more recent advancement of cognitive behavioural therapy (Beck et al., 1987) arose in an age of computerisation, and this model accentuates the mind's function in terms of neurons, stimulus-response and computational algorithms. Each psychological paradigm is heavily entrenched in the social, political and economic context at the time they were developed.

More recently, attachment theory (Bowlby, 1969) indicates that a child's quality of attachment to his or her caregiver is extremely important for subsequent healthy emotional development. Theorists from an attachment perspective suggest the effects of PTCD lie mainly in the therapist's presence, such as the provision of a 'secure base' in the therapeutic relationship (Bowlby, 1969; Daniel, 2006; Shorey & Snyder, 2006), whilst facilitating client movement from an insecure to a secure attachment (Holmes, 1994). Similarly, Winnicott (1965) also proposed the client requires a holding, facilitative environment in which to regress in order to move forward. In this way, the effect of PTCD is to encourage the therapist to present him or herself to the client in a different way, or to present the client with a different type of relationship that goes beyond just collaboration. Both theories speak much of the historical context in which they were constructed, and Bowlby's (1969) attachment theory has received much criticism from feminists. The emphasis lies on the mother, as opposed to the father, in the importance of creating a 'secure base': 'Bowlby's ideas about care imposed impossible demands on the conscientious mother,' (Burman, 1994, p.79) and 'suggest children who have personal or behavioural problems in their later lives have been inadequately mothered,' (p.78). Hence it becomes a responsibility of women rather than men, to provide an adequate environment in which the child can develop emotionally (Birns, 1999). Women are held in the grip of the socially constructed and powerful discourse of the patriarchal nuclear family where women are obligated to 'do' mothering because it is a 'natural outcome' of motherhood (Franzblau, 1999). Bowlby's (1969) attachment theory also implies that a woman's priority is to be at home with the child and therefore forfeit study or work. As such, powerfully divisive socially constructed gender roles are inherent in PTCD.

In addition to attachment theory, older psychoanalytic theories of child development make reference mainly to the mother within this patriarchal construct, for instance, Klein's (1946) 'good breast' and 'bad breast', and Winnicott's (1965) 'good enough mothering'. As a woman and mother, Klein's emphasis on the role of the mother in her theories showed gender roles being adopted and enforced by women as well as men. More recently, some theorists have placed less emphasis on the mother, with Holmes (1994) claiming the importance of the secure base provided by mother or father.

As such, psychoanalytic and psychodynamic theories receive much criticism, most likely due to their dogma and lack of scientific credibility. For instance, Freud's theory that dreams were 'the royal road to the unconscious' (Freud, 1900) was contested by Løvlie (1992) who stated that the interpretation of dreams is 'regressive, but progressive and even futuristic,' (p. 129), and such interpretations produce meaning about the person's unconscious mind, instead of holding meaning which can be discovered. Løvlie (1992) refuted any possibility of dreams holding meaning, but instead only replaced Freud's theory with another which is just as dogmatic.

The problem as Fish (1999) sees it, is that psychological theories ignore socially oppressive and powerful ideology, and that this needs to be deconstructed from a postmodern perspective. Not only were PTCs written within the confines of a western society and bound by the restraints of white, upper class men, but they were first practiced and refined on upper class citizens (Richer, 1992). In this sense, Freud and his colleagues had vested interest in analysing and pathologising women and the lower classes, evident in the theory of 'hysteria' devised by Breuer and Freud in 1898 (Phillips, 2006). This served to sustain a dominant misogynistic discourse, which is emulated in the field of mental health today, with the majority of diagnosed cases of borderline personality disorder (Ford & Widiger, 1989) and histrionic and antisocial personality disorder being women (Nehls, 1998). In addition to this, the DSM V (Diagnostic and Statistical Manual of Mental Disorders V) is forecast to create a new diagnostic category for the disorder of 'premenstrual dysphoric disorder' which labels mood swings, irritability, anger, depression, anxiety, lethargy and appetite fluctuation in women as 'disordered' (Jackson, 2012). It seems that in some instances social discourses are still being used to oppress and marginalise.

Again in a more contemporary context, White and Watts (1973) defined what they believed to be cross-culturally shared characteristics of 'competent' 3-year-olds, such as interacting in socially acceptable ways, expressing affection and mild hostility, and self-control in the absence of external constraints. Kierkegaard (quoted in Sroufe, 1979) also identified optimal conditions for raising children, in which independence and self-confidence flourish. Similar to psychodynamic or psychoanalytic theories, these theories are generated from western societies and are often applied to other cultures. Cole and Cole (2001) identify that in Eastern cultures (such as China and Japan) dependence is favoured above independence, and hence a 'competent' 3-year-old in that society could be defined very differently. Judaism also shows different social constructions of childhood, and the norm in that culture is that girls and boys are considered adult at 12 and 13 respectively (Cole & Cole, 2001), as opposed to 16-18 for both sexes in the UK. This suggests that the development of children

is largely socially constructed and dependent on what is seen as 'correct' within their particular culture at that time.

The notion of 'childhood development' has determined from a realist perspective what is 'adequate' or 'competent' for particular periods of life. These ideas are now challenged and understood more as socially constructed milestones for the child to reach by a given age, and are now seen to be devised within the confines of culture and society. Perhaps there are 'sensitive periods' in childhood when it is optimal for a child to develop some capacity, given the growth and plasticity of the brain (Cole & Cole, 2001), yet this 'progression' into adulthood requires the child to develop acceptable behaviours and competencies in line with current social discourses. Rather than childhood development being a progression through innate stages in which they achieve certain milestones which were pre-determined, or the achievement of socially acceptable behaviours which are unchanging and 'correct', perhaps they could be viewed as in accordance with dominant social discourse. For instance, 'lesbian and gay parents are absent from all current developmental psychological texts,' (Burman, 1994, p.70) and the white nuclear family (father, mother and children) is defined as the norm. Young single mothers are therefore regarded as deviant (Burman, 1994) and non-married, lesbian and gay people were given the right to adopt as late as in 2002, according to the Adoption and Children Act (2002).

Psychodynamic theories of child development fall to a similar fate: social, cultural and historical factors are not greatly acknowledged, if at all. What is identified here is a number of competing psychodynamic theories of child development, all which make claims to a child's definitive need for optimal development. Some are even directly opposed to one another. For instance, Freudians and Kleinians had the view that suppression of sexual instincts and desires (Freud, 1917; Klein, 1943) would lead to later psychopathology, whilst Winnicott thought the suppression of the 'true' self happens in order to accommodate the needs of the mother (Winnicott, 1965). Even when environmental factors are taken into account, these are often embedded in assumptions of powerful discourse. For instance these theories endorse the misogynistic oppression of women, as they are named responsible for inadequate child development or later psychopathology (Burman, 1994). It is assumed that a woman has a 'maternal instinct' and any deviation from this makes them wrong or at risk of being dismissed from society.

Views of PTC and therapy differ: are they useful only in increasing insight and acceptance of an absent mother in childhood, for example, or as Bowlby's (1969) attachment theory proposes, to experience a secure base that was absent in childhood by provision of this quality in the relationship with the therapist? Both applications need to be deconstructed in their historical and social underpinnings, to attempt to break down the continuing imposition of powerful divisive discourses.

As Szasz (1978) writes: ‘the positivistic-medical, psychological and scientific approach to psychotherapies is today even more entrenched, concealed behind even thicker smoke screens of semantic and institutional legitimizations than it had been in 1933,’ (p. 182).

2.3 *How does Theory Inform Practice?*

The way PTCs are interpreted seems to be important in how they are applied. Schön (1987) argues that to be competent in practice, practitioners need more than theory: they need a level of artistry to frame a problem, implement a theory and to improvise as the moment takes them. It is suggested here that interpretation of a theory constitutes a level of artistry in the application of theory to practice, and that epistemology and theory application are inextricably linked. Explored below are some ideas from the literature which theorise about how theory is applied, which brings the epistemological debate to a more practical understanding of what might be happening in the therapeutic workplace.

There are perspectives in the literature which identify different ways that theories are applied to practice. Schön (1987) refers to artistry when applying theory to practice which he calls ‘reflection-in-action’, and argues that rather than applying theory to practice mechanically, reflexivity on theory and its influence is the key to successful practice. As such, he argues that theory is insufficient, and does not have an all-encompassing effect on practice. Indeed, universities at that time were questioning whether the knowledge students were taught was sufficient for working in practice (Schön, 1987). Similarly, Eccles et al. (2005) commented on translating theory to practice as a time-consuming, unpredictable and haphazard process. Could this ‘artistry’ that Schön (1987) remarks upon be the ability to reflect on theory from a postmodern perspective, and as such treating one theory as only a possible explanation and not necessarily representing the truth?

This is suggested by Bero et al. (1998) who note that practitioners of varying professions need additional strategies to assist the application of theory to practice, and that ‘passive dissemination of information is generally ineffective,’ (p. 465). Despite these refutations of a crude or mechanistic application of theory to practice, Johnson (1988) states that experts have trouble in pulling together information that is diverse and incompatible, and they ‘appear to examine information in a top-down fashion, using their knowledge [of medical education] to structure their search,’ (p. 217). Yet perhaps more is going on under the surface that Johnson (1988) failed to recognise. Another view is proposed by Dreyfus and Dreyfus (1986), who write that to be an expert one needs to ‘know-how’ on an unconscious level, and when one comes to recall their skills through verbal representation they will struggle to access the information that they once could recall. Similar to this, Clancey (1988) wrote

that to be experienced is to have 'facts proceduralized' (p. 380) into generalisable rules that can be applied to practice.

Socrates's search to understand expertise is quoted by Dreyfus and Dreyfus (1986) as they analyse a historical perspective of theory application: 'Euthyphro does just what every expert does when cornered by Socrates: He gives him examples from his field of expertise...none could articulate the principles on which he acted. Socrates concluded that no one knew anything,' (p. 105). Perhaps then the application of theory to practice partly occurs on a level which is out of awareness. This might have implications for whether or not it is possible to always use theory reflexively (Schön, 1987). If theories are being applied out of one's awareness, they may not be continually evaluated in how they fit into the current context, or for what assumptions and truth claims they might be making.

In most skills-based professions people are required to perform certain functions rather than recall information which has been learned, which may be, in a simplistic sense, similar to riding a bicycle or driving a car. Perhaps this provides an understanding of why the application of theory to practice is difficult to conceptualise verbally. Dreyfus and Dreyfus (1986) also note the stages through which a person progresses when learning a new skill, which could provide one way of understanding how therapists learn theories and apply them to practice. They explain that initially the practice of new skills is not fluent, and only becomes so when the knowledge has been assimilated into a person's 'know-how', or procedural (Clancey, 1988) knowledge.

As previously mentioned, there are alternative views that address the application of theory to practice. One such view is proposed by Martin et al. (1989) who focus less on 'reflection in action' and artistry, and more on how certain theories are technically applied. In their study they claim that experienced counsellors (those with a doctoral or masters degree), in contrast to inexperienced counsellors (those still studying) used 'fewer unique or additional concepts specific to conceptualisations of individual clients and their problems,' (Martin et al., 1989, p. 399). They reported that novice counsellors used more client-specific concepts rather than having a 'fine-tuning of their schemata for counselling processes in general,' (Martin et al., 1989, p. 399). These schemata are developed, they say, to save time and energy, yet they note that further research is needed to find out whether the more experienced counsellors' interventions were more effective for this reason. This seems to fit with what Dreyfus and Dreyfus (1986) describe as working from a level out of awareness, rather than explicitly searching for theory and applying it in practice. Tracey et al. (1988) conducted a similar study in which they concluded that doctoral level professional counsellors used immediacy and confrontation more often with their clients, and more flexibly. Student counsellors were shown to use their skills more 'rigidly', and demonstrated more dominance with their clients. Despite taking a different approach to theory application than Schön (1987), this literature also supports the idea that

knowledge and skills become more fluid over time and with experience, in line with Dreyfus and Dreyfus's (1986) claims.

Bohart (1999) writes about the application of theory to practice in psychotherapy, and similar to Schön (1987), emphasises the on-going need for creativity in new situations. Bohart's (1999) ideas rest on the notion that no two situations are the same, and hence theory needs updating and alteration to fit the present context. However, it suggests a viability of previous theory despite new situations being different. In what sense then are new situations limited to the theoretical frameworks devised from old experiences? The literature seems to suggest that a translation of theory to practice is a complex process in a number of professions, which is not yet fully understood. It is suggested that creativity is needed in addition to a knowledge base, and that this 'knowledge' is not always directly accessible and can remain out of awareness. These ideas are couched in assumptions that the mind, or brain, is able to store information, and it is possible to 'have' knowledge, almost like choosing a book from a library.

However, returning to Schön (1987), perhaps in psychoanalytic practice 'inquiry proceeds from an overarching theory but does not, in any mechanical sense, apply it,' (p. 249). He sees psychoanalytic theory as a guide for the practitioner, but rejects the notion of theory application. When is theory 'applied' rather than guiding inquiry? Is there any difference? In a similar sense to Schön (1987), Hoffman (1987) sees PTC as potentially 'sensitizing the analyst to certain possibilities that may apply to a particular patient at a particular moment,' (p. 209). In both of these accounts it seems theorists are aware of the potential problems in the forcing of theory onto new situations, and words such as 'sensitise' are used to imply that theory is not the only element involved in this process.

2.4 Implications of PTC on Clinical Practice

This section outlines how PTC, in particular, are applied to practice, and identifies that studies which approach this subject in the literature are relatively limited. This study focuses on a number of contemporary papers that explain current psychological symptoms with PTC, which have a small epilogue of suggestions for clinical practice (Gergerly & Watson, 1996; Fonagy & Target, 1996; Frederick & Goddard, 2008). Yet it is recognised that, for instance, attachment theory's 'application to clinical practice has barely been explored,' (Biringen, 1994, p. 404). Mikulincer et al. (2003) developed a flow chart to show how attachment strategies develop from early childhood, alongside the following suggestion for clinical practice. They suggested that clients they labelled as 'anxiously attached' should be worked with to address their 'helplessness and fear of being alone' (p. 100), whilst those who are 'avoidant' should work toward becoming more in touch with their emotions.

These claims suggest clients can be categorised into certain types of personality depending on how they present to the therapist. It appears to be a positivist interpretation of attachment theory when the theorists are suggesting the client's style of attachment is independent from their relationship with the therapist, and perhaps even static over time. It could therefore be that these theories are imposed and in effect are continuing to control individuals who feel they must, for instance, meet the ideal standard of a 'secure attachment'.

Despite this, these general principles create a framework for working with a patient. What they tend not to do is dictate what the therapist should do, moment to moment (Hoffman, 1987) and despite this lack of exact guidance of how to use PTC, general implications lay focus on the therapist offering their client interpretations about repetitions of past behaviours and expectations in current life. Kernberg (1979) gives an example of this, which is based in the theories of transference and regression:

I then told the patient that in the sessions he slept in he was treating me as if I were his father and, in the sessions he tried desperately to be a good boy in, as if I were a harsh mother demanding perfection. I added that he felt there was nothing to hope from me as he had felt disappointment from both his parents, (p. 235).

Here Kernberg (1979) relates his patient's difficulty in relationship with him to his experience of his mother and father. This interpretation is couched in the discourse of what a good nuclear family might consist of.

More contemporary psychodynamic work (Kahn, 1991; Clarkson, 2003; Romano et al, 2008) provides a rationale for the provision of the therapeutic relationship and tools for understanding it. For instance, Fonagy and Target (1996) developed the theory of 'mentalisation', a concept which explains the way the client relates to the therapist, and is used to describe and explain a person's ability to imagine and understand the existence of the minds of others. Again this is from a positivist perspective but it does lay down a framework of understanding for the therapist.

Another framework for understanding the inner world of a client is the concept of 'transference'. This term identifies that at times the therapist should understand his or her own and others' relationships with the client as the client's re-enactment of past experience. Transference is one particular psychodynamic theory which indicates that an internal object relationship (Gomez, 1997) developed in childhood is transferred onto relationships in a person's present world. Freud (1914) defined transference as a process whereby clients tend to relate to the therapist and others in their adult lives as they related to their primary objects. In terms of the application of this theory to practice, Bollas

(1987) explains the mechanisms of 'transference' and 'countertransference' as concepts which provide ways of working with and understanding the client's past disturbances within the relationship with the therapist. However, others go further to say that the therapist should give the client the type of relationship that this suggests he or she is seeking, for instance the 'comforting' mother figure (Sudbery & Winstanley, 1998). Yet in an ever-increasing population where more and more people are living alone and socially isolated from communities, could it be that the patient has actually had a 'good mothering' experience, but is looking for the comfort of social interaction with peers as a basic human need? These theories which emphasise the importance of the person's childhood experiences might miss other constituents which play a part in the patient's distress. In addition to this, should looking for a 'comforting' mother figure be pathologised, or does this play into the western ideal of independence as opposed to an eastern high regard for dependence and community?

In terms of attachment theory's application to clinical practice, Romano et al. (2008) conducted research which concludes that clients who feel securely attached to their therapists find they are more likely to explore difficult emotions, or parts of themselves about which they feel uncertain. Mitchell (1988) went a step further and claimed a remedial value to therapy, where past problems are corrected and 'developmental gaps plugged up,' (p. 152) in the right therapeutic environment. Similarly, Clarkson (2003) proposed the idea of the 'developmentally needed' or 'reparative' relationship, which is comparable to the secure base in that something is seen to be offered to the client which emulates that which a good caregiver would have provided when the client was young. Yet in contrast to this, Blass (2009) argues that the therapist cannot offer the client what they have missed out on as a child, and that they must alert them to what they have missed instead.

PTCD are also considered a tool which therapists use to 'guide clients into where to look,' (Bohart, 1999, p. 303), and although these theories do not rigidly dictate what is done or said, their influence and effect seem to be far-reaching, and therapeutic intervention is changed by the impact of these theories, depending on how the therapist chooses to implement them. Perhaps therapists are being guided by theories heavily embedded in powerful social discourse which can serve to ostracise and limit certain groups in society.

2.5 *Research into PTCD*

The following section of the literature review addresses how theorists have been driven to ascertain scientific credibility for the efficacy of psychodynamic ideas and their applications to practice. These studies have become more prolific over recent years due to the restructuring of the major provider of psychological interventions in the UK: the National Health Service (NHS) (Risq, 2012). This seems

to be an attempt to secure the place of psychodynamic practice in the evermore competitive context of psychological healthcare. Perhaps as a result of this, research into PTSD seems to lean towards the interpretation of theories as representing truths about reality, as opposed to postmodernist thought. This epistemological stance is identified in much of the research literature, which contributes to the argument made by this study that it is the interpretation of PTSD and its associated research which is of importance. A positivist approach to research is also critiqued in this section with examples from the literature, drawing particularly from the idea of a 'two-person psychology' (Ullman, 1997) and a social constructionist argument (e. g.: Gergen, 1982).

Prior to the restructuring of the NHS, a number of theorists made attempts to secure evidence to ascertain the impact of negative early experience on later psychopathology. Crittenden (1988) devised the term 'internal representational models' from Bowlby's attachment theory (1969), with the intention of identifying how Bowlby's theory is directly applicable to practice. This was based on the idea that 'a person's internal representational model of relationships (derived from past experiences with relationships) influences the relationships he or she later forms,' (Crittenden, 1988, p. 183). Through observation and a 'separating anxiety test' (Ainsworth et al., 1978), Crittenden (1988) claimed that relationships were distorted in all aspects of the families' lives, including with other family members, partners and professionals. She also concluded that maltreating parents 'experience life as fragmented and incoherent,' (p. 197), whereas this and other claims rest in the observation of families, rather than being accounts of the families themselves as to how they experience life. This research assumes objectivity of the researcher and is embedded in the assumption that there is something called 'attachment' that exists regardless of how it is conceptualised. Coming from a realist perspective, these theorists interpret theory in a way which may serve to continue and confirm powerful dominant discourses.

More recently, Fonagy (2003) conducted a meta-analysis into psychopathology, and concluded that mental health problems tended to be a result of early attachment distortions or dysfunctions. His critique of genetic-based research led him to deduce that 'interpersonal interpretative capacity' (the ability to process new experiences and understand others' behaviours, beliefs and desires), is influenced by experiences of early relationships. Another meta-analysis by Schore (2003) suggests that in the first two years of life the brain is at its most malleable, the external environment having the largest impact on the development of the right hemisphere at this time. Schore (2003) states that this hemisphere is responsible for the processing of 'socioemotional' information and coping with emotional stress, therefore concluding that an unsupportive environment in these first two years of life may result in neurobiological and psychological deficits, the inability to regulate affect, and the suppression of emotions through the mechanisms of defences. This theory connects both traditional

psychoanalytic concepts with current neurobiological research. What appears to be provided by studies such as these is a rationale for treating these theories as if they denote the truth, and it seems that therapists are encouraged by these studies to approach theories of child development with certainty.

Although psychodynamic concepts are not easily operationalized within positivist research methods, Tellides et al. (2008) attempted to study the manifestation of transference in psychotherapy. They claimed that upon assessing a client's general interpersonal themes and through the 'assessment of relationship narratives', they found that relationship factors such as 'control issues' were transferred into their relationship with the therapist. This assumes the researcher takes an objective stance when 'assessing' clients, and can remain outside and separate from the focus of study. As such, Tellides et al. (2008) did not mention the impact of the therapist on the client, and simplified 'transference', taking it in isolation from other factors that may have had an influence on the relationship.

Despite many theorists conducting research in an attempt to prove cause and effect in terms of childhood development and later psychopathology, Silverman (1986) reviewed research which addressed the use of PTC as a basis for making retrospective inferences in psychodynamic therapy. She posited a challenge to a linear view of human development and states that 'one must be extremely cautious about making inferences from current adult pathological behavior to its early roots,' (p. 65). Therefore, although PTC are based on the belief that past influences present, these theories do not tend to account for the continuing social interactions throughout adulthood and the impact these may have. Symbolic interactionists argue that not only do past social interactions account for actions and decisions, but so do current social interactions (Blumer, 1969).

Whilst historically PTC have been heavily based on a 'one-person psychology' (Ullman, 2007) which assumes the objectivity of the therapist, more recent developments in the psychodynamic approach to psychotherapy place emphasis on issues such as sexuality and aggression as being constituted by relationships. This is opposed to a more traditional psychoanalytic view which placed more emphasis on instinctual drives within the person (Mitchell, 1988). This relational perspective does see development in terms of genetics and physiology, but with a primary emphasis on relationships and social interaction. This appears to be based on a similar philosophy to symbolic interactionism, as 'social interaction is a process that forms human conduct instead of being merely a means or a setting for the expression or release of human conduct,' (Blumer, 1969, p.8). As such, in clinical practice the therapist's openness to the inevitable impact that he or she has on the client is of upmost importance (Ullman, 2007). Kahn (1991) describes a level of 'intersubjectivity' (p. 70) in the

therapeutic relationship, as the conscious and unconscious responses of both client and therapist have an effect on the therapeutic process.

Ferenczi (1921) also critiqued a 'one-person psychology', where the client is seen as an object to be observed (Ullman, 2007), and made an argument for more therapist involvement in relationship with their clients. In 1924 he wrote:

I started to listen to my patients when, in their attacks, they called me insensitive, cold, even hard and cruel... Then I began to test my conscience in order to discover whether, despite all my conscious good intentions, there might after all be some truth in these accusations, (Ferenczi, 1924, p. 197).

Ferenczi (1924) allows for the possibility that the client could feel something about him and not just a 'transferential object' projected onto him. What then becomes a priority is a 'real' or 'person-to-person' relationship (Clarkson, 2003). Stern et al. (1998) and Spinelli (1995) also argue that an overemphasis on theory can lead to missed opportunities at relational interaction. In effect, if theory is used dogmatically the client could be objectified in such a way that the therapist does not consider his or her own impact on the relationship and the client's presentation.

The application of theory to practice is critiqued further by Anderson and Goolishian (1992), who give an example of a therapist asking theory-laden questions to a client, who as a result becomes panicked that he or she will get the answer wrong, because he or she feels that the therapist has an expectation of what the answer should be. They suggest that questioning a client in this way shuts down the possibility of a trusting and open encounter between the therapist and client. Instead they place more emphasis on the creation of a narrative between client and therapist. However, creating a new narrative with the client is at odds to a modern, positivist, solution-focused approach to psychological therapy, because it might not be based in scientific evidence.

From a scientific perspective, Fonagy (1993, 2001, 2002) (a contemporary descendant of Bion (1962)) has conducted extensive research and the meta-analyses. He concluded that there is evidence for the influence of attachment history on later development and that approximately seventy-percent of the time, sensitive care-giving in childhood endures as a representational model of attachment relationships (Fonagy, 2001). He also claimed that psychopathology can be predicted from an insecure or disorganised attachment style. The meaning given to 'psychopathology' can also be questioned, as can his meaning of 'personality' or 'attachment style', as again these terms are based on a positivist and medical-model discourse.

In response to these terms, social constructionists argue that there is not one 'self' or 'personality', and that a person's 'self' is heavily, if not entirely, dependent on social context (Burr, 2003). Social constructionists claim inevitable inconsistency of a person's 'self', which makes the task of measuring this implausible, or at least much more complicated than an attachment measure which assigns a person into one of four categories, each relating to a different style of attachment (Ainsworth et al., 1978). The effect attachment theory has on therapeutic practice is therefore an important question to ask, as this theory implies internal consistency of the self, and largely promotes a predictive value to childhood experience. It also can be seen as constrictive, pathologising people in society who do not have the qualities of a 'secure attachment style'. For instance, Fonagy (1993) states that 'clinical psychoanalysis commonly, and inevitably, deals with individuals whose past experience has left them particularly vulnerable to the repetition of past relationship experiences' (p. 257). Therefore, while Fonagy (2001) claims that people who are 'insecurely attached' are most likely to become 'disordered' later in life, in some societies children are raised by communal groups or orphanages, where the development of a secure attachment to one main caregiver might not be possible (Cole & Cole, 2001). Could it be that healthy emotional development can result from a number of different attachments? Why does it have to be one, and primarily the mother? Again attachment theory is seen to be embedded in the social ideal of a nuclear, western family.

Gergen (1982) also states that there is no 'normal' lifespan trajectory and it is dangerous to believe there is. He maintains that there is no way to determine which 'trigger' is responsible for development and refutes the idea of norms which indicate truths about the world, and rather sees these 'norms' as socially constructed realities which serve to control people. Could the use of PTCD therefore be a practice of power and control? Research that attempts to identify a causal link between childhood experience and later psychopathology is even challenged by the well-established developmental theorist Mahler (1971):

My intention at first was to establish...a linking up in neat detail of the described substantive issues with specific aspects of borderline phenomena...I have come to be more and more convinced that there is not a "direct line" from the deductive use of borderline phenomena to one or another substantive finding of observational research, (p.415).

Despite some methodological flaws and assumptions of objectivity, valiant attempts have been made to provide empirical evidence for PTCD and their relevance for practice. Theorists, researchers and practitioners alike are striving to support their practice through the promotion of the therapeutic effects of PTCD. This seems to encourage the adoption and endorsement of the idea that past

influences present, and that there exists a linear trajectory from childhood to adulthood with identifiable triggers for adult psychopathology.

2.6 *PTCD and the Power of Social Discourse*

In this section the potential power of social discourse is addressed through examples in the extant literature. PTCD were written in a time when positivism was the main epistemological standpoint, and hence these theories were proposed to reflect a truth about the world, taking on a power of their own (Hoffman, 1987). This power of theory is discussed in a broader sense, and is linked to a critique of PTCD used in a powerful way in the therapeutic setting.

Some theorists demonstrate an awareness of the potential power inherent in using theory in any context, from Marxist labour camps to social work (Penna, 2004). Such theorists claim to value the client's interpretation of the problem above their own desire for 'correctness' or 'conviction' (Hoffman, 1987). PTCD are written with conviction (for example, see Klein, 1930) and this influences the way they are applied, often with negative consequence (Hoffman, 1987). On the receiving end of such conviction was the psychotherapist Valentine (1996), who describes how theory was applied in her personal therapy:

The fact that I had had a number of troubling and traumatic losses in my childhood seemed a matter of indifference to [the therapist]. But she was interested in "phantasies" – an interest seemingly in isolation from any relationship with the external world. She was highly attuned to spotting signs of idealization, grandiosity, envy, hate and competition. Once I told her how much I liked small babies. I was told categorically that I idealized them. When I developed a very painful abscess on my gum and took time off to visit the dentist, I was told I was more in touch with my bodily pain than psychic pain. Furthermore, I was told I was "teething", (p. 177).

Stolorow and Atwood (1997) and Lomas (1999) argue against this style of therapy in which the analyst believes him or herself to be an observer who can apply theory to discover the 'truth' about hidden desires, instincts or early experiences of relationships. Yet again this is countered by Issacharoff (1976) who writes that it *is* possible for the analyst to remain objective, neutral and anonymous with their client. PTCD are 'tools,' he says, 'to explore the psychic reality of the patient,' (p. 412). Spinelli (1995) and Judd (2001) argue that claims such as these are dogmatic and power-mongering, and that the therapist bases his or her interpretations on 'mere guesswork'.

From the perspective of seeing PTCD as socially constructed and acting as powerful discourses, Judd (2001) writes that the concept of transference absolves therapists from being responsible for their actions and the impact of these on the client. Even the psychoanalyst Winnicott (1965) argued that the theory of transference is employed to maintain a professional stance, and therefore any feelings directed towards the analyst are not considered 'real'. In this way PTCD allow therapists to explain away elements of the relationship between them and the client, seeing everything that arises in the context of the patient's 'psychopathology'. In this sense the therapist might be misunderstanding the meaning of the client's communication, and overlooking a real encounter between him or herself and the client (Spinelli, 1995; Judd, 2001).

There is also the concern that empathy, which could also be a part of a real encounter between therapist and client, is limited by theory. While Reynolds and Scott (1999) found that high empathy results in positive outcome in therapy, in their meta-analysis they found that when professionals searched for factual information about the client they lacked empathy. This tended to happen the more 'knowing' the profession was (i.e.: doctors, nurses, ministers and psychologists) (see studies by Carkuff & Berenson, 1967; Squier, 1990). According to these studies, the effect of PTCD could be that they cause the therapist to become consumed by discovering the 'truth' about their client, whilst forfeiting empathy. Gross (1999) also argues that ethical integrity is compromised by the therapist's 'overriding concerns with the psychological [theory],' (p. 125), and he questions whether in this way psychotherapy can ever be ethical. Along the same line of argument, Lomas (1999) wrote:

There is secondary gain in the enjoyment of the puzzle. This is not only the challenge of trying to help someone but the fascination of solving an enigma, (p. 26).

A desire to 'know' can reduce a professional's ability to empathise (Reynolds & Scott, 2000; Squier, 1990; Carkuff & Berenson, 1967), yet could a desire for insight or knowledge be appropriate, or even helpful to the client? Issacharoff (1976) writes about the 'epistemophilic impulse' (originally quoted by Klein, 1930) – 'the impulse to seek knowledge and to explore the world around oneself,' (Issacharoff, 1976, p. 411). Yet even Issacharoff (1976) states that the epistemophilic impulse can lead to the avoidance of unconscious feelings, as the pursuit of knowledge becomes a priority over and above the connection at a deeper level with repressed feelings. Freud admitted to his interest in making sense of people, which he even prioritised above healing people (Frosh, 1987; Szasz, 1978). Yet while therapists satisfy their desire and their epistemological impulse by searching for truths, Lomas (1999), along with social constructionists, argues that there is not one 'ultimate truth' that can be found. Moreover, perhaps a therapist's particular type of training must be of utmost importance, as

‘very different theoretical frameworks can arrive at very similar treatment approaches,’ (Fonagy, 1999, p. 516). Further to this, training in PTCD (as well as other disciplines) can lead to a control over the ‘minds and actions’ of those who learn them (Gergen & Gergen, 2003, p. 36). Not only do PTCD then influence what is seen in one’s patients, but the way in which the theories have been written suggests their correctness, objectivity and validity most likely because they were mostly written in a modern era.

Therapists Gallop and Reynolds (2004) write about their personal experiences of theoretical training having an overwhelming influence on their beliefs about the genesis of mental health problems. Through their training which began from a psychodynamic discipline, they later broadened their theoretical awareness through further training, and concluded that the complexity of the human condition is to combine a social, biological and psychodynamic perspective. They later began to emphasise the need for a multiplicity of models. Perhaps this is not a situation limited to Gallop and Reynolds’s (2004) experiences, as Spong (2007b) writes that trainees are more likely to ‘adopt unquestioningly the ideas taught to them’ (p. 57).

Instead of staying with one frame of reference, perhaps therapists need to acknowledge that development continues throughout life and depends on social, economic and political context, war, famine, sexuality, poverty and culture (Chess, 1986; Watchel, 2008). In this sense what is needed is a perspective that advocates a multiplicity of models (Marmor, 1983), and to simply use PTCD would limit and disallow a holistic view. Therefore, it is possible that in training therapists can become consumed by PTCD and led to believe that is *the* way to formulate psychological problems, and falling head-first into these discourses ‘makes others invisible,’ (Swan, 1999, p. 105).

Others take a more radical stance and dispute the use of theory in any way. This view insists that therapists should view and interact with their clients without imposing on them a previously formulated understanding: a ‘non-intentional’ approach (Levinas, 1989b). Through the study of his work with a client labelled with ‘dementia’, Greenwood (2008) noticed how this preceded a therapeutic interaction between them: ‘a considerable part of the therapy appeared to be concerned with getting beyond the preconceptions associated with the dementia diagnosis,’ (p. 21), and therefore purports the ‘I-Thou’ rather than an ‘I-It’ relationship (Buber, 1987). This implies relating to the other as a person rather than an object. But is non-intentionality a question of who has the power to decide that one discourse holds more credentials than another, or is it a statement that says do not use *any* theory and listen to that of your client? Perhaps rather than dismissing theory altogether, therapists should keep coming back to the concern that, ‘in the pursuit of knowledge one may lose sight of the subject of study,’ (Brody, 1982, p. 532).

Approaching a client with ‘non-intentionality’ (Levinas, 1989b) has the aim of reducing theory imposition on clients and requires that the therapist doesn’t see him or herself as all-knowing: ‘Who has the power, the authority and the legitimacy to define a problem?’ (Valentine, 1996, p. 174). ‘Within the therapy room, who decides what is true and what is false, what is “real” and what is “illusion”?’ (Totton, 2007, p. 9). Guilfoyle (2002) and Totton (2009) write about the therapist assuming a powerful role:

The practitioner can claim more authority to pronounce on the situation, because of their expertise, training, status, experience, and so on. This claim can be made explicitly, as used to be the norm, but it doesn’t have to be: there are many subtle ways in which the therapist can imply they know better than the client, (Totton, 2009, p. 18).

So is it possible for a therapist to be truly non-intentional, or are more subtle power dynamics at play? Furthermore, do practitioners proceduralise their knowledge into generalisable rules for application to new situations (Clancey, 1988), but continue to have an awareness of their intentionality?

Alternatively, could the skills for being ‘non-intentional’ be proceduralised themselves? Clancey (1988) argues that experts can and do revisit and reframe the rules they have learned and assimilated into their procedural memory, if the information they come across does not fit with any predicted hypotheses. However, it seems that in terms of power in therapy, a question is raised about whether one should aim to approach clients without theory and therefore with no presupposed ideas about the client, or whether this is actually not possible and that the therapist should aim to educate themselves in an openness to a multitude of theories, but without using any dogmatically.

From this brief review of the literature that looks at power in relation to theory, it seems that PTCDD are embedded in socially constructed discourses which can potentially restrict a therapist’s ability to empathise or to see other theoretical perspectives, whilst dangerously providing an illusory sense of conviction. So does this mean theory should be eradicated altogether? Despite knowledge becoming an obstruction and a dynamic of power, Brody (1982) still emphasises that it is possible to investigate, understand and discover ‘psychogenetic contributions to pathology’ (p. 584). How do therapists manage this difficulty in working with PTCDD? Both these stances take similar epistemological positions in that they challenge the idea of positivist thinking, and what has been highlighted in this section are the problems with taking a positivist epistemology to the counselling situation. What follows is an account of different epistemological perspectives within the fields of counselling psychology and counselling.

2.7 *Epistemology and Psychodynamic Theory: Further Reflections*

This section links previous arguments of postmodernism with current and historical interpretations of psychodynamic ideas. It addresses the different epistemological stances that a therapist can take to his work with clients, particularly in relation to his or her uses and interpretations of PTCD.

This discussion of the literature begins with a quotation by Szasz (1978) who identifies that Freud seemed to be in an epistemological conflict:

Sigmund Freud's claims about psychoanalysis were fundamentally false and fraudulent. He did not discover a new science, (Szasz, 1978, p. 101).

Although Freud (1937) wrote about his theories being 'constructions', he still gave them status as 'factual' (Leary, 1994). As such, PTCD in their traditional form are based on a modern epistemology (Neimeyer, 1998; Hansen, 2004), and drive-structural models, self-psychology and psychoanalysis all have their foundations in objectivism (Leary, 1994), as does most of psychotherapy (House, 1999; Bekerman & Tatar, 2005). In 1992 Gergen and Kaye wrote that the mental health profession originated and remained in a modernist context: 'Thus from Freud to contemporary cognitive therapists, the general belief is that the professional therapist functions (or ideally should function) as a scientist...the professional is armed with knowledge', (Gergen & Kaye, 1992, p. 169). Yet post-modernism argues that there is no objective knowledge (Laugharne & Priebe, 2006). This contradiction has led to an epistemological confusion within psychoanalysis and counselling psychology. For example:

...it is not the marvelous deductive unfolding of the system which makes a theory rational or empirical but the fact that we can examine it critically...subject it to attempted refutations, including observational tests, (Popper, 1963, p. 221).

Psychoanalysis does not lend itself to these refutations or tests, as it does not propose hypotheses that are testable by conventional scientific methods (Hanly, 1990; Valentine, 1996; Judd, 2001; Stern, 2002), and its theories are seen by some as cyclical in their argumentation (Hanly, 1990; Spinelli, 1995). Despite this, Collin (1996) writes that some therapists show the desire to discover truths about their clients even though they are aware of the incongruence between PTCD, science and certainty. Therefore, it is likely that therapists tend to regard PTCD as truth claims about human nature. Whilst the field of counselling psychology claims to train students as 'scientist-practitioners' (Williams & Irving, 1995), Peavy (1996) states that counselling should be seen as 'a cultural practice rather than a scientific undertaking,' (p. 141). Hamos (1965) argued almost 50 years ago that a scientific rationale for counselling should be withdrawn, since 'the counsellor seems to receive

inspiration from a context of faith which is extraneous to science,' (p. 116). Szasz (1978) also points out that both Carl Jung and Sigmund Freud questioned whether psychotherapy was medical or religious. The scientist-practitioner model was developed during post-war America and Britain and at that time reflected the needs of the public and the profession (Corrie & Callahan, 2000). However, is it still necessary to regard PTCD from a modernist epistemology, or can they be adapted to suit a post-modern epistemology instead?

