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Experiences of Countertransference in Beginning Psychotherapists

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I declare that this research report is my own, unaided work. It has not been admitted before for any other degree or examination at this or any other university.

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Abstract

Given the rise of intersubjective theory (Marzi, Hautman & Maestro, 2006) and contemporary formulations of countertransference as an integral aspect of the psychotherapeutic process (Cassorla, 2005; Marchon, 2006), understandings of countertransference are still being developed and explored in the psychoanalytic literature. This study explores beginning psychotherapists' experiences and understandings of countertransference and countertransference-related phenomena. In depth data was obtained from five volunteer psychotherapists in their first three years of practice who were interviewed using a semi-structured interview schedule. These interviews were analysed using a psychoanalytically informed narrative methodology. The need for an experiential model of countertransference that remains true to the often alive, elusive and indescribable nature of countertransference experiences was a central finding of the project. A secondary focus of the research was the therapists' development of their sense of professional identity. The paucity of research exploring the interaction of countertransference and professional identity development rendered this an important area of investigation. The effect of this process upon the way in which the beginning psychotherapists made sense of their countertransference experiences, was a finding of further significance.

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Chapter One: Introduction

Introduction

The concept of countertransference has become a focal point in many contemporary debates within the psychoanalytic literature. Its theoretical meaning, initially as a concept representing the influence of the psychotherapist's unconscious upon a psychotherapy, has expanded since its coinage by Sigmund Freud over 100 years ago (Gabbard, 2001; Jacobs, 1999; Marchon, 2006). As a result, contemporary views and uses of the term countertransference represent a range of interpersonally-based psychological processes. This expansion of meaning has occurred amidst the general and historical development of psychoanalytic theory, and the introduction of concepts such as projective identification (Klein, 1946), role-responsiveness (Sandler, 1976) and countertransference-enactment (cf. Ivey, 2008). As each of these concepts seeks to capture the events that occur in psychotherapy with direct reference to the psychotherapist's behaviour or subjective experience, they represent ideas that have become conflated and entwined with the term countertransference (Mills, 2004).

This study explores the experience of countertransference in a sample of psychotherapists in their first three years of practice. Given the conflation and entwining of countertransference and similar concepts, as referred to above, and as it is *the experience* of the psychotherapist that is sought, the study's scope includes all psychoanalytic concepts that may refer to such experience. These concepts include primary identification (Arnold, 2006; Elliot, 1995; Grotstein, 1980; Sandler, 1993), sympathy (Sandler, 1993), empathy (Hinshelwood, 1999; Sandler, 1993), projective identification (Bion, 1957a, 1957b; Ogden, 1979), role-responsiveness (Sandler, 1976), countertransference (Gabbard, 2001; Heimann, 1950; Jacobs, 1999; Little, 1951; Racker, 1957; Reich, 1960; Winnicott, 1949) and countertransference-enactment (Ivey, 2008). The above concepts are collectively referred to below as "countertransference and related phenomena" and as "countertransference-type" experiences/phenomena.

This research project seeks to provide a psychoanalytically informed, experience-near and narrative contribution to a subject under dispute yet central to the act of therapy. The experience-near aspect of the study relates to the intention of investigating countertransference qualitatively from the perspective of newly qualified psychotherapists. The study followed an approach that aimed to remain as close to the experiences depicted by the sampled psychotherapists as was possible. This was achieved by contextualising the psychotherapists' experiences of countertransference within

the therapeutic process, and by understanding their defences, enactments and meaning-making to derive from the *local level* of interaction, an experiential and interactive rather than an intrapsychic focus (BCPSG, 2007). The narrative aspect of the study is linked to the storied nature of the data. A narrative analytic approach was chosen to examine this data as a result. The study's central focus is the depiction of the sampled psychotherapists' experiences of countertransference and related phenomena, as well as the therapists' understanding of these events. A secondary concern in the study is the psychotherapists' development of an associated sense of professional identity. The study attempts to contextualise the findings related to the therapists' experiences and their understanding of their experiences (the central focus) within the context of their development. The idea of an associated sense of professional identity provides such a context.

The study does not make a distinction between *psychoanalysis* and *psychotherapy*. While there are clear and distinct differences between these practices, there is little reason to believe that the ideas of countertransference and related phenomena are not equally applicable to the practice of psychotherapy. Thus although the study interviewed psychotherapists who practice psychotherapy, it made use of the psychoanalytic literature that is largely the forum of psychoanalysts practicing psychoanalysis. Lemma (2003) and McWilliams (2011) directly support the approach stated. Given this approach, and for simplicity, when psychoanalytic literature is cited within the study, psychoanalysts are referred to as "psychotherapists" and the practice of psychoanalysis is referred to as "psychotherapy". It is recognised that such a depiction is inaccurate, yet it is made use of in this study to avoid distinctions between the two disciplines that are tangential to the study's aims and foci. Note that psychotherapy is at times referred to as "therapy" and psychotherapists are referred to as "therapists".