In defence of psychoanalysis, Leary (1994) asserted that a postmodern approach reduces people to lacking implicit memory on an unconscious level, and as unable to appreciate that events occur in time. Also challenging postmodernism, Kandel (1999) equates implicit, procedural memory (for which there are established scientific measures) with Freud's theory of repression and the unconscious. This is in an attempt to push forward the idea that there is a biological correlate to psychodynamic theoretical constructs, which 'proves' the existence of such theoretical structures as defense mechanisms and instinctual drives. Yet although there may be an argument for a scientific basis behind the principles of PTCD, this does not mean these theories are true to life and the only way of explaining the human mind. Although Hanly (1990) questions whether 'there are as many true life histories as there are theories that can give a consistent account of them,' (p. 379), he answers this with a stark 'no' and reinforces his view that there exist 'obvious' interpretations which if shared with the client begin a process of change. He therefore seems to think there is a definitive 'right' or 'wrong', much in opposition to postmodern thought.

Some would argue that not being confined to the idea that one's developmental past impacts on their present is liberating, as it frees the client from being a passive victim of the developmental factors in his or her past (Mitchell, 1988), and from being subjected to socialisation (Loewenthal, 1996) through being labelled as pathological if he or she does not confine him or herself to societal norms. Swan (1999) argues that social or contextual understandings of mental health problems should be taken into account, and that explaining individual psychopathology through troubles in attachment, unresolved or hidden feelings originating from one's childhood does not encompass all possibilities. For instance, instead of defining a woman with anorexia as suffering from a fixation in the oral stage of development (A. Freud, 1946), this could be considered a result of media and the acceptable body shape endorsed by western society.

It seems from the literature that there is a continuing debate between differing epistemological positions within the fields of counselling and psychology. This is relevant to PTCD and their use in the therapeutic context, as a positivist epistemology seems to endorse the therapist with power in the

therapeutic relationship, allowing for theory imposition and the exercising of dominant social discourse.

2.8 *PTCD and Uncertainty*

From reviewing the literature it seems that the debate between a positivist and postmodernist approach to PTCD is on-going. Postmodernist approaches, however, incur a level of uncertainty, which will now be addressed as it is proposed in the literature. This is followed by a review of the literature which critiques professionalism in relation to believing one is the owner of theoretical knowledge. These themes are addressed here as they begin to elaborate on the potential problems incurred by powerful social discourse in the context of using PTCD in therapeutic practice.

While some therapists using PTCD claim they know why and how their interventions are helpful (for examples see Kernberg, 1979; Brody, 1982; Chess, 1986; Biringen, 1994; Lopez, 1995; Gergely & Watson, 1996; Sudbery & Winstanley, 1998; Mikulincer et al., 2003; Wallin, 2007 and Laughton-Brown, 2010), this is contended by Fonagy (1999), who writes that ‘psychoanalysts do not understand, nor do they claim to understand, why or how their treatment works,’ (p. 515). So there seems to be a split in the literature between those that feel certain about their practice and associated theories, and those who are unsure. Yet this split does not necessarily fall neatly between those with a scientific or positivist way of thinking, and those with a postmodern or social constructionist epistemology. Demonstrating this is Fonagy who, as mentioned earlier, seems an almost positivist thinker, yet still doubts the certainty that some practitioners have about their practice.

Therefore, an element of uncertainty seems to be present in applying PTCD to practice, and about how accurate or representational PTCD are in describing client presentations. This uncertainty is perceived as a discomfort which Stern (1998) writes is ‘the price we pay if we choose to wait for our thoughts to come to us of themselves,’ (p. 343). But instead perhaps therapists ‘cling to such beliefs’ because every human being needs to belong to something, and has a desire to be part of something elite, a group of people who ‘know’ something more (Valentine, 1996). Yet some think that therapists need to tolerate a level of uncertainty, as Keats wrote as far back as 1817:

I mean negative capability, that is when man is capable of being in uncertainties,
Mysteries, doubts, without any irritable reaching after fact and reason, (p. xxii).

From a psychological perspective Billow (2000) comments that Keats’ (1817) ‘negative capability’ asks therapists to put to one side what is thought to be known about a client, and what is hoped to be

achieved by the analytic process. Similarly, Spinelli (1997) argues for the therapist's openness to possibility, and coined the term, 'un-knowing'. He describes this as being open to whatever may present itself in the relationship with the client, which allows the therapist to discover new meanings and different possibilities to what is already known. This approach is somewhat in opposition to treating theories as statements about reality.

Perhaps by rejecting Spinelli's notion of 'unknowing' (and hence uncertainty), therapists opt for security in the illusion that one has knowledge to draw upon in working with clients (Spong, 2007b). In turn this may contribute to therapists legitimising their practice through claiming expertise (House, 2003) in the form of memory and acquisition of knowledge (Posner, 1988). Yet this brings into question whether this 'knowledge' is considered in a postmodern or positivist sense, and whether the therapist allows his or her knowledge to be challenged or seen as just one way of understanding a given phenomenon.

From a different angle, Hoffman (1992) questions this 'unknowing' and whether it is actually possible. Through watching therapists work who claimed an unknowing stance, it seemed to her that they approached clients as if they *did* know. Lerner (1999) states that there is a problem in being powerful and *claiming not to be*. Is it therefore questioned in the literature whether it is possible for therapists to take upon themselves a stance of not knowing, as 'most therapists have a story about how problems develop and are solved or dis-solved,' (Hoffman, 1992, p. 19). Perhaps those therapists who claim a stance of 'unknowing' are exercising a concealment of power, which could be more dangerous (Guilfoyle, 2002).

So again, there are mixed views in the literature about whether therapists should have conviction, uncertainty, or a combination of the two. Either way, the therapist's beliefs about PTC D are likely to influence how they are thought about and used in practice. This can impact on whether the therapist claims to be an expert on the client's past and present life problems, or whether he or she takes up a position of uncertainty and 'unknowing'. Yet could there be an alternative, somehow between these opposing approaches? The question of how therapists interpret PTC D could indicate whether there is another stance which falls between claiming expertise and complete uncertainty.

2.9 *PTCD and Professionalism*

If PTC D are interpreted as representing truths about the world, and hence, providing the therapist with a sense of expertise, this could lead to a sense of professionalism which is dependent on knowledge which one can impart to the client. While counselling is being increasingly seen as a 'healthcare

profession' (Hansen, 2007), some have the perspective this is a move towards satisfying vested interests (Loewenthal, 1996). Having a body of knowledge which is believed to accurately represent reality allows therapists to adopt a professional status (Spong, 2007b). However, Hansen (2007) proposes that there is no logical basis for calling counselling a 'healthcare profession' as it does not fit the same ideology, as it advocates technique-based practice similar to those associated with other professionals, and it also deviates from the medical model of mental illness. However, perhaps a therapist can advocate him or herself as a professional, 'proclaim[ing] his ability to help and usually has a theory as to how this is best done', (Lomas, 1999, p. 117).

Can the desire for professionalism lead to a more positivist interpretation of PTCD? Hamos (1965) wrote about counsellors' desire for professionalism being based in a need for 'usefulness' and a 'sense of worth', and the belief that he or she is 'a "curer" of ills, that he [or she] is an applier of skills and an achiever of tangible "results",' (p. 167). Hamos (1965) goes on to say that a desire for professionalism should not be shamed, but the ambiguities inherent in it must be acknowledged. However, professionalism itself is a socially constructed term which can endorse the idea of the therapist as expert with a body of unchallengeable knowledge. However, does the term 'professional' forfeit a negotiation of understanding between therapist and client (Gergen & Gergen, 2003)? Can a therapist not be a professional and have a social constructionist perspective, without enforcing a particular set of theories on a client? Much of the literature seems to view counsellors and psychologists as either positivist or postmodernist.

Perhaps the client also benefits from the 'picture of the counsellor as an omniscient expert,' (Onnismaa, 2004, p. 43), as it could satisfy a need to meet with someone who supposedly has more expertise about the human condition than they do. Whether or not this is illusory is debatable. Considering the advantages of professionalisation, Onnismaa (2004) emphasises that professionals have a code of conduct to protect the client, which limits the 'breaking of norms' (p. 44). She sees the advantage that professional identity links one with colleagues, and provides enjoyment, self-esteem and the use of imagination. Borys (1994) also argues that theoretically-driven practice promotes effective treatment, giving the example that therapeutic boundaries encourage a feeling of safety and predictability for the client. Yet the need or desire that therapists have for professionalism must be taken into account, as after all, therapists dedicate their careers to this field of work. Could it be that 'it is better to have a clearly defined, respectable package which can be sold,' (Riikonen & Vataja 1999, p. 180) because this is required by the therapist? Does counselling psychology have no value without claims to knowledge?

It could be that a sense of professionalism reduces the therapist's sense of uncertainty. Mackay et al. (2001) conducted a grounded theory study into therapists' experience of changing their practice to a psychodynamic-interpersonal modality after already being trained in alternative models. They found that in doing this, therapists experienced uncertainty, fear and stress, and felt weakened in their identity. This suggests that for some, giving up an already established identity as a therapist of a different modality is debilitating, de-skilling and de-professionalising. Nonetheless, once the conversion had 'taken place' (no further indication of what 'taken place' was taken to mean), therapists 'described stronger identification, feeling that the psychodynamic-interpersonal model provided them with a secure base from which to work,' (Mackay et al., 2001, p. 33). What this implies is that there could be a function or effect of PTC in providing this security, which could be seen as primarily in the interests of the therapist, but in light of Onnismaa (2004) and Borys's (1994) views, in the interests of the client as well. Yet this could serve to continue to enforce powerful psychodynamic discourses that oppress rather than empower clients, as every discourse is dangerous (Foucault, 1980). Indeed, House (1999) warns that the professionalisation of counselling is leading to the therapist's increased ability to abuse his or her clients through the encouragement of a dependent transference and the imposition of therapist expertise. He states that professionalism 'actively encourages a particular psychic state within patients, which then requires extensive "treatment" to cure,' (p. 381). Should therapists then abandon their professional status altogether?

It seems PTC are demonised for sexist, dependency-mongering strategies by which they maintain their own professional status and yearly income. Yet Foucault (1980) states that 'the guy at the top of the heap' should not be to blame (Richer, 1992, p. 114), and rather one should see oppression and power as a result of social dynamics and symbolic interaction (described further in chapter 3, page 39). Therefore the client's role in seeking another with an 'expert' or 'professional' status must be considered, but perhaps the therapist should not succumb to playing into this role. Clients themselves have an influence on the professionalism of counselling, as they have expectations of the therapist and a power relationship exists before work even begins (Totton, 2009). Perhaps the therapist should be making it his or her duty to act ethically in the knowledge that his or her position can carry such weight for the client. However, Foucault (1980) states that society cannot exist without the power of some groups over others, but recommends that as little domination as possible should be succumbed to as a result of power dynamics. Therefore the expectations of both therapist and client may contribute to the professionalisation of counselling psychology and other therapeutic roles.

There are, evidently, differing views on the professionalisation of practice in the literature. On one hand professionalism is argued to provide therapists with a sense of expertise, a sense of group membership and making their practice marketable. In doing so, problems of oppressive practice,

therapist domination and self-legitimation seem to be put to one side. However, to use PTCD perhaps one does not need to buy into the discourses with which they were written. While PTCD were written in a language that makes many assumptions and can serve to marginalise groups of people, this does not necessarily mean that therapists have to continue to use them this way. However, it seems that whilst some therapists are aware of the potential social oppression and power of these ideologies (Fish, 1999), some are not, and continue to use them dogmatically.

What is addressed next is an appraisal of the literature surrounding the concept that PTCD serve the therapist by abating their anxieties within the therapeutic encounter. By having their anxieties removed or subdued, the illusion of professionalism might continue to be possible.

2.10 PTCD and Therapist Anxiety

Therapist anxiety is intertwined with a desire for professionalism, and hence becomes important to consider when considering how counselling psychologists and other therapists interpret PTCD, as it may provide an explanation for why PTCD are interpreted from a more positivist, rather than postmodernist, stance.

In a study which looked at the relationship between therapist anxiety and ‘countertransference behaviour’, Hayes and Gelso (1991) claimed that male counselling trainees ‘withdraw from their clients’ (p. 289) when the client presented with more anxiety-provoking issues. Unfortunately the researchers used their own operationalisation of countertransference, rather than investigating the meaning this term held for participants, and they did not specify what it meant to ‘withdraw’. Yet despite these potential flaws the study suggests that working with clients can be an anxiety-provoking process, and this anxiety is not necessarily a projection from the client.

The theory of countertransference is based on the idea that the client projects onto the therapist an emotion that is a result of the client’s presenting problem in relationship with others (Freud, 1938). However, the concept of countertransference is critiqued by Yulis and Kiesler (1968) because they claim it allows the therapist to withdraw from personal involvement with the client if he or she feels under pressure, defensive, or anxious. In Yulis and Kiesler’s (1968) study, therapists were given a tape of a ‘hostile’, ‘sexual’ or ‘neutral’ client to listen to, and then given a choice of two pre-established responses they would have made to the client. Being a positivist study with a pre-established hypothesis, this ruled out all possible original responses a therapist might have used, and takes the situation out of context of a relationship that would have developed between therapist and

client. However, the overall claim of this study was that the effect of theory is that it allows therapists to distance themselves from clients in order to reduce their own anxiety.

Perhaps this study provides a way of understanding why therapists experience difficulty in dropping the 'safety blanket of a transference interpretation when things become uncomfortable,' (Judd, 2001, p. 32). Hamos (1965) replicates this point by writing that the therapists who find uncertainty 'too painful' (p. 123) are 'the ones' who try to explain the inner psyche with ordinary empirical observation. Again this is blaming the individual but perhaps the social context needs to be taken into account, and what social interactions they have had and are having in their current lives. It could be that they try to explain human behaviour because theories propose that this is possible. For instance, Freudian theory assumes that a therapist can be a 'neutral', 'blank screen', allowing transference to occur (Freud, 1938). In contrast to this approach Stolorow and Atwood (1997) argue that the therapist 'hides' behind concepts such as 'neutrality' and 'transference' to protect him or herself. To this day, therapists seem to follow in Freud's footsteps. For example, Thomas (2010) confesses in his article:

Over the years I have seen patients, employing the classical model of the transference, and for shelter have cloaked myself in the ubiquity of the blank screen, (p. 62).

Thomas (2012) sees this as problematic, and goes on to say that having a more relational approach (Ullman, 2007) is more therapeutic, discovering this through becoming a father himself and allowing a more 'real' engagement with others as a result. However, through his personal experience he admits to a time when the effect of theory on his practice was to shelter himself from anxiety-provoking experiences. Epstein (1977) also acknowledges his use of theory to allow him to bear his patient, yet without the same apprehension:

I attempted to counter the actual feelings induced by this patient by creating a more sympathetic image of her in my mind. This enabled me to affect a posture of forbearance vis-à-vis her withholding, rejecting and contemptuous treatment of me, (p. 449) ...However hateful she is, we are committed to the theory that the patient needs us to be a so-called object of her transference neurosis and, therefore the target of all her feelings... we attempt to imagine the deprived, damaged and vulnerable child-self behind the defensive façade, (p. 453).

To create a sympathetic picture of the client he reminded himself of the early loss of her mother and disdainful treatment by her father; a view influenced by PTCDD. His commitment to theory therefore

allowed him to tolerate an anxiety in himself by the way the client was treating him. The way PTCD have been interpreted here and applied to practice defends the therapist from feeling hated by his or her client, and provides a framework of understanding for the client's behaviours.

Despite some therapists believing theory should not be employed in this way as a façade or protective blanket (Lomas, 1999), Bandura (1956) argued that it is important for theory to protect the therapist, as it is important that the anxieties of the therapist do not heighten those of the client. He supports this claim through his research, in which he found that anxious therapists tend to 'divert the discussion, [make] premature interpretations that block the patient's expressions, paraphrase...without essential clarification, [give] unnecessary reassurance or unwitting disapproval, etc.,' (Bandura, 1956, p. 333). In this sense he describes theory as giving therapists protection against their own anxieties, hence making them more useful to their clients.

At a time when positivist psychology was most respected, Bandura (1956) conducted this quantitative research into the therapeutic effectiveness of forty-two psychotherapists, with an observer who gave them ratings of 'anxiety' and 'insight' into their own 'dependency', 'hostility' and 'sexuality'. Ratings of competence were judged by the psychotherapists' supervisors, whilst this was correlated with the observer's ratings of anxiety. The results of the study showed that 'anxious therapists were rated to be less competent psychotherapists than therapists who were of low anxiety,' (Bandura, 1956, p. 336). However, Bandura does not elucidate what he means by competency, and with this study he implies that the views of the supervisors were objective measurements of the participants, enforcing the notion of a one-person psychology (Ullman, 2007). It could have been that the 'more competent therapists' who showed less anxiety were using theory to maintain their confidence through believing they had a reliable body of knowledge to share with their client (Downing, 2004). Furthermore, the more anxious therapists might have not fit their supervisor's ratings of competency but might have been more able to allow themselves to be in the moment with their clients and experience a level of anxiety.

Some are much opposed to therapists using theory to calm their anxieties in the therapeutic context, or to provide them with a sense of professionalism. Totton (2009) sees these uses of theory as powerful and dangerous, and argues that practitioners 'denigrate and despise' their clients through 'power manipulations, blackmails, seductions and seizing of the moral high ground,' (pp. 18-19) in order to cope with their anxiety. However, it seems a shame to believe this is true of all therapists, or to suggest that therapists would act this out whilst being aware they are doing so. From less of a critical perspective than Totton (2009), Beres (1980) comments that perhaps rather than theory being a conscious form of malevolence, therapists need reassurance that comes with the feeling of knowing

something, which simply outweighs a person's capacity to tolerate the unknown. Again it appears to be important that the therapist is aware of how he or she interprets theoretical ideas and how this influences his or her practice, rather than these power games continuing to function on a level which is out of awareness.

The literature suggests that therapists seem to use theory to shield themselves against a client's angry attacks, limiting real engagement and creating a more predictable environment for the therapist. It therefore could be that an effect of PTCD on practice is an increased ability to reduce uncertainty, increase a sense of professionalism and reduce anxiety for the therapist.

2.11 Epistemological Confusion

The following section of this chapter reviews the literature which tackles what appears to be an inconsistency between epistemological stances in relation to how theory is interpreted in the literature, for instance whether this is from a positivist or a social constructionist perspective. This section identifies an incongruity of epistemological stance in counselling and counselling psychology training, the theoretical literature and therapeutic practice, identified by a number of historical and contemporary authors.

Some identify that therapists can fall into a 'trap' whilst trying to find the balance between acknowledging theory and accepting an inability to 'know' (Spong, 2007b) in an attempt to traverse these two contradictory approaches. Some show concern that therapists are expected to believe fully in their theories for their practice to be effective (Omer & Strenger, 1992). In this sense it seems dominant discourses are executing their power, and perhaps it should be questioned how much these discourses are influenced by theorists marketing their theoretical frameworks. This trap may be a result of teaching practices not advancing to include social constructionist or postmodern perspectives for their trainees. A dialogue that brings this into awareness therefore might be of use.

The dominant discourses (particularly those provided by PTCD) seem to cause confusion, as 'psychotherapists tend to make truth claims for theory, even when claiming to reject this as a position,' (Spong, 2007b, p. 58). Even Freud (1912) seemed caught in this contradiction, because even though he dedicated his life to the creation of theory to understand the human psyche, he insisted that:

If [the analyst] follows his expectations (i.e.: memory) he is in danger of never finding anything but what he already knows; and if he follows his inclinations (i.e.: desire) he will certainly falsify what he may perceive, (p. 112).

Freud's commitment to theory does not fit comfortably with this statement, yet it does reflect his openness to theoretical change, and as Billow (2000) noted, he changed and updated his theories constantly throughout his lifetime. This invites the question of why his theories were written with such conviction if they were subject to change.

Research by Buckley et al. (1979) highlighted an epistemological contradiction over thirty years ago. Through questionnaires given to experienced psychodynamic psychotherapists about transference and countertransference, it was found that therapists claimed to prefer 'value-free' therapy, yet their tendency was to impose their values in practice nevertheless. These types of findings are reported elsewhere by Fonagy (1999) and Downing (2004), who state that even therapists who question the nature of truth are drawn into modernist interpretations of theory when working with clients.

Spinelli (1995) also highlights an incongruity between what is preached and practiced, and argued that even though contemporary theorists claim to appreciate the possibility of a 'real' or 'person-to-person' relationship (Clarkson, 2003), the majority of practitioners still use the concept of 'transference'. This contradictory state seems to be intensified by authors who preach uncertainty, such as Spinelli (1995) and Gross (1999) who view theory as thwarting the therapeutic encounter. They also propose that, in training, therapists should learn from experience rather than theory, encouraging the trainee to find his or her own language and meaning with the client, which is not impinged upon by theory. Some think differently however, and emphasise the importance of positivist ideas, particularly in the early stages of training:

Novices need time to develop their practice, and in its early phases they often find the principles, concepts and classifications that positivist theory offers helpful, (Collin, 1996, p. 71).

However, as in Spong's (2007b) accounts, it seems to be denied that this could also be the case for experienced therapists.

Frank (1973) describes that therapists begin their training with positivist theory only to be immersed in postmodern thinking later down the line, and that the two approaches contradict each other completely. Perhaps if the therapist is initially taught modernist theory and only later does he or she become exposed to a more postmodern way of thinking, he is caught in this contradictory, impossible

position. Leary (1994) takes a fatalistic approach to combining modern and postmodern theory, with the attitude that one must be sacrificed for the other, and the therapist must choose his or her epistemology:

Psychoanalysis recast as postmodernism and the more familiar accounts of psychoanalytic psychology yield a clash of discourses. Postmodernism and psychoanalysis are not equivalent systems and do not employ common assumptions. Postmodern ideas simply cannot work if one holds psychoanalytic notions about prior, real world referents to conscious and unconscious mind. Similarly, psychoanalytic theories do not exist in anything approaching their usual incarnation with postmodern discourse, (Leary, 1994, p. 451).

According to this attitude, if the therapist later takes on a postmodern approach, he or she is then at odds with the ‘confined, standardized, therapy manualized, treatment packaged, predicted, controlled, tamed, neurotransmitted, behaviorally-managed, protocol driven, manage care approved, and empirically validated, medical model’ (Anderson, 1999, p. 316). Yet despite the contradictory approaches, can therapists find a way of managing this tension?

However, some practitioners still write with evident certainty about PTCD (Laughton-Brown, 2010). This is demonstrated by the therapist Mouque (2005) who wrote that as a client she *‘began to understand the transference and its effect on the therapeutic relationship’* and *‘came to recognize the resistance’*, (italics added, p. 153). In Mouque’s (2005) account of her own therapy, she gives the impression that she is ‘discovering’ something new that was there all along, rather than seeing transference and resistance as potentially useful constructions she reinvented with her therapist. Although neither way of viewing these phenomena can be said to be correct, this demonstrates a split in the literature between those with a positivist or a postmodern epistemological stance towards psychodynamic frameworks of understanding.

Can the epistemological confusion be resolved? Downing (2004) attempted a resolution to this dilemma by proposing a ‘dialective of conviction and uncertainty in psychotherapy practice’ (p. 138). He claimed that therapists cannot function without theory but must ‘strive to remain uncertain of the truth,’ (p. 139). In struggling to manage this epistemological confusion, Downing (2004) identified ‘an enduring tension between affirmation and critique: the therapist’s conviction, which grounds the therapeutic exchange, pitted against the therapist’s uncertainty, which questions all assumptions,’ (p. 123). This provides a possible way of managing the ambiguity which is faced by therapists in their practice.

Another proposed solution to the contradiction is proposed by Cecchin (1992) who writes in relation to the adoption of a social constructionist epistemology:

A social constructionist therapist may, at different moments, follow many different leaders, but never obey one particular model or theory. He or she is always slightly subversive towards any reified 'truth'. In this sense the therapist illustrates a postmodern sensibility wherein the relational context is recognised as providing the therapeutic constraints and possibilities...yet the irreverent therapist does not enter any therapeutic relationship void of ideas, experience, or privileged constructions...the challenge is the negotiation and co-construction of viable and sustainable ways of being, (p. 93).

What seems important in these proposed ways of managing epistemological contradiction is that they don't themselves create a new dogma whereby this way of practicing becomes the 'correct' way. This critique of the literature has aimed to give an account of the general theories about linking theory and practice, a deconstruction of PTCD and an outline of some of the existing research in the area. It has reviewed the extant literature which both critiques and supports the professionalism of practice, and therapist anxiety. Despite the literature identified, the effects of how PTCD are interpreted and the subsequent effects of this on practice have been largely unaddressed by researchers in counselling psychology, hence the need for further inquiry.

The following chapter identifies the chosen methodology and method of the current study, and is followed by the results in chapter four. Chapter five presents a discussion of how the existing literature reviewed here relates to the findings of the current study.

CHAPTER 3: METHODOLOGY AND METHOD

This chapter gives an outline of the underlying social constructionist approach to the study, and the method through which this epistemology was implemented. It is addressed that social constructionism (Burr, 2003) and symbolic interactionism (Mead, 1934; Blumer, 1969) arose from the postmodern turn in epistemological thinking, and these perspectives are considered in relation to counselling psychology and research, and compared to other epistemological approaches. Following this is a description of the method, including the design, population, sample and sampling procedures, and the instrumentation of the study.

The qualitative analysis of semi-structured interviews with counselling psychologists was conducted using a grounded theory method and social constructionist methodology. The resultant ‘theory’ from this analysis is also subjected to the rigours of social constructionism: the theory constructed as a result of this research is only able to represent ‘local knowledge’ (Neimeyer, 1998). Findings are the creation of both researcher and participant, bound by the symbols of the language used to describe it, and therefore does not reflect a ‘truth’.

3.1 Methodology

The methodology underpins the method of inquiry and describes the way in which the researcher viewed the phenomenon being investigated. It not only had an impact on the way the data was collected and analysed, but it also formed the philosophical assumptions underlying the study.

3.1.1 Positivism vs. Relativism

Most psychological theories rest on a positivist, objectivist epistemology and ontology (Hansen, 2004). August Comte (1798-1857) set out positivism as a perspective (Lees, 2008) and described it as a truth of a theory being based in the ability of the theory to predict happenings. Hence, a positivist perspective indicates that objects exist independently of human perception, and they can be accurately perceived and researched as they exist in the world. Therefore, positivism suggests that there exists a reality, and that there is only one accurate way of perceiving it (Burr, 2003). This perspective assumes that humans can achieve true knowledge and objectivity through rigorous research methods: a universal truth can be attained through the administration of scientific procedures, and that the researcher can be an unbiased, passive observer (McLeod, 2003; Charmaz, 2006). Objectivity claims that subjective thought, culture, time and other influences can be controlled and subsequently prevented from having an influence on data. While positivists would argue that qualitative research is

‘impressionistic’ (Charmaz, 2006, p. 6), it is agreed here that the findings are representative of the researcher’s impression of the data, but that quantitative methods give the illusion of objectivity when in fact they are also influenced by the researcher’s subjectivity, or the particular view of the world endorsed by the tools used to measure the phenomenon in question.

In contrast to positivism is the relativist perspective, which states that there is no way of perceiving reality as it is, as one’s perception is bound by his or her humanness. From this perspective there is a multiplicity of truths: ‘our theories and hypotheses must of necessity arise from the assumptions that are embedded in our perspective’, (Burr, 2003, p.152). As Crotty (1998) remarks, realism (the belief in a reality outside of perception) should not be contrasted with social constructionism or relativism. It is possible to think that there exists a reality, although a positivist would declare this reality as accurately measurable, whilst a social constructionist would claim to be limited by social discourse which shapes and limits how the world is perceived (Crotty, 1998). Hence social constructionists don’t agree with finding ‘truths’ but accept that there may be a reality that exists beyond definition.

Under the umbrella of postmodernism, a relativist social constructionist epistemology challenges the premises of positivist thinking. It sees statements of ‘truth’ as socially oppressive and powerful routes to dictatorship (Burr, 2003). For instance, the validation of one viewpoint above another is seen as enforcing the dominant social groups which constructed that particular meaning. Some social constructionists call themselves critical realist, whereby knowledge and discourses are seen to somewhat reflect reality. From this perspective it is assumed that even though there are a multitude of ways of perceiving the world, there are discourses which reflect the nature of reality which are more valid than others in determining the ‘truth’. This position is not adopted in this research as it attempts to traverse the argument between realism and relativism. This is problematic because suggesting one discourse can be more ‘accurate’ than another, the perspective seems to return to a positivist outlook. In the current research a relativist ontology is adopted to inform the analysis of the findings and how they might be understood.

This research is also based on a premise of social constructionism which states that knowledge is contextual and dependent on culture and society (Burr, 2003): objectivity is not possible. The adopted perspective takes into account that all humans are inextricably linked to language and discourse, and perception depends on discourses constructed within the social environment. Therefore, one can never get to the real essence of what is, and cannot bracket out such influences (Luca, 2010). Instead what is seen is completely determined by language, interaction and social constructs. Although in history this approach has been used more by social psychologists than counselling psychologists (Gergen, 1973), it is highly relevant to the practice of counselling psychology, counselling and

psychotherapy as professionals in this field are grappling with a multitude of theories about the human mind. It also adjusts the view of the person from the individual to the context and influences of society.

3.1.2 *Symbolic Interactionism*

Within the social constructionist framework lie the principles of symbolic interactionism, a set of ideas which inform the theoretical framework which underpins this research. Symbolic interactionism rests on the principles that humans act towards objects depending on the meaning that object has for them, and that meanings come about as a result of social interaction with others and through a process of internal dialogue (Mead, 1934; Blumer, 1969). The use of the word 'symbolic' refers to a person's interpretation of the meanings of the actions of others, as opposed to non-symbolic interaction which can be equated to a response to a stimulus, or a simple reflex (Blumer, 1969).

Symbolic interaction occurs through negotiating language with others and through the process of 'internal conversation' and 'self-talk' (Porpora & Shumar, 2010). As such, Vandenberg (2010) states that symbolic interactionism is a theory of 'linguistically mediated collective action,' (p. 60). Blumer (1969) stated that people act and interact depending on the meaning that others have for them, which in turn has been developed through the process of symbolic interaction throughout the course of that person's life. A self-concept is also developed through 'the observation of others, life experiences, reflection within, and discussion with others,' (Crooks, 2001, p. 14-15).

Symbolic interactionism influenced Crooks (2001) in her study of factors and situations that influence women's health. She used it as a guide, and reported that it made her ask questions to seek an understanding of what her participants knew, how they perceived, what they understood and prioritised, what definitions they used, how they acted in the past and present, and to understand how they solved problems. So rather than focusing solely on the individual as an actor independent from his or her surroundings, a continually changing context and social influence is taken into account when analysing his or her accounts. For instance, Crooks (2001) identifies that when interviewing nurses it became apparent that they had 'been socialized to view the world from the biomedical perspective,' (p. 22).

Symbolic interactionism emphasises questioning how meanings are constructed in the interview context between acting agents. For instance, if as symbolic interactionism states, humans have a

number of different ‘selves’ which arise in different contexts (Charon, 2007), how might the ‘self’ the researcher and interviewee are choosing to portray in the interview setting influence what is said, or what is not being said? What impact does the meaning the participant places on the interview have? What impact does the researcher’s assigned meaning to the situation have? The fluidity of meanings which arise through the symbolic interaction between participant and researcher makes both parties responsible for the explanation of the phenomenon. Alongside social constructionism this accounts for both the micro and macro influences on a person’s spoken word and meanings they assign to objects and others.

3.1.3 Symbolic Interactionism and Social Constructionism

Social constructionism and symbolic interactionism are both a challenge to the tenet that humans can be objective observers, and both oppose a positivist approach to empirical research. An implication of this for this research is that meanings or theories that emerge through this study remain wholly contestable and open to change (Neimeyer, 1998). This is opposed to previous epistemological thinking within the field of psychology, which has been based on a positivist framework for much of its existence (Fassinger, 2005), but recent developments have begun to include consideration of these ideas which address the impact of the researcher, social influence and perception.

In believing that by coming together people create meaning (Fassinger, 2005), it must be acknowledged in this research that another researcher might follow a different route of inquiry, or see some themes as more prominent. As Charmaz (2006) states, this is because each stage of inquiry is influenced by our assumptions, interactions and therefore unique interpretations. This research is based on the subjective and interpretive analysis of data: ‘the task of the researcher is ultimately to place a ‘text’... in some kind of interpretive framework of meaning,’ (McLeod, 2003, p. 7), whereas positivism assumes that the researcher can view what is happening as contained, generalisable and static across time (McLeod, 2003).

The theories of symbolic interactionism and social constructionism reframe the study of human processes from a social context. For example, a social constructionist epistemology endorses the view that psychopathology should be reframed as a difference to what is the socially constructed norm, and, for example, a difficulty living in a different culture to one’s own shouldn’t be located as a problem in the individual who struggles. In this way, social constructionism brings a new perspective.

3.1.4 *Social Constructionist and Symbolic Interactionist Grounded Theory*

Grounded theory is appropriate for research in counselling psychology, as this method is rare in its ability to integrate theory and practice through ‘the construction of theory from the lived experiences of participants’ (Fassinger, 2005, p. 165). It does not seek to test existing theory, and rather, allows a theory to emerge (Wimpenny & Gass, 2000). Despite these fundamental principles, grounded theory is used from a number of conflicting philosophical underpinnings, and more recently has been developed from a social constructionist perspective (Charmaz, 2006). This has received some criticism in the literature.

Glaser (2002) challenges the view that grounded theory is solely a constructionist enterprise in his paper ‘Constructivist Grounded Theory?’ He argues for objective reliability associated with the careful and precise use of the techniques guided by grounded theory:

The [grounded theory] researcher does not “compose” the “story”...they are generating a theory by careful application of all the GT procedures. The human biasing whatever is minimized to the point of irrelevancy in what I have seen in hundreds of studies. The GT reflections of the researcher are his/her skill at doing GT, (Glaser, 2002, p. 16).

From this perspective, findings are viewed as accounts which can accurately describe and explain phenomena, with the assumption that it is possible to denote truth and discover new knowledge. Glaser (2002) also states that ‘the carefulness of the GT method...makes the generated theory as objective as humanly possible,’ (p. 19), and goes on to say that a social constructionist view simply underplays the influence of the participants’ view and overplays that of the researcher.

Charmaz (2006) responds to these arguments and asserts that theory is constructed and does not exist independently, awaiting discovery. Her version of social constructionist grounded theory (Charmaz, 2006) sees ‘bias’ as the researcher’s inescapable influence upon the data, and hence acknowledges that the results from such a study incorporate both the participants’ and researcher’s views. As Mischler (1991) describes, the meaning of questions and their answers are created in the discourse between researcher and the participant as they try and understand what each other is saying. Therefore, although this research aims to inform the practice of counselling psychology, findings remain disputable and changeable, and are certainly not all-encompassing. Social constructionist grounded theory does not assume that the theories it constructs have overarching applicability (Mills

et al., 2006), but the findings provide one way of describing and explaining the social processes for those particular therapists at that particular point in time, and within their particular culture.

Although a number of qualitative research methods use similar data collection techniques, interviewing strategies and analytical procedures, a social constructionist grounded theory method seemed most appropriate for research of this nature, as a theory was to be constructed about social processes, with particular reference to the interaction between people (Blumer, 1969). Interpretative Phenomenological Analysis (IPA) was not used as it seeks only a description of a phenomenon (Wimpenny & Gass, 2000). Rather than this, grounded theory intends to construct a theoretical model which gives possible contextual and inter-personal explanations for the process being studied. Phenomenological methods such as IPA focus on ‘embodied experience’ (Starks & Trinidad, 2007) and individual construction of meaning (a constructivist epistemology), whereas this research is concerned with the construction of meaning between people. Rather than producing a description of the individual therapists’ experience, a theory is generated which proposes an understanding of the intricate social processes which have an influence on the effect of PTC and their application to practice, as social processes are accountable for the actions of the participants.

Although discourse analysis could have been implemented from a social constructionist epistemology, this was not the method of choice, as it focuses on the meanings from words and text rather than on the created meanings in social interaction (Starks & Trinidad, 2007). Discourse analysis focuses on how things are said (for instance, the meaning of pauses between words and sentences), and ‘involves tracing the historical evolution of language practices and examining how language both shapes and reflects dynamic cultural, social, and political practices,’ (Starks & Trinidad, 2007, p. 1374). Whilst an understanding of language is central to discourse analysis, grounded theory places more emphasis on meanings negotiated through social processes. Despite the importance of language in psychological therapy, this study focuses on how therapists manage their role in a highly social field of work. The underlying influences, pressures, coercions and social ties were sought through the construction of a framework which provides an understanding of the therapist’s role at a deeper level.

Charmaz (2006) emphasises the emergence of theory and is averse to fitting data into restricted, pre-formed categories. In Strauss and Corbin’s (1998) version of grounded theory they suggest using a ‘coding paradigm’, which includes the process of ‘axial coding’. This requires the researcher to find implicit information in the data, such as conditions, interactions amongst actors, strategies, tactics and consequences. Glaser (1978) suggested theoretical coding according to his six categories: causes, contexts, contingencies, consequences, covariances, and conditions, which to him constitute the six

‘coding families’. Charmaz (2006) argues that these methods close off potential routes of inquiry, and Heath and Cowley (2004) also state that themes should emerge more freely. They argue that Strauss’s (1987) approach leads to ‘moving down irrelevant paths which effectively close off the research,’ (Heath & Cowley, 2004, p. 148). On reflection, the researcher considered that Charmaz’s (2006) argument was somewhat contradictory, coming from a social constructionist epistemology. If one is to believe that what is perceived is inherently biased by social context, past social experiences and culture, then the data and analysis will always reflect this. Either method could have been used in this study, as long as the researcher strived for reflexivity.

Charmaz’s (2006) approach consists of initial and focused coding, constant comparisons, and ‘emerging’ themes, followed by theoretical coding to integrate around a core category. Memos were created and later became a part of the emerging theory (Charmaz, 2006). Although Charmaz (2006) speaks of codes ‘emerging’, this study refers to codes and categories being constructed as a result of the researcher’s interaction with the data. It was not assumed that codes emerged free from the researcher’s influence, perspective, biases or dogmas. Again this highlights the importance of reflexivity. Fassinger (2005) noted that, ‘[Grounded theory] is considered reflexive in that the influences and processes of the researcher are made explicit’, (p. 157). The researcher’s reflexivity is discussed at greater depth in chapter five, and during the data collection and analysis the researcher used memos as a method of noting down personal thoughts and influences, as described later in this chapter.

Finlay (2002a) also emphasises the importance of reflexivity, for which tools are used to acknowledge the impact of the researcher, whether it be the conscious or unconscious dynamics within the research-participant relationship, or the viewpoints and interpretations of the data by the researcher. Reflexivity provides an evaluation of the research process and method, all of which may have a profound effect on the quality and type of data that is collected or constructed. For these reasons a methodological log of research decisions was kept throughout the research process to account for decisions made along the way, in addition Charmaz’s (2006) recommendation of memo-ing. These two tasks provided an ‘audit-trail’ of the ideas and decisions of the researcher (Starks & Trinidad, 2007).

3.2 Data Collection

3.2.1 Sampling Procedure

The initial purposive sample was taken from a population of counselling psychologists, chartered with the British Psychological Society (BPS). Counselling psychologists were preferentially chosen as participants because this research was aimed at giving counselling psychologists a voice, as it is a developing and relatively young profession, with differences to other therapies in its reported integration of science and practice (Williams and Irving, 1995). Chartered counselling psychologists are required to have training that incorporates at least two therapeutic modalities, in an integrative framework (British Psychological Society (BPS), 2008). For involvement in this research, participants must have had at least one year's full time training in psychodynamic theory.

The sample also included therapists accredited with the United Kingdom Council for Psychotherapy (UKCP) and British Association for Counselling and Psychotherapy (BACP), due to a lack of response from counselling psychologists across the UK. The nature of the study suggested that other therapists should also be equally equipped to answer the research question, given they have had at least a year's psychodynamic training. Counselling psychology has learned and borrowed heavily from these accrediting bodies, and as a whole therapeutic practice across these professions is often based on the same theoretical models, such as the psychodynamic, psychoanalytic, person-centred, cognitive-behavioural and existential models (UKCP, 2008; BPS, 2008). It was essential that all participants had training in a psychodynamic modality so they were equipped to answer the research question, and therefore these inclusion criteria were made explicit in the advertisement and recruitment information.

Participants were later sampled theoretically in order to refine the concepts and categories of the developing theory (Charmaz, 2006). It became apparent that integrative therapists were tending to find the question hard to answer; therefore the researcher sought therapists who were trained purely in the psychodynamic model as well. The intention of this was to pursue the question of whether this was just a phenomenon associated with integrative therapists or whether the same applied to therapists who were specialist in this area. This helped to refine the sub-category 'finding the research question hard to answer', as through sampling two purist psychodynamic practitioners it seemed apparent that they also struggled to explain how PTCd affect their practice.

To generate a sufficient amount of data, twelve participants were recruited in total. Although Charmaz (2006) recommends continuing with data collection until the point of 'saturation', where new themes cease to 'emerge' (Charmaz, 2006), the researcher chose not to carry out the sampling in

this way as it was thought saturation could not be reached. The collection of data could be everlasting as there are many valid ways in which the data can be perceived. Instead, the recruitment of twelve participants provided adequate data to create a meaningful theory within this particular social context, at this particular time. This research does not claim to have reached a point of ‘saturation’ because this might implying, misleadingly, that there is no new data to be added to the theory and the theory is accurate or objective.

The sampling procedure followed these steps:

1. The researcher searched the BPS, UKCP and BACP online directories for therapists who adhered to the inclusion criteria as above, where their orientation is made apparent
2. Therapists who fit the inclusion criteria were entered into a list of ‘possible participants’, and were e-mailed to enquire about their interest and suitability for the study.
3. Those who responded and who were eligible for inclusion were sent the recruitment information form (see appendix IV, page 137) to further enquire about their interest and suitability.
4. An advertisement was placed on the BPS website to which no participants responded, so all participants were recruited by contacting them by email. The BPS Policy Advisor was contacted to ascertain the ethical suitability of contacting potential participants by email, whilst UKCP and BACP websites had criteria which made explicit the therapists’ preference whether or not to be contacted for research purposes.
5. As and when respondents showed their interest, the researcher organised times and dates to carry out the individual interviews. The recruitment of participants was an on-going process throughout the data collection and analysis phase, and ceased after the twelfth participant had agreed to take part. No other participants volunteered for the study and therefore no participants were turned away from taking part. If more therapists had volunteered to take part they would have been interviewed depending on the time constraints of the study.

3.2.2 The Interview Schedule

To begin the interviews, participants were asked how they tended to practice, to encourage them to speak freely about a very broad topic. They were later asked the research question: ‘What effect, if any, do PTCd have on therapeutic practice?’ They were given prompts, and questions such as ‘What does that mean to you?’, ‘Can you tell me more?’ and such. The initial interview schedule (appendix I, page 131) was used more often if the participant became seemingly off-topic or was struggling to answer the initial question. The researcher asked questions which encouraged elaboration by the participant (Starks & Trinidad, 2007), which became more focused on particular themes in the latter

half of the interviews (Charmaz, 2006). The interview schedule changed between individual interviews as themes began to take shape (see the final interview schedule in appendix II, page 132).

3.2.3 Procedure

1. The participant and researcher organised a mutually appropriate time and place to meet for the first interview.
2. The participant was asked to sign the consent form and given the chance to ask any questions before the interview began.
3. The interview began and the tape recorder was turned on.
4. The interview finished when it came to a natural end (when all questions were asked and when the discussion seemed to be coming to a close), usually around one hour later.
5. The participant was asked to sign the debriefing document (appendix VI, page 141), and verbally informed of their right to withdraw. Participants were later emailed to say that their data would be destroyed 6 years later, as this was initially missing in the debriefing document.
6. The interview content was transcribed and analysed.

3.3 Data Analysis

3.3.1 Initial Coding

Initial coding began after the first interview had taken place, in conjunction with the data collection from subsequent interviews. Codes were constructed from the data by moving through the written transcripts word-by-word and line-by-line, whilst being alert to possible meanings being expressed by the participants (Charmaz, 2006). From a social constructionist perspective, the data was analysed with regard to the social and individual constructions entrenched in what was said (Burr, 2003). The research question was kept in mind, and throughout the analysis the researcher would ask herself, ‘What social discourses could be influencing the participant at this time?’, ‘What is the participant trying to say about the effect of PTCd here?’ and ‘What are they saying about how they practice, and what can be inferred from what they say about their practice?’ (Charmaz, 2006). Some examples of initial codes that came up were, ‘explaining client’s predicament’, ‘struggling to answer the research question’, and ‘feeling initially confused’. The initial codes, written in the form of ‘actions and processes’ (Charmaz, 2006, p. 69), were noted in the margins of the transcripts. After individual transcripts were created, these were filed as ‘master copies’, separately from the participant’s identifying details. An example of the initial coding is shown in appendix VII (page 144).

3.3.2 *Focused Coding*

Sections of transcript that had relevance to different themes were copied and filed within a separate categorical system. The aim of this ‘focused coding’ was to ‘synthesize and explain larger segments of data’ (Charmaz, 2006, p. 57). Through this process, comparisons were made between new and earlier data and codes were checked for their relevance to the larger code they were chosen to represent (see appendices VII to X, pages 144-170, for an example of how the focused coding developed). This process involved cutting the transcripts into sections and sorting these sentences or paragraphs into different groups, each one representing a focused code. The focused code was a phrase chosen to represent a group of initial codes, which was sometimes the same as the name of an initial code itself: an ‘in vivo’ code (Charmaz, 2006). In vivo codes were preferable as they stayed closer to the words that participants had used.

Through this process, new data was synthesised with previous focused codes that had arisen from prior interviews. Through the process of ‘constant comparison’ (Charmaz, 2006), new initial codes were compared with the previous ones and the names of focused codes were adjusted accordingly. This led to the accumulation of approximately one hundred focused codes. These were later condensed and collapsed into categories prior to theoretical coding.

3.3.3 *Theoretical Coding*

Theoretical coding creates explanations for the relationships between focused codes (Charmaz, 2006). The ‘categories’ that are a result of this phase integrate around a core category (Heath & Cowley, 2004; Charmaz, 2006). Theoretical coding brings the codes created through focused coding into a coherent analytic story (Charmaz, 2006). In this research two main categories were formed through the process of theoretical coding, which subsumed all of the focused codes and categories. A core category was then developed to bring these two main categories together into a theoretical model.

As an example, focused codes such as: ‘explaining clients’ presentations with PTCD’ and ‘finding the research question difficult to answer’, were brought together under the same overarching theme: ‘an unquestioning use of PTCD’.

3.3.4 *Theoretical Sampling*

The purpose of theoretical sampling is to refine categories and focused codes (Charmaz, 2006) so they are described in as much clarity and depth as possible. As such, the researcher ‘construct[ed] conceptual categories from the data and sampl[ed] to develop these categories,’ (Charmaz, 2006, p. 101). Areas of inquiry that arose as a result of the data analysis were therefore pursued through going back to the field, such as through the recruitment of two purist psychodynamic practitioners.

Theoretical sampling can also take the form of changing the interview schedule (Charmaz, 2006). This could include adding, subtracting and altering questions posed to participants in order to gain greater depth and understanding. Theoretical sampling also ‘helps to...check, qualify, and elaborate the boundaries of [the] categories, and to specify the relations among categories,’ (Charmaz, 2006, p. 107). Although Charmaz (2006) expresses concern that more focused questions may seem as if they are leading the participant in a particular direction, she notes that it is important to see focused questions as a skilled strategy to deepen and refine categories. In this study, the theme ‘theory abates therapist anxiety’ was refined by taking the subject to the following participants. The researcher listened to see if they brought up this idea independently, prompting them on the subject if not. In this way the interview schedule developed and was driven by what previous participants raised about issues they thought were important.

The researcher also took ideas such as the focused code ‘PTCD have an impact on the boundaries therapists keep’ (as raised initially by participant 3) to later participants. This had the effect of getting participants to talk about their experience of how PTCD changed their practice, and led to the development of focused codes such as ‘explaining clients’ presentations with PTCD’. In this way the development of the interview schedule seemed to be a useful part of the process in eliciting more information from participants about the way they worked. Ideally this would have continued to a point where all prominent focused codes were brought back to participants to refine them, although the time limitation didn’t allow for this depth.

Grounded theory is very much reliant on the hunches and ideas of the researcher, but theoretical coding allows for more participant involvement in the development of the theory. Through this process participants are encouraged to comment on, refine and challenge the ideas of previous participants and the researcher’s analysis of them, leading to a more refined theoretical model. This is a form of reflexivity, comparable to Finlay’s ‘inter-subjective reflection’ (2002b).

3.3.5 *Memo-Writing & Theoretical Sorting*

Memos were a way of writing down ideas and thoughts that came to the mind of the researcher, and was a continual process throughout the research process. Charmaz (2006) states that memo-writing is a way for the researcher to analyse his or her ideas about codes and categories, making it possible to see some of the effect the researcher has on the data. Memo-writing was also used to identify gaps in categories, and as such, it served as a tool to indicate where theoretical sampling would be useful for the development of themes. Memos, along with codes and categories, were brought back together again by ‘theoretical sorting, diagramming and integrating,’ (Charmaz, 2006, p. 115).

3.4 **Category Saturation**

‘Saturation’ is the principle in grounded theory that the researcher can stop collecting data when the interviews cease to bring anything new to the categories identified by the researcher (Charmaz, 2006). Although sufficient depth had been reached in each category to form a coherent construction of meaning, ‘saturation’ was not a principle endorsed by this research, as mentioned above.

It could be challenged that theoretical saturation might not be possible in any research, no matter how expansive, and the ‘saturation’ of emergent categories can from this perspective be seen as a catch-all phrase which can be used to legitimise small participant samples (Charmaz, in interview with Puddephatt, 2006). In this study, saturation was also viewed as impossible because finding a limit to the number of ways therapists can explain their practice or how theories affect their practice is not necessarily achievable. A social constructionist perspective maintains that there are numerous ways of viewing or explaining a particular phenomenon, and it would not be within the researcher’s power to ascertain when the maximum number of viewpoints had been reached (Burr, 2003).

3.5 **Participant Demographics and Context**

Participants varied in demographics and length of experience in both training and personal therapy (see also appendix III, page 134, for a summary of participant variables). Although a more homogenous group was aimed for, very few therapists responded to the advertisement for the study, and therefore sampling was very much based on opportunity. The data was analysed with the following variants in mind.

Gender: Participant numbers 1, 5, 8 and 12 were male, and the rest were all female, which may reflect that counselling psychology and psychotherapy are female-dominated professions.

Alternatively it may have been that women had more incentive to participate than men, perhaps due to the nature of the question.

Age: Participants were aged between 37 and 59

Race: All were white-British apart from one being white-Italian and one white-Russian.

Interview Setting: All participants were interviewed in their usual workplaces, whether this was a private therapy room (participant 12), a charity organisation funded by the NHS (participants 1, 10 and 11), the NHS (participant 4), a university setting (participant 7) or at their therapy room at home (participants 2, 3, 5, 6, 8 and 9).

Primary type of work: All participants apart from participant 7 (who was also a lecturer for a counselling psychology doctorate course) worked solely as therapists seeing clients. Other participants either worked purely privately (participants 2 & 8), privately alongside NHS work (participants 3, 5, 6, and 12), privately alongside NHS or private hospital work (participant 9), for a charity organisation funded by the NHS (participants 1, 10 and 11), or in an NHS hospital setting (participant 4).

Current political/economic climate: Interviews were carried out in 2010, at a time of turbulent change within the profession of counselling psychology. The government's initiative called 'IAPT' (Improving Access to Psychological Therapies) began to push out more psychodynamically-thinking practitioners from the NHS workplace in favour of those with a strong skill-set in Cognitive Behavioural Therapy (CBT) (National Institute of Clinical Excellence (NICE), 2011; Risq, 2011) from its launch date in 2008 (Lewis, 2012). Even before the introduction of IAPT, the NHS began to require an evidence-base, from a biomedical-positivist standpoint, which Corrie and Callahan (2000) wrote posed a challenge to the role and practices of counselling psychologists who had previously focused their work on 'opinion and experience'. In addition to this they emphasised that counselling psychology is still a newly-emerging discipline within Britain, whereas counselling has been established for some time.

Type of training: All had been trained in the UK and were practising in the country. A criterion for inclusion in the study was that the therapists had been trained psychodynamically for at least one year, and due to primarily sampling counselling psychologists, this was in the context of an integrative training including at least one other model (BPS, 2008). Only participants 9 and 12 had pure psychodynamic training in courses that lasted 2 years full-time, whilst the rest had an integrative

training which included at least one year's full-time training in psychodynamic theory and practice. These were sampled according to the chosen method, to further delineate the properties of a particular category, as explained below.

Professional body: Participants 1, 2, 3, 4, 6 and 7 were chartered counselling psychologists with the BPS. Participants 10, 11 and 5 had UKCP accreditation, and 9 and 12 had BACP accreditation. Participant 8 was an accredited member of both the BACP and UKCP.

Length of time in practice: Participants 1, 2 and 11 had five years or less experience of working therapeutically with clients, whilst participants 3, 4, 5, 6, 7, 8, 9, 10 and 12 had over five years of experience. The person with the most experience was participant 9 who had sixteen years of experience, followed by participants 4, 5, and 6 who had fifteen years. Therefore, the length of experience each therapist had had in practicing therapy varied considerably, which is considered a limitation to the study, and which is followed up in the discussion, chapter 5.

Length and type of personal therapy: The participants fell within one of the two constructed groups – those with over seven years, and those with less than 7 years of personal therapy. Those with over seven years were 4, 9, 10 and 12, and those with less were 1, 2, 3, 6, 7, 8, and 11. Those who had therapy from an integrative approach were participants 2, 3, 7, 8, whilst the rest had purely psychodynamic or psychoanalytic personal therapy. It appeared that those participants with generally less experience of both counselling and personal therapy were participants 1, 2 and 11, which is explored in relation to the findings.

Religious beliefs: The majority of participants had no religious beliefs, although two said they were Jewish.

Status of the interviewer/researcher: Participants knew that besides the researcher being their primary audience in the interview, the research would be seen by supervisors, potentially peers and other people within the counselling psychology community.

Other significant variables: Participant 8 requested payment for the interview- he said that he had done enough volunteering and felt his time should be paid for.

This chapter has addressed the methodological orientation that the researcher has taken in this study, and the method by which the research was conducted. It is indicated where the researcher deviated from Charmaz's (2006) depiction of social constructionist grounded theory. The following chapter presents the findings of the study as a result of the analysis described above.

CHAPTER 4: RESULTS

This chapter illustrates how the social constructionist grounded theory method (Charmaz, 2006) has been used to create a theory about the way therapists think about PTCB from a social constructionist and symbolic interactionist perspective. One core category and two main subcategories were constructed through initial, focused and theoretical coding methods. These categories were then organised to form a theoretical model which brought the findings together into a meaningful construct. The focused codes and categories that constitute this model are described in detail, and examples of transcript from the raw data are given. A matrix demonstrates the different levels of abstraction from the raw data (acquired from 12 semi-structured interviews), and examples of the coding processes are shown in appendices VII to XI (pages 144-170). This demonstrates that the researcher's interpretations and abstractions are grounded in the data (Charmaz, 2006). From a social constructionist and symbolic interactionist perspective, data was analysed with regard to participants' varying length of experience in clinical practice and personal therapy, their registering body and type of training, their demographics, the current social, political and economic context and in the context of the interview.

4.1 Example Matrix

The example matrix shows how the categories were arrived at from the raw data. Two main categories are presented which fall under the core category: *Tension in negotiating an epistemological standpoint*. It is placed here to demonstrate the different levels of abstraction, from raw data, to initial coding, to focused coding, to category. In the far right column, excerpts from the raw text are shown. The initial codes derived by the researcher from this text are shown the next column to the left. These initial codes were then collapsed into larger focused codes (shown in the next column to the left), which incorporated two or more initial codes. These were again collapsed into categories, demonstrated in the far left column, in order to condense the data for the formation of a theoretical concept.* Participants are from here on referred to as 'P'.

Placing high value in theoretical	Doing extra training, publishing articles because of good theory-base, reading up on theory	Studying attachment theory Seeing relating theory to practice as very	<i>'Yes, I think I've done quite a lot on attachment, I've done quite a long course on attachment theory,' (P10, lines 21-22)</i> <i>'The two case studies I have published, I think one is in psychology and psychotherapy, I, the reason why I had them</i>
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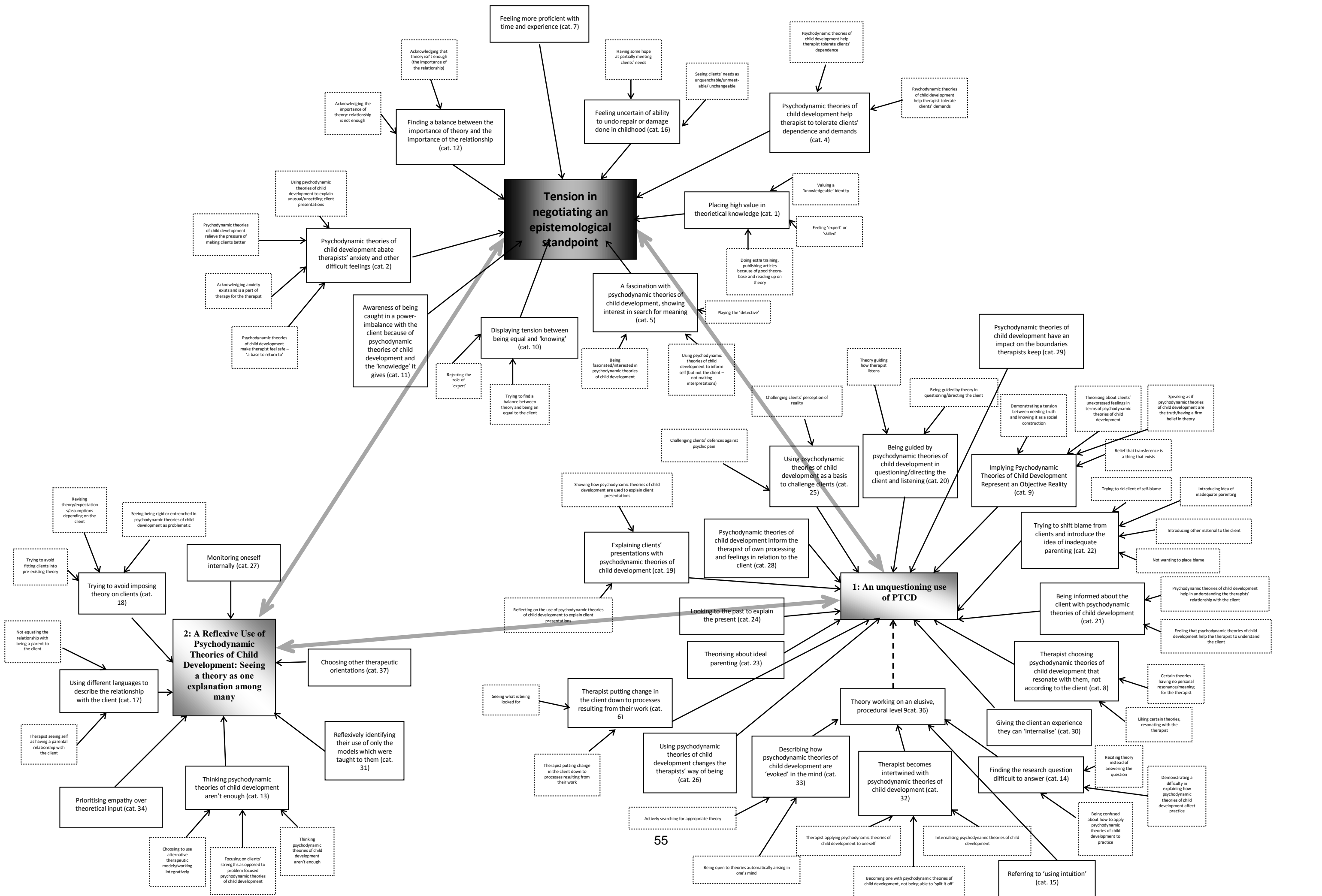
* Appendices VII to XI (144-170) give further examples of the stages of 'initial coding' and 'focused coding'.

knowledge		important	<i>published, I'll tell you now, is because of the theoretical backbone in them,' (P7, lines 714-718)</i>
	Valuing a 'knowledgeable' identity	Thinking of theory in the session and attributing this to academic status Seeing self as a specialist	<i>'...because I'm an academic I definitely do, because two days a week that's what I do, I'm teaching people,' (P7, lines 417-419)</i> <i>'I'm specialist learning disability psychotherapist but the reason they refer to me is around loss and bereavement,' (P5, lines 589-591)</i>
	Feeling 'expert' or 'skilled'	Feeling skilled Feeling expert	<i>'Yeah, it's very important, I do think so. It's a very skilled profession, I think,' (P6, lines 645-646)</i> <i>'Doing a bit of detective work, paying a lot of attention to the base and security,' (P5, lines 997-999)</i>
PTCD abate therapists' anxiety and other difficult feelings	Using PTCD to explain unusual/unsettling client presentations	Wanting to know why something happens or why people are how they are, this abating anxiety Finding reason for feeling upset	<i>'...you see the client as a result of all those years of upbringing. Someone like [client] who I have to look at as a young teenager rather than the man he is, because it's a bit too scary in that situation,' (P10, lines 895-899)</i> <i>'...sometimes you can finish the session with the client and feel upset, I don't feel so upset anymore so much, but sometimes the client can say something and after it you can feel angry and it's not about you,' (P8, lines 783-786)</i>
	PTCD relieve the pressure of making clients better	Using previous frameworks for understanding the client, saving the therapist from anxiety of not knowing Searching for theory due to feeling pressured by client wanting to improve	<i>'...it is quite helpful for me to recognise that actually that's what happens when people are bereaved. So that thought crossed my mind, this is part of a grieving process... I think the reason it was helpful for me is because I can't make it better for her,' (P9, lines 144-153)</i> <i>'Rather than looking for [theory], yeah. But sometimes there is a lot of pressure isn't there? I mean we because the patient comes, you know a lot of them wants to get better but yeah,' (P4, lines 706-709)</i>
	PTCD make the therapist feel safe – a base to return to	Using theories as support when in training Wanting to know the territory before she sets out with a client	<i>'...what I found initially when I was in training was that the theories gave me a basis upon which I could stand,' (P11, lines 375-377)</i> <i>'...so if there's a guardrail that stops you from going over the edge with your client, as it were, then hopefully you can be freed up to you know, look at what the territory is laid out</i>

			<i>there for you with the patient, with the knowledge that a guardrail exists to stop you from you know, going somewhere risky. ' (P12, lines 542-549)</i>
	Acknowledging anxiety exists and is a part of therapy for the therapist	Validating anxiety in all therapists regardless of experience Still feeling anxious at times	<i>'I think it, the anxiety in the therapist, both trainee and somebody you know, qualified for a long time, it is quite appropriate really, ' (P12, 505-508)</i> <i>'I still feel anxious sometimes, if I'm going to meet somebody new I feel excited about it and anxious at the same time, ' (P9, 658-660)</i>

4.2 Diagrammatic Representation of the Findings

The following diagram illustrates the theoretical model and shows how the focused codes, subcategories and categories are interpreted as being in relation to each other as well as the core category. The core category is illustrated by the darkest grey box at the top of the diagram, with the two other main categories illustrated by the lighter grey boxes on the left and right of the diagram. Subcategories (the white boxes with black borders) filter into the core category and two main categories, and the focused codes (the white boxes with perforated borders) filter into these.



4.3 A Grounded Theory

There is a tension in the way therapists talk about their practice. An unquestioning use of PTCD (main category 1) persisted whereby these theories remained uncontested and were spoken about as if they were indicative of reality. This alternated with a reflective use of PTCD (main category 2) where a theory was seen as one explanation among many. As these positions are epistemologically opposed, tension results (core category). There appears to be a seductive pull to use PTCD unquestioningly because these theories abate anxiety and provide a sense of professionalism and expertise. The benefits of thinking objectively about PTCD draw therapists to speak of them in this way, even if this is not in line with their epistemological standpoint at other points in time. The tension created by opposing epistemological viewpoints could be seen to result from societal demands and contextual pressures such as a mostly objectivist national health service culture and the modernist language in which PTCD are written, as well as the inter-relational discourse with the researcher.

4.4 The Interview Setting

All participants were interviewed in their usual workplaces, whether this was a private therapy room (participant 12), a charity organisation funded by the NHS (participants 1, 10 and 11), solely the NHS (participant 4), a university setting (participant 7) or at their therapy room at home (participants 2, 3, 5, 6, 8 and 9). For the majority of participants that saw clients at home, it was reported that this work was funded by insurance organisations such as BUPA, or employee assistance programmes (EAPs).

The place in which the interview was conducted did not have a noticeable impact on the findings. One might have thought that if the interview was conducted in a therapy room at home it may allow the therapist to be freer from the constraints of the NHS or hospital setting, allowing freedom to speak more critically, perhaps. This did not seem to have an impact on the findings.

4.5 Main category 1: An unquestioning use of PTCD

At times, the way PTCD were spoken about in their application to practice leaned to a more positivist epistemology. The current political and economic circumstances and the style in which PTCD are written are described in the discussion as potentially constructing this phenomenon.

In the interviews, to answer the question of how PTCD affect their therapeutic practice, participants *explained clients' presentations with theory* (cat. 19). This appeared in all interviews, regardless of the length of experience the participant had in therapeutic work:

The theories would thereby help explain what is going on, (P12, lines 338-339).

He was afraid of being freed up because he couldn't deal with the, the difficulties around his early experience and the difficulties with his attachment, (P7, lines 625-628).

In a similar way, participants showed that they valued diagnosis and described clients according to theoretical constructs:

To be aware of, yeah to be capable and hear theory but capable of making some sort of diagnostic assessment...being able to distinguish patients who, the representation of difficulties in their internal world...and for who, borderline or psychotic retreat, is possible, (P12, lines 513-526).

I didn't collude with him, so his experience was that he had bad parenting, the other thing, Freud came in – the over-critical father. So he hated his father, he was so angry and this was projected, it was projecting in his relationships, (P8, lines 229-233).

So I was very much working with the idea of splitting as a defensive strategy, strong level of disconnection in the therapy which again I see as him being defensive and unable at that point to sort of process very competing emotions, (P7, lines 597-602).

...Generally there's often anxiety that's something that gets triggered off as a result of the loss, (P5, lines 608-610).

Although it was not made explicit by participants, the researcher thought that the language they used indicated positivist leanings. This might not reflect their beliefs about at theory denoting a 'truth' because they have been taught these theories and given a language in which to describe them, and PTCD are heavily couched in modernist terms. It may have been that therapists thought of PTCD more tentatively but spoke of them as if they provided an objective viewpoint of the client.

Participants described *being guided by PTCD in questioning, directing and listening to the client* (cat. 20):

...To really sit back and listen with another kind of ear on. And the ear was much more around the questions in my mind and a level of curiosity that was saying, what

is actually going on here...so I was listening almost at a kind of removed and abstract way, (P7, lines 308-318).

I suppose that if I am reflecting on that and thinking more about their childhood then I would make an intervention that would find out, to see what that brought, (P1, lines 391-394).

Well I think on a basic level I'll be looking first of all of the role of the parents, you know, the parental upbringing, I would put as a central, you know, the main influence... Yeah, I look for it and think about it (P6, lines 125-129 and 549).

Similar to being guided by PTCD, participants spoke about being *informed about the client with PTCD* (cat. 21):

...It's mainly about informing me about how people relate... it gives me some sort of theoretical framework for understanding clients, (P8, lines 107-110),

So hypothetically, you know if I didn't have [theory], plus I firstly wouldn't have known anything about transference or what might've been going on there, like really going on about what his needs were and what he was coming to me for, (P11, lines 730-735),

[PTCD of child development] inform me I think how I understand how I feel about her and her issues and how I should work with her and should be, so I can be a good enough mother to her which is that I make sure I'm there if she wants me, (P2, lines 466-470).

Participants expressed that an understanding of the client is made possible by these theories:

I think it's a good tool for understanding the past, the present, the person, they are who they are because of their past you know, good or bad, so I think it's useful in that sense, it's really helpful, (P8, lines 583-586),

Just having an understanding of why people are like they are is very helpful for the therapist really and the client, (P10, lines 188-190).

It was also said that *PTCD changes therapists' ways of being* (cat. 26) with their clients:

And I think what I've got from that is a way of being which is filtered through the theories...which is open to the client expressing themselves in certain ways and receiving me in a way that might be about re-parenting or about an enhanced relationship... I don't think I could've got to the place that I can sit back and listen to the music if I hadn't also done the reading, (P7, lines 333-349).

By being guided by PTCD it seems the therapist has something to look for and understand about their client. For example, at the beginning of her interview and in response to being asked how she tends to practise as a counselling psychologist, participant 3 described focusing on the client's background, with the expectation that underlying issues can and will be revealed:

...Understanding and talking about the background more as the sessions progress, trying to understand what the underlying issues are, (P3, lines 15-17).

In these examples participants speak as if they have an expectation that something can be 'discovered', such as a 'truth' or an 'underlying issue'. Participant 11 makes an interesting statement about the importance of theory:

Where I may have initially experienced in front of me, a high level of distress, I may have dismissed it as being simple bereavement because he'd just lost his dad...I was ill for one session, so I had to cancel short notice, and we were then able to work with what felt like, did he feel like he was abandoned? Now that, that awareness of what that would be, wouldn't be known without theory, (P11, lines 649-757).

Participant 11, a UKCP accredited practitioner with 5 years' experience unquestioningly states that this '*awareness wouldn't be known*' if it weren't for theory. Although he had less experience than most of the other participants he, at this point, managed to articulate his use of theory well but also went on to express an openness to uncertainty. This suggests that the lesser experienced participants didn't necessarily fit more into any particular category.

An unquestioning use of PTCD seemed to occur because thinking in this way serves the therapist. For instance, participants chose theories *that resonated with them, not according to the client* (cat. 8), whilst some chose to disregard theory that had no personal meaning for them. At times participants *put change in the client down to processes resulting from their work* (cat. 6) and did not appear to question other contextual factors in the client's progress. Participant 7 seemed to exude a sense of success that she helped the client through the use of her theoretical knowledge.

So I really felt that was very successful, and I see the components of that being around the transference, (P7, lines 635-637).

While it could have been that this client's success resulted from what the therapist is naming 'transference', PTCD could be seen to serve the therapist here in providing a sense of expertise. Questioning PTCD might imply questioning the therapists' effectiveness.

Other data that shows participants spoke in a way which suggested an unquestioning use of PTCD was grouped into the focused code: *trying to shift blame from clients by introducing the idea of inadequate parenting* (cat. 22). Participant 10, a UKCP accredited, integratively-trained counsellor said:

If they have a difficult relationship with their parents and they've never even thought about it, it can give them comfort in that it's not them that's bad or, bonkers, actually that's something that's happened to them, and that's why they are like they are, (P10, lines 840-845).

Participants *theorised about ideal parenting* (cat. 23) in response to how PTCD affect their practice, and a certain standard of parenting seemed to be a consensus. It appeared that participants were somewhat certain about what it means to be a 'good parent', perhaps as if there was an ultimate truth or universal rule to describe it, as opposed to the idea that all good parenting is a socially constructed consensus about how children should be raised. Again, PTCD were written with this certainty and it appears therapists are, at times, taking on this attitude unquestioningly.

PTCD include ideas about transference patterns from previous relationships (Freud, 1938). As such, when asked how PTCD affect their practice, participants would respond by explaining that they *look to the past to explain the present* (cat. 24). In these excerpts from two counselling psychologists (P3 & P6) and one participant accredited by both the UKCP and BACP (P8) it seems PTCD are spoken about in a language that implies objectivity:

...A need to cling on to the attachments that she's made, basically because there was so much abandonment when she was younger...that relates to her childhood, you know and how that difficulty attaching, comes from them, (P3, lines 62-68).
So in a way, the, you know, the past, we are made up of our whole past in a way, (P6, lines 608-609).

I think people need to talk about the past, and most of client, it's all about the past, and it goes back to childhood, and it tends to be bad parents, or unsupportive critical parents, unfortunately, (P8, lines 290-294).

With the above quotations as examples, participants suggested by their use of theoretical discourse that it was possible to find the root cause to their clients' struggles through pursuing an investigation into their pasts.

In addition to this, participants *used PTCD as a basis to challenge clients* (cat. 25). Participant 4, a counselling psychologist with 15 years of experience, challenged her client's perception of reality, as did participant 5, an integrative, UKCP accredited counsellor also with 15 years of experience:

...So these are ideas that are based on developmental theory. Increased maturity, increased facing of reality, (P4, lines 733-735),

And she's able now to tell me, it's gone from the very idealised view when he died, to actually, he was an alcoholic, you would be talking about wanting to drink all during the day, all sorts of things were coming out and getting a more *real* picture of it now, (P5, lines 820-826).

This was also seen to be happening with participant 1, a counselling psychologist with 1 years' experience – significantly less than the other participants:

The thing is they overestimate and escalate negative thoughts. So they're totally - incongruent there, (P1, lines 222-224).

Clients' defences against psychic pain were also spoken about being challenged:

So the way to work with people like that is to watch and make them, encourage them to feel more and to bear more psychic pain – that's what maturity is, (P4, lines 145-148),

...Picking up on her distress, noticing it, trying to think about her anxieties, trying to think about her negative feelings as well and face them, (P5, lines 817-820).

From the language participants use, it seems that PTCD are thought to give an objective explanation of what anxiety and defences are. PTCD therefore give the therapist the opportunity to challenge the client's understanding and to encourage the client to 'face' his or her negative feelings.

Another practical way in which PTCD influenced practice was how they made an *impact on the boundaries therapists keep* (cat. 29). Participant 2 said she wanted to accommodate her client who was let down in the past by her parents, which was based on the idea that a provision of boundaries in the therapeutic relationship can in some way make up for a lack of them in the past. The concept of having ‘boundaries’ in a therapeutic relationship are partly the product of PTCD, as mentioned by participant 4. In addition to this, participants also spoke of PTCD influencing them by suggesting they *give the client an experience they could ‘internalise’* (cat. 30) which is an idea bedded in PTCD such as attachment theory (Bowlby, 1969):

...Maybe the idea is that he would internalise that, try to value himself more, (P4, lines 600-602).

So a patient would draw from the relationship and kind of become quite close in a sense, and then goes out there and has the kind of independence from that therapy that they’ve had to in between sessions, (P6, lines 119-122).

Participant 3 also comments on striving to help the client take a stable attachment with them once the sessions had finished, as an internal part of themselves:

...At the same time as providing her with that good object, the stable attachment figure, I would also encourage her to do things to try to develop that for herself, (lines 151-154).

Participants also spoke of using PTCD to *inform themselves of their own processing and feelings in relation to the client* (cat. 28):

I’m very keen on attachment theory. It helps me understand why I feel like I do when I’m with her, (P2, lines 455-457).

Therapists’ own emotions were understood in such a way which turned the focus back onto the client. For instance if the therapist were to have an emotion, this was sometimes seen by participants as resulting from the client’s own psyche rather than belonging to the therapist:

I have someone recently who’s very manipulative, and I felt quite irritated...and that’s when I look to the theory, she was given nothing...that was very important for me to hold on to, to understand the manipulation, (P8, lines 485-493).

Again, this statement was given in the interview with certainty, which implied an unquestioning use of PTCD at times. This comment from participant 8 occurred after I asked him what he thought of the concept of the 'secure base' (Bowlby, 1969), as this was raised in previous interviews.

Although it can be argued that speaking with certainty about PTCD does not necessarily mean that participants believed them to be true, there were moments when it did appear as if participants were indicating they had a positivist epistemological approach. For instance, participants were *speaking as if PTCD represent an objective reality* (cat. 9). Despite the participants speaking in this way, it was not clear whether a positivist or critical realist position was being adopted, and it did not indicate whether the therapists were idealist or realist. Despite this, it did appear to be a position which did not consider PTCD as one of many possible interpretations. Instead it suggested that the participants periodically took up the idea that reality can be objectively observed:

It's a part of what we're trying to achieve with patients, something that they're not expecting to discover about themselves...Attachment theory is very applicable in schools because you see it around you all the time, it's so observable, (P12, lines 148-153 and 595-597),

...Which again was probably reinforced by repressed feelings of having feelings for his mother, (P3, lines 306-308),

It's taken a long time to access her anger, I actually felt it before she did, (P2, lines 638-639),

We've only just got to identifying the critical parent and there was competition in life that this stems from, (P1, lines 42-44).