Aims

The research project has three specific aims. The first is the exploration of the sampled psychotherapists' countertransference-type experiences. This aim is intentionally open ended as the literature suggests that countertransference-type experiences may be diverse and varied. It allowed for the inclusion of different types of countertransference phenomena, as well as for the exploration of the meaning associated with the experiences that the psychotherapists' described. The second aim is the investigation of the ways in which psychotherapists came to understand their experiences of countertransference phenomena. Key to this second aim is an exploration of the thought processes, ideas and feelings that the therapists made use of in understanding their experiences. The study's third aim is an examination of the interaction between psychotherapists' (a)

countertransference-type experiences and (b) the sense-making processes used by the psychotherapists in order to understand their countertransference events, upon the development of a sense of professional identity. This third aim was a secondary focus within the study.

Rationale

There are many definitions of countertransference that have developed historically (Gabbard, 2001; Hinshelwood, 1999; Jacobs, 1999). There has been little synthesis of these divergent and often contrasting perspectives and as a result both the clinical utility and scope of countertransference remains unclear (Mills, 2004). For example, while some of the perspectives include projective identification in their understanding of countertransference (Sandler, 1993), even the historical development of this concept has resulted in a scope and nature that is undefined and without clarity (Garfinkle, 2005, 2006; Lubbe, 1998). Similarly, the concepts of empathy (Hinshelwood, 1999) and countertransference-enactment (Ivey, 2008) are in a parallel state. In addition, there have been shifts in the meaning, use and understanding of these psychological constructs over time and across contexts (Holder, 2005; Sandler, 1983; Vaughn, Spitzer, Davies & Roose, 1997). As a result, little consensus and agreement upon the definition of the countertransference-type phenomena or the way in which they relate to each other currently exists. It is important to note the above, as despite this confusion of concept definition, usage and distinction, countertransference-type phenomena remain an essential component of clinical work (Ivey, 2008; Renik, 1993, 1998). As such, the importance of the ongoing exploration of countertransference and related constructs is clear.

A review of the countertransference research literature reveals a field alive with content, application and endeavour. Examples of contemporary research into countertransference include studies that aim to generalize the countertransference reactions of clinicians when faced with patients of a particular diagnosis (cf. McIntyre & Schwarts, 1998; Rossberg, Karterud, Pederson & Friis, 2007, 2010); studies that document countertransference reactions to patients of a particular type, for example adolescents with eating disorders (cf. Satir, Thompson-Brenner, Boisseau & Chrisafulli, 2009) or HIV positive children (cf. Kuhn, 2008); studies that make use of quantitative measures (cf. Betan, Heim, Conklin & Westen, 2005; Hafkenscheid & Kiesler, 2007); and those exploring countertransference in relation to psychotic patients (cf. Connolly & Cain, 2010; Laufer, 2010). In contrast to this, this research study investigates countertransference across its many manifestations and specificities.

While the studies stated illustrate the diversity of current research into countertransference, the researcher was only able to find three countertransference studies employing a narrative type method, two of which are unpublished dissertations: Davidtz (2007), Dennis (2005) and Elliott, Loewenthal and Greenwood (2007). The first analyses narratives about the management of countertransference, the second explores clinician reactions to obese patients and the third focuses on a particular case of erotic countertransference. The researcher was unable to find any research articles that focused upon: (a) the experience-near investigation of countertransference, (b) the thought processes or events involved in making sense of countertransference-type experiences, or (c) the formation of a sense of professional identity via countertransference. In addition, Avdi (2008) emphasises the importance of a narrative approach by suggesting that language based research into psychoanalytic concepts are underutilized.

While there has been growing interest in the development of beginning therapists (e.g. Brott & Myers, 1999; Jennings, Goh, Skovholt, Hanson & Banerjee-Stevens, 2003; Skovholt & Ronnestad, 1992, 2003; Spruill & Benshoff, 2000) and some interest in the development of a professional identity in this population (e.g. Gibson, Dollarhide & Moss, 2010; Nelson & Jackson, 2003), no literature linking either the beginning therapist population or the construct of professional identity development to countertransference-type phenomena was found.

In addition, Rosenbloom (1992) asserts the need for research into how countertransference is resolved within psychotherapy. This study's explicit focus upon the way in which the sampled psychotherapists resolved their countertransference-type experiences addresses this need.

Much of the existing research on countertransference and related phenomena provides a contribution to a theoretical base of knowledge. While this is important, the nuanced nature of these concepts means that these additions tend to be highly abstract and difficult to apply in a practical, clinical setting (Fonagy, 2003). As such, the utility of an experience-focused study which may in part encourage the development of a practical model that could be useful in clinical settings is highlighted.

Finally, it is important to note that there is a growing interest in the psychoanalytic intersubjective movement (Marzi, Hautman & Maestro, 2006), which has a focus on relational co-construction. As a result of this movement, the relevance of the therapist's subjectivity to clinical theory has been debated (Louw & Pitman, 2001; Renik, 1993, 1998). These debates emphasise the necessity of

exploring countertransference and the way in which it is understood by therapists. Thus, given the centrality that countertransference-type phenomena hold within relational theory, and the current growth of this perspective, the continued exploration of countertransference-type phenomena may be seen as integral in contributing to such debates.

Outline of Chapters

Chapter Two begins with a conceptual and historical overview of countertransference and related constructs. This section discusses the inter-relatedness