Statements such as this occurred at times in all the interviews, but to differing degrees. It could be that speaking of theory in this way provides another sense of security and professionalism for the therapist, particularly if it is believed that a body of knowledge is held which the client does not have. It is also important to note that the context of the interview might have brought about shifts in apparent epistemological stances, as the researcher herself was also unknowingly drawn into speaking of PTCD as if it represented an objective reality. Post-data collection it was noted that participants tended to shift epistemological viewpoints when the researcher responded to their dogmatic phrases about theory by slipping into this dogma herself, or when questions were posed to participants about whether they thought PTCD made them feel less anxious with their clients (a question arising from the first few interviews). These interactions with the researcher seemed to bring about a change, as

sometimes the participant would then speak in a more reflexive way about PTCD, questioning its role. This other stance is explored in the next main category.

However, returning to the category which identifies participants *speaking as if psychodynamic theories of child development represent an objective reality*, some participants spoke, for example, as if 'transference' (Freud, 1917) was an entity which exists. Again this appeared to be independent of integrative or purist training, accrediting body or length of experience. These examples are from participants 1 & 7, both counselling psychologists, participant 5, a UKCP accredited integrative counsellor, participant 11, a UKCP accredited integrative counsellor and participant 12, a purist BACP accredited psychodynamic practitioner:

R: Mmm, so do you find the psychodynamic theories of child development useful with that client group?

P: It's very useful in that I think it can bring together a level of understanding which is quite different from other theories. Largely centred around attachment theory, I would say. Because obviously the processing of a present loss is affected by the processing of previous losses or the lack of processing of a previous loss. (P11, lines 35-45).

...Take something like the transference, that's very difficult to pinpoint...it's just a felt sense of it...I think you have to have confidence and faith in that... There was something in the transference that just clicked, (P7, lines 389-397 and 561-562),

Because once you're with someone it's there, transference is there you know, (P5, lines 981-983).

Researcher: Yes, so it's a really joint endeavour in trying to understand where this is all coming from and why...

Participant: Yeah it's almost why, I sort of prefer, being like a bit of a detective, trying to, you know, having the model we have, in our mind it's thinking about your childhood experiences and what led these experiences into where you are today. I think there's a strong correlation, Bowlby makes this, between early experiences in grief or how the grief and loss is handled in early childhood, and if it's not dealt with well it can lead to later problems in adulthood. I.e.: depression, but perhaps even more seriously, psychosis, (P5, lines 446-460).

This transcript is taken from the participant's response to the general question about how PTCD affect his practice. He describes his thoughts about there being a strong correlation between early experiences and problems in adulthood, an idea central to psychodynamic principles.

As demonstrated in these quotes, at times participants spoke as if they believed there to be truths waiting to be discovered, and that therapists play the role of being the detective and unearthing lost pieces of a puzzle, as opposed to the construction of a new meaning or narrative. However, it is questioned how much language has to account for this, as it may not reflect their beliefs but be the only way in which they have language to express themselves.

Through analysing the interviews, it seemed PTCD were *spoken about as working on an elusive, procedural level* (cat. 36). For instance, at times participants appeared to be guided by theory but with little awareness that this was happening. This was thought to potentially contribute to an unquestioning use of PTCD because on this procedural level (Dreyfus & Dreyfus, 1986) they might be incorporated into a series of theoretical frameworks a person has about the world. A reflection on their use of PTCD might then become difficult, if not impossible.

This category (36) subsumed and represented other categories. Theory seemed to be working on an elusive, procedural level because participants *found the research question difficult to answer* (cat. 14). It seemed that verbalising this process was difficult. The following data is from interviews with BPS (P1, 4, 6 and 7), BACP (P9) and UKCP (P5) accredited practitioners:

Theories of development, I struggle with how to put it into practice, (P1, lines 529-530).

I'm still a bit vague, I probably will be vague for some time, (P4, lines 154-155).
Some students say this to me, they say, "what do I do? I've heard all about psychodynamic theory but what do I do?" It's not like CBT where you say, right you identify thoughts then you challenge them, I don't know what to do. And that's not something I find easy to explain, (P7, lines 323-328),

How it's done. Very hard to put into words what you do, (P6, 504-505).

In response to being asked the research question: 'what effect do PTCD have on your practice?' some recited theory, which again was interpreted as suggesting there was a difficulty in verbalising the process of applying theory to practice:

I think just general other things about childhood, of theories, is a more developmental model, you know this at certain developmental stages, latency, for example, is a period where the child is generally almost like preparing itself for the storms to come in adolescence... (P5, lines 193-199).

After this theme first arose in the analysis, theoretical sampling was conducted in order to see if purist psychodynamic trained practitioners also experienced this phenomenon (hence the recruitment of participants 9 and 12). Prior to this a question remained about whether therapists receive sufficient training in psychodynamic theory on integrative courses to be able to answer such a question. There appeared to be no difference between participants with this finding whether they were trained and accredited by the BPS, BACP or UKCP, their length of experience in practice or whether they were integrative or purist psychodynamic practitioners. For example, one purist practitioner (P9) also commented on finding the research question hard to answer, which suggests it is not the depth of training which is causing the problem:

I don't know how I would do that, how would you translate... how are you meant to carry the theory to practice? It's difficult because I'm just trying to think, what did I used to do? (P9, lines 615-619).

So even with purist training this participant found the research question hard to answer at times, which suggests theory can work on an elusive level, out of awareness. From the other comments in all the participants' interviews it seems theory *is* used to inform practice, but it becomes hard to articulate *how*.

The influences of PTCD seem far-reaching: they influence practice and the way things are seen or explained. It was even mentioned that there is a sense of *becoming intertwined with PTCD* (cat. 32). The following quotes further suggest that theory is working on a level out of awareness:

I see it as vital that every therapist has had some sort of substantial experience in personal therapy, and because I think that contributes in a really important way to one's internalising theory, (P12, lines 293-297).

It's just absorbed... You can't sort of split it off can you? No, (P9, lines 134 & 746-747).

I think with psychodynamic work you incorporate it in yourself really... it's not the filter [theory] that you're taking into the room, it's who you are having run through that, (P7, lines 352-365).

...If in retrospect I didn't have theory at all, and obviously it's very difficult to think of, if I didn't have something, (P11, lines 643-645).

Again, the purist practitioners did not noticeably differ from the integrative in this category, and neither did their length of experience seem to change the type of response they gave. PTCD seem elusive as their influence can be beyond the control of the therapist, as participants were *describing how PTCD are 'evoked' in the mind* (cat. 33). This took the form of the participant being open to theories automatically arising in one's mind:

I don't really think of theory... the theory just comes up, (P8, lines 624-626),

I don't tend to think about theory, I mean I suppose it's a bit like, we don't think about our grammar, we just speak anyway, (P9, lines 123-126),

...Some theories of child development that stays in the back of my mind, it's not something I explicitly seek, (P4, lines 307-309).

What this suggests is that therapists cannot separate themselves from theory, that they are inextricably linked to it once it has been learnt. With this and other examples, this category demonstrates the power that theory has, and its influence on practice in a number of ways, some of which are contradictory to participants' ethical and epistemological belief system.

Overall, this main category shows that therapists place high value in theoretical knowledge and use theories to attribute successful outcomes to their work. PTCD seem to work on an elusive and procedural level, as the therapists seemed to describe becoming entwined with theory, experiencing theoretical ideas being evoked in the mind.

They are used to inform questioning and listening in the therapeutic situation, to shift blame from clients, whilst adhering to a consensus of what adequate parenting is. The past is drawn upon to explain the present and PTCD are used to challenge clients' perceptions of reality and defence structures, the extent to which at times it is implied that PTCD represent an objective reality. PTCD influenced therapists' ways of being with clients in terms of the boundaries they kept and influenced them to strive to give the client an experience they could internalise, whilst monitoring their own actions and internal reactions to the client. Whilst PTCD were reported to inform the therapists in these ways, their uses and meanings went unquestioned at various points throughout all interviews.

4.6 Main category 2: A reflexive use of psychodynamic theories of child development: seeing a theory as one explanation among many

This main category shows that participants also spoke of PTCD reflexively and as if these theories were only hypotheses or explanations amongst an array of competing theories. Therefore, this category begins by describing categories which show participants taking this more social constructionist approach to PTCD.

As half of the participants were counselling psychologists, and all but two had had training in at least two theoretical modalities, the majority were able to choose alternative therapeutic models, or to work integratively. For instance, the integrative therapists spoke of times when they would not use psychodynamic theory, and would purposely *choose other therapeutic orientations* (cat. 37) from which to practice. Yet because all participants, integrative or purist, were also *reflexively identifying their use of only the models which were taught to them* (cat. 31), this potentially indicates that how they speak of their work is limited to the perspective of their modality of their training, and an awareness of other models which they either were or were not also trained in. This awareness of there being other ways in which to practice was also reflected in participants stating that *PTCD aren't enough* (cat. 13). This demonstrated the tendency to want to dismiss PTCD at times completely from their work.

Participant 1 seemed most in favour of dismissing psychodynamic theories from his work. He favoured working from a CBT orientation despite having equivalent psychodynamic training to the other participants. He had only one year of post-qualification experience at the time of interview, which might account for this finding:

...Most research is saying that the sorts of clients that respond better or more effectively to a more proactive type of intervention. And possibly, going in with something more purist psychodynamic would be a bit more severe, and not necessarily what the client is looking for, (P1, lines 99-104).

Despite participant 1 being the only therapist to comment on PTCD being 'severe', there seemed a general concern amongst all participants about *imposing PTCD on clients* (cat. 18), and a rejection of an 'expert' status as the therapist. Again this was shared between participants regardless of their length of experience or registering body:

...It's a conversation involving the unconscious, it's not about an expert with a body of theory which they are then going to impose on their ideas about the patient or the client, but that first and foremost it's a meeting or an encounter between two

minds...As soon as it becomes a rigid formula for understanding the patient I think it becomes, yeah, worse than useless really, sort of undermining of a truly therapeutic experience, (P12, lines 113-119 and 177-181),

...Essentially you always need to be person-centred throughout because it's about being there and the client is the expert. They know their own sort of solutions to their problems, (P7, lines 23-26),

I mean, I certainly don't have a template which I put onto clients, I mean I work very much with what they bring, and try to figure out what it is they need, with them obviously, (P3, lines 18-22).

These statements highlight a more reflexive use of PTCD. The theories are thought about more tentatively, and as hypotheses that are reported as offered and revised according to the client. Participant 4, an integrative counselling psychologist, identified herself revising theory, her expectations and assumptions:

I suppose every client, you know, you need to develop the theory anew for that client. All these things are based on experiences with clients, all these theories have been developed. Often it's the clients that teach the therapists about this. So they have their own theories as well, (P4, lines 916-921).

Participant 4, despite at times seemingly using PTCD unquestioningly, was perhaps the most tentative of all participants in her use of psychodynamic language. She often used phrases such as 'can indicate' or 'perhaps' or 'might be' when referring to theory, without prompting. She was a counselling psychologist with 15 years of experience, working full time in the NHS. Participant 12, a purist psychodynamic practitioner with 8 years of experience spoke in a similar way:

It's really important to my mind to be, to be constantly revising one's expectations and assumptions, ideas, theories, based on the experience of what you see, (P12, lines 617-621).

From what seemed to be a real feeling of concern, theory was reported as 'subversive', 'undermining', or causing the therapist to be 'blinkerred' (P7 lines 271-273), and it was suggested that a level of understanding, possibly empathy, was highly important:

They will have their own theory about their experience and it's that that I'm more interested in working with...I think it is so important not to become entrenched in a

particular theory, the unconscious, as I see it, is a really subversive aspect of us all and a master in disguise, waiting to trip us up, (P12, lines 424-427 and 634-638).

From their point of view, how they see themselves, not how I see them, but how they see their experience and trying to understand that and I think that's, I think that's really valuable for people to try and understand what it's like to be them, (P9, lines 594-599).

As was determined from this last statement, *empathy was sometimes prioritised over theoretical input* (cat. 34), and participants reflected on the possibility that psychodynamic theory can be restrictive in this sense. Participants also suggested alternatives to being 'blinker' by PTCD. For instance, participant 10, although previously speaking of her desire to know the truth behind child development, later rejected an expert role, and commented on the importance of being tentative:

I also know counsellors who are always making interpretations about other people, utterly irritating, because you think, how do they know? Then it's not like "I wonder if..." which I think is alright, it's "this is the way it is", (lines 615-619).

Participants tended to *monitor themselves internally* (cat. 27), suggesting a reflexive watching of one's own use of theory. This might imply PTCD themselves are questioned in their relevance to the client. For instance, participants applied PTCD to themselves, inspecting their own associations and unconscious:

...I have somebody here like myself, saying, oh it's interesting that you said that, maybe I should think about, why did I say that at that point? You know, or how it can sort of be, I can be my own internal supervisor, (P9, lines 370-375).

Very often I'm listening, I'm monitoring myself, so I suppose you'd call that countertransference or congruence, (P6, lines 414-416).

Despite this potentially indicating a more reflexive use of PTCD, it does not necessarily indicate a view of any theory as one of many possibilities, or a relativist rather than positivist viewpoint. However, a relativist epistemological stance *is* suggested by participants showing a toleration of different theories. For instance, PTCD are referred to as 'hypotheses' of which participants can still be 'sceptical':

...Not taking one [theory] as sort of, in conflict with the other, (P12, lines 284-285),

It's only my hypothesis...Not that I would dismiss any of those theories, I just think that, they're very effective perspectives that people have had in the past, (P11, lines 149, 200 & 382-385).

I was a bit sceptical of that language, still am, you know, not totally unambiguous about the whole thing, (P4, lines 772-774).

These statements seem to be suggesting a surrendering of an objectivist, unquestioning allegiance to PTCD, and taking up the idea of theories being hypotheses of which one should remain sceptical. This category demonstrates that therapists, at times, almost surrender their sense of expertise. Of course this is the case with some therapists more than others, but this did not seem to be influenced by their length of experience or accrediting body. Therapists show a sense of humility and evident concern about imposing theoretical ideas onto clients, and a striving not to be 'blinkered' or limited by theory. In this sense therapists have a preference for 'not knowing', refusing to endorse a status of expertise and handing the expertise instead to the client. In consideration of the first main category, the above data highlights that therapists take radically different epistemological stances towards PTCD during a relatively short space of time.

4.7 Core category: A tension in negotiating an epistemological standpoint

The participants seemed pulled between two standpoints: a reflexive use or an unquestioning use of PTCD. This and other data indicated that participants were in the grip of a tension between the two positions, and often this seemed to remain outside of the participants' (and researcher's) awareness. This category did not arise as a conceptual category until after all the interviews were completed, and therefore was not raised or prompted with the participants during interviews.

In terms of length of experience, the participant with only one year of post qualification experience did not directly reflect on a tension between epistemological standpoints, although his responses did suggest a tension was apparent. However, even with over 5 years of experience some therapists (i.e.: participants 5 & 8) did not speak about a tension either, suggesting experience does not guarantee a more reflexive stance. In addition to this, the participant who appeared to be most aware of a tension was participant 11 with the second-least number of years of experience (5 years), therefore providing more reason to think that length of experience does not necessarily mean more reflexivity, or more concern about an epistemological contradiction in their work.

This pull between epistemological poles was demonstrated by participants speaking of a *tension between being humble or equal to the client, as opposed to 'knowing' or 'expert'* (cat. 10). From

these extracts it appears a real challenge to remain in a position where PTCD are thought about as just possible explanations rather than truths, particularly when under pressure from clients, or from an organisation's demands (such as the NHS). The following quotes emerged in discussion with the researcher about the necessity of theory in practice:

There is something within the transference around help and there will be parentally, or course that would be the transference so that's there. So in theory I should (laughs), put the client there, knowing something that they don't, and I think that's another thing to be careful of, very much, (P11, lines 323-329).

It seems as if there is tension for participant 11, even in this short excerpt. He states almost objectively that the transference 'is there', but follows this by speaking of how one must be careful of this and the power dynamic it exerts.

I suppose that's one of the things I've moved away from, I think if you make an interpretation you can get it wrong...and it could be quite damaging. So you have to be quite careful, (P10, lines 212-219).

Participant 10 also notes feeling she needs to be more careful, but identifies that her tentativeness has developed over time. It seems that to allow oneself to be 'not knowing' is an uncomfortable, tense position to be in:

I met practitioners that are excellent at holding and containing within themselves the not knowing. And I'm not (P11, 625-627),

That's one of the challenges of the job really. Very difficult really, it's a long time before one's even kind of vaguely comfortable with that, it's quite an uncomfortable role I think. The way it should be, (P12, 159-163).

Participant 5 spoke of being a specialist in bereavement and learning disabilities, and receiving referrals because of this particular status. Perhaps the seduction of this 'specialism' and potential expertise causes him to speak of PTCD unquestioningly. This may be reinforced by the need for work to make a living, and to receive referrals:

I'm a specialist learning disability psychotherapist but the reason they refer to me is around loss and bereavement, (P5, lines 589-591).

This potentially contributes to a tension, as to be a specialist in particular client groups requires ‘expert’ knowledge. To then abandon this expert status would be at odds with one’s career and income.

Participants also mentioned feeling uncomfortable with practising without being theoretically informed, which could also indicate a tension between epistemological stances:

I think theory definitely has its place. I am uncomfortable with people practising without being theoretically informed. Having not thought it through, read it through, beforehand, (P7, lines 449-452).

This suggests that she values theory but does not use it dogmatically. But still a tension remains: how does one remain theoretically informed without imposing one’s theories on clients? Participants seemed to manage this dilemma by ‘not taking one [theory] as sort of, in conflict with the other’, (P12, lines 284-285) or viewing them as ‘hypotheses’ (P11 and P12). Yet a tension still remains, as participants often spoke of PTCD not as hypotheses but as truth claims. Perhaps this was out of their awareness, as it was to the researcher during the interviews.

The following quotation is in response to asking participant 12, a purist psychodynamic BACP accredited therapist with 8 years of experience, a question that arose through previous interviews about PTCD abating anxiety. She identified the anxiety of the client creating what seems to be a tension in her, in which she is demanded to have expert knowledge:

And many of our patients want us to know something to, so it’s a very understandable anxiety it’s not just our own. The patient will come to us and expect us to know, and generate feelings and thoughts in us, to which we respond, as the person who knows, because that’s what’s being demanded of us, (P12, 483-490).

The following quote in particular highlights a tension and *temptation* to practice in a way which one ascertains one’s status as an expert:

Researcher: (*In response to the participant raising the issue that theories should be seen as hypotheses*). I know what you mean, it’s having an idea of what could be true in your mind about clients, and thinking you know, I might be completely wrong, it’s just a theory and, not necessarily the be-all and end-all of this client.

Participant: Which is I guess in practice, the difference between...well this is obviously happening, this is what's going on, is the *temptation* as opposed to offering it out into the room as a possibility and seeing what the client does with it, (P11, lines 422-433).

Participant 11, a UKCP accredited integrative therapist, openly reflects on the dilemma he experiences as a result of researcher participation in dialogue about using theories as hypotheses, which he has previously raised. The quotes above demonstrate the researcher and participant in social interaction, creating meaning between them about the uses of PTCD.

So not only are therapists in a social and professional role where there is an expectation of theoretical expertise and knowledge, but the role also requires them to tolerate uncertainty. Therefore there is a temptation to use PTCD unquestioningly, and a tension resulting from the idea that PTCD are only hypotheses.

Participant 10, who previously commented on personally feeling more able to question PTCD with more experience in the profession, stated:

It could be that actually the counsellors that are really attracted to the psychodynamic approach, purely, actually underneath feel less confident than the counsellors that can go in as an equal with their client and accept whatever comes, in a way that's you know, an equal way, (P10, lines 464- 469).

So perhaps using PTCD unquestioningly does provide a somewhat seductive sense of confidence, expertise or knowledge. However, this was not limited to novices, as participant 11 had five years of experience compared to participant 10's thirteen, but with eight years less experience was still able to question his use of PTCD.

Tension seemed to arise as participants were *caught in a power-imbalance with the client because of the supposed 'knowledge' PTCD give* (cat. 11). Whilst at times participants would adopt a powerful role in response to this tension, at other times the power imbalance was reflected on and the discomfort was managed:

The equally challenging thing I find for me in my practice is not to accept [theories] as rote. So, is that really what's going on? Is it, it's obviously my hypothesis, I may have some point have checked out with the client, but of course the dynamic is that, as much as I might deny it, is that they're coming to me for help, and so there's

a power difference. Now even working in a person-centred capacity, this, there is something within the transference around help and there will be parentally, or course that would be the transference so that's there. So in theory I should (laughs), put the client there, knowing something that they don't, and I think that's another thing to be careful of, very much. And I need to know myself to deal with that, or a bit about myself. As much as I can. And so, very much the theories have helped and do help, (P11, lines 314-332).

I think to try and cast the relationship into a parent-child one would be highly threatening for the person if it's not what they're wanting at that time, or if it actually provoked difficult memories, responses, of what it was like to be close to someone in that way. So it's quite a... There could be a possible power-imbalance in that. So I'd be careful with that, (P7, lines 228-235).

Whilst the tension creates what seems to be a level of discomfort, so did the therapists' *uncertainty in their ability to undo or repair damage done in childhood* (cat. 16). Some saw clients' needs as 'unquenchable', yet some showed hope at partially meeting the needs of the client that could remain from childhood. In a similar sense, participants struggled to find *a balance between the importance of theory and the importance of the relationship* (cat. 12). There was the view that the relationship was not enough without theory, but that one theory is not enough on its own. This was expressed regardless of training orientation or accrediting body:

I think the key thing is the relationship. It doesn't matter about the theories. But theories obviously help you understand clients, (P8, lines 48-50).

In the early stages of his interview, Participant 8 said that theories don't matter but they help the therapist to understand clients. This was in response to being asked how he tends to practice as a therapist. Whilst starting the interview from a position of reflexively using theories, with the idea that there were many competing theories and no one which was true or correct, Participant 8 seemed to slip into a more unquestioning approach later in the interview when asked what effects these theories have on his practice:

So his experience was that he had bad parenting, the other thing, Freud came in – the over-critical father. So he hated his father, he was so angry and this was projected, it was projecting in his relationships, it was about women and I remember the client he used to explode at work, he was very isolated at work and everyone at work was an 'idiot' (laughs) and so, it was all about authority figures and you know, so it was quite an interesting case (P8, lines 229-237).

As participant 8 did not verbally reflect on these opposing statements in the interview, the researcher interpreted that perhaps in his case there wasn't a tension but a lack of awareness about the different epistemological stances he was speaking from. In the context of the interview, as participant 8 had previously lectured students in psychodynamic theory, the researcher started to feel like a student herself, with him as the lecturer. There might have been an unspoken dynamic of teacher-student in the room where he felt he had to show his expertise, and therefore was perhaps less likely to open up and admit to a tension or lack of certainty.

What contributes to a tension is that *using PTCD unquestioningly* actively serves the therapist in a number of ways, causing a seductive pull to this way of thinking. For instance, the participants *placed high value in theoretical knowledge* (cat. 1) at varying points throughout the interviews. Through putting so much time, effort and expense into training or being a teacher, the tension seems to arise partially through having to, in some senses, forfeit that knowledge as being true or correct. For instance, this is a response from participant 7, a lecturer in counselling psychology at a university:

Researcher: I wonder if you ever think about theory when you're in a session with somebody. If you think, oh about their attachment or something?

Participant: Mmm, I do again because I'm an academic. I definitely do, because two days a week that's what I do, I'm teaching people, I'm looking at recent papers and you know, so on... it's partly a product of what I do for a living, (P7, lines 413-421).

It seemed important to them that additional training was undertaken, and that theoretical material was read as well as valued:

...Every now-and-again I dip into some books because new things, you know, and new continuing professional development and I read up on various theories and new ideas and so on, (P6, lines 407-410),

...The reason why I had them published, I'll tell you now, is because of the theoretical backbone in them, (P7, lines 716-718).

Participant 5, a UKCP registered purist psychodynamic practitioner, commented on possessing knowledge about the client and hence seeing himself as a specialist:

Part of the reasons people refer to me is I'm more sort of specialist... I probably need to see him another couple of times before I reach a decision... Why are they treating me like this, you know. Doing a bit of detective work about it, (P5, lines 42-43, 671-673 and 996-998).

Tension in having opposing epistemological stances is also demonstrated by participants mentioning *feeling more proficient with time and experience* (cat. 7), but also expressing confusion due to an increasing awareness of a multiplicity of theories as one gains time and experience in practice:

I started in the training fairly certain, and the more and more I practice and the more I'm in training the more I'm confused... I guess realising the myriad of possibilities, (P11, lines 455-460).

This describes the adoption of a stance more in line with the main category: '*A Reflexive Use of PTCD*'. So while some tended to imply that with time and experience their sense of proficiency improved, participant 11 speaks of being more confused with the number of possibilities demarcated by theoretical knowledge. However, perhaps in this case a lack of certainty doesn't mean this participant feels a lack of proficiency: it might be that he feels more proficient in tolerating this uncertainty.

PTCD also have a function in *abating therapists' anxiety and other difficult feelings* (cat. 2), which the therapist interpreted as contributing to a pull to a positivist way of thinking about PTCD, as demonstrated in this quote from participant 10, an integrative UKCP counsellor with 13 years of experience:

So perhaps then it becomes easier to be with clients who become quite abusive to you, they are only five you know... You could sit solidly without feeling too damaged yourself, I suppose, kind of take it and think, oh he's annoyingly childish!... You see the client as a result of all those years of upbringing. Someone like [client] who I have to look at as a young teenager rather than the man that he is, because it's a bit too scary in that situation, (P10, lines 802-804, 818-820 and 896-899),

For the therapists, regardless of their training, accrediting body or experience, theories seem to reduce or replace anxiety with feelings of safety, comfort or protection:

...Whenever I've had clients, I haven't really had really disturbed clients, but, I want to keep that blank screen to protect myself. You know, that's where I think it's useful, (P8, lines 732-735).

It can be very comforting to know what's going on, (P11, lines 463-464).

Participant 12, who had also had extensive experience of 13 years of personal therapy, acknowledges a sense of clinging to theory to avoid 'somewhere risky':

Sometimes theory is very important to know...you can be freed up to, you know, look at what the territory is laid out there for you with the patient, with the knowledge that a guardrail exists to stop you from going somewhere risky, P12, (lines 539-549).

It seems that personal self-awareness and self-reflection does not remove the therapist's anxiety when working with clients. It seems using PTC D unquestioningly reduces this anxiety. Participant 4, a counselling psychologist working in the NHS states the need for certainty also comes from a pressure from the client:

Researcher: So you let the theory come to you rather than...(summarising her previous response).

Participant 4: Rather than looking for it, yeah. But sometimes there is a lot of pressure isn't there? I mean we, because the patient comes, you know a lot of them want to get better, (P4, lines 704-709).

All participants *apart from* 1, 5 and 8 at some point were reflexive in acknowledging theory's function of abating anxiety. Participants 1, 5 and 8 were all but one of the male participants who took part in the study.

All participants had experience of their own personal psychodynamic therapy, which might be considered a factor in one's own ability to tolerate anxiety. The experience of personal therapy varied widely between 30 hours and 13 years. Despite this, some participants spoke about the concept of theory abating anxiety directly, demonstrating an awareness that theory served this purpose, whilst some participants would make comments that only suggested theory was making them less anxious in sessions, rather than directly addressing this concept, whether prompted to or not. Surprisingly this could not be accounted for by participants' length of time in personal therapy, their type of training or

accrediting body, or their length of experience in the profession. Neither did length of experience seem to account for the participants' demonstration of their ability to tolerate anxiety.

In addition to reducing feelings of anxiety, PTCD protect the therapist from feeling deskilled, and help the therapist cope with the pressure of helping clients to improve:

...Sometimes the client can say something and after it you can feel angry and it's not about you...you feel quite, deskilled, disempowered, and that's how the client feels, (P8, lines 785-790).

Participant 8, a UKCP and BACP accredited integrative practitioner with 11 years' experience, seemed to be using the theory of projective identification (Klein, 1955) to protect himself from feelings of disempowerment. Theory was used here to explain the therapist's emotions in terms of the client's problem. Perhaps for participant 8 the need to feel skilled was particularly important, as he was the only participant to ask for payment from the researcher for the interview. This was interpreted as something to do with the meaning he attached to his time, and the interview process being something which only I would gain from, perhaps emphasising his expertise.

In addition to anxiety, irritation is managed by using PTCD to explain client presentations. By referring to PTCD, this *helps therapists to tolerate clients' dependence and demands* (cat. 4):

I have someone recently who's very manipulative, and I felt quite irritated you know...but I had to understand, why is this person doing that? And that's when I look to the theory, well she was given nothing. There was something, she wasn't held as a child, (P8, lines 485-490).

The use of theory is fuelled by a *fascination with PTCD* (cat. 3). This fascination shows undercurrents of wanting to discover something about participants, or indeed themselves. Participants showed personal interest in searching for meaning:

Psychodynamic theory is very exciting when you first learn it. A body of information which people out there don't have... I've always wanted to know the truth behind child development, what really happens, (P10, lines 178-180 and 285-287),

I sort of prefer, being like a bit of a detective, (P5, lines 474-475).

Similarly, participants chose theories *that resonated with them, not according to the client* (cat. 8), whilst some chose to disregard theory that had no personal meaning for them.

What this core category aims to demonstrate is a conceptual link between the first two main categories which describe therapists taking an unquestioning approach to the use of PTCD, which is opposed to taking a reflexive stance to PTCD and regarding a theory as one possibility of many. As these two main categories are epistemologically different, a tension arises. Therapists are pulled into using PTCD unquestioningly because this comes with benefits such as certainty and a reduction of anxiety or irritation with their clients. PTCD are also seductive in their ability to fascinate and draw therapists in to believing they hold truths about a linear developmental path from childhood to adult psychopathology. Whilst PTCD are both powerful and elusive, therapist are also drawn to a reflexive approach towards theory where they are seen as hypotheses rather than objective truths about clients. This may be either through having had integrative training or simply being aware of other models of therapeutic practice that are available to them. This tension, however, is both ‘uncomfortable’ and ‘challenging’ to manage. Therapists try to resist the ‘temptation’ to use PTCD unquestioningly.

4.8 Post-Analytic Reflections

It was noticed that the transcripts from the initial interviews (1, 2 and 3) tended to show fewer moments of reflexive use of PTCD (main category 2). Additionally, it was noted that participants seemed to be more reflexive the later the interview was conducted in the process of the research. This suggests that through theoretical sampling and the alteration of interview questions according to previous responses and emerging categories, participants towards the end of the process were prompted further by the researcher to reflect on how they used and thought about PTCD. At the beginning there were no prompts in this direction as this had not emerged as a theme. Through doing this purposefully, the researcher influenced a gradual process of construction and definition of the two separate and distinct main categories. However it may have also been happening on a level out of the researcher’s awareness, as her own biases and interests prescribed what she saw and interpreted from the data. Despite this, the researcher had the intention of staying as close to the data as possible whilst rendering a theoretical model.

The shift between speaking in a way which suggested an unquestioning use of PTCD and a less dogmatic approach seemed to occur in two noticeable situations, although there may have been additional triggers for this. Firstly, this seemed to happen when the researcher unknowingly began to collude with the participants in speaking of PTCD as if they represented an objective reality, or when the participant began to collude with the researcher in this process. Secondly, this happened when the

researcher asked the participant to reflect on any potential pitfalls of PTCD, such as in regard to therapist anxiety (a question devised from initial interviews). The shift occurred a number of times, to varying degrees in the interviews, which did not appear to be dependent on the participants' training, registering body or length of experience or personal therapy.

This shift in epistemological stance could be a result of the development of the interview schedule and the progress of the analysis shaping the focus for subsequent interviews. Hence, the interviewer and interviewee became enveloped in a dance together where they would collude with one another's dogmatic thinking about theory, and then one party would notice this and shift the emphasis to speaking about theory as if it was one of many ways of understanding the same phenomenon. On reflection, over the course of the 12 interviews the researcher's awareness of the power of psychodynamic discourse became clearer over time. In chapter 5 the researcher further analyses her own ideas in relation to the research question which influenced the direction of the interviews.

The majority of participants who showed they were more comfortable with not knowing tended to have over 5 years of experience in personal therapy from a psychodynamic or psycho-analytic modality, and had over 8 years of experience of one-to-one counselling work. Those with less experience tended not to speak of an 'expert' status, yet they would demonstrate that they took on an expert role with their clients in speaking about their work. Despite this finding there were participants with less experience who were still able to speak from a reflexive viewpoint and comment on a tension and anxiety inherent in uncertainty. Also, as mentioned earlier, there seemed to be little difference between participants and the length of experience they had, in the way they used theory to describe client presentations. As such, variants in length of experience or accrediting body did not factor largely in the results.

Participant 2's data was not omitted from the study, yet this was harder to integrate with the bulk of the rest of the data, as the participant described her client work in terms of the client's life story, and in her interview she focused on empathic responses and unconditional positive regard, hence appertaining to the person-centred approach more than the psychodynamic. She was asked questions that prompted her to speak of her understanding of how PTCD affect therapeutic practice, yet she did not mention PTCD without being prompted. Integrating her responses was somewhat possible, but for these reasons her interview did not drive the focus of the study. She was a counselling psychologist with 6 years of experience in practice and a year and a half of personal therapy, hence also demonstrating, as stated above, that the more experienced participants did not necessarily interpret theory in a more or less reflexive or uncertain way than those with less experience.

4.9 Conclusions

The theoretical model constructed from this study describes a tension in the way therapists talk about their practice. An unquestioning use of PTCD (main category 1) persisted whereby these theories remained uncontested and were spoken about as if they were indicative of reality. This alternated with a reflexive use of PTCD (main category 2) where a theory was seen as one explanation among many. As these positions are epistemologically opposed, tension therefore results (core category). This tension is expressed either directly or through a demonstration of a seductive pull to use PTCD unquestioningly because the theories abate anxiety and provide a sense of professionalism and expertise. The benefits of thinking objectively about PTCD pull therapists to speak of them in this way, even if this is not in line with their epistemological standpoint at other points in time. The tension is possibly produced by societal demands, contextual pressures and the language in which PTCD are written, as well as partly being a product of the inter-relational discourse with the researcher.

This epistemological shift was later seen to emerge at times when the researcher either prompted them with a question such as ‘Are there any pitfalls to PTCD?’, or if the researcher herself colluded unknowingly with the participant by speaking in a way which suggested an unquestioning use of PTCD. This seemed to sometimes trigger a shift for the participants, who would then reflect on PTCD from a more postmodern epistemological stance. However, the shift was also seen to emerge at other times as well. For instance, if the participants spoke about applying theory to themselves, PTCD was spoken about more dogmatically. Alternation between these stances seemed to occur a number of times throughout the interviews, as a result of both interaction with the researcher (who was subject to the same phenomenon and hence may have influenced its occurrence in the interview situation) and perhaps also social interactions and constructions that had impacted them in the past.

The following chapter addresses how the findings relate to the existing literature, and discusses the results and their potential implications for future practice.

CHAPTER 5: DISCUSSION

This chapter provides a discussion of the main themes that were constructed through the analysis and compares these with the existing literature from a social constructionist and symbolic interactionist perspective. Each major theme is reviewed in the context of existing theoretical ideas and research. The importance and relevance of each of these themes in the field of counselling psychology and therapeutic practice is addressed. Reflexivity and limitations of the research design, choice of method, methodology and analysis are addressed and improvements are suggested. This is followed by suggestions for further research in the field.

5.1 An Unquestioning Use of Psychodynamic Theories of Child Development

Despite advocating that PTCD are hypotheses or tentative theories with which to guide practice, all participants at times also spoke of these theories unquestioningly. Counselling psychology as a discipline is seen by some as based in a social constructionist epistemology where ‘reflexivity of practice’ (Strawbridge & Woolfe, 2003) and ‘reflection-in-action’ (Schön, 1987) are models prioritised over the application of theory to practice in a mechanical sense. Despite this overarching perspective, it seems therapists are called back to an unquestioning use of PTCD, in which a process of ‘reflection-in-action’ is not apparent.

Even though participants were at times speaking in a way which suggested *an unquestioning use of PTCD* (main category 1), for instance by making statements that suggested they *thought PTCD represent an objective reality* (cat. 9), this does not necessarily indicate that they believed PTCD should not be questioned, or that they provide testable evidence-based truths about their clients. In addition, it could not be determined from these interviews whether participants adopted a positivist, or a critical realist position when speaking of PTCD in this way. What must be taken into account here is the modernist underpinnings of most psychodynamic theories (Neimeyer, 1998; Hansen, 2004) as they were constructed in a time which precluded postmodernist ideas. Therefore, the language of PTCD may induce therapists to speak as if they represent an objective reality, as they were most certainly written in this way, despite Freud sometimes claiming them to only be constructions (Leary, 1994).

Participants did not explicitly say they believed the theories to be true, but during the analysis this was inferred by the researcher from the way participants spoke. It was considered that it might have been too premature to reach such a conclusion about their beliefs, but despite this, the way in which they used language implied that at times there was a belief that PTCD represent an objective reality.

Alternatively it could be understood as therapists being limited to the language and discourses available to them, but also at times being seduced by this language and fascinated by the concepts to the point where they were being used unquestioningly. Perhaps therapists still have a desire to discover truths about their clients despite being aware of a need to treat PTCD as hypotheses (Colin, 1996), as indeed participants spoke of *looking to the past to explain the present* (cat. 24). Perhaps as humans ‘we could not live or think as we do without taking for granted that one event causes another, that causes produce effects,’ (Culler, 1982, p. 86) because this is a tendency humans have. Perhaps there is this desire to pinpoint cause and effect. However, instead of ‘identifying’ the cause or origination of an event, the cause itself is constructed: it is possible to ‘cause the production of a cause,’ (Culler, 1982, p. 87).

This finding does not seem to be limited to these participants. Researchers such as Ainsworth et al. (1978), Fonagy (1993, 2001, 2002, 2003), Williamson et al. (1991), Crittenden (1988), and neuropsychologists such as Schore (2003) and Kandel (1999) have put much time and effort into identifying evidence which strives to fulfill scientific requirements and proves a causal relationship between childhood experience and adult psychopathology. They have sought biological explanations for psychodynamic principles, such as equating the unconscious with procedural memory (Kandel, 1999). Even this century the search for answers continues within a positivist or critical realist, rather than a relativist, paradigm. For instance, some researchers claim that various PTCD have satisfied scientific requirements and hence fit within the positivist/empiricist paradigm (Gergen & Kaye, 1992).

Yet the argument is balanced on both sides. Gergen (1982) and Silverman (1986) warn of the dangers in placing importance in theories that portray there to be a ‘normal’ lifespan trajectory, as they emphasise that there is no way of determining what triggers a certain event, due to an abundance of uncontrolled variables. The views of Marmor (1983), Swan (1999) and the later works of Mahler (1971) also make claim to the randomness of life and disbelieve that causal factors for psychopathology can be pinpointed. It seems that both in the literature and with these participants, views differed in relation to whether or not causal explanations for adult psychopathology can be found. This highlights the seductive pull of PTCD, as they are written and defined in ways which serve the therapist by providing them with answers and truths for their clients’ difficulties. The problem, as Guilfoyle (2002) sees it, is that therapists proceed beyond a client’s resistance in the name of theory. This seemed to occur in the findings where participants showed they were using theory to challenge clients’ perception of reality and the defences clients had set up against psychic pain (cat. 25).

Therapists explain their clients' presentations with PTC (cat. 19), or in participant 11's words, 'explain what is going on' (line 339) and hence bring themselves out of a place of uncertainty through theoretical explanation. Spong's (2007b) work suggested that counsellors with fewer years of experience have less of a tolerance for uncertainty. However, both the experienced and inexperienced participants (with regards to personal therapy and counselling experience), and regardless of whether their accreditation was with the BPS, UKCP or BACP, at times used PTC with what seemed to be certainty, to describe client presentations. It seems Keats' (1817) 'negative capability', the ability to tolerate uncertainty, is possible for only short bouts of time. Perhaps therapists need to return to the safety of knowledge periodically given the pressure from their workplace to 'perform' (Strawbridge & Woolfe, 2003) or to satisfy their clients by having theoretical knowledge which they can impart.

As the majority of participants were involved in working for the NHS or privately through insurance companies or EAPs, perhaps a level of certainty in PTC is necessary for their accountability to their jobs. Corrie & Callahan (2000) comment that 'counselling psychology has to adapt its underlying philosophy to be consistent with the new research-oriented NHS culture,' (p. 419). The majority of the NHS culture was then, and still is positivist (see the NICE guidelines, 2011 and Risq, 2011). In such a culture it might be seen as jeopardising one's career to take a radical, postmodern view that there are 'no truths'. In addition to this, if clients are also in a positivist mode of thinking, perhaps they would be cautious about seeing a practitioner who couldn't help them to discover certainties and instead offered a new narrative: if positivist themselves they might wonder what they're getting for their money. Moreover, in a society where knowledge and truth is valued and many people think from a positivist standpoint, how difficult it would be to go against the grain and resist such a powerful social discourse.

Some theorists write about the development of meaning for clients through finding explanations for their symptoms (Epstein, 1977), yet the possibility that this could be in the therapist's interests is not so readily acknowledged in the literature. Freud's (1938) work declared that explaining client presentations makes the client seem less pathological *to the therapist*, yet did not state that this was partially for the benefit of the therapist. Hanly (1990), Leary (1994) and Brown (1977) criticise using theory to explain client presentations, and argue that when the client is perceived in terms of theory, this 'contaminates' how they are viewed. However, this seems to imply that an objective view of the client is possible without theory, which Stolorow and Atwood (2007) would argue not to be possible. As well as possibly encouraging certainty, PTC seemed to serve the therapist in helping him or her to explain and put change in the client down to processes resulting from his or her work (cat. 6). For instance, participant 7, an integrative counselling psychologist with 10 years' experience, saw her

work as successful due to working through transference issues (lines 635-637). Participant 2, also an integrative counselling psychologist but with 6 years' experience, asked her client if talking was helping her, and the client responded that through doing so she could better understand her situation with her adult mind (lines 514-524). Similarly a *lack* of change was explained by theory in the work of Laughton-Brown (2010) who describes her clients' lack of progress as due to 'failing to develop trust in the therapeutic relationship,' (p. 11). So, while in the literature, some therapists who use PTC D claim their interventions to be helpful (for examples see Kernberg, 1979; Brody, 1982; Chess, 1986; Biringer, 1994; Lopez, 1995; Gergely & Watson, 1996; Sudbery & Winstanley, 1998; Mikulincer et al., 2003; Wallin, 2007 and Laughton-Brown, 2010), this certainty is also reflected in this study.

This poses the question, to what extent is the therapist seeing what he or she is looking for, and supporting the case for his or her work by explaining it with theory? For instance, participant 12 commented on attachment theory being 'so observable' (line 597) in schools. However, concepts or objects might only be observable if the therapist knows what he or she is trying to observe. For instance, improvement might be seen as a result of 'the transference' (P7, lines 635-637) because that is the way in which the therapist has formulated the work. Perhaps the therapist who is driven by these theories has on a pair of lenses which might only allow him to see a certain way, so long as he or she remains unaware of them (Schön, 1983; Hanly, 1990; Leary, 1994; Valentine, 1996). In this sense these theoretical lenses may encourage therapists to approach their client with a 'pre-understanding' (Greenwood, 2008), inhibiting them from being able to stand back from theory and be 'non-intentional' (Levinas, 1989b) with clients.

Participants stated PTC D gave them an understanding of their clients, and informed them of their own processing and feelings in relation to the client (cat. 28). In their practice, participants also spoke of shifting blame from clients by introducing the idea of inadequate parenting (cat. 22), and theorising about ideal parenting (cat. 23). Levinas (1989b) argues for letting go of this type of 'pre-understanding', and Anderson and Goolishian (1992) also recommend as the 'dialogical creation of new narrative,' (p. 29) with the client, which this sort of pre-understanding does not seem to allow for. 'Reciting theory' was a focused code subsumed by the category: '*finding the research question hard to answer*' (cat. 14), which indicates theory working on an elusive, procedural level (cat. 36). Dreyfus and Dreyfus (1986) and Clancey (1988) state that expertise requires the application of 'proceduralized facts' (Clancey, 1988, p. 380) on a level which is out of the practitioner's awareness. If PTC D are functioning beneath the surface of the therapists' awareness, it is likely that they are using these theories unquestioningly. All participants, at times, seemed to find it hard to identify how PTC D influence their practice, whether this was through saying to the researcher it was a difficult question,

or reciting theory which could have been a way of avoiding grappling with the difficulty of how it influences their work. As previously mentioned, this theme arose towards the beginning of data collection, which spurred the researcher into theoretically sampling two pure psychodynamically trained therapists to find out whether this seemed to be a phenomenon particular only to therapists trained integratively. If this had been so, the interpretation of this finding might have been that integrative therapists do not receive an in-depth training in PTCD and therefore find the question hard to answer. However, the two purist psychodynamic therapists seemed to fall prey to the same difficulty, and also either recited theory or spoke about how it was hard to identify how PTCD affect their practice.

Yet perhaps practitioners are using PTCD with certainty on an *elusive and procedural level* (cat. 36). For instance, finding the question hard to answer was interpreted as theory working on a level which is not wholly accessible. Dreyfus and Dreyfus (1986) state that professionals who have reached a state of proficiency in their practice can forget the rules they use, even though these aided them in becoming an expert. Their formulation of expertise sheds light on the possibility that humans act intuitively and this is based on theory as well as past experience: 'With talent and a great deal of involved experience the beginner develops into an expert who intuitively sees what to do without applying rules,' (Dreyfus and Dreyfus, 1986, p. 108). Similarly, therapists spoke about intuition and 'listening with another kind of ear on', but generally found it difficult to report how PTCD affected their practice. Perhaps *using intuition* (cat. 15) is an internalised, proceduralised form of theory (Clancey, 1988). Upon reaching proficiency PTCD could be stored in a less accessible part of their minds, although with this idea there is a danger of falling back into the unchallenged assumption that the mind works on two levels, similar to Freud's claim of the conscious and unconscious (Freud, 1938).

Another category subsumed by the category: *theory works on an elusive and procedural level* (cat. 36) indicated that PTCD are spontaneously, and often uncontrollably, 'evoked' in the mind (cat. 33). For instance it was expressed that the therapist doesn't 'really think of theory...the theory just comes up' (P8, lines 624-626) or '...stays in the back of my mind,' (P4 line 308). Similarly, Bohart (1999) suggests that 'we know many things tacitly, intuitively, and unconsciously, beyond what we have put into words,' (p. 293).

In this sense, for those therapists who claim they are non-intentional it might be that they *are* guided by theory but unaware of this happening. While participant 7 comments on 'sitting back' and listening 'with another kind of ear on' (lines 308-309), Schön (1987) argues that theory pushes forth inquiry, in a way which seems much more active than 'sitting back'. Totton (2009) and Lerner (1999)

state that to claim that one is not guided by theoretical ideas, whether psychodynamic or otherwise, is possibly more dangerous than knowingly practising with certainty. They argue that theory and values of the therapist are still imposed upon the client, but on an unconscious or discreet level. As examples from this study, participants 8 and 12 at times, adopted a powerful role whilst later claiming not to impose theory (lines 482-483, and lines 381-383, respectively). In this sense, no therapist is able to remove his or her way of perceiving the world to achieve non-intentionality. It might even be that participants were *guided by PTCD in questioning, directing and listening to the client* (cat. 20) on this 'procedural' level (Dreyfus & Dreyfus, 1986; Clancey, 1988). In this sense PTCD might not only be seductive due to the benefits they provide to the therapist in terms of abating anxiety and providing a sense of expertise, but they also might be elusive which causes difficulty in reflecting on how PTCD affect their practice.

The participants seemed to be saying that once theory has been learned, one can never escape it, which also resonates with Langer (1989) who writes:

...If you have understood the concept of the unconscious, even though it may be only through the analysis of a dream or a slip of the tongue you can never forget that, (Langer, 1989, p. 137).

Perhaps the concept of the unconscious is not forgotten, but exerts its influence out of the therapists' awareness. If it is assumed that one is always intentional, then PTCD are no more socially oppressive than the relational therapist who claims he or she is not driven by theory at all, but has implicit theories that he or she cannot help but apply. As posited in the literature, therapists, even those who claim to come from a theory-less place, 'have a story about how problems develop and are solved or dis-solved,' (Hoffman, 1992, p. 19). This provides more of an argument for a questioning, rather than unquestioning, use of PTCD, but not a recommendation to the other extreme where one claims an absence of any theory.

The effects of PTCD (in this study with these participants) seem to be that they provide therapists with the feeling that they possess theoretical knowledge to offer the client, and with these explanations and ways of understanding they then can claim 'expert' status. Upon later reflection on the interview process, it appeared that the researcher was also seduced into taking a positivist stance towards client presentations and believing herself that PTCD could represent objective realities about clients.

5.2 A Reflexive Use of Psychodynamic Theories of Child Development: Seeing a theory as one explanation among many

At times, participants spoke in a different way about PTCD. PTCD were related to as providing ‘hypotheses’ or spoken about in a language which was much more tentative and questioning as opposed to dogmatic, which has been suggested in the previous main category. The idea of ‘hypotheses’ rather than ‘truths’ reflects the philosophical standpoint of social constructionism, as Burr (2003) remarks:

All claims to have discovered such truths must be regarded as political acts. They are attempts to validate some representations of the world and to invalidate others, and therefore to validate some forms of human life and to invalidate others, (p.153).

As such, participants spoke of trying to *avoid imposing PTCD on their clients* (cat. 18), avoid becoming entrenched in or blinkered by theory (e.g.: P12, lines 634-638), and not to accept PTCD as ‘rote’ (P11, lines 314-316). Penna (2004), Gross (1999), and Loewenthal (1996) also write about the imposition of theory being unethical. Participants spoke reflexively about their practice, indicating a way in which PTCD could be incorporated into their work, but only as possible explanations. For instance, participants spoke of offering interpretations to clients tentatively rather than, for instance, *challenging the client’s perception of reality* (cat.25) with PTCD as if they indicate a different and ‘correct’ reality.

Anderson and Goolishian (1992) are also critical of therapists who ask theory-laden questions of their clients. While therapists in this research seemed to value this ‘unknowing’ (Spinelli, 1997), uncertain approach to working with clients, Greenwood (2008) also put forward the argument that therapists should approach clients without a pre-understanding of their condition. Similarly, Van Deurzen (1997) argues that to ‘do’ phenomenology (or ‘study the essence of consciousness’) assumptions about the phenomena must be dismantled to allow perception of the ‘essences underneath all of these interpretations,’ (p. 60). This approach has the intention of opening the therapist to the real essence of the client, and bracketing all the preconceptions of the therapist. Taking this argument into account, should therapists refrain from using PTCD to inform themselves about the client, because this imposes a pre-understanding on them? Perhaps not, as from a postmodern and social constructionist perspective people do not have a continuous, unchanging ‘essence’ (Burr, 2003), and in addition to this, one could never dismantle his or her assumptions to the point where something is perceived as it really is. This line of argumentation leads back to positivism and the belief that things can be objectively observed outside of preconception.

The phenomenological research methodology suggests that researchers should 'bracket' their own thoughts and perceptions and allow the data to speak for itself (Starks & Trinidad, 2007), or put to one side what is known (Billow, 2000). While bracketing is described as keeping prior knowledge and beliefs about an object to one side to allow for clarity of perception (Powers and Knapp, 1995), if the therapist always has implicit theories about the way the world works (Hoffman, 1992) it seems unlikely that this could ever be achieved (Luca, 2010). From the perspective of the theory of symbolic interaction, it is not possible to remove oneself from the way things are perceived because that is the reason they are perceived as such (Blumer, 1969). A social constructionist approach would also say perceptions are based in learning from society, such as culturally agreed norms and values (Burr, 2003), and therefore to step out of this might well be impossible. Following on from this argument, perhaps PTCD need to be accepted as frameworks which replace or add to a layperson's theories. It seems that to 'do phenomenology' is very difficult indeed, as participants demonstrated a difficulty in separating themselves from PTCD once they had learned them.

Participants discussed how they would approach their clients from a place of openness rather than theory, expressing certainty that they did not have a template which was put onto clients, (i.e.: P3, lines 18-22). From this standpoint, labelling a client as 'insecurely attached' (Ainsworth et al., 1978) or to say they are engaging in a defence process such as 'projective identification' (Klein, 1955) is laden with intention and preconception, as much as they are frameworks of understanding. From the previous argument it seems that theory might not ever be used without imposing it, and perhaps it is not possible to be without theory, whether PTCD or laypersons' theories. Could this be resolved by therapists reflexively monitoring the extent to which theory is imposed with an awareness of its effects? This approach, if consistent, would put 'all understandings, scientific and non-scientific alike, on the very same footing. They are all constructions. None is objective or absolute or truly generalisable,' (Crotty, 1998, p. 17).

Taking into account the existing literature, the intention of the participants was to be non-imposing, humble or more open with clients (cat. 2), but they continued to slip back into more dogmatic ways of speaking about theory. This shift happened out of their awareness and in relation to who they are talking to, and was a product of the social pressures and demands of the workplace and the general society. PTCD are reported to enrich therapeutic work and provide possible frameworks of understanding, so perhaps psychodynamic ideas can be used to encourage the therapist to think about varying possibilities of meaning (Raisanen et al., 2010), but used reflexively and tentatively. This approach, however, seems to create tension and poses a 'challenge' (P11) to counselling psychologists and other therapists alike.

5.3 A Tension in Negotiating an Epistemological Standpoint

Bruner (1986) has already distinguished between ‘narrative’ and ‘paradigmatic’ epistemologies. This difference was further acknowledged by Kasket and Gil-Rodriguez (2011) with particular reference to counselling psychology: ‘Counselling psychologists are expected to have two strings to their bows, one empirical-scientist string and one subjective-reflective-practitioner string,’ (p. 21). Kasket and Gil-Rodriguez (2011) and Spong (2007b) state that trainees struggle to hold in mind a number of models of theory and practice and retain a level of reflexive criticism about their practice. What this research adds is an account of a tension that not only trainees but also qualified practitioners experience, with regard to these contradictory philosophies. Downing (2004) also identifies that even for experienced therapists, the contradiction between conviction and uncertainty is an on-going issue, which supports the interpretations of the current research findings. It seems to be an on-going issue for practitioners regardless of their length of experience in therapeutic practice (between one and sixteen years’). It is also indicated here that this phenomenon is not limited to counselling psychologists, as UKCP and BACP accredited therapists seemed to be experiencing it as well. Strawbridge and Woolfe (2003) suggest that *all* psychologists are in this grip of a tension between the dominant scientific paradigm and humanistic values endorsed by a constructionist perspective. They identify the cause for this tension as the ‘pressure to conform to the criteria of the dominant’ (p. 7) mainly due to ‘economic forces’. Whilst this is an interesting and useful perspective, it is suggested in this study that there are a number of reasons for therapists using PTCD unquestioningly and ‘conforming to the dominant’, which results in tension for the psychological practitioner.

As counselling psychologists and therapists accredited with the BACP and UKCP were recruited for this study, it seems that there is an internal struggle or tension that is experienced by practitioners who use PTCD regardless of whether or not they identify themselves as scientist-practitioners (Corrie & Callahan, 2000): the phenomenon is therefore inherent in a wider social context. One might have expected counselling psychologists to harbour more of an internal battle, having to live up to the label of objective scientist-practitioner whereas UKCP and BACP professionals do not, but this did not appear to be the case with the participants interviewed for this study.

A tension was demonstrated by participants in the following way: speaking of a tension between being humble or equal to the client, as opposed to ‘knowing’ or ‘expert’ (cat. 10), finding a balance between the importance of theory and the importance of the relationship (cat. 12), an awareness of being caught in a power-imbalance (cat. 11) and feeling uncertain of the ability to undo or repair damage done in childhood (cat. 16). This tension is described here as occurring due to a number of factors. For instance, the participants expressed feeling more proficient with time and experience (cat. 7), placing high value in theoretical knowledge (cat. 1), theory abating anxiety (cat. 2), PTCD helping

therapists to tolerate clients' dependence and demands (cat. 4) and the therapists' fascination with PTCD and showing interest in searching for meaning (cat. 7).

Participants appeared to be caught in the contradiction outlined above to varying degrees. Some (i.e.: participants 1, 5 and 8 – all male) spoke from both positions: an unquestioning use of PTCD and a more reflexive use of PTCD, but their responses were more so in the former position. Interestingly, participant 11 (also male) who was one of the participants with the least experience (5 years) and whose accrediting body was the UKCP, appeared to be the participant who was most reflexive. At times he would speak of PTCD as hypotheses or one explanation among many. Whilst this could be accounted for by the fact that he was the second-last participant to be interviewed and a change in the structure of the interview schedule may have prompted him to speak in this way, upon reflection the interview schedule did not prompt for this category in particular, as it was a theme that emerged after all the data collection was completed. It might be more to do with other factors influencing participant 11's stance however, as participant 8's responses were mostly from a position of an unquestioning use of PTCD, yet this interview was conducted well into the research process.

To demonstrate the 'tension' in negotiating an epistemological position, it is highlighted that participants *spoke of a power-imbalance between them and the client* (cat. 11), and acknowledged it as a problem (e.g.: P11, lines 314-332). It was said that it is a challenge not to accept PTCD as rote, and that there is a need to be careful with the application of theory. Spong (2007b) identifies a temptation, as did participant 11, to practice in a position of power and knowledge. The findings also suggest that PTCD serve therapists by allowing them to think of themselves as expert and professional, and providing a way of abating anxiety in an otherwise very uncertain predicament. As mentioned in the results, a position of expertise and power seemed to be taken on but not reflected on by male participants 1, 5 and 8. Indeed it was also these participants who seemed to be less reflexive in their practice, and whose responses were based more on the second core category of findings: an unquestioning use of PTCD. Interestingly, the only thing these participants had in common was their gender. Participant 1 (BPS) had the least amount of experience with clients (1 year) whereas participant 5 (UKCP) had 15 years' experience and participant 8 (BACP & UKCP) had 11. This raises questions about what might have been happening in the interview with regard to gender, as the researcher is female in the social context of a female-dominated therapy profession. Perhaps men feel more need to assert themselves as dominant or more knowledgeable to assert their place in this female-dominated profession. This seemed particularly apparent with participant 8 as the researcher had to reimburse the participant for the interview, and for this researcher it was felt that this created a less collaborative, more expert-learner dynamic.

Rather than analysing differences according to gender, Tracey et al. (1988) suggested from her study that *lesser experienced* counsellors perform some of their skills more rigidly and tend to assert more dominance. Extrapolating from this, perhaps more experienced participants are more comfortable in their expertise perhaps lying in empathy, communication and relational skill (Schön, 1983) rather than having to be an expert in theory. If, as Tracey et al. (1988) stated, counsellors show less rigidity in how they use theory the more experience they have, those who feel more insecure might grasp at theory to try and prove their dominance and expertise, in terms of having a large knowledge base. However, contrary to what might have been expected, this was not apparent in the results of this study. Neither did the type of training seem to impact upon the results in this way. Whether the participant was trained to masters or doctoral level as a counselling psychologist or an accredited UKCP or BACP therapist, none of these variables seemed to significantly influence the findings. All the therapists who participated in this study were fully qualified but some had more years of experience than others, and in Tracey et al.'s (1988) study the participants were either still in training or qualified, which may explain why a similar finding was not reached. However, Tracey et al.'s (1988) study does not account for individual difference in terms of social influence. It views the results as revealing a scientific and empirical truth about counsellor's use of theory, which can be generalised. This positivist view of their findings is acknowledged, but for the purposes of this research their results are seen as possible narratives about the way therapists work, in the same way that the results from this study are to be viewed.

A tension between epistemological poles was also demonstrated by participants speaking of a *tension between being humble or equal to the client, as opposed to 'knowing' or 'expert'* (cat. 10).

Participants spoke of a 'temptation' of falling into an expert role, as if it is something that is extremely difficult to resist given the pressure from NHS, insurance companies and employee assistance programmes (EAPs) to work with more certainty and more of an 'evidence base' (Strawbridge & Woolfe, 2003, p. 7). But it seems this temptation is also based in a wider social context. Perhaps the therapist's anxiety is partially created by the client requiring answers and certainty.

The concept of the therapist being expert is heavily debated in the literature, with Valentine (1996) and Totton (2007, 2009) arguing on the side of the therapist being humble or equal to the client. In their work they show concern about a therapist's power, and they ask why a therapist should assume he or she knows the truth while the client does not. In line with this argument, Spinelli, (1995) advocates approaching clients from a place of 'unknowing', a concept also raised and valued by participants in this research. What contributes to this tension is that using PTCD *unquestioningly* acts to serve the therapist in a number of ways, causing a seductive pull to this approach. For instance, therapists *place high value in theoretical knowledge* (cat. 1) at varying points throughout the

interviews: some spoke about being a 'detective' or a 'specialist', whilst others showed pride in having published work with a 'theoretical backbone'. This is also prolific in the literature: many therapists and clinicians value theoretical knowledge highly (Epstein, 1987; Mouque, 2005; Laughton-Brown, 2010).

From a critical viewpoint, Lomas (1999) questions the incentive behind the value therapists give to theoretical knowledge, and argues that a therapist's professional pride is intertwined with theoretical beliefs. He states that the more one believes in theory, the more professional one feels. If this is the case, PTCD could serve the therapist in increasing the therapist's sense of professionalism, hence increasing the tension and pressure to move back to an unquestioning use of PTCD. Clarkson (1995) also contests the therapist's aim in being an expert or professional, labelling this a desire to be exclusive and excellent, particularly when economic circumstances threaten the ability to make a living. She writes that therapists do still consider themselves to be professional in some sense, as they continue to need to sell their services to make a living. Clarkson's (1995) comment on therapists needing to sell their services as professionals or experts is highly relevant to the current economic and political climate in the UK with regard to the provision of psychological therapies. In recent years The National Health Service (NHS) has introduced 'Improving Access to Psychological Therapies' (IAPT) which has resulted in large-scale restructuring of the provision of psychological care by the biggest employer of counselling psychologists in the UK (Bor & du Plessis, 1997; NICE, 2011). As Risq (2011) identifies, large numbers of trainees have been recruited and existing psychotherapeutic practitioners are either being integrated or made redundant through this process. The new emphasis, she states, is on outcome measurement, moving patients 'towards recovery' and using standardised assessments and treatment protocols, all of which are based in a positivist, objectivist epistemology which requires an evidence base and measurable outcomes.

As the majority of participants were employed by the NHS, insurance organisations or EAPs, this indeed may account for the therapists in this research feeling drawn to regard themselves as experts or professionals in their field, and having a 'knowledge base' rather than taking the epistemological standpoint of postmodernism which might leave them ignored or dismissed by the NHS. As Kouw (2005) suggests, psychotherapeutic practice 'yields to economic coercion by insurance companies and other third parties. The march toward mechanical application of "protocol" interventions in what is (still) called therapy denies or contradicts the fundamental premise of human contact,' (p. 9). Perhaps a draw to '*an unquestioning use of PTCD*,' is a matter of survival, fulfilling criteria for the NHS, insurance companies and EAPs, which maintain allegiance to the diagnostic, medicalisation of psychological therapy (Kouw, 2005). Strawbridge and Woolfe (2003) add that counselling psychologists are increasingly demanded upon to provide technical expertise and evidence for their

interventions within organisations such as EAPs. Hence an unquestioning use of PTCD might carry more weight in a heavily objectivist NHS and political culture.

Counselling psychology training is not funded by the NHS, yet clinical psychology training is. The fundamental difference between the two is their philosophy of practice (Corrie & Callahan, 2000) which indicates that a positivist-empiricist paradigm is preferable in that context. Perhaps preference is given to clinical psychology because it ‘could not only justify itself as a social institution but also procure the prestige necessary for its survival,’ (Corrie & Callahan, 2000, p. 416). In her article, Risq (2011) speaks of a rising anxiety amongst NHS employees due to this structural reshuffling, which results in ‘uncertainty, chaos and not knowing,’ (p. 40). Therefore, perhaps not only did anxiety arise for participants in their direct work with clients, but also this could be due to having to defend their practice within the objectivist culture of the NHS, EAPs and insurance companies. Hence there would be more need to fall back on the certainty that PTCD are true, objective theories that can in some way measure up to the protocol of cognitive behavioural therapy (CBT) (Beck et al., 1987), which bases its theories on ‘empirical evidence’ and has subsequently won a larger and firmer place within the government’s provision of psychological therapies over the last few years.

As previously mentioned, participants worked either purely privately (with a proportion of clients coming to them through insurance companies or EAPs) (participants 2 & 8), privately alongside NHS work (participants 3, 5, 6, and 12), privately alongside private hospital work (participant 9), for a charity organisation funded by the NHS (participants 1, 10 and 11), or in an NHS hospital setting (participant 4). With such a high proportion of work being funded by the NHS, EAP or insurance companies, participants could have been experiencing an anxiety arising from an increasing scrutiny from employers (Corrie & Callahan, 2000), a difficulty in securing a job role or making a living. It is conceivable that practicing from a postmodern or social constructionist perspective could be controversial in these contexts.

Lewis (2012) indicates that counselling psychologists who do not have specialist CBT knowledge (and therefore other practitioners not trained in CBT) seem to be considered as using ineffectual therapeutic interventions (such as psychodynamic therapy), according to guidelines published by the National Institute of Clinical Excellence (NICE, 2011). Perhaps this also helps to explain a tension for therapists in not knowing which epistemological position to adhere to.

Counselling psychology arose as a profession at a time that was ‘dominated by the medical model which was both positivist and empirical in its foundations,’ (Corrie & Callahan, 2000, p. 415). Perhaps therapists are in a time now where this change is taking place and each individual is playing

with the idea of what it might mean to work from a more reflexive perspective, as a result of interacting with each other, learning from each other and collectively building and constructing a new mode of relating to PTCD. Furthermore, as all but one of the participants had over 5 years of experience, some with up to 16, they are likely to have worked during a time when positivist thinking heavily dominated the profession, even more so than currently. Therefore not only are PTCD rooted in positivistic language, but perhaps the contexts in which they trained and worked throughout their careers endorsed this epistemology.

In the existing literature a number of therapists have written on the subject and see a position of uncertainty as paramount, compared to a position of expertise, even since the introduction of structural change in the NHS (i.e.: Totton, 2009). For instance, Stern et al. (1998) speak of tolerating uncertainty to allow new thoughts to come to them and their clients. Risq (2008) endorses that therapists should purposefully abandon certainty and therefore relinquish their authority in the therapeutic situation. So why, despite the cultural, political and economic atmosphere, do some therapists continue to question objectivism and press ahead with a postmodern epistemology? It seems a new discourse is being formed and developed as therapists converse, raising therapists to a different sphere where they are becoming more and more self-reflexive and less dogmatic in their thinking. However, this shift somewhat goes against the realist nature of the NHS and other organisations, and therefore tension results.

As participants spoke about *feeling more proficient with time and experience* (cat. 7), this suggests that a letting go of PTCD might be difficult. Comments about proficiency and experience were couched within talk of theoretical knowledge and expertise, hence giving rise to the idea that proficiency and experience is more related to knowledge of theory rather than other domains of therapeutic work such as the relationship or inter-personal skills, for example. This concept is emulated in the literature by Posner (1988) who claims that ‘expertness lies more in an elaborated semantic memory than in a general reasoning process,’ (p. xxxv). As such, much time, effort and expense is invested in becoming a therapist, and expertise is thought to be a part of what is acquired throughout this process, as counselling is being increasingly regarded as a profession (Hansen, 2007). Peavy (1996) supports this idea that professionalism serves both the therapist and the client, and provides a framework which is containing, in an otherwise confusing or uncertain situation. Questioning one’s own sense of why one is professional might give rise to confusion or uncertainty, which may also be challenging.

PTCD appeared to be their function in *abating therapists’ anxiety and other difficult feelings* (cat. 2). Downing (2004) states that PTCD, as conceptual systems, ‘introduce structure into what would

otherwise be an overwhelmingly complex and chaotic experience. They allow us to manage and navigate an unpredictable world successfully', (p. 127). Similarly, Bandura (1956) wrote that a therapist's competence is increased by reducing his or her anxiety.

Participants in this research said that by having PTCD, they were able to feel less 'damaged' (P10, line 819) in dealing with situations or clients that were 'too scary' (P10, line 899) or even those clients who the therapist felt were 'abusive' (P10, line 803). Yulis and Kiesler (1968) similarly found that theory was used as a barrier to protect the therapist from his or her anxiety reaching an unbearable level. One participant of the current research said he used a 'blank screen' approach from traditional psychoanalysis (P8, lines 322-323) to protect himself against more disturbed clients. This 'blank screen' approach assumes the therapist's ability to have very little impact on the client, thereby acting as an objective observer of the client. It was thought that remaining passive in the room with a client gave the therapist the ability to analyse his or her client's psyches. This was even employed to the degree where the therapist would sit behind the client to 'remove' the possibility of having any influence on the client's thought processes (Aron, 1990).

However, Thomas (2010) identified through reflecting on his own practice that using the 'blank screen' as a barrier restricted him from being relational. The relational approach is based on the premise that the therapist is on an objective observer and is involved in relationship with the client (Ullman, 2007). This highlights the incompatibility between a postmodern or reflexive use of PTCD and a use which is unquestioned, and has the possibility of assuming an objective view of the client. It seems that believing PTCD provide a sense of certainty or objectivity about clients reduces therapist anxiety and allows therapists to ascertain that their work is effective. Choosing a reflexive approach where theories are thought of only as possible narratives would be likely to remove certainty and therefore increase therapist anxiety about both the effectiveness of practice and with less of a shield against 'more disturbed clients'.

As such, Lomas (1999) and Totton (2009) are critical of the use of theory for the therapist's protection, as they believe that the client's complaints are not taken to reflect the real aspects of the therapeutic relationship, and are instead interpreted in terms of the client's inadequate mother or abusive father, for example. If therapists explain a client's verbal abuse with the theory of projection of an uncaring and inadequate maternal object based on his or her experience of early childhood (Freud, 1914), this removes the possibility that it might have been the therapist that actually angered the client, due to a more 'real' component of the relationship (Clarkson, 2003). In this way the use of theory could become dogmatic, as some argue that through abating anxiety, theory stands in the way of a real, relational encounter between the client and therapist (Spinelli, 1995; Judd, 2001). Perhaps

more importantly, an unquestioning use of PTC D could be serving a socially constructed discourse which keeps therapists in a position of power (Foucault, 1980).

The majority of the literature reviewed in this research suggests that the use of theory in practice to abate anxiety is common, but labels it bad practice. This begins to converge with the argument against a 'one-person' psychology, which relational theorists such as Ullman (2007) and Mitchell (1988) address.

As mentioned in the results, all participants apart from participants 1, 5 and 8 at some point acknowledged theory's function in abating their anxieties when working with clients. Interestingly, these three participants were male. This raises questions of socially constructed gender roles and whether men are forced into a discourse such as: 'Anxiety is weakness and men must be strong', or 'Women are used to being more open about their anxieties, as women are socially understood as the more 'emotional' sex'. Being a young, white British female, the researcher had the impression that the power dynamic between her and the male participants had this quality, and interestingly, the only participant who charged a fee for the interview was male. It could have been that the researcher was acting out an internalised sexism assuming her own incompetence (Bearman et al., 2009) whereby she unknowingly communicated that she was looking to the male participant for answers and certainty. Alternatively, as Hayes and Gelso (1991) claimed that male trainees 'withdraw from their clients' (p. 289) when the client presented with more anxiety-provoking issues, perhaps a similar occurrence is happening with qualified therapists.

As a conglomerate of theories mostly written and developed by white, western men, PTC D seem to continue to enforce powerful discourses within which men, and now also female therapists, can keep up the image of all-knowing experts, free from their own anxieties. To feel de-skilled might fundamentally challenge this notion. For Spong (2007b) and Mackay et al. (2001) note that feeling skilled provides the therapist with a sense of security, or a 'secure base from which to work' (Mackay et al., 2001, p. 33).

Within the main category: an unquestioning use of PTC D, participants seemingly expressed a desire for causal explanations for client symptomatology, particularly in participant 5's comment about being:

...like a bit of a detective, trying to, you know, having the model we have, in our mind it's thinking about your childhood experiences and what led these experiences into where you are today' (lines 446-460).

Similarly, participant 10 spoke about wanting to know ‘the truth behind child development’ (lines 285-286). This idea is heavily refuted in the literature (Stolorow and Atwood, 1997), particularly by those who claim objective knowledge is impossible (Burr, 2003; Laugharne & Priebe, 2006), but is supported by researchers who strive to pave a path for PTCD in the scientific realm. It seems the latter viewpoint would be difficult to abandon, as, if these theories can be seen as objective or scientific, they can potentially serve the therapist in helping the therapist feel proficient, valuable and proud of their academic or theoretical knowledge (cat. 1). This need to feel proficient and ‘to know the truth’ could be due to a number of factors. It is likely that therapists’ own backgrounds and previous social interactions have a part to play in this, but it seems likely that due to psychology’s professional alliance with the medical world and its discourses, this draws therapists into using ‘biomedical language and practices (e.g.: psychopathological assessment categories),’ (Strawbridge & Woolfe, 2003, p. 17) which likely indicates an unquestioning and more certain, truth-seeking use of PTCD.

As mentioned in the results, it was noted when and how the ‘shift’ from an unquestioning use of PTCD to a reflexive use of the theories occurred. This seemed to take place with some participants when they spoke about themselves and how the theories help their own self-understanding. A shift also occurred upon interaction with the researcher, either when she prompted the participant to speak about what they thought might be the pitfalls of PTCD, or when the researcher unknowingly began to also speak in a way which suggested an unquestioning use of PTCD. This tended to prompt the participant to speak about using a more reflexive approach, seeing PTCD as hypotheses as opposed to truths, as if the researcher’s collusion had raised their concerns, as it perhaps had become more of a dogmatic conversation.

Therefore the researcher was embodied in the data and findings, as she also was in the same contradictory position as the participants were. It may have been that this influenced participants to do the same, although the transcripts seemed to reflect a dialogue in which researcher and participant grappled to find meaning together, and a way of answering the research question. However, as symbolic interactionism (Blumer, 1969) also helps to elucidate, shifts may have occurred in interviews not only due to social interaction with the researcher but also due to the participant’s internal dialogue and previous interactions with other people, training courses, working environments, colleagues and clients. The social context, as previously mentioned, was likely to play a part as most participants were involved or had been involved with the NHS, a mostly positivist organisation (Risq, 2011). In addition to this, it seemed apparent that both researcher and participants were in this dance together, both torn between epistemological poles.

5.4 The Importance and Implications of the Findings

Penna (2004) recommends that rather than their mechanistic application, there needs to be guidance in assessing the limitations of theories. Perhaps there needs to be further education in the possibility of multiple truths (Freshwater, 2008), and further research and discussion into the ways in which one can minimise the imposition of theory on clients in practice. Therapists could be considered experts in their skills of discipline and self-awareness, with inquisitive attitudes, seeking to create meaning rather than 'discover' reason and cause, or be theoretically knowledgeable (Szasz, 1965). This could help therapists to avoid falling into 'dangerous' discourses (Foucault, 1980) which dominate, marginalise and exclude people (Richer, 1992). This research suggests that there is a need to find a way in which therapists can still reap the benefits of feeling professionally able, of worth and knowledgeable, without basing this on the omnipotent valuing of modernistic and positivist theoretical knowledge. Perhaps therapists can still be certain of their skills, themselves and their ability to question and empathise, without conviction being extended to believing in an ultimate truth to the basis of the client's psychological complaints, or even speaking as if they have such a belief when they may not. This could provide a way of managing the dilemma that therapists seem to experience, between uncertainty and conviction (Downing, 2004).

This research has raised questions about how, when and why theory is used and thought about. To try to answer these questions could open up alternative explanations and meanings for client distress, increase therapist flexibility, and allow the co-constructing meanings and new understandings with the client, whether influenced by PTCD, or not. Postmodern and social constructionist ideas seem to be accessible and available, yet it seems that some therapists are still making a conversion to this epistemology from a more modernist stance. What is potentially most relevant, however, is whether the client benefits more from therapists taking a postmodern or modern epistemology in their work. Do clients prefer therapists who claim knowledge of truths because they appear to provide answers and can absorb their anxieties? Perhaps a postmodern therapist leaves the client with more anxiety and the uphill struggle of learning that there are no answers or certainties. On the other hand, postmodernism opens up a number of different understandings and can free the client from oppressive discourses that may have caused their difficulty in the first place.

If non-intentionality, phenomenology and bracketing are not possible, and the 'neutral analyst' is indeed a myth (Stolorow & Atwood, 1997), the question then becomes more about how the therapist can use theory in a way which is non-imposing. Either way, it seems that the relationship between theory and practice is a large and somewhat unaddressed philosophical issue, which is in need of both further research and further awareness in therapeutic practice.

Despite this, Corrie and Callahan (2000) state that the dominating model remains medical and positivist, and they write with concern that counselling psychologists may have to adjust to this epistemological framework:

For counselling psychology, this may include adjusting to a closer working relationship with traditionally more medically oriented professionals, loss of a former sense of freedom to implement professional values in a more idiosyncratic way or having to accept a model of professional practice that seems incongruent with the value system underlying the profession, (p. 420).

It may be that the dialogue between medical-positivists and postmodern-constructionists has to end in the abandonment of a more open and inclusive approach to therapy, one which does not use PTCD as dogma, and does not impose its rules and regulations on clients. This could lead, and has led to discourses of power: the very thing that social constructionists aim to avoid (Burr, 2003). This study has highlighted that despite being drawn to this way of working, there is hope that this new way of thinking is becoming increasingly acceptable, as participants were daring to go to a place of uncertainty, even if for just a brief time.

This research highlights the tension inherent in the movement away from a positivist epistemology when thinking about and using PTCD. To be warned about the tension caused by being pulled between opposing epistemologies might help to reduce the anxiety raised through embracing a position of uncertainty. This pre-warning could prepare therapists for a struggle but provide them with a level of comfort to know it is not uncommon. This in turn would lead to less of a reliance on using PTCD unquestioningly, as if they represent truths about clients. In addition to encouraging a postmodern epistemology, this is another way in which dogma and power can be kept to a minimum. These findings were embedded in the context of an interview with the researcher, but in terms of client work a very different social interaction might ensue. Both researcher and participant were acting and speaking in response to the meanings they interpreted through interacting with the other (Blumer, 1969), and if this research were to apply to client work, the client's interaction with the therapist would be crucial to consider. It might be that in desperation therapists look for answers, hence potentially causing more tension and strain on their epistemological perspective.

For those therapists who are less inclined to use PTCD reflexively and fall more into using these theories unquestioningly, acknowledging a tension between epistemologies might help them to reflect on why they might cling to and impose these theories. This study highlights some of the reasons why PTCD continue to be thought about unquestioningly. Through considering whether these reasons

apply to themselves, therapists will be more able to reflect on their own use of PTCD, why they might rely on them as objective theories and what to expect if and when they start to question them.

5.5 Limitations and Improvements

It is somewhat controversial that a method of qualitative inquiry which generates theory has been used to investigate the underpinning philosophies therapists use when working with PTCD, for there is the chance that the newly constructed theory will become another set of positivist assumptions. Despite this, as Charmaz's (2006) version of grounded theory is based on social constructionism (Burr, 2003), the claims made by the 'theory' which is generated by this research are not based in modernist epistemology in the same way that many PTCD are. The findings therefore cannot be generalised, and are representative of this group of participants in their particular culture at this point in time, and are the researcher's subjective interpretation of the phenomenon which was occurring within a particular social context, and during the social interaction of the interview.

5.5.1 Critiquing Social Constructionism and Symbolic Interactionism

Hansen (2004) argues that if wholly socially constructionist, there is no solid foundation for decisions about ethics, treatment quality or outcomes, as this epistemology doesn't subscribe to one way of perceiving the world: '[Social constructionism] is not an adequate epistemology to explain all levels of knowing that occur in the counselling situation,' (Hansen, 2004, p.134). As a resolution to the problems proposed by Lyddon (1998) and Hansen (2004), Neimeyer (1998) suggests having a foot in both social constructionism and constructivist camps:

Selective cross-fertilization of some forms of social constructionist theory with more agentic forms of psychological constructivism can provide a more useful frame for counselling practice than does either approach considered alone, (p. 5).

Hansen (2004) goes one step further and provides an argument for epistemic impurity, as he writes that human experience reflects modernism, social constructionism and constructivism. He argues that the field needs objective rules of practice, needs to acknowledge the power of the social and also to give credence to choice, personal autonomy and responsibility. However, this argument could be seen as a slow process back to critical realism, indicating that there *must* be a truth particularly in relation to ethics or outcomes of treatment. Although Hansen's (2004) argument is acknowledged as a sticking point for social constructionism and symbolic interactionism, it is argued that one person's

ethical morals may be different from another's depending on social context and previous social interactions. Hence it can never be determined which ethical moral is 'correct' or 'true to life', but both are important to acknowledge.

Lyddon (1998) states that social constructionism is a deterministic theory and argues that autonomy is removed if the future is determined and limited by social constructs and constraints, rather than in the hands of the individual. He criticises the theory being written as if it is a 'real truth' whereas it itself is a social construction (Lyddon, 1998). Burr (2003) identifies that if the principles of social constructionism are rigorously followed then it is agreed that human action and behaviour is completely determined by discourse, which is in turn determined by society. What then does this mean for personal agency and the debate between free will versus determinism? Symbolic interactionism provides a possible resolution to this issue, as it suggests that language and symbols are used as a means of communicating to one another, and it is a choice from a range of discourses that are available.

Inherent in a symbolic interactionist approach, however, is the idea of 'personalities' and preferences. Although this is described as resulting from previous social interactions and internal conversations, humans are still thought to have some sort of essence, and hence independent choice. This is an idea to which social constructionism is opposed, as it is thought that people are different depending on their social context, and there is nothing about them that remains consistent, such as a personality (Burr, 2003). Symbolic interactionism suggests that there is something 'real' to be discovered about a person (Burr, 2003). However, if choice is seen as less to do with personality and more as informed by the discourses that have shaped beliefs, it then becomes more compatible with social constructionism but still allows for personal agency.

5.5.2 Delaying the Literature Review & the Grounded Theory Method

Delaying the literature review is a method recommended by grounded theorists including Charmaz (2006) and Strauss and Corbin (1998). Initially it was a concern that conducting the literature review before the data collection and analysis would 'contaminate the data'.

Charmaz (2006) sees the literature review as serving the purpose of locating data in previous findings:

Novices may become enthralled with other people's ideas; established scholars may become enamoured with their own. In either case, scholars old and new may force their data into pre-existing categories. The intended purpose of delaying the

literature review is to avoid importing preconceived ideas and imposing them on your work. Delaying the review encourages you to articulate your ideas, (Charmaz, 2006, p. 165).

From the viewpoint of social constructionism and symbolic interactionism, experience cannot be bracketed out as the world is seen through socially constructed ideas, language and symbols (Burr, 2003). So rather than being 'forced' into pre-existing categories, data is constructed within a social context which could include the existing literature. This idea of avoiding forcing data is similar to the argument of phenomenology (Husserl, 1931), where it is assumed preconceived ideas can be bracketed out (Heath & Cowley, 2004; Starks & Trinidad, 2007).

The idea to initially 'bracket' out the existing literature from the collection of data assumes that its influence will therefore be reduced or eradicated, and the researcher will see a clearer representation of the data as it really is, in 'reality'. Conducting the literature review prior to the data collection may have guided the study in a different direction, but it would not indicate that the data would have reflected a more accurate 'truth' about the participants' experiences had it been delayed. What this method fails to acknowledge is that participants' accounts are socially constructed through previous social interactions and symbols that are negotiated between individuals, groups and societies (Blumer, 1969), and therefore the influence of existing literature would serve to contribute to a wider account of what is being studied.

Participants' accounts were embedded in social discourse, previous social interactions they had had, and what arose through discussion with the researcher. As an embodied piece of research, the involvement of the researcher in the formation of data is acknowledged and hence bracketing is seen as an impossibility (Luca, 2010). Therefore, it may have been that a thorough review of the literature prior to data collection helped refine categories and develop a theory which incorporates previous thought in the subject area, rather than trying to 'reinvent the wheel' per se.

In a similar way, the technique of theoretical sampling and interview schedule change could be criticised because interviews can become leading and generate data which the researcher is seeking, rather than letting concepts and themes emerge naturally. Again, a phenomenological approach would imply that if the interview schedule were to 'bracket out' the influence of the researcher, one could get closer to the essence of the participants' accounts (Starks & Trinidad, 2007). However, what was aimed for in this piece of work was not an objective representation of participants' accounts, but rather a reflexive account which considered the influence of the researcher in the construction of the data. Therefore the interview schedule was adjusted as the data collection continued, and as a

result interviews developed a focus on themes of power, expertise, who the theory served and the conflict between a postmodern and positivist epistemology.

Another criticism of Charmaz's (2006) grounded theory is that she claims theory *emerges* from the data, which implies data has within it a theory that is revealed through the analysis of data. This prompted the researcher against using Strauss and Corbin's (1998) model of grounded theory because it was feared that 'axial coding' enforced a pre-established frame of reference onto the data, and that theory should be allowed to emerge from it instead. On reflection this idea of theory 'emerging' was questioned, and instead it was thought that theory is created or generated, and any theory has a pre-established frame of reference as it is a result of inter and intra-personal dialogue.

The findings are therefore also subject to the researcher's interpretation, as opposed to Glaser's (2002) claim that it is possible to produce an objective theory grounded in the data, and that researchers 'take great pains not to intrude their own views in the data,' (p. 14), which leads to the identification and removal of researcher bias. However, the researcher had a large influence over the way the data was handled, from the stage of initial coding and interpretation of the raw data, to the way that data was compiled, condensed and formulated into a theoretical model. For instance, translating raw data into codes could result in more and more distance from the data, as the words, phrases, nuances and subtleties of the participants' words are gradually shifted further and further away from what they originally were. From this example the degree to which the researcher influences the data is apparent.

5.5.3 Reflexivity and the Influence of the Researcher

Reflexivity (Finlay, 2002a; 2002b) is a concept which denotes the researcher's acknowledgement of the ambiguity of language, and actively encourages the researcher to reflect on inter-subjective processes and hence their involvement in the research process. It is proposed that, 'regardless of the extent to which persons are prepared to represent their experience in "good faith", the experience is both constituted in part and influenced by interests, values, beliefs, and so on,' (Rennie, 2000, p. 484). Grounded theorists work to account for their own subjectivity whilst striving to keep their theory 'grounded' in the data (Charmaz, 2006), and as closely representative of participants' accounts as possible.

In an attempt to be reflexive, the researcher kept a log of methodological decisions (such as noting how the interview schedule developed and changed, and which categories were subsumed by others), and kept a series of memos to note her own ideas and thoughts about the meaning of the data, as recommended by Charmaz (2006). Rather than an attempt to achieve results which more closely

resemble a 'truth', reflexivity allowed the researcher to keep note of her own influences both in the context of the interview and during the analysis of the data, in order to continue to try and account for the views of the participants.

The researcher is a white woman, trained in counselling psychology in the UK. She was raised in Hong Kong for the majority of her childhood, a place where mental health was the recipient of much stigma, and where it seemed uncommon to seek counselling between the 1980s and 1990s. The researcher is 27 and the participants were all at least 10 years older than she was. The researcher's interest in the subject came about through her first experience of therapy, before she had begun training in counselling psychology herself. After relaying her personal story to the therapist, she was told that she had an 'insecure attachment'. Upon later training, certain questions arose in the researcher's mind, such as, 'Do theories improve a therapist's work with his or her clients? Can they incorporate the client's felt experience, and used in a way which is not oppressive? Do they cloud the counsellor's understanding of a person, or can they enhance it, and if so, how? Could theory be getting in the way, or providing a framework through which therapeutic work can be improved?'

The researcher found that conducting this study took her on a journey from a much more realist, positivist way of thinking to a viewpoint which also incorporates a reflexive use of theory, from a postmodern perspective. This occurred as a result of the process of interviewing participants and analysing the transcripts. Throughout the research process the researcher started at a point where PTCs were seen to shed light on what had *really* happened in her clients' lives. From this, and further into the process of the study, she went through moments of feeling dismissive of PTCs as if they were too dogmatic to even consider using in her own practice. She was left with uncertainty about the profession, PTCs and exactly what purpose the field of counselling psychology was trying to achieve. Although a distressing and disorientating experience, the researcher, she believes through interaction with her participants, the data and the literature, noticed that participants had another way of relating to theory, a reflexive and tentative approach which the researcher had not fully realised or digested prior to the study. This approach was in conjunction with moments of almost realist leanings, which suggests the initial difficulty the researcher experienced was not limited to her.

At first the process which the researcher went through caused her to interpret some of the results in a way which were more biased to her own thoughts as opposed to reflecting the meaning of the participants. For instance, as her epistemological leanings began at a more positivist or critical realist standpoint, when participants spoke of PTCs as representing an objective reality she made the assumption that this meant the participants *believed* PTCs were accurate and true to life. At that

point she did not entertain the idea that perhaps the language within which PTCD were written often endorsed positivism and therefore might account for participants speaking in such a way.

The data reflects a struggle in participants that the researcher herself experienced throughout the work. Could this have been the researcher playing out her own internal contradictions in the research and data, or was the researcher experiencing this struggle as a result of interacting with participants and analysing the data, constructing meaning from it? It is very difficult to pull apart what might have been going on, but important to acknowledge that the researcher herself played a large part in construction of the data and creating a theory which she felt best explained what was going on. It is also important to acknowledge that the researcher is aware that she is espousing a *reflexive* use of PTCD as preferable to having an unquestioning approach to using PTCD. This comes from her own education, background and work with clients. She particularly acknowledges the viewpoints and epistemological standpoints of the majority of her lecturers throughout training as a counselling psychologist herself, who made it possible for her to take on a new viewpoint herself. Perhaps if this had been a different experience the researcher would have remained in a mostly positivist epistemological standpoint, and a positivist would have presented this research in a very different way and might have used Glaser's (2002) original ideas that grounded theory, if done accurately, can objectively represent and account for what is being studied.

Another point to reflect on in the method of the study is that questioning deviated from the interview schedule. Grounded theory accounts for this through the method of theoretical sampling: the alteration of interview questions as the work progresses to allow a focus (Charmaz, 2006). The interviews began with broad, open questions, and through allowing themes to emerge between participant and researcher the questions became more focused (Glaser & Strauss, 1967; Charmaz, 2006). For example, the researcher introduced the concept of the 'secure base' (Bowlby, 1969) in interviews after this had been raised by a previous participant, and the intention was to allow discussion to unfold around this particular terminology. To what extent the participant took this idea on because the researcher introduced it, is uncertain. It may have been that the participants valued this as a concept in the interview because they thought this was expected of them. It is possible that data would be less biased had the interviews been limited to the main research question and short prompts, but without theoretical sampling and the alteration of interview questions a focus would have been difficult to achieve. In addition to this, as soon as the emphasis is removed from the participant's spoken word and replaced with the researcher's chosen label for a 'code', it becomes the interpretation of the researcher, which must be taken into account in order to be truly reflexive. It is acknowledged that the researcher's own theoretical constructs were imposed whilst analysing the data. One such construct was the researcher's belief in unconscious meaning, and that verbal

expression does not always capture the meaning which may underlie the spoken word. This might be criticised as a departure from grounded theory, as it falls more into the realm of what Rennie (2000) describes as ‘depth hermeneutics’, in which it is ‘the latent rather than the manifest meaning of the text that is interpreted,’ (p. 484). For instance, using the initial code ‘wanting to feel expert’ was the researcher’s interpretation of hidden meaning behind participant 5 speaking about wanting to be a detective (lines 474-475), and taking into account the rest of the interview in making this judgment as there seemed a desire to be an expert in other areas of the transcript. This could be problematic, as the researcher allowed herself to be guided by the theory of the unconscious and latent meaning. The researcher acknowledges this could be a bias and reiterates that the findings are one set of interpretations, of which there may be many (Freshwater, 2008).

5.5.4 The Sampling Procedure and the Impact of a Non-homogenous Sample

The variations between participants were in some cases fairly extreme, which made the analysis complicated and the findings harder to pull together. The data analysis was conducted to include the possibility that length of experience, accrediting body, length of personal therapy, gender, workplace and interview setting could have accounted for the findings. However, very little difference was found between participants that could have been accounted for by these variables. Instead the theory spans a number of therapists regardless of these differences, and hence could reflect a more general difficulty to do with epistemology, science and current context. Despite this, if the study were to be repeated a more homogeneous participant group would have been interviewed (if time permitted, as this caused the limitation initially). It is thought that a more homogenous group would allow the data to look even further into the participants’ more subtle differences which may account for the findings, perhaps creating a deeper and more refined theory.

Although the sample was assumed not to be representative of all counseling psychologists and other therapists, the method of recruitment could also be questioned. Participants were self-selected through opportunity sampling. The bearing this may have had on the results is impossible to establish exactly, but it could be that those who elected themselves were particularly proud of their professional status or knowledge of PTCD. This is supported by the researcher receiving three emails from potential participants who expressed their interest but stated they did not ‘know’ enough about PTCD to contribute. Therefore, in selecting themselves as research participants they may have been claiming to have some knowledge to offer, which suggests there are other practitioners whose views are not represented by the findings of this research, who take a less ‘knowing’ approach, but still are informed by PTCD.

In future research the method of recruitment, the subtle implications and expectations of the research question and the style of advertisement would be important factors to reconsider, particularly as this study would have benefitted from the inclusion of practitioners who were more questioning of PTCD.

5.5.5 *The Impact of the Interview Process*

Rosenthal (1976) highlights the impact of the researcher's psychosocial attributes, such as their anxiety, hostility, dominance, authoritarianism, need for approval, intelligence or warmth, as having an impact on the responses by his or her subjects. Through a meta-analysis of experimenter effects, he concluded that 'higher status experimenters tend to obtain more conforming but less pleasant responses from their subjects' and 'warmer experimenters tend to obtain more competent and more pleasant responses from their subjects', (Rosenthal, 1976, p. 86).

Rosenthal (1976) also states that 'a given theory or interpretive framework may affect the perceptual process in such a way as to increase *errors of observation*,' (italics added, p. 17). However, if there is no correct way of objectively seeing something, then one cannot err in how they observe. Rosenthal's (1976) argument about a researcher's 'interpretive effect' is based in a positivist epistemology which assumes objectivity to be possible, but here it is assumed that findings are based on researcher interpretation and existing ideas, and it is not possible that these are 'bracketed' out of the results, as phenomenological approaches to methodology suggest (Heath & Cowley, 2004).

In contradiction to the view of Rosenthal (1976), no interpretation is more or less biased, or more 'accurate' than another. All observations are perceptually subjective and dependent on the observer's implicit theory about the way the world works (Hanson, 1961). Heath and Cowley (2004) assert that:

...No one would claim to enter the field completely free from the influence of past experience and reading, (p. 143).

It could therefore have been that the findings reflected the participants' feeling obliged or pressured to satisfy the researcher, or even the participants' concerns that they might appear to not know enough to answer the question. This effect may have been lessened by participants being interviewed in their own environments (at home or in their offices), or because the researcher was a student, and therefore of lesser status, in the discipline in which they had more experience. However, it might have been that, as a trainee counselling psychologist, interviewing therapists who were not counselling psychologists caused friction, as indeed, there seems to be a power feud between different types of accreditation in an increasingly competitive area of work (Clarkson, 1995; 2003).

While participant 6 said she felt she trusted the researcher enough to disclose the truth about how she sees her practice, participant 8 (male) requested payment for the interview, which may have caused an underlying tension between BACP (him) and BPS (the researcher). In this and other circumstances, the researcher might have unknowingly made it difficult for the participants to be open and to answer the research question. The difference, for example, between participant 6 and 8 was that participant 6 was more open to discussing an uncertainty and reflexive use of PTCd, whereas participant 8 discussed this much less, and tended to speak unquestioningly of PTCd. Whilst this could have been due to their individual ways of working, this may have been occurring in the context of the interview due to an underlying tension between him and the researcher due to being asked for payment, or because of the male-female dynamic. Being asked for payment and told that he 'no longer works for free' put the researcher on edge somewhat, as she felt discouraged by his lack of motivation to participate in research purely for the benefit of the profession. This led her to believe that perhaps there was some tension for him in knowing the research was in the discipline of counselling psychology whereas he was a therapist accredited by the BACP and UKCP.

Whilst a tension between differing accrediting bodies could have been an overall influence on the study, interviews with the other UKCP or BACP accredited participants did not have the same atmosphere, and these participants were open to discussing personal uncertainty, anxiety and other difficult aspects of practice.

5.1.1 Definition of Key Terms

Aside from the limitations of using a qualitative method such as grounded theory, other improvements would have strengthened the study. For example, terms such as 'transference', 'countertransference', 'relationship', 'intuition' and 'expert' needed further exploration as it was inevitable that they had different meanings for different participants, and in different contexts. For instance, it should have been determined whether by 'relationship', participants meant a psychodynamic analysis of the transference relationship, or a real relationship, and a further analysis into whatever these terms might then have meant to the participant.

Overall, it is recognised that the findings reflect what the participants thought and said about their practice, rather than an illustration of their actual practice. The researcher was in a sense one step removed, as participants gave an interpretation of their practice according to how they thought they worked, which was also likely to be influenced by how they wanted others to perceive them and their

practice, as well as by what they may have subjectively remembered. A possible resolution would be to conduct a sister study of taped client work which would allow the researcher to analyse the process of their therapeutic practice. It would have been interesting to see if this matched the participants' portrayal of their work, but again these tapes would be at the mercy of the researcher's subjective interpretation and her frame of reference.

5.6 Alternative Explanations for the Findings

Could it have been that a reflexive stance was spoken about in interviews because participants felt pressured to do so by the researcher? What previous social interactions had they had that might have contributed to a caution about speaking about PTCD dogmatically? For instance, could previous lecturers or supervisors have warned them against it?

It is possible that the results of the data could have been interpreted differently, and much of this depends on the background and interests of the researcher, their implicit and explicit theoretical constructs, and her pursuit of what is believed to be important and worthy of further analysis. More emphasis might have been placed on the function and process of translating theory to practice. For instance, more emphasis could have been placed on when and where participants use PTCD, creating a meta-theory about how and when theory is applied. Although this was a theme that arose in this research, it did not take precedence over what the researcher thought was the more pressing issue of where the therapists placed themselves epistemologically.

It could be that the contradiction between an unquestioning approach to PTCD and a reflexive use of the theories revolved around the social context of the interview. As previously mentioned, the participant may have felt obliged to speak of a more relational approach to therapy, given that the research question could be interpreted as an attack on PTCD. Hence, participants could have been more, or less, dogmatic about theory than they led the researcher to believe. Because PTCD are based in a modernist epistemology (Hansen, 2004), perhaps this provides a way for therapists to feel expert until they speak to someone who challenges theory (in this case the researcher), then a more relational, constructionist stance is noticed, and complied with.

Taking Dreyfus and Dreyfus's (1986) work into account in terms of the findings of this study, the researcher might have expected the experienced participants to use their skills more fluently than those with less counselling experience, and to feel more proficient. Participants did comment on feeling more proficient with time and experience, and more able to bear uncertainty, but this did not seem to differ between the more experienced and less experienced participants. According to Martin

et al.'s (1989) study, experienced therapists would perhaps have shown an application of practice using more general frameworks of theory (schemata) than specific theories and concepts. This was not found in the current study, perhaps because Martin et al.'s (1989) study incorporated both trainees and trained counsellors. From the current findings it seems that participants spoke about specific client presentations and theories, as well as more general rules around 'transference' or 'empathy' for example.

5.7 Suggestions for Further Research

This research seems to identify a need for further questioning about how therapists tend to think about theory. For instance, participants could be asked more directly about what epistemology they take, and how they manage this in the context of therapeutic practice.

An analysis of taped sessions with clients might show more about the effect of PTCD, and would perhaps give more insight to the social processes occurring between therapist and client, particularly in regard to how the client might have the expectation that the therapist is knowledgeable, and the adoption of this role by the therapist. As Totton (2009) writes, clients have an expectation of the therapist and a power differential exists despite the subsequent actions of the therapist. Analysis of taped sessions would also provide a view of whether theory seems to be imposed on the client, and how this is different to the therapist's reports of their own practice. Yet of course this would be subject to the researcher's interpretations of what it means for theory to be imposed.

A crucial area for exploration would be the impact of PTCD on the client, as only an inference can be made having not heard from the client first-hand. From a social constructionist point of view, the therapist should not be taken in isolation from his or her surroundings or from the relationship (Ullman, 2007); therefore a more thorough study would look into the impact of PTCD on clients and have this as an additional input into the findings. Similar interviews with clients could contribute to the findings, but choosing careful wording which takes into account their lay status. This seems necessary as this research challenges the need for an unquestioning use of PTCD for the client's benefit and implies further research could be done into how they serve the client as well. It also might show how the client has an impact on the therapist's sense of professionalism, perhaps through the influence of their own epistemological standpoint of the therapist, and vice versa.

5.8 Conclusion

The discussion offers a theoretical model which attempts to organise the findings into a meaningful construct, which embodies not only the researcher's influence but also the social context, and context of the interview. It is thought that a social constructionist and symbolic interactionist perspective helps to elucidate these factors which can account for research findings regardless of the effort to control variables. Having attended to these factors helps the researcher to identify possible explanations for the findings, but only as one of many possible interpretations, much like the participants taking this viewpoint about PTC D in the interviews.

Despite how the findings were brought about, they seemed to suggest that therapists tend to speak about using PTC D unquestioningly, but also describe tolerating ambiguity and the idea that each theory is one explanation of many and that PTC D should be treated in this way, which suggests epistemological incongruence. This alternation between certainty and conviction is a contradiction, but is it not necessary to use such generalisations to make sense of the world? A world which is unpredictable is likely to be unmanageable, and therefore this contradiction seems somewhat inescapable.

Perhaps this research will allow for greater reflection on the way theory is both thought about and used, helping to make implicit assumptions explicit, for a greater integrity of practice. The findings of this research challenge the unquestioning adoption of PTC D without a fuller understanding of whose benefit the theory is for, or without questioning the theory's ability to represent the truth and considering the extent to which it is being imposed on the client. The findings highlight a different way of using PTC D, which requires tolerating that they do not represent an objective reality and can only be seen as possible explanations. Whilst this perspective is a difficult one to adopt due to societal pressures and the uncertainty it leaves therapists with, it encourages a more justifiably confident, yet tentative, form of practice. Perhaps if therapists can reflect on and become aware of how they may be speaking in ways which suggest they use PTC D unquestioningly, dogma and theory imposition on clients might be monitored and reduced, making for more ethical and epistemologically congruent practice.

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APPENDIX I: INITIAL INTERVIEW SCHEDULE

(Format derived from Charmaz, 2006)

Introduction:

- Thank you for agreeing to take part in this study
- Signing of consent form, ensuring clarity about confidentiality and its limits
- Asking permission to audio-tape the interview
- Allowing for any questions or comments before the recording begins
- Participants reminded to conceal all identifying details of any client whom they speak about

Initial Open-ended Question:

- Can you tell me briefly how you tend to practice as a counselling psychologist/therapist/counsellor/psychotherapist?

Intermediate Questions:

- What do you understand psychodynamic theories of child development to be?
- What effect, if any, do psychodynamic theories of child development have on your practice?
- Why would you use certain theories of child development and not others?
- What do you think are the benefits and pitfalls of using psychodynamic theories of child development in practice?

Prompts:

Can you explain exactly how you do that?

Why do you do that?

What goes on in your mind then?

Ending Questions:

- Is there anything you feel is important that hasn't been raised yet?
- Is there anything you would like to ask me?

Debriefing:

- Tape recorder is turned off
- Any further comments, questions or concerns, noting now that the tape recorder is off
- Participant provided with the debriefing form, which includes contact details of the researcher (interviewer), supervisors and dean of the school
- Participant is thanked for their time and asked if they would like to know of the results, and if so will be emailed a copy of the abstract upon completion of the study

APPENDIX II: FINAL INTERVIEW SCHEDULE

*Please note that interviews did not rigidly stick to the below questions, and if a participant raised an area of inquiry this was questioned further by the researcher. However, it was the researcher's intention to have covered all the questions below by the end of the interview.

Introduction:

- Thank you for agreeing to take part in this study
- Signing of consent form, ensuring clarity about confidentiality and its limits
- Asking permission to audio-tape the interview
- Allowing for any questions or comments before the recording begins
- Participants reminded to conceal all identifying details of any client whom they speak about

Initial Open-ended Question:

- Can you tell me briefly how you tend to practice as a counselling psychologist/therapist/counsellor/psychotherapist?

Intermediate Questions:

- What effect, if any, do psychodynamic theories of child development have on your practice?
- Why would you use certain theories of child development and not others?
- What do you think are the benefits and pitfalls of using psychodynamic theories of child development in practice?
- What's going on in your mind when you're in a session – do you think of theory? Do you talk about theory directly with your clients?
- Do you use theory in the session or do you try and leave it outside the door? Do you think this is possible?
- Do you think psychodynamic theories are enough, or do we need more in our practice?
- Do you think we are aware enough of how psychodynamic theories of child development affect our practice?
- Is this question in any way hard to answer for you?
- Previous participants have spoken about theory being there for them as well as their client, for example reducing their anxiety. What are your thoughts about this?
- Previous participants have spoken about how theory is absorbed in some way, and it changes the way you listen and perceive. What are your thoughts on this idea?
- How do you think you fit together your knowledge from your training and reading, with your practice?
- Have you applied psychodynamic theories of child development to yourself, and if so, with what result in terms of your practice?
- Do you have any clinical examples to demonstrate the way you work, that you wouldn't mind sharing with me?
- How do you think about the relationship between therapist and client?
- What are your thoughts about blame, in relation to psychodynamic theories of child development and practice?
- What are your thoughts about uncertainty and unknowing?

Prompts:

Can you explain exactly how you do that?

Why do you do that?

What goes on in your mind then?

Ending Questions:

- Is there anything you feel is important that hasn't been raised yet?
- Is there anything you would like to ask me?

Debriefing:

- Tape recorder is turned off
- Any further comments, questions or concerns, noting now that the tape recorder is off
- Participant provided with the debriefing form, which includes contact details of the researcher (interviewer), supervisors and dean of the school
- Participant is thanked for their time and asked if they would like to know of the results, and if so will be emailed a copy of the abstract upon completion of the study

APPENDIX III: PARTICIPANT DEMOGRAPHICS

PARTICIPANT	AGE	NATIONALITY	RELIGIOUS BELIEFS	LENGTH OF TIME IN PRACTICE	TYPE OF TRAINING	PROFESSIONAL REGISTERING ORGANISATION	COUNSELLING PSYCHOLOGIST	COUNTRY OF TRAINING	PUBLICATIONS	TYPE OF PERSONAL THERAPY	LENGTH OF PERSONAL THERAPY
1	38	BRITISH	NONE	1 YEAR	INTEGRATIVE	BPS	YES	UK	NONE	PSYCHODYNAMIC	30 HOURS
2	55	BRITISH	NONE	6 YEARS	INTEGRATIVE	BPS	YES	UK	NONE	INTEGRATIVE PSYCHODYNAMIC	60 HOURS 12 HOURS
3	37	BRITISH	NONE	7 YEARS	PGDIP COUNSELLING PSYCHOLOGY, MSC COUNSELLING PSYCHOLOGY, MSC PRACTICE OF COUNSELLING PSYCHOLOGY PERSON CENTRED, CBT, PSYCHODYNAMIC	BPS	YES	UK	NONE	PERSON-CENTRED & PSYCHODYNAMIC	1 YEAR 1 YEAR
4	59	BRAZILIAN/ BRITISH	SECULAR JEWISH	15 YEARS	DIPLOMA IN COUNSELLING PSYCHOLOGY (THIS INCLUDED MPhil IN PSYCHOLOGY), BY THE INDEPENDENT ROUTE. MY MAIN MODALITY OF TRAINING HAS BEEN PSYCHODYNAMIC. SECOND MODALITY HAS BEEN CBT.	BPS	YES	UK	WILL HAVE A CHAPTER PUBLISHED BY SAGE IN THEIR HANDBOOK OF COUNSELLING AND PSYCHOTHERAPY ON WORKING WITH HIV PATIENTS.	PSYCHODYNAMIC	10 YEARS

									THIS WILL BE EARLY 2011.		
5	47	BRITISH	NONE	15 YEARS	UKCP INTEGRATIVE (SPECIALISED IN ATTACHMENT THEORY)	UKCP	No	UK	LOTS A NUMBER OF BOOK REVIEW FOR COMMUNITY LIVING, 2 CHAPTERS IN RESPOND BOOK, 2 ARTICLES IN THIS MONTH JUNE BILD JOURNAL AND OTHERS	3X A WEEK PSYCHOANALYSIS	8 YEARS
6	56	BRITISH	CHURCH OF ENGLAND/ JEWISH	15 YEARS	COUNSELLING PSYCHOLOGY PROGRAMME MASTERS DEGREE QUALIFICATION CHARTERED WITH BPS, HPC	BPS	Yes	UK	NONE	PSYCHODYNAMIC, INTEGRATIVE AND PSYCHOANALYTIC	5+ YEARS
7	42	BRITISH	NONE	10 YEARS	BSc PSYCHOLOGY, MSc COUNSELLING PSYCHOLOGY, PhD PSYCHOLOGY	BPS	Yes	UK	2 PUBLICATIONS ON OBSESSIVE COMPULSIVE DISORDER	INTEGRATIVE	4 YEARS
8	52	BRITISH	NONE	11 YEARS	DIPLOMA IN	UKCP	No	UK	NONE	INTEGRATIVE	2

					COUNSELLING AND PSYCHOTHERAPY (TRANSPERSONAL), DIPLOMA IN PSYCHODYNAMIC COUNSELLING, DIPLOMA IN CBT AND DIPLOMA IN PSYCHOSEXUAL HEALTH	AND BACP					YEARS
9	55	BRITISH	ATHEIST	16 YEARS	PGDIP PSYCHODYNAMIC THERAPY (4 YEARS), PGDIP ADDICTIONS COUNSELLING (1 YEAR), MA PSYCHOANALYTIC AND SYSTEMIC THERAPY (2 YEARS)	BACP	No	UK	NONE	PSYCHOANALYTIC	7 YEARS, TWICE WEEKLY
10	56	BRITISH	NONE	13 YEARS	INTEGRATIVE PSYCHOTHERAPY (UKCP)	UKCP	No	UK	NONE	KLEINIAN, PERSON- CENTRED	13 YEARS +
11	39	BRITISH	ATHEIST	5 YEARS	MA COUNSELLING AND PSYCHOTHERAPY (INC. ONE YEAR PSYCHODYNAMIC TRAINING) DIPLOMA IN ATTACHMENT-BASED THERAPY	UKCP	No	UK	NONE	PSYCHODYNAMIC	3 YEARS
12	45	BRITISH	NONE	8 YEARS	ADVANCED DIPLOMA IN PSYCHODYNAMIC COUNSELLING: PSYCHOANALYTIC/PSYCHODYNAMIC	BACP	No	UK	NONE	IN THERAPY WITH JUNGIAN ANALYST SINCE 1997; ONGOING DUE TO FURTHER TRAINING REQUIREMENTS.	13 YEARS

APPENDIX IV: RECRUITMENT INFORMATION FORM

Recruitment Information

Title of the Research: What effect, if any, do psychodynamic theories of child development have on therapeutic practice?

Thank you for expressing an interest in this study. I hope that the information below will help you in making your decision of whether or not to take part. If you have any questions, please do not hesitate to contact me.

Brief Description of Research Project

The aim of the study is to seek the opinions of counselling psychologists and reach a point of greater understanding about what effects (positive and/or negative) psychodynamic theories of child development have on therapeutic practice with this client group.

What are the potential benefits?

I hope that you will find it interesting taking part in this study, if you choose to, whilst having the opportunity to express your opinion and demonstrate how you work therapeutically. If you are to participate, my research will benefit from a deeper understanding of your perspective on the use of psychodynamic theories of child development. From the contributions of twelve participants, I hope to identify any emerging themes, and write up the results for my research project as part of the practitioner doctorate in counselling psychology.

What will your taking part involve?

If you choose to participate you must have had training in a psychodynamic model of therapy, and have some experience of working with clients who experienced neglect in childhood.

Participation involves an individual interview lasting approximately 1 hour (allowing an additional 15 minutes for debriefing) at a location convenient to you such as your home or where you practice, or at Roehampton University, where I study. The interview will be audio-recorded and transcribed, then analysed on its own and in relation to other participants' transcriptions.

Anonymity

Your personal details will be kept in confidence. Your transcription and written answers to any questions will be given unique number, which will ensure anonymity and allow for your contributions to be removed from the study if you decide to withdraw. Any mentioned names, dates and places will be changed.

What difficulties might arise?

As a result of talking about your opinions and practices, it is always a possibility that unexpected concerns may arise. If this happens or for other any reason you wish to withdraw, you are within your rights to have any of your recorded information destroyed. A date will be given by which it is advised you withdraw by, before your data is analysed to create themes within the research. However, even though your contribution to overall themes cannot be removed after the date given, you can still have your transcription and audio-tape destroyed.

There will be a chance to discuss any issues you may have had, after the interview and when the audio-recorder has been switched off.

If you're interested, what to do next

If you are still interested in taking part, please get in contact by email or phone, as provided below, and feel free to ask any questions you have about this research. We will then arrange a time to meet and carry out the interview.

Thank you for your time in reading this document, whether or not you decide to participate in the study.

Kind Regards,

Lucy Mabbott
Counselling Psychologist in Training

Researcher contact details:

Lucy Mabbott
School of Human and Life Sciences
Roehampton University
Whitelands College
Holybourne Avenue
London SW15 4JD

Email: mabbottl@roehampton.ac.uk

Tel: (+44) 07745545134

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or, as the researcher is a student, you can also contact the Director of Studies).

Director of Studies Contact Details:

Dean of School Contact Details:

Steve Farnfield
School of Human and Life Sciences
Roehampton University
Whitelands College
Holybourne Avenue
London SW15 4JD
S.Farnfield@roehampton.ac.uk
0208 392 4505

Michael Barham
School of Human and Life Sciences
Roehampton University
Whitelands College
Holybourne Avenue
London SW15 4JD
M.Barham@roehampton.ac.uk
0208 392 3617

Participant ID:



ETHICS BOARD

PARTICIPANT CONSENT FORM

Title of Research Project: What effect, if any, do psychodynamic theories of child development have on therapeutic practice?

Brief Description of Research Project: The aim of the study is to seek the opinions of counselling psychologists and reach a point of greater understanding about what effects psychodynamic theories of child development have on therapeutic practice. Consenting to take part in this study means you are agreeing to an hour-long audio-recorded interview (with 15 minutes for debriefing), and you consent to have your contributions anonymously formulated into themes and discussion points for other participants.

Investigator Contact Details

Lucy Mabbott
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD

Email: mabbottl@roehampton.ac.uk
Tel: (+44) 07745545134

Consent Statement:

I agree to take part in this research, and am aware that I am free to withdraw at any time by letting the researcher know. This will result in my audio-recording and transcription being destroyed, although data in an aggregate form may still be used. I understand that the information I provide will be treated in confidence by the investigator and that my identity will be protected in the publication of any findings. I am aware of the limits to confidentiality and that the researcher is ethically bound to reporting unsafe practice which includes harm to self or others.

Name

Signature

Date

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or, as the researcher is a student, you can also contact the Director of Studies).

Director of Studies Contact Details:

Steve Farnfield
School of Human and Life Sciences
Roehampton University
Whitelands College
Holybourne Avenue
London SW15 4JD

S.Farnfield@roehampton.ac.uk
0208 392 4505

Dean of School Contact Details:

Michael Barham
School of Human and Life Sciences
Roehampton University
Whitelands College
Holybourne Avenue
London SW15 4JD

M.Barham@roehampton.ac.uk
0208 392 3617

Participant ID:

Debriefing Information Form

Thank you for taking part in the study.

Title of the Research: What effect, if any, do psychodynamic theories of child development have on therapeutic practice?

Brief Description of Research Project

The aim of the study is to seek the opinions of counselling psychologists and reach a point of greater understanding about what effects psychodynamic theories of child development have on therapeutic practice.

Please let me know if you would like to withdraw from the study and/or have your recorded material destroyed. Your data will be analysed and used to create themes and questions for discussion in a second interview with all participants.

If the interview brought up any difficult feelings and/or concerns, please either discuss them with me, or seek support from your therapist, if you have one. In the case that you don't have a therapist, there are directories for psychologists, counsellors or therapists on the following websites:

- British Psychological Society
[http://www.bps.org.uk/bps/e-services/find-a-psychologist/psychoindex\\$.cfm](http://www.bps.org.uk/bps/e-services/find-a-psychologist/psychoindex$.cfm)
- British Association for Counselling and Psychotherapy
<http://wam.bacp.co.uk/wam/SeekTherapist.exe?NEWSEARCH>
- UK Council for Psychotherapy
http://www.psychotherapy.org.uk/find_a_therapist.html

Please let me know if you would like to withdraw from the study and/or have your recorded material and transcript destroyed. If you withdraw after the date given, your data may still be used in aggregate form. After this date you can still have your transcript and recording destroyed, however your data will have been analysed and will have contributed to the general analysis of the research.

Please speak to me now or email me later if you have any questions or comments about the study.

This study was conducted as part of the researcher's doctorate in Counselling Psychology.

Contact Details

Researcher:

Lucy Mabbott
School of Human & Life Sciences
Roehampton University
Whitelands College
Holybourne Avenue
London SW15 4JD

Email: mabbottl@roehampton.ac.uk

Tel: (+44) 07745545134

Director of Studies:

Dr. Steve Farnfield
School of Human & Life Sciences
Roehampton University
Whitelands College
Holybourne Avenue
London SW15 4JD

Email: S.Farnfield@roehampton.ac.uk

Declaration:

I confirm that the interview was conducted in an ethical and professional manner and that I am happy for the research to proceed using my material.

Name of Participant:

Signature:

Date:

Name of Researcher:

Signature:

Date:

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or, as the researcher is a student, you can also contact the Director of Studies).

Director of Studies Contact Details:

Steve Farnfield
School of Human and Life Sciences
Roehampton University
Whitelands College
Holybourne Avenue
London SW15 4JD

S.Farnfield@roehampton.ac.uk
0208 392 4505

Dean of School Contact Details:

Michael Barham
School of Human and Life Sciences
Roehampton University
Whitelands College
Holybourne Avenue
London SW15 4JD

M.Barham@roehampton.ac.uk
0208 392 3617

APPENDIX VII: EXAMPLE OF FOCUSED CODES AND ASSOCIATED INITIAL CODES

EXPLAINING CLIENTS' PRESENTATIONS WITH PD THEORIES OF CD (46)

Reflecting on their use of theories of CD to explain client presentations

3¹¹, 12, 11, 5, 10

3
P.B.
, so clients like Jane who have kind of been brought up in damaged families, dysfunctional families and there's been some of, when things have been OK and then when there's been... often the oedipal stage, that's probably more the one I would use. So yeah.

Early trauma = damaged/dysfunctional families.
Miss oedipal stage when no such childhood trauma.

330 And I need to know myself to deal with that, or a bit about myself.
331 As much as I can. And so, very much the theories have helped and do help.

Acknowledging
Theory allows him to know himself so he can step out of the powerful role as much as possible, but acknowledge its pervasiveness.

332 R: But you don't hold on to it too strongly?
333
334 P: I would say, not without evaluating. Because the fundamental is around a relationship, and then the theories would thereby help explain what is going on. So, and that's what's going on in the present, in the here and now. For me, for them, for us, and what's gone on with them in the past. So you need the past and the present elsewhere, so you get, sort of 16 people in the room when it's just me and the client.

Evaluating the theories he uses. Theories provide an explanation for what happens in the therapeutic relationship. Trying to unpick deeper meaning in the encounter for the client and himself. Bringing in other relationships & their influence on him + the client.

3 informs my understanding of how they relate to me and again I use different types, bits of psychodynamic theory for different clients. I am thinking about what their attachment style is or thinking about the Freudian stages, the oral the oedipal stuff.

Informs P's understanding of how CDs relate to her. Taking bits from psychodynamic th. for diff CDs.

113.
And also to
514 be aware of, yeah to be capable and hear
515 theory but capable of making some sort of
516 diagnostic assessment. By that I don't mean
517 developing rigid ideas about where patients
518 are, but being able to distinguish patients
519 who, the representation of difficulties in
520 their internal world, can either take the form
521 of verbal interaction, their emotions can be
522 represented verbally and, and the patients
523 for whom that sort of symbolic
524 representation of their experience is not, is
525 not possible, and for who, borderline or
526 psychotic retreat, is possible, maybe
527 potentially. So I think that theory is an
528 important guardrail as it were, when making
529 diag... assessments of the patient you're
530 working with and yeah.

Wanting to be capable of diagnostic assessment.
Trying not to have rigid ideas.
Fitting patients into some sort of framework.
Separating clients into those that experience symbolically + verbally.

12

Seeing theory as a guardrail, a framework?

Showing how th of CD used to explain cl. presentations (examples)

3⁽⁶⁾, 11⁽³⁾, 8⁽¹⁵⁾, 4⁽⁷⁾, 5⁽⁶⁾, 7⁽⁴⁾, 10⁽⁴⁾, 9⁽²⁾

7
626 That in a way he was afraid of
627 being freed up because he couldn't deal with the, the
628 difficulties around his early experience and the difficulties with his attachment.

Helping the client to understand the function of his defence, as she sees it.

229 there, I didn't collude with him, so his experience was that

We sort of got

Not colluding w/ cl's "black + white view - does this mean he thinks he's correct? That the theory tells it how it is?

8

could he be colluding with the model instead?

5
science aspect
nurture ego ← what does theory do for us as therapists? → manage & understand
satisfy ← gratify

said w/ certainty

No longer a client but a case?

bad in whose judgment? Assuming an ideal.

230 he had bad parenting, the other thing, Freud came in - the
231 over-critical father. So he hated his father, he was so
232 angry and this was projected, it was projecting in his
233 relationships, it was about women and I remember the
234 client he used to explode at work, he was very isolated at
235 work and everyone at work was an 'idiot' (laughs) and so,
236 it was all about authority figures and you know, so it was
237 quite an interesting case. Why?
238

Expressing gratification that another theory can be applied.
Understanding his behaviour due to inner conflict rather than prejudice or discrimination from society.
Discounting possibility that the cl. may have an accurate perception of others.

3 because she hasn't got anything internal to support her.

She regressed quite quickly using theory of regression
Cl has returned to child-like state because of a lack of her own support.

598 very much working with the idea of splitting as a
599 defensive strategy, strong level of disconnection in the
600 therapy which again I see as him being defensive and
601 unable at that point to sort of process very competing
602 emotions but uhm... and hopefully sort of uhm, rather
603 than having a split parental model internally, having
604 models that were kind of more authentically
605 internalised because mum and dad weren't all good or
606 all bad, there were both aspects to both of them.

Understanding cl. w/ idea of splitting to explain cl's disconnection in therapy. Stop her from considering alternatives (?)

Have an aim for the client - to reach a state of integrating good + bad.

3 So that's such a split between her, all that, anything about her childhood that has just been completely repressed and was all very shame-bound. So that was,

Identifying this as a 'split'. Inability to acknowledge ch. self is responsible.

3 So my thinking about what happened to him was, was very much informed by this feeling that dad had left the family, so you know, for young, let's call him 'Michael', the young Michael, he had kind of won the oedipal battle and had won his mother and she never remarried.

Using theory to explain cl's difficulty w/ his father leaving.

5 608 what generally there's often anxiety that's
609 something that gets triggered off as a result of
610 the loss.

so and
Theorising / predicting a rise of anxiety due to loss.

APPENDIX VIII: CATEGORY INDEX 1

CATEGORY NUMBER	CATEGORY	FOCUSED CODES	LINKS (THESE EVENTUALLY HELP TO COLLAPSE CATEGORIES)
1	SEEING PSYCHODYNAMIC THEORY AS UNCONVINCING/IRRELEVANT	FOCUSING ON BUILDING A RELATIONSHIP IS NOT IN THE PSYCHODYNAMIC REPERTOIRE	LINKS TO 16 - REFLECTING ON OWN (THERAPIST'S) DIFFICULTY OF BEING A PARENT
2	LINKING CURRENT BEHAVIOUR WITH CHILDHOOD <i>DEVELOPMENT</i> /CURRENT DIFFICULTY WITH CHILDHOOD <i>EXPERIENCE</i>	PAST EVENTS STILL HOLDING EMOTIONAL SIGNIFICANCE YEARS LATER. REFLECTING ON PAST AND CHANGE THAT TIME BRINGS ABOUT	LINKS TO THERAPIST RELIEVING CLIENT'S GUILT/SELF-BLAME LINKS TO 14 – MAKING PSYCHODYNAMIC INTERPRETATIONS.
3	SIMPLIFYING THEORY – USING OWN IDEAS/INTUITION/THEORIES	USING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT BUT NOT OVERTLY LINKING THIS TO ANY SPECIFIC THEORY. CONFUSION OF WHICH THEORIST CAME UP WITH WHICH THEORY.	
4	FINDING THE RESEARCH QUESTION HARD TO ANSWER		
5	CHOOSING NOT TO USE PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT	WANTING A MORE PROACTIVE/INTERACTIVE APPROACH. USING PSYCHODYNAMIC /CBT (INTEGRATIVE) TECHNIQUES OF VISUALISATION AND IMAGERY. SEEING PURE PSYCHODYNAMIC WORK AS WAITING AND WORKING THINGS OUT UNCONSCIOUSLY. ARMING CLIENT WITH COPING STRATEGIES.	
6	THEORISING BUT NOT REALLY LINKING THIS TO PRACTICE	CLIENTS USE ALCOHOL AS A 'TRANSITIONAL OBJECT'	
7	BELIEF THAT COUNSELLING PSYCHOLOGISTS APPRECIATE SOCIAL CONTEXT		
8	DRAWING CLIENTS' AWARENESS TO THEIR CHOICES AS AN ADULT		
9	USING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT OUTSIDE THE SESSION	USED WHEN REFLECTING ON SESSION. GIVES A NEW PERSPECTIVE.	

		NOT MAKING INTERPRETATIONS WITH THE CLIENT, ONLY MAKING INTERPRETATIONS TO SELF.	
10	IMPROVING CLIENT'S SELF-ESTEEM AND SELF-EFFICACY		LINKS TO 53 – ADMIRATION FOR CLIENT
11	CHALLENGING CLIENT'S INCONGRUENCE		
12	SHOULD WE SPEAK OF THEORY DIRECTLY WITH CLIENTS?	YES – MAKING THEORY OVERT, AGE APPROPRIATELY. NO – SEEING THIS AS INAPPROPRIATE, BUT NOT IN OTHER MODELS	LINKS TO 13 – TIME FRAME FOR THERAPY
13	TIME FRAME FOR THERAPY	PREFERABLY HAVING MORE TIME TO WORK PSYCHODYNAMICALLY. SHORT-TERM THERAPY NEEDS TO BE OVERT/DIRECTIVE. DOING CLIENT'S DISSERVICE TO USE PSYCHODYNAMIC THEORY OF CHILD DEVELOPMENT IN SHORT-TERM CONTRACTS.	LINKS TO 12 – SPEAKING OF THEORY WITH CLIENTS
14	MAKING PSYCHODYNAMIC INTERPRETATIONS	LINKING PAST AND PRESENT	LINKS TO 2 - LINKING CURRENT BEHAVIOUR WITH CHILDHOOD <i>DEVELOPMENT</i> /CURRENT DIFFICULTY WITH CHILDHOOD <i>EXPERIENCE</i>
15	DIFFERENT TYPES OF NEGLECT	UNCONSCIOUS, UNINTENTIONAL, DIFFERENT SEVERITIES	
16	REFLECTING ON OWN (THERAPIST'S) DIFFICULTY OF BEING A PARENT		LINKS TO 1 – SEEING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT AS UNCONVINCING/IRRELEVANT
17	PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT INFORMS THE THERAPIST'S OWN PROCESSING AND UNDERSTANDING OF THEIR FEELINGS		
18	PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT ARE USEFUL AS 'BACKGROUND'		
19	NOT WANTING TO ASSUME ANYTHING ABOUT THE CLIENT		

20	THERAPIST USING/MAKING REFLECTIONS ON OWN RELATIONSHIP WITH CLIENT		
21	CLIENT SEEN AS NEEDING STRENGTH TO TOLERATE PSYCHODYNAMIC MODEL		
22	THERAPIST THINKING INTERPRETATION OF DEFENCES IS BETTER THAN USING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT		
23	WORKING INTEGRATIVELY	UNSURE AT FIRST OF WHICH MODEL TO USE. DECIDING ON MODEL DEPENDING ON CLIENT'S PRESENTATION.	LINKS TO 26 – CHANGING BOUNDARIES
24	EMPATHISING WITH CLIENTS	THERAPIST USING OWN PERSONAL EXPERIENCE TO EMPATHISE. STRONG EMOTIONAL REACTION TO CLIENT MATERIAL.	LINKS TO 45 – TRANSFERENCE OF PARENTAL RELATIONSHIP TO THERAPEUTIC RELATIONSHIP
25	THERAPIST SEEING NEGLECTED CLIENTS AS MORE DIFFICULT TO WORK WITH		
26	CHANGING BOUNDARIES	SETTING UP/ESTABLISHING BOUNDARIES. RELAXING BOUNDARIES FOR CERTAIN CLIENTS, ACCOMMODATING 'NEEDY' CLIENTS THERAPIST TRYING TO MAKE SELF AVAILABLE IF CLIENT'S MOTHER HASN'T IN THE PAST. LACK OF BOUNDARIES IN CHILDHOOD, INAPPROPRIATE PAST RELATIONSHIPS.	LINKS TO 23 – WORKING INTEGRATIVELY LINKS TO 37 – TRYING TO BE 'GOOD ENOUGH MOTHER' FOR THE CLIENT LINKS TO 35 – COUNTERTRANSFERENCE
27	TAKING ON A SMALL NUMBER OF LONG-TERM CLIENTS AT A TIME	FINDING LONG-TERM WORK EMOTIONALLY DEMANDING	
28			
29	LACK OF NUTURING IN CHILDHOOD – LACK OF PARENTAL INTEREST OR PRESENCE	CULTURALLY IMPLICIT – MOTHER AS MAIN CARER – MOTHER'S ABSENCE. CLIENT NOT LOVED OR MOTHERED AS A CHILD. ASSUMPTION – CHILDREN NEED A LOT OF EMOTIONAL CARE	
30	CLIENT TRYING TO FORGIVE		

	OTHERS FOR PAST		
31	SYMPATHISING WITH CLIENT		
32	CURRENT FACTUAL INFORMATION ABOUT THE CLIENT		
33	THERAPIST RELAYING CLIENT'S STORY	CLIENT WANTING TO TELL THEIR STORY AND FOR SOMEONE TO LISTEN. THERAPIST RELAYING THE CLIENT'S 'LEGACY' – WHAT HAS BEEN HANDED DOWN TO HER. THERAPIST PROMPTING CLIENT TO TALK ABOUT EARLY LIFE.	
34	THERAPIST COMPARING SELF DEVELOPMENTALLY TO THE CLIENT	AGE, MATURITY	
35	COUNTERTRANSFERENCE	MOTHERING WANTING TO RESCUE STRONG EMOTIONAL RESPONSE TO CLIENT.	LINKS TO 26 – CHANGING BOUNDARIES LINKS TO 37 – TRYING TO BE GOOD ENOUGH MOTHER
36	THERAPIST THEORISING THAT CLIENT FEELS HUNGER FOR A MOTHER-FIGURE	STRONG RELATIONSHIP BETWEEN CLIENT AND THERAPIST. IN THE THERAPEUTIC RELATIONSHIP AND IN RELATIONSHIPS OUTSIDE THERAPY	LINKS TO 35- COUNTERTRANSFERENCE LINKS TO 37- TRYING TO BE A GOOD ENOUGH MOTHER LINKS TO 26 – CHANGING BOUNDARIES
37	TRYING TO BE 'GOOD ENOUGH MOTHER' FOR THE CLIENT	SEEING THIS AS MAJOR PART OF THERAPEUTIC WORK. THERAPIST NOTICING CLIENT'S DEPENDENCE ON THEM. THERAPIST IS EITHER OK WITH THIS OR FINDS IT UNCOMFORTABLE, DISCOURAGING OF THIS.	LINKS TO 26 – CHANGING BOUNDARIES LINKS TO 35 - COUNTERTRANSFERENCE
38	CLIENT CARING FOR THEMSELVES AS A CHILD		LINKS TO 48 - ASSUMING AN 'INTERNALISATION' OF THE THERAPIST NEEDS TO TAKE PLACE
39	CLIENT RE-EXPERIENCING THINGS WITH AN ADULT MIND	DEVELOPING NEW ADULT UNDERSTANDING	
40	TRYING TO RID CLIENT OF SELF-BLAME/RELIEVE THE CLIENT'S GUILT	ABOUT PAST OCCURRENCE OR ABOUT CURRENT PROBLEMS WHICH HAVE BEEN THEORISED TO BE A RESULT OF EARLY EXPERIENCE.	LINKS TO 2 – LINKING PAST AND PRESENT

41	FACILITATING CLIENT TO TALK ABOUT CHILDHOOD EXPERIENCES		
42	THEORISING ABOUT CLIENT'S UNEXPRESSED EMOTIONS	REPRESSION - ANGER THEORY OF THE UNCONSCIOUS /BELIEF IN THE UNCONSCIOUS	
43	USING SUPERVISION	TO HELP WITH STRONG FEELINGS TO ASK FOR ADVICE	
44	SELF-DISCLOSURE ABOUT FEELINGS IN RELATION TO CLIENT'S SITUATION	NOT EVIDENT IN SOME, BUT EVIDENT IN ONE THERAPIST	
45	TRANSFERENCE OF PARENTAL RELATIONSHIP TO THERAPEUTIC RELATIONSHIP		LINKS TO 24 - EMPATHISING WITH CLIENTS
46	<i>EXPLAINING</i> CLIENT'S PRESENTATION WITH PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT	ATTACHMENT THEORY, OBJECT-RELATIONS, THE OEDIPUS COMPLEX, SPLITTING	LINKS TO 42 – THEORISING ABOUT CLIENT'S UNEXPRESSED EMOTIONS
47	<i>PREDICTING</i> CLIENT'S BEHAVIOUR USING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT	ATTACHMENT THEORY	
48	ASSUMING AN 'INTERNALISATION' OF THE THERAPIST NEEDS TO TAKE PLACE	INTERNALISATION OF A SOOTHING PARENT VERBALLY ENCOURAGING CLIENT TO TREAT SELF BETTER THAN PARENTS DID. ENCOURAGED TO DEVELOP MORE COMPASSION TOWARDS THE SELF. ENCOURAGEMENT TO DEVELOP A FAIRER SUPER-EGO OR NUTURING INNER-OBJECT	LINKS TO 37 - TRYING TO BE 'GOOD ENOUGH MOTHER' FOR THE CLIENT LINKS TO 38 - CLIENT CARING FOR THEMSELVES AS A CHILD
49	DESCRIBING THE CLIENT'S CHILD-LIKE STATE WITH PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT	REGRESSION TO AN EARLIER STAGE OF DEVELOPMENT	
50	THEORISING ABOUT 'SPLITS' IN THE CLIENT		
51	RELATING CLIENT'S AGE TO A PARTICULAR PSYCHODYNAMIC THEORY OF CHILD DEVELOPMENT		
52	HELPING CLIENT TO RECOVER MEMORIES		

53	HIGHLIGHTING RESILIENCE. ADMIRING CLIENT'S ACHIEVEMENTS DESPITE THEIR PAST. ADMIRATION FOR CLIENT.		LINKS TO 10 – IMPROVING CLIENT'S SELF- ESTEEM/SELF-EFFICACY
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*Blank categories indicate where the researcher has collapsed and combined previous categories together.

APPENDIX IX: CATEGORY INDEX 2

CATEGORY NUMBER	CATEGORY AND FOCUSED CODES
1	<p>SCEPTICISM ABOUT THE NEED FOR PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT, OR ABOUT THE CONTENT OF THE THEORIES</p> <ul style="list-style-type: none"> • SEEING PSYCHODYNAMIC THEORY AS UNNECESSARY, NOT ENOUGH
2	<p>LINKING CURRENT BEHAVIOUR WITH CHILDHOOD <i>DEVELOPMENT</i>/CURRENT DIFFICULTY WITH CHILDHOOD <i>EXPERIENCE</i>, WITHOUT REFERENCE TO A SPECIFIC THEORY</p> <ul style="list-style-type: none"> • AN ASSUMPTION THAT PAST ALWAYS AFFECTS PRESENT VS. IDEA THAT IT DOESN'T ALWAYS HAVE TO • REFLECTING ON CLIENT'S PAST EVENTS STILL HOLDING EMOTIONAL SIGNIFICANCE YEARS LATER, ASSUMING THIS MUST BE TRUE • THERAPISTS SEE THAT CLIENTS FIND THESE LINKS HELPFUL
3	<p>USING INTUITION</p> <ul style="list-style-type: none"> • DO THERAPISTS NEED INTUITION TO WORK WITH PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT?
4	<p>FINDING THE RESEARCH QUESTION DIFFICULT TO ANSWER</p> <ul style="list-style-type: none"> • PARTICIPANT FINDING IT EASIER TO RECITE THEORY • PARTICIPANT FEELING INTIMIDATED BY THE QUESTION
5	<p>CHOOSING NOT TO USE PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT/USING THEM WITHOUT REALISING THEY ARE DOING SO</p> <ul style="list-style-type: none"> • WANTING A MORE 'PRO-ACTIVE' APPROACH • USING CBT STRATEGIES INSTEAD • INTERPRETING DEFENCES NOT SEEN AS USING A PSYCHODYNAMIC THEORY OF CHILD DEVELOPMENT – 'DEFENCES' – PART OF A THEORY IS REMOVED FROM ITS CONTEXT, OR THEORY OF HOW THESE DEVELOP NOT SEEN AS NECESSARY
6	<p>RECITING THEORY RATHER THAN ANSWERING THE QUESTION</p> <ul style="list-style-type: none"> • NOT LINKING THIS TO PRACTICE • OFTEN SPEAKING OF THEORY AS IF IT IS TRUTH
7	<p>BELIEF THAT COUNSELLING PSYCHOLOGISTS APPRECIATE SOCIAL CONTEXT</p> <ul style="list-style-type: none"> • ACKNOWLEDGING BOWLBY'S CLASH WITH FEMINISM • SAYING SOCIAL CONTEXT IS APPRECIATED WITHOUT GIVING AN EXAMPLE
8	<p>DRAWING CLIENTS' AWARENESS TO THEIR CHOICES AS AN ADULT</p> <ul style="list-style-type: none"> • WITH THE AIM OF HELPING CLIENT TO MAKE A DECISION • ASSUMPTION THAT A DECISION NEEDS TO BE MADE • FREEING CLIENT FROM POWERLESSNESS OF CHILDHOOD
9	<p>CHOOSING TO/NOT TO THINK ABOUT PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT WHEN IN THE SESSION WITH THE CLIENT</p> <ul style="list-style-type: none"> • USED WHEN REFLECTING ON SESSION, TO GIVE A NEW PERSPECTIVE • NOT MAKING INTERPRETATIONS DIRECTLY WITH THE CLIENT • VS. MAKING INTERPRETATIONS THAT LINK PAST AND PRESENT, DIFFERENT WAYS OF DOING THIS – MORE SUBTLE THE MORE EXPERIENCE THE THERAPIST HAS

10	<p>IMPROVING CLIENT'S SELF-ESTEEM AND SELF-EFFICACY</p> <ul style="list-style-type: none"> • HIGHLIGHTING THE CLIENT'S RESILIENCE AND STRENGTHS • NOT FITTING WITH 'PROBLEM' ORIENTATED APPROACH OF PSYCHODYNAMIC WORK
11	<p>CHALLENGING CLIENT'S INCONGRUENCE</p> <ul style="list-style-type: none"> • HIGHLIGHTING HOW MUCH A CLIENT IS DRINKING (LINKS TO ETHICAL STANCE/SEEING 'REALITY')
12	<p>SHOULD WE SPEAK OF THEORY DIRECTLY WITH CLIENTS? Yes/No</p> <ul style="list-style-type: none"> • EXPLAINING THERAPEUTIC PROCESS TO THE CLIENT • CONCERN ABOUT THEORIES OF CHILD DEVELOPMENT NOT BEING UNDERSTOOD BY THE CLIENT, WANTING CLEAR COMMUNICATION • NOT WANTING TO 'LABEL' THE CLIENT • BEING OVERT ABOUT THEORY WHEN SEEING CLIENTS AS ABLE TO USE IT • SOME THERAPISTS EXPLAIN PERSON-CENTRED THEORY BUT NOT PSYCHODYNAMIC THEORY (WHY?)
13	<p>PREFERRING LONGER-TERM THERAPY FOR WORKING WITH PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT</p> <ul style="list-style-type: none"> • WANTING MORE TIME, FEELING NEED TO BE MORE DIRECTIVE IN SHORT-TERM CONTRACT, SPEAKING ABOUT THEORY
14	
15	
16	<p>THEORISING ABOUT WHAT 'IDEAL' PARENTING IS.</p> <ul style="list-style-type: none"> • REFLECTING ON OWN DIFFICULTY OF BEING A PARENT • SEEING BAD PARENTING AS OFTEN UNINTENTIONAL, NOT SEEKING TO PLACE BLAME
17	<p>PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT INFORMS THE THERAPIST'S OWN PROCESSING AND UNDERSTANDING OF THEIR FEELINGS</p> <ul style="list-style-type: none"> • NOTING OWN FEELINGS AND EXPLAINING THESE THROUGH THINKING ABOUT WHAT DRAMA/ROLE THE CLIENT HAS 'PLACED' THEM IN
18	
19	<p>AFFIRMING THE CLIENT'S EXPERIENCE</p> <ul style="list-style-type: none"> • RELATING THIS TO KOHUT'S THEORY OF MIRRORING THE CLIENT
20	<p>THERAPIST USING/MAKING REFLECTIONS ON OWN RELATIONSHIP WITH CLIENT</p> <ul style="list-style-type: none"> • DIRECT USE OF OBJECT-RELATIONS AND TRANSFERENCE OF PAST RELATIONSHIPS INTO THE RELATIONSHIP WITH THE CLIENT

21	CLIENT SEEN AS NEEDING STRENGTH TO TOLERATE PSYCHODYNAMIC MODEL
22	
23	WORKING INTEGRATIVELY <ul style="list-style-type: none"> • BASING THE APPROACH ON WHAT THE CLIENT BRINGS/PRESENTS WITH/GOALS • NOT USING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT WITH EVERY CLIENT • TAKING THE VIEW THAT PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT ARE ENRICHING TO THERAPEUTIC WORK BUT NOT ALWAYS NECESSARY
24	EMPATHISING WITH CLIENTS <ul style="list-style-type: none"> • USING OWN EXPERIENCE TO EMPATHISE WITH THE CLIENT • STRONG EMOTIONAL REACTION TO CLIENT MATERIAL
25	
26	DIFFERENT PERSPECTIVES ON THE IMPORTANCE OF BOUNDARIES <ul style="list-style-type: none"> • ESTABLISHING BOUNDARIES • RELAXING BOUNDARIES FOR SOME CLIENTS, ACCOMMODATING CLIENT NEEDS • LACK OF BOUNDARIES IN CHILDHOOD, ASSUMING AN 'IDEAL PARENTING' • USING BOUNDARIES AS THERAPEUTIC TOOL
27	GIVING SPACE FOR EXPRESSION OF NEGATIVE FEELINGS <ul style="list-style-type: none"> • NOT RELATING THIS TO ANY THEORY
28	INTRODUCING IDEAS/CONCEPTUALISATIONS TO CLIENTS/SHARING INTERPRETATIONS WITH CLIENTS <ul style="list-style-type: none"> • INTRODUCING IDEA OF DISSATISFACTORY PARENTING • TRYING TO RID CLIENT OF SELF-BLAME/RELIEVE THE CLIENT'S GUILT • HELPING CLIENT TO RECOVER MEMORIES
29	LACK OF NURTURING IN CHILDHOOD <ul style="list-style-type: none"> • LACK OF PARENTAL INTEREST OR PRESENCE • ASSUMPTION ABOUT CULTURAL NORM OF 'IDEAL' PARENTING • 'MOTHER'S ABSENCE' - CULTURALLY IMPLICIT NORM FOR WOMEN TO BE CARERS, AND MOTHER'S RESPONSIBILITY FOR EMOTIONAL WELFARE OF CHILD • UNDERSTANDING NEGLECT TO MEAN A LACK OF NURTURING IN CHILDHOOD
30	CLIENT TRYING TO FORGIVE OTHERS FOR PAST <ul style="list-style-type: none"> • THERAPIST QUESTIONING THE POSSIBILITY OF THIS – THERAPIST HOLDING A GRUDGE AGAINST CLIENT'S PARENTS? (CRYING AT CLIENT'S STORY) DOES THIS IMPINGE ON THE CLIENT'S PROGRESS?
31	SYMPATHISING WITH CLIENT
32	

33	<p>THERAPIST RELAYING CLIENT’S STORY AND CURRENT FACTUAL INFORMATION ABOUT THE CLIENT</p> <ul style="list-style-type: none"> • THERAPIST GIVING THE CLIENT • THERAPIST PROMPTING THE CLIENT TO TALK ABOUT THEIR EARLY LIFE • THERAPIST RE-TELLING THEIR CLIENT’S STORY – (AS A DIVERSION FROM THE RESEARCH QUESTION?) • CLIENT USING THERAPY TIME TO TALK, WANTING SOMEONE TO LISTEN • THERAPIST REFERRING TO CLIENT’S STORY AS A ‘LEGACY’
34	
35	<p>COUNTERTRANSFERENCE</p> <ul style="list-style-type: none"> • THERAPIST WANTING TO MOTHER THE CLIENT • THERAPIST WANTING TO RESCUE THE CLIENT • STRONG EMOTIONAL RESPONSE TO THE CLIENT • ABSORBED INTO THE WORLD OF THE CLIENT
36	<p>THERAPIST THEORISING THAT CLIENT FEELS HUNGER FOR A MOTHER-FIGURE</p> <ul style="list-style-type: none"> • SEEING THIS IN THERAPEUTIC RELATIONSHIP AS WELL AS RELATIONSHIPS OUTSIDE THERAPY • THERAPIST NOTICING CLIENT’S DEPENDENCE ON THE THERAPIST
37	<p>TRYING TO BE ‘GOOD ENOUGH MOTHER’ FOR THE CLIENT/OR PROVIDING A SAFE SPACE</p> <ul style="list-style-type: none"> • DIFFERENT WAYS OF THEORISING ABOUT THE RELATIONSHIP • PROVIDING STABILITY, ENCOURAGING CLIENT TO GET STABILITY FROM ELSEWHERE • SOME THERAPISTS NOT FEELING COMFORTABLE WITH THIS
38	<p>RELAYING STORY ABOUT CLIENT CARING FOR THEMSELVES AS A CHILD</p>
39	<p>CLIENT RE-EXPERIENCING THINGS WITH AN ADULT MIND/DEVELOPING NEW ADULT UNDERSTANDING</p>
40	
41	<p>THERAPIST THEORISING THAT THEY ARE BEING A ‘SECURE BASE’ FOR THE CLIENT</p>
42	<p>THEORISING ABOUT CLIENT’S UNEXPRESSED EMOTIONS</p> <ul style="list-style-type: none"> • THEORISING ABOUT CLIENT’S UNEXPRESSED ANGER – USING THEORY OF ‘REPRESSION’ AND UNCONSCIOUS PROCESSES OF CLIENT
43	<p>USING SUPERVISION TO HELP WITH STRONG FEELINGS OR FOR ADVICE</p>
44	<p>RELATIONAL - A LETTING GO OF PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT</p> <ul style="list-style-type: none"> • THE ANALYTIC STANCE VS. RELATIONAL THERAPY • SELF-DISCLOSURE ABOUT FEELINGS IN RELATION TO CLIENT’S SITUATION • WANTING TO BE HUMANE AND NOT TAKE ANALYTIC STANCE

45	<p>NOTICING SIMILARITIES OF PARENTAL RELATIONSHIP TO THERAPEUTIC RELATIONSHIP-CALLING THIS TRANSFERENCE</p> <ul style="list-style-type: none"> • EXPLAINING CLIENT’S PRESENT BEHAVIOUR WITH PAST EXPERIENCE
46	<p>EXPLAINING CLIENT’S PRESENTATION WITH PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT</p> <ul style="list-style-type: none"> • DESCRIBING THE CLIENT’S CHILD-LIKE STATE WITH PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT • THEORISING ABOUT ‘SPLITS’ IN THE CLIENT • EXPLAINING MATURITY/IMMATURITY OF CLIENT WITH KLEIN’S THEORIES • THINKING WITHIN A PARTICULAR FRAMEWORK • DESCRIBING CLIENT’S CHILD-LIKE STATE WITH THEORY OF ‘REGRESSION’ • EXPLAINING HOW/WHY CLIENTS RELATE TO A THERAPIST A CERTAIN WAY
47	<p>PREDICTING CLIENT’S BEHAVIOUR USING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT</p> <ul style="list-style-type: none"> • IN RELATION TO CLIENT’S BEHAVIOUR IN OTHER RELATIONSHIPS
48	<p>ASSUMING AN ‘INTERNALISATION’ OF THE THERAPIST NEEDS TO TAKE PLACE</p> <ul style="list-style-type: none"> • ASSUMING/HOPING THAT SOMETHING IS ‘TAKEN’ FROM THE THERAPEUTIC RELATIONSHIP • CLIENT ENCOURAGED TO DEVELOP MORE COMPASSION TOWARDS THE SELF, DEVELOP A ‘FAIRER SUPER-EGO’, OR ‘MORE NURTURING INNER-OBJECT’ • ENCOURAGING CLIENT TO TREAT SELF BETTER THAN PARENTS HAD
49	<p>SEEING THERAPY AS A DEVELOPMENTAL PROCESS LIKENED TO THEORIES OF CHILD DEVELOPMENT</p>
50	<p>THERAPIST ADMITTING TO NOT BEING SURE OF WHAT THEY DO</p>
51	<p>RELATING CLIENT’S AGE TO A PARTICULAR PSYCHODYNAMIC THEORY OF CHILD DEVELOPMENT</p>
52	<p>SEEING THE RELATIONSHIP AS MOST IMPORTANT FACTOR IN THERAPY</p> <ul style="list-style-type: none"> • NOT RELATING THIS TO ANY PARTICULAR PSYCHODYNAMIC THEORY OF CHILD DEVELOPMENT OR OTHERWISE • SECURE BASE/GOOD ENOUGH MOTHER/’JUST WORDS’ – WHAT IS THE RELATIONSHIP CLASSIFIED AS? AND WHAT DOES THIS MATTER?
53	<p>HAVING POSITIVE FEELINGS FOR THE CLIENT, NOT NECESSARILY EXPRESSING THESE</p> <ul style="list-style-type: none"> • HIGHLIGHTING RESILIENCE • ADMIRING CLIENT’S ACHIEVEMENTS DESPITE THEIR PAST • ADMIRATION FOR CLIENT • DEEP LOVE AND RESPECT FOR CLIENT • ACKNOWLEDGING AND RESPECTING THE POWER-DYNAMICS IN THE THERAPEUTIC RELATIONSHIP • WORRY ABOUT UPSETTING THE CLIENT (BRITISH CULTURE?)

54	
55	<p>NOTICING CLIENTS FINDING BREAKS DIFFICULT</p> <ul style="list-style-type: none"> • THERAPIST LINKING THIS TO THE CLIENT'S NEEDS, 'HUNGER FOR MOTHER', OR OTHERWISE
56	<p>TALKING ABOUT CLIENT'S EMOTIONS IN THE THERAPEUTIC RELATIONSHIP WITH REGARDS TO THE THERAPIST</p> <ul style="list-style-type: none"> • UNDERSTOOD AS TRANSFERENTIAL (BUT COULD BE REAL)
57	<p>THINKING THEORY HELPS THERAPIST TO UNDERSTAND THE CLIENT'S CHILDHOOD FROM THEIR PERSPECTIVE (HOW?)</p>
58	
59	<p>THERAPIST FINDING IT DEMANDING/UNCOMFORTABLE TO PROVIDE THE CLIENT WITH WHAT THEY NEED/DEMAND OF THEM</p> <ul style="list-style-type: none"> • THERAPIST SEEING NEGLECTED CLIENTS AS MORE DIFFICULT TO WORK WITH, TAKING ON A SMALL NUMBER OF LONG-TERM CLIENTS AT A TIME
60	<p>FOCUSING ON CLIENT'S EMOTIONS BROUGHT UP BY TALKING ABOUT CHILDHOOD</p>
61	<p>THERAPIST HAS STRONG PERSONAL ASSOCIATIONS WITH PARTICULAR THEORIES OF CHILD DEVELOPMENT (WHY?)</p> <ul style="list-style-type: none"> • PARTICULAR THEORIES EVOKED IN THE MIND OF THE THERAPIST • THEORIES IN THE 'BACK OF THE MIND'
62	<p>ENCOURAGING CLIENT TO BEAR MORE PSYCHIC PAIN, FACE REALITY, BE MORE WORRIED</p> <ul style="list-style-type: none"> • GIVING RATIONALE – TO DECREASE SPLIT BETWEEN PARANOID-SCHIZOID AND DEPRESSIVE POSITIONS (KLEIN) • TRYING TO INCREASE CLIENT'S MATURITY • TRYING TO REMOVE CLIENT'S 'STUCKNESS' • (BUT WHO SAYS THE THERAPISTS SEE THE 'CORRECT REALITY' AS IF THERE ARE TRUTHS TO BE FOUND ABOUT THE CLIENT)
63	<p>THE IDEA THAT CLIENTS DON'T HAVE TO HAVE HAD POOR CHILDHOOD RELATIONSHIPS FOR DEVELOPMENTAL THEORY TO BE USEFUL</p> <ul style="list-style-type: none"> • THEORY THAT TRAUMA CAUSES A PERSON TO BECOME OUT OF TOUCH WITH GOOD INNER OBJECTS – THERAPIST THEORISING ABOUT CLIENT'S PRESENTATION ACCORDING TO THE MODELS AVAILABLE/PREFERRED
64	<p>LOOKING AT SYMBOLISATION AND SIGNIFIERS – RELEVANCE OF OBJECTS AND WHAT THEY MEAN</p> <ul style="list-style-type: none"> • ASSUMING AN UNDERLYING MEANING TO CLIENT MATERIAL

65	<p>INITIAL CONFUSION</p> <ul style="list-style-type: none"> • AT FIRST FINDING THEORY DIFFICULT TO DRAW ON WHEN WITH THE CLIENT • TRYING TO ALLOW THE THEORY TO ARISE INTO MIND WITHOUT FORCING/SOMETIMES ACTIVELY PURSUING A RELEVANT THEORY • TRYING TO REACH A DECISION ABOUT THE CLIENT
66	<p>SEEKING ADDITIONAL TRAINING AND PERSONAL DEVELOPMENT</p> <ul style="list-style-type: none"> • WANTING TO FEEL EQUIPPED WITH MORE THEORETICAL KNOWLEDGE
67	<p>DEVELOPING THEORY ANEW WITH EACH CLIENT</p> <ul style="list-style-type: none"> • LEARNING FROM THE CLIENT
68	<p>SEEING UNDERSTANDING THE CLIENT AS IMPERATIVE</p> <ul style="list-style-type: none"> • (IS IT POSSIBLE TO UNDERSTAND THE CLIENT? LEVINAS – THE MESSAGE SENT IS NEVER THE MESSAGE RECEIVED)
69	<p>CLIENTS CAN BE REPAIRED VS. CLIENTS CAN'T BE REPAIRED</p> <ul style="list-style-type: none"> • 'KNOWING' THAT CLIENTS NEEDS CAN BE MET THROUGH THERAPY • BELIEVING THAT LONG-TERM PSYCHODYNAMIC THERAPY CAN REPAIR PAST ABUSE/TRAUMA • (WHAT DOES IT MEAN TO REPAIR?)
70	<p>DOES THEORY OPEN UP OR CLOSE DOWN AVENUES OF INQUIRY?</p> <ul style="list-style-type: none"> • (REVEAL OR CONCEAL – GADAMER, HEIDEGGER) • PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT ARE USEFUL AS 'BACKGROUND' • FACILITATING CLIENT TO TALK ABOUT CHILDHOOD EXPERIENCES • THERAPIST HOLDING A MOTIVATION FOR THE CLIENT TO CHANGE, THROUGH THEIR ROUTE OF INQUIRY
71	<p>WHAT THERAPISTS SAY THEY DO IS DIFFERENT TO WHAT THEY DO</p> <ul style="list-style-type: none"> • (PRESSURE TO BE 'PROFESSIONAL' OR 'KNOWLEDGEABLE'?)
72	<p>PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT DON'T DESCRIBE ALL CLIENTS AND ALL SITUATIONS</p> <ul style="list-style-type: none"> • SOMETIMES PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT ARE NOT CROSS-CULTURALLY APPLICABLE
73	<p>OPENING MIND TO IDEA THAT LATER TRAUMATA (AFTER PARENTING) CAN HAVE AN EQUALLY ADVERSE EFFECT ON WELL-BEING</p> <ul style="list-style-type: none"> • NOT RULING OUT THIS POSSIBILITY
74	<p>PERSONAL INTERPRETATION OF PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT</p> <ul style="list-style-type: none"> • INTERPRETING THEORY IN A PARTICULAR WAY DEPENDING ON THE INDIVIDUAL • POSSIBILITY OF A HUGE PERSONAL IMPACT OF THE THERAPIST IN THE THEORY THEY CHOOSE AND HOW THEY INTERPRET IT
75	<p>THEORY IS SOMETHING THAT SATISFIES THE THERAPIST IN THEIR SEARCH FOR MEANING (BUT NOT NECESSARILY FOR THE CLIENT)</p>

	<ul style="list-style-type: none"> • RATIONALISING THIS INTEREST • WANTING TO PLAY ‘DETECTIVE’
76	<p>THERAPIST RECOGNISING THEIR MORAL RESPONSIBILITY/IMPLICITLY RAISING ISSUE OF MORAL RESPONSIBILITY</p> <ul style="list-style-type: none"> • HETERONOMY VS. AUTONOMY? • THERAPIST HAVING A FIRM ETHICAL STANCE IN RELATION TO DIFFERENCE AND DISABILITY • WANTING TO SHOW ANTI-DISCRIMINATORY PRACTICE
77	<p>COLLABORATING WITH CLIENT/CONCERN ABOUT IMPOSING THEORY ON CLIENTS</p> <ul style="list-style-type: none"> • NOT WANTING TO ASSUME ANYTHING ABOUT THE CLIENT • USING THEORY THAT MAKES SENSE TO THE CLIENT
78	
79	<p>THERAPIST COMPARING SELF DEVELOPMENTALLY TO THE CLIENT</p> <ul style="list-style-type: none"> • THERAPIST APPLYING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT TO THEMSELVES
80	<p>WANTING TO FEEL ‘EXPERT’ OR ‘KNOWLEDGEABLE’ (OR NOT WANTING TO)</p>

*Blank categories indicate where the researcher has collapsed and combined previous categories together. An increase in categories from the previous category index is due to the ongoing analysis of interviews.

APPENDIX X: CATEGORY INDEX 3

CATEGORY NUMBER	CATEGORY AND FOCUSED CODES
2	<p>BELIEF THAT PAST AFFECTS PRESENT LINKING CURRENT BEHAVIOUR WITH CHILDHOOD <i>DEVELOPMENT</i>/CURRENT DIFFICULTY WITH CHILDHOOD <i>EXPERIENCE</i>, WITHOUT REFERENCE TO A SPECIFIC THEORY</p> <ul style="list-style-type: none"> • REFLECTING ON CLIENT’S PAST EVENTS STILL HOLDING EMOTIONAL SIGNIFICANCE YEARS LATER, ASSUMING THIS MUST BE TRUE • THERAPISTS SEE THAT CLIENTS FIND THESE LINKS HELPFUL
3	<p>USING INTUITION</p> <ul style="list-style-type: none"> • DO THERAPISTS NEED INTUITION TO WORK WITH PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT?
4	<p>FINDING THE RESEARCH QUESTION DIFFICULT TO ANSWER</p> <ul style="list-style-type: none"> • PARTICIPANT FINDING IT EASIER TO RECITE THEORY • PARTICIPANT FEELING INTIMIDATED BY THE QUESTION • THERAPIST ADMITTING TO NOT BEING SURE OF WHAT THEY DO
5	<p>CHOOSING NOT TO USE PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT/USING THEM WITHOUT REALISING THEY ARE DOING SO</p> <ul style="list-style-type: none"> • WANTING A MORE ‘PRO-ACTIVE’ APPROACH • USING CBT STRATEGIES INSTEAD • INTERPRETING DEFENCES NOT SEEN AS USING A PSYCHODYNAMIC THEORY OF CHILD DEVELOPMENT – ‘DEFENCES’ – PART OF A THEORY IS REMOVED FROM ITS CONTEXT, OR THEORY OF HOW THESE DEVELOP NOT SEEN AS NECESSARY
6	<p>RECITING THEORY RATHER THAN ANSWERING THE QUESTION A DIFFICULTY IN ANSWERING THE QUESTION</p>
8	<p>DRAWING CLIENTS’ AWARENESS TO THEIR CHOICES AS AN ADULT</p> <ul style="list-style-type: none"> • WITH THE AIM OF HELPING CLIENT TO MAKE A DECISION • ASSUMPTION THAT A DECISION NEEDS TO BE MADE • FREEING CLIENT FROM POWERLESSNESS OF CHILDHOOD
9	<p>CHOOSING TO/NOT TO THINK ABOUT PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT WHEN IN THE SESSION WITH THE CLIENT</p> <ul style="list-style-type: none"> • USED WHEN REFLECTING ON SESSION, TO GIVE A NEW PERSPECTIVE • NOT MAKING INTERPRETATIONS DIRECTLY WITH THE CLIENT • VS. MAKING INTERPRETATIONS THAT LINK PAST AND PRESENT, DIFFERENT WAYS OF DOING THIS – MORE SUBTLE THE MORE EXPERIENCE THE THERAPIST HAS
10	<p>IMPROVING CLIENT’S SELF-ESTEEM AND SELF-EFFICACY</p> <ul style="list-style-type: none"> • HIGHLIGHTING THE CLIENT’S RESILIENCE AND STRENGTHS • NOT FITTING WITH ‘PROBLEM’ ORIENTATED APPROACH OF PSYCHODYNAMIC WORK
11	<p>CHALLENGING CLIENT’S INCONGRUENCE</p> <ul style="list-style-type: none"> • HIGHLIGHTING HOW MUCH A CLIENT IS DRINKING (LINKS TO ETHICAL STANCE/SEEING ‘REALITY’)
12	<p>SHOULD WE SPEAK OF THEORY DIRECTLY WITH CLIENTS? Yes/No</p> <ul style="list-style-type: none"> • EXPLAINING THERAPEUTIC PROCESS TO THE CLIENT

	<ul style="list-style-type: none"> • CONCERN ABOUT THEORIES OF CHILD DEVELOPMENT NOT BEING UNDERSTOOD BY THE CLIENT, WANTING CLEAR COMMUNICATION • NOT WANTING TO 'LABEL' THE CLIENT • BEING OVERT ABOUT THEORY WHEN SEEING CLIENTS AS ABLE TO USE IT • SOME THERAPISTS EXPLAIN PERSON-CENTRED THEORY BUT NOT PSYCHODYNAMIC THEORY (WHY?)
81	<p>TREATING THEORY AS TRUTH VS. ACKNOWLEDGING IT AS A SOCIAL CONSTRUCTION</p> <p>IE: BELIEF THAT TRANSFERENCE IS A THING THAT EXISTS OPERATING A ONE-PERSON MODE OF PSYCHOLOGY THERAPIST USING/MAKING REFLECTIONS ON OWN RELATIONSHIP WITH CLIENT</p> <ul style="list-style-type: none"> • DIRECT USE OF OBJECT-RELATIONS AND TRANSFERENCE OF PAST RELATIONSHIPS INTO THE RELATIONSHIP WITH THE CLIENT • THEORISING ABOUT CLIENT'S UNEXPRESSED ANGER – USING THEORY OF 'REPRESSION' AND UNCONSCIOUS PROCESSES OF CLIENT • RELATIONAL - A LETTING GO OF PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT • THE ANALYTIC STANCE VS. RELATIONAL THERAPY • SELF-DISCLOSURE ABOUT FEELINGS IN RELATION TO CLIENT'S SITUATION • WANTING TO BE HUMANE AND NOT TAKE ANALYTIC STANCE <p>PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT DON'T DESCRIBE ALL CLIENTS AND ALL SITUATIONS</p> <ul style="list-style-type: none"> • SOMETIMES PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT ARE NOT CROSS-CULTURALLY APPLICABLE
16	<p>THEORISING ABOUT WHAT 'IDEAL' PARENTING IS.</p> <ul style="list-style-type: none"> • REFLECTING ON OWN DIFFICULTY OF BEING A PARENT • SEEING BAD PARENTING AS OFTEN UNINTENTIONAL, NOT SEEKING TO PLACE BLAME
17	<p>PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT INFORMS THE THERAPIST'S OWN PROCESSING AND UNDERSTANDING OF THEIR FEELINGS</p> <ul style="list-style-type: none"> • NOTING OWN FEELINGS AND EXPLAINING THESE THROUGH THINKING ABOUT WHAT DRAMA/ROLE THE CLIENT HAS 'PLACED' THEM IN
83	<p>WORKING TOWARDS BREAKING DOWN THE TRANSFERENCE</p>
19	<p>AFFIRMING THE CLIENT'S EXPERIENCE</p> <ul style="list-style-type: none"> • RELATING THIS TO KOHUT'S THEORY OF MIRRORING THE CLIENT
21	<p>CLIENT SEEN AS NEEDING STRENGTH TO TOLERATE PSYCHODYNAMIC MODEL IMPLYING THE THERAPY IS HARD FOR THE CLIENT THE CLIENT'S PERCEIVED FRAGILITY DICTATING HOW MUCH INTERPRETATIONS ARE USED</p>
86	<p>THE THERAPIST'S APPROACH DEPENDS ON THE MODELS THAT HAVE BEEN TAUGHT USING SUPERVISION TO HELP WITH STRONG FEELINGS OR FOR ADVICE</p>

24	EMPATHISING WITH CLIENTS <ul style="list-style-type: none"> • USING OWN EXPERIENCE TO EMPATHISE WITH THE CLIENT • STRONG EMOTIONAL REACTION TO CLIENT MATERIAL
25	
27	GIVING SPACE FOR EXPRESSION OF NEGATIVE FEELINGS <ul style="list-style-type: none"> • NOT RELATING THIS TO ANY THEORY
28	INTRODUCING IDEAS/CONCEPTUALISATIONS TO CLIENTS/SHARING INTERPRETATIONS WITH CLIENTS <ul style="list-style-type: none"> • INTRODUCING IDEA OF DISSATISFACTORY PARENTING (INHERENT PROBLEMS WITH THIS, WHICH ARE NOT ADDRESSED BY THE PARTICIPANT) • TRYING TO RID CLIENT OF SELF-BLAME/RELIEVE THE CLIENT'S GUILT • HELPING CLIENT TO RECOVER MEMORIES
30	CLIENT TRYING TO FORGIVE OTHERS FOR PAST <ul style="list-style-type: none"> • THERAPIST QUESTIONING THE POSSIBILITY OF THIS – THERAPIST HOLDING A GRUDGE AGAINST CLIENT'S PARENTS? (CRYING AT CLIENT'S STORY) DOES THIS IMPINGE ON THE CLIENT'S PROGRESS?
31	SYMPATHISING WITH CLIENT
32	
33	THERAPIST RELAYING CLIENT'S STORY AND CURRENT FACTUAL INFORMATION ABOUT THE CLIENT <ul style="list-style-type: none"> • THERAPIST GIVING THE CLIENT • THERAPIST PROMPTING THE CLIENT TO TALK ABOUT THEIR EARLY LIFE • THERAPIST RE-TELLING THEIR CLIENT'S STORY – (AS A DIVERSION FROM THE RESEARCH QUESTION?) • CLIENT USING THERAPY TIME TO TALK, WANTING SOMEONE TO LISTEN • THERAPIST REFERRING TO CLIENT'S STORY AS A 'LEGACY' • LACK OF PARENTAL INTEREST OR PRESENCE • ASSUMPTION ABOUT CULTURAL NORM OF 'IDEAL' PARENTING • 'MOTHER'S ABSENCE' - CULTURALLY IMPLICIT NORM FOR WOMEN TO BE CARERS, AND MOTHER'S RESPONSIBILITY FOR EMOTIONAL WELFARE OF CHILD • UNDERSTANDING NEGLECT TO MEAN A LACK OF NURTURING IN CHILDHOOD
34	

35	COUNTERTRANSFERENCE <ul style="list-style-type: none"> • THERAPIST WANTING TO MOTHER THE CLIENT • THERAPIST WANTING TO RESCUE THE CLIENT • STRONG EMOTIONAL RESPONSE TO THE CLIENT • ABSORBED INTO THE WORLD OF THE CLIENT
36	JUDGING WHAT KIND OF RELATIONSHIP THE CLIENT NEEDS OR WANTS THERAPIST THEORISING THAT CLIENT FEELS HUNGER FOR A MOTHER-FIGURE <ul style="list-style-type: none"> • SEEING THIS IN THERAPEUTIC RELATIONSHIP AS WELL AS RELATIONSHIPS OUTSIDE THERAPY • THERAPIST NOTICING CLIENT’S DEPENDENCE ON THE THERAPIST
37	DIFFERENT LANGUAGES/THEORIES TO DESCRIBE THE RELATIONSHIP DIFFERENT EMPHASES ON THE FUNCTION OF THE RELATIONSHIP TRYING TO BE ‘GOOD ENOUGH MOTHER’ FOR THE CLIENT/OR PROVIDING A SAFE SPACE <ul style="list-style-type: none"> • DIFFERENT WAYS OF THEORISING ABOUT THE RELATIONSHIP • PROVIDING STABILITY, ENCOURAGING CLIENT TO GET STABILITY FROM ELSEWHERE • THERAPIST THEORISING THAT THEY ARE BEING A ‘SECURE BASE’ FOR THE CLIENT
39	CLIENT RE-EXPERIENCING THINGS WITH AN ADULT MIND/DEVELOPING NEW ADULT UNDERSTANDING
45	NOTICING SIMILARITIES OF PARENTAL RELATIONSHIP TO THERAPEUTIC RELATIONSHIP-CALLING THIS TRANSFERENCE <ul style="list-style-type: none"> • EXPLAINING CLIENT’S PRESENT BEHAVIOUR WITH PAST EXPERIENCE
46	EXPLAINING CLIENT’S PRESENTATION WITH PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT <ul style="list-style-type: none"> • DESCRIBING THE CLIENT’S CHILD-LIKE STATE WITH PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT • THEORISING ABOUT ‘SPLITS’ IN THE CLIENT • EXPLAINING MATURITY/IMMATURITY OF CLIENT WITH KLEIN’S THEORIES • THINKING WITHIN A PARTICULAR FRAMEWORK • DESCRIBING CLIENT’S CHILD-LIKE STATE WITH THEORY OF ‘REGRESSION’ • EXPLAINING HOW/WHY CLIENTS RELATE TO A THERAPIST A CERTAIN WAY

48	<p>ASSUMING AN ‘INTERNALISATION’ OF THE THERAPIST NEEDS TO TAKE PLACE</p> <ul style="list-style-type: none"> • ASSUMING/HOPING THAT SOMETHING IS ‘TAKEN’ FROM THE THERAPEUTIC RELATIONSHIP • CLIENT ENCOURAGED TO DEVELOP MORE COMPASSION TOWARDS THE SELF, DEVELOP A ‘FAIRER SUPER-EGO’, OR ‘MORE NURTURING INNER-OBJECT’ • ENCOURAGING CLIENT TO TREAT SELF BETTER THAN PARENTS HAD
49	<p>SEEING THERAPY AS A DEVELOPMENTAL PROCESS LIKENED TO THEORIES OF CHILD DEVELOPMENT</p>
51	<p>RELATING CLIENT’S AGE TO A PARTICULAR PSYCHODYNAMIC THEORY OF CHILD DEVELOPMENT NOT DONE VERY OFTEN</p>
52	<p>DEBATE ABOUT THE IMPORTANCE OF THEORY</p> <ul style="list-style-type: none"> • NOT RELATING THIS TO ANY PARTICULAR PSYCHODYNAMIC THEORY OF CHILD DEVELOPMENT OR OTHERWISE • SCEPTICISM ABOUT THE NEED FOR PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT, OR ABOUT THE CONTENT OF THE THEORIES • SEEING PSYCHODYNAMIC THEORY AS UNNECESSARY, NOT ENOUGH • WHAT IS MEANT BY ‘RELATIONSHIP’ ?
54	
55	<p>NOTICING CLIENTS FINDING BREAKS DIFFICULT</p> <ul style="list-style-type: none"> • THERAPIST LINKING THIS TO THE CLIENT’S NEEDS, ‘HUNGER FOR MOTHER’, OR OTHERWISE
56	<p>TALKING ABOUT CLIENT’S EMOTIONS IN THE THERAPEUTIC RELATIONSHIP WITH REGARDS TO THE THERAPIST</p> <ul style="list-style-type: none"> • UNDERSTOOD AS TRANSFERENTIAL (BUT COULD BE REAL)
57	<p>THINKING THEORY HELPS THERAPIST TO UNDERSTAND THE CLIENT’S CHILDHOOD FROM THEIR PERSPECTIVE (HOW?) WHAT IS IT TO UNDERSTAND? NO PARTICIPANTS EXPLAIN WHAT THEY MEAN BY THIS. SEEING UNDERSTANDING THE CLIENT AS IMPERATIVE</p> <ul style="list-style-type: none"> • (IS IT POSSIBLE TO UNDERSTAND THE CLIENT? LEVINAS – THE MESSAGE SENT IS NEVER THE MESSAGE RECEIVED)
85	<p>THEORY ABATES ANXIETY SUPERVISION ABATES ANXIETY INITIAL CONFUSION – BEARING THE ANXIETY BEFORE GRABBING ONTO THEORY INITIAL CONFUSION</p> <ul style="list-style-type: none"> • AT FIRST FINDING THEORY DIFFICULT TO DRAW ON WHEN WITH THE CLIENT • TRYING TO ALLOW THE THEORY TO ARISE INTO MIND WITHOUT FORCING/SOMETIMES ACTIVELY PURSUING A RELEVANT THEORY • TRYING TO REACH A DECISION ABOUT THE CLIENT

59	<p>THERAPIST FINDING IT DEMANDING/UNCOMFORTABLE TO PROVIDE THE CLIENT WITH WHAT THEY NEED/DEMAND OF THEM</p> <ul style="list-style-type: none"> • THERAPIST SEEING NEGLECTED CLIENTS AS MORE DIFFICULT TO WORK WITH, TAKING ON A SMALL NUMBER OF LONG-TERM CLIENTS AT A TIME
60	<p>FOCUSING ON CLIENT’S EMOTIONS BROUGHT UP BY TALKING ABOUT CHILDHOOD</p>
61	<p>THERAPIST HAS STRONG PERSONAL ASSOCIATIONS WITH PARTICULAR THEORIES OF CHILD DEVELOPMENT (WHY?)</p> <ul style="list-style-type: none"> • PARTICULAR THEORIES EVOKED IN THE MIND OF THE THERAPIST • THEORIES IN THE ‘BACK OF THE MIND’
62	<p>ENCOURAGING CLIENT TO BEAR MORE PSYCHIC PAIN, FACE REALITY, BE MORE WORRIED</p> <ul style="list-style-type: none"> • GIVING RATIONALE – TO DECREASE SPLIT BETWEEN PARANOID-SCHIZOID AND DEPRESSIVE POSITIONS (KLEIN) • TRYING TO INCREASE CLIENT’S MATURITY • TRYING TO REMOVE CLIENT’S ‘STUCKNESS’ • (BUT WHO SAYS THE THERAPISTS SEE THE ‘CORRECT REALITY’ AS IF THERE ARE TRUTHS TO BE FOUND ABOUT THE CLIENT)
64	<p>LOOKING AT SYMBOLISATION AND SIGNIFIERS – RELEVANCE OF OBJECTS AND WHAT THEY MEAN</p> <ul style="list-style-type: none"> • ASSUMING AN UNDERLYING MEANING TO CLIENT MATERIAL
69	<p>CLIENTS CAN BE REPAIRED VS. CLIENTS CAN’T BE REPAIRED</p> <ul style="list-style-type: none"> • ‘KNOWING’ THAT CLIENTS NEEDS CAN BE MET THROUGH THERAPY • BELIEVING THAT LONG-TERM PSYCHODYNAMIC THERAPY CAN REPAIR PAST ABUSE/TRAUMA • (WHAT DOES IT MEAN TO REPAIR?)
70	<p>DOES THEORY OPEN UP OR CLOSE DOWN AVENUES OF INQUIRY?</p> <ul style="list-style-type: none"> • (REVEAL OR CONCEAL – GADAMER, HEIDEGGER) PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT ARE USEFUL AS ‘BACKGROUND’ • FACILITATING CLIENT TO TALK ABOUT CHILDHOOD EXPERIENCES • THERAPIST HOLDING A MOTIVATION FOR THE CLIENT TO CHANGE, THROUGH THEIR ROUTE OF INQUIRY • RELAYING STORY ABOUT CLIENT CARING FOR THEMSELVES AS A CHILD • PREDICTING CLIENT’S BEHAVIOUR USING PSYCHODYNAMIC THEORIES OF CHILD

	<p>DEVELOPMENT - IN RELATION TO CLIENT'S BEHAVIOUR IN OTHER RELATIONSHIPS OPENING MIND TO IDEA THAT LATER TRAUMATA (AFTER PARENTING) CAN HAVE AN EQUALLY ADVERSE EFFECT ON WELL-BEING</p> <ul style="list-style-type: none"> • NOT RULING OUT THIS POSSIBILITY (OR RULING IT OUT CAN CLOSE AVENUES OF ENQUIRY) <p>THE IDEA THAT CLIENTS DON'T HAVE TO HAVE HAD POOR CHILDHOOD RELATIONSHIPS FOR DEVELOPMENTAL THEORY TO BE USEFUL</p> <ul style="list-style-type: none"> • THEORY THAT TRAUMA CAUSES A PERSON TO BECOME OUT OF TOUCH WITH GOOD INNER OBJECTS – THERAPIST THEORISING ABOUT CLIENT'S PRESENTATION ACCORDING TO THE MODELS AVAILABLE/PREFERRED
71	<p>WHAT THERAPISTS SAY THEY DO IS DIFFERENT TO WHAT THEY DO</p> <ul style="list-style-type: none"> • (PRESSURE TO BE 'PROFESSIONAL' OR 'KNOWLEDGEABLE?')
74	<p>PERSONAL INTERPRETATION OF PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT</p> <ul style="list-style-type: none"> • INTERPRETING THEORY IN A PARTICULAR WAY DEPENDING ON THE INDIVIDUAL • POSSIBILITY OF A HUGE PERSONAL IMPACT OF THE THERAPIST IN THE THEORY THEY CHOOSE AND HOW THEY INTERPRET IT <p>DIFFERENT PERSPECTIVES ON THE IMPORTANCE OF BOUNDARIES</p> <ul style="list-style-type: none"> • ESTABLISHING BOUNDARIES • RELAXING BOUNDARIES FOR SOME CLIENTS, ACCOMMODATING CLIENT NEEDS • LACK OF BOUNDARIES IN CHILDHOOD, ASSUMING AN 'IDEAL PARENTING' • USING BOUNDARIES AS THERAPEUTIC TOOL
75	<p>THEORY IS SOMETHING THAT SATISFIES THE THERAPIST IN THEIR SEARCH FOR MEANING (BUT NOT NECESSARILY FOR THE CLIENT)</p> <ul style="list-style-type: none"> • RATIONALISING THIS INTEREST • WANTING TO PLAY 'DETECTIVE'
76	<p>THERAPIST RECOGNISING THEIR MORAL RESPONSIBILITY/IMPLICITLY RAISING ISSUE OF MORAL RESPONSIBILITY</p> <ul style="list-style-type: none"> • HETERONOMY VS. AUTONOMY? • THERAPIST HAVING A FIRM ETHICAL STANCE IN RELATION TO DIFFERENCE AND DISABILITY • WANTING TO SHOW ANTI-DISCRIMINATORY PRACTICE
77	<p>COLLABORATING WITH CLIENT/CONCERN ABOUT IMPOSING THEORY ON CLIENTS</p> <ul style="list-style-type: none"> • NOT WANTING TO ASSUME ANYTHING ABOUT THE CLIENT • USING THEORY THAT MAKES SENSE TO THE CLIENT <p>DEVELOPING THEORY ANEW WITH EACH CLIENT</p> <ul style="list-style-type: none"> • LEARNING FROM THE CLIENT • THIS DOESN'T NECESSARILY CHALLENGE THAT THEORY IS SEEN AS TRUTH – MORE ABOUT FINDING THE THEORY THAT IS TRUE FOR A PARTICULAR CLIENT.
79	<p>THERAPIST COMPARING SELF DEVELOPMENTALLY TO THE CLIENT</p> <ul style="list-style-type: none"> • THERAPIST APPLYING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT TO THEMSELVES

80	<p>WANTING TO FEEL ‘EXPERT’ OR ‘KNOWLEDGEABLE’ (OR NOT WANTING TO) HAVING POSITIVE FEELINGS FOR THE CLIENT, NOT NECESSARILY EXPRESSING THESE – A HUMBLE APPROACH – NOT BEING THE ONE TO KNOW EVERYTHING.</p> <ul style="list-style-type: none"> • HIGHLIGHTING RESILIENCE • ADMIRING CLIENT’S ACHIEVEMENTS DESPITE THEIR PAST • ADMIRATION FOR CLIENT • DEEP LOVE AND RESPECT FOR CLIENT • ACKNOWLEDGING AND RESPECTING THE POWER-DYNAMICS IN THE THERAPEUTIC RELATIONSHIP • WORRY ABOUT UPSETTING THE CLIENT (BRITISH CULTURE?) <p>SEEKING ADDITIONAL TRAINING AND PERSONAL DEVELOPMENT</p> <ul style="list-style-type: none"> • WANTING TO FEEL EQUIPPED WITH MORE THEORETICAL KNOWLEDGE – PLACING SUCH HIGH VALUE ON THEORY.
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*Blank categories indicate where the researcher has collapsed and combined previous categories together. An increase in categories from the previous category index is due to the ongoing analysis of interviews.

APPENDIX XI: FINAL CATEGORY INDEX

CATEGORY NUMBER	CATEGORY	FOCUSED CODES
1	PLACING HIGH VALUE IN THEORETICAL KNOWLEDGE	<i>DOING EXTRA TRAINING, PUBLISHING ARTICLES BECAUSE OF GOOD THEORY-BASE, READING UP ON THEORY</i> <i>VALUING A 'KNOWLEDGEABLE' IDENTITY</i> <i>FEELING 'EXPERT' OR 'SKILLED'</i>
2	PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT ABATE THERAPISTS' ANXIETY AND OTHER DIFFICULT FEELINGS	<i>USING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT TO EXPLAIN UNUSUAL/UNSETTLING CLIENT PRESENTATIONS</i> <i>PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT RELIEVE THE PRESSURE OF MAKING CLIENTS BETTER</i> <i>PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT MAKE THE THERAPIST FEEL SAFE – A BASE TO RETURN TO</i> <i>ACKNOWLEDGING ANXIETY EXISTS AND IS A PART OF THERAPY FOR THE THERAPIST</i>
4	PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT HELPS THERAPIST TO TOLERATE CLIENTS' DEPENDENCE AND DEMANDS	<i>PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT HELP THERAPIST TOLERATE CLIENT DEPENDENCE</i> <i>HELPS TOLERATE CLIENT DEMANDS</i>
5	A FASCINATION WITH PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT, SHOWING INTEREST IN SEARCH FOR MEANING	<i>PLAYING 'THE DETECTIVE'</i> <i>BEING FASCINATED/INTERESTED IN PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT</i> <i>USING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT TO INFORM SELF (BUT NOT THE CLIENT – NOT MAKING INTERPRETATIONS)</i>
6	THERAPIST PUTTING CHANGE IN THE CLIENT DOWN TO PROCESSES RESULTING FROM THEIR WORK	<i>THERAPIST PUTTING CHANGE IN THE CLIENT DOWN TO PROCESSES RESULTING FROM THEIR WORK</i> <i>SEEING WHAT IS BEING LOOKED FOR</i>
7	FEELING MORE PROFICIENT WITH TIME AND EXPERIENCE	
8	THERAPIST CHOOSING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT THAT RESONATE WITH THEM, NOT ACCORDING TO THE CLIENT	<i>LIKING CERTAIN THEORIES, RESONATING WITH THERAPIST</i> <i>CERTAIN PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT HAVING NO PERSONAL RESONANCE/MEANING FOR THE THERAPIST</i>
9	SPEAKING AS IF PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT REPRESENT AND OBJECTIVE REALITY	<i>SPEAKING AS IF PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT REPRESENT AND OBJECTIVE REALITY</i> <i>THEORISING ABOUT CLIENT'S UNEXPRESSED FEELINGS IN TERMS OF PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT</i> <i>BELIEF THAT TRANSFERENCE IS A THING THAT EXISTS</i> <i>DEMONSTRATING A TENSION BETWEEN NEEDING TRUTH</i>

		<i>AND KNOWING IT AS A SOCIAL CONSTRUCTION</i>
10	DISPLAYING TENSION BETWEEN BEING EQUAL AND 'KNOWING'	<i>TRYING TO FIND A BALANCE BETWEEN THEORY AND BEING AN EQUAL TO THE CLIENT</i> <i>REJECTING THE ROLE OF 'EXPERT'</i>
11	AWARENESS OF BEING CAUGHT IN A POWER-IMBALANCE WITH THE CLIENT BECAUSE OF PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT AND THE 'KNOWLEDGE' IT GIVES	<i>ADOPTING A POWERFUL ROLE</i> <i>DISCUSSING THEIR AWARENESS OF A POWER IMBALANCE</i>
12	FINDING A BALANCE BETWEEN THE IMPORTANCE OF THEORY AND THE IMPORTANCE OF RELATIONSHIP	<i>ACKNOWLEDGING THE IMPORTANCE OF THEORY: RELATIONSHIP IS NOT ENOUGH</i> <i>ACKNOWLEDGING THAT THEORY ISN'T ENOUGH (THE IMPORTANCE OF THE RELATIONSHIP)</i>
13	THINKING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT AREN'T ENOUGH	<i>CHOOSING TO USE ALTERNATIVE THERAPEUTIC MODELS/WORKING INTEGRATIVELY</i> <i>THINKING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT AREN'T ENOUGH</i> <i>FOCUSING ON CLIENT STRENGTHS AS OPPOSED TO PROBLEM FOCUSED PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT</i>
14	FINDING THE RESEARCH QUESTION DIFFICULT TO ANSWER	<i>RECITING THEORY INSTEAD OF ANSWERING THE QUESTION</i> <i>BEING CONFUSED ABOUT HOW TO APPLY PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT TO PRACTICE</i> <i>DEMONSTRATING A DIFFICULTY IN EXPLAINING HOW PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT AFFECT PRACTICE</i>
15	USING INTUITION	
16	FEELING UNCERTAIN OF ABILITY TO UNDO OR REPAIR DAMAGE DONE IN CHILDHOOD	<i>SEEING CLIENTS' NEEDS AS UNQUENCHABLE/UNMEETABLE/UNCHANGABLE</i> <i>HAVING SOME HOPE AT PARTIALLY MEETING THESE NEEDS</i>
17	USING DIFFERENT LANGUAGES TO DESCRIBE THE RELATIONSHIP WITH THE CLIENT	<i>THERAPIST SEEING SELF AS HAVING A PARENTAL RELATIONSHIP WITH THE CLIENT</i> <i>NOT EQUATING RELATIONSHIP WITH BEING A PARENT TO THE CLIENT</i>
18	TRYING TO AVOID IMPOSING THEORY ON CLIENTS	<i>TRYING TO AVOID FITTING CLIENTS TO PRE-EXISTING THEORY</i> <i>SEEING BEING RIGID OR ENTRENCHED IN PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT AS PROBLEMATIC</i>

		<i>REVISING THEORY/EXPECTATIONS/ASSUMPTIONS DEPENDING ON THE CLIENT</i>
19	EXPLAINING CLIENTS' PRESENTATIONS WITH PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT	<i>REFLECTING ON THE USE OF PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT TO EXPLAIN CLIENT PRESENTATIONS</i> <i>SHOWING HOW PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT ARE USED TO EXPLAIN CLIENT PRESENTATIONS</i>
20	BEING GUIDED BY PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT IN QUESTIONING/DIRECTING THE CLIENT, AND LISTENING	<i>THEORY GUIDING HOW THERAPIST LISTENS</i> <i>BEING GUIDED BY THEORY IN QUESTIONING/DIRECTING THE CLIENT</i>
21	BEING INFORMED ABOUT THE CLIENT WITH PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT	<i>PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT HELP IN UNDERSTANDING THE THERAPISTS' RELATIONSHIP WITH THE CLIENT</i> <i>FEELING THAT PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT HELP THE THERAPIST TO UNDERSTAND THE CLIENT</i>
22	TRYING TO SHIFT BLAME FROM CLIENTS AND INTRODUCING IDEA OF INADEQUATE PARENTING	<i>TRYING TO RID CLIENT OF SELF-BLAME</i> <i>INTRODUCING IDEA OF INADEQUATE PARENTING</i> <i>INTRODUCING OTHER MATERIAL TO THE CLIENT</i> <i>NOT WANTING TO PLACE BLAME</i>
23	THEORISING ABOUT IDEAL PARENTING	
24	LOOKING TO THE PAST TO EXPLAIN THE PRESENT	
25	USING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT AS A BASIS TO CHALLENGE CLIENT'S...	<i>PERCEPTION OF REALITY</i> <i>DEFENCES AGAINST PSYCHIC PAIN</i>
26	USING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT CHANGES THERAPISTS' WAY OF BEING	
27	MONITORING ONESELF INTERNALLY	
28	PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT INFORM THERAPIST OF OWN PROCESSING AND FEELINGS IN RELATION TO THE CLIENT	
29	PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT HAVE AN IMPACT ON THE BOUNDARIES THERAPISTS KEEP	
30	GIVING THE CLIENT AN EXPERIENCE THEY CAN 'INTERNALISE'	

31	USING THE MODELS WHICH WERE TAUGHT TO THEM	
32	THERAPIST BECOMES INTERTWINED WITH PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT	<p><i>INTERNALISING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT</i></p> <p><i>BECOMING ONE WITH PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT, NOT BEING ABLE TO SPLIT IT OFF</i></p> <p><i>APPLYING PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT TO ONESELF</i></p>
33	DESCRIBING HOW PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT ARE 'EVOKED' IN THE MIND	<p><i>BEING OPEN TO THEORIES AUTOMATICALLY ARISING IN ONE'S MIND</i></p> <p><i>ACTIVELY SEARCHING FOR APPROPRIATE THEORY</i></p>
34	BEING ABLE TO EMPATHISE	
35	NOT SPEAKING OF COMPLEX PTCO TERMS WITH THE CLIENT	<p><i>EXPLAINING SOME THEORY TO THE CLIENT</i></p> <p><i>NOT SPEAKING OF THEORY IN THE SESSION</i></p>
36	THEORY WORKING ON AN ELUSIVE, PROCEDURAL LEVEL	<i>SUBSUMES FOCUSED CODES 14, 26, 32, 33 AND 35</i>
37	CRITIQUING PARTICULAR PSYCHODYNAMIC THEORIES OF CHILD DEVELOPMENT	
38	CHOOSING OTHER THERAPEUTIC ORIENTATIONS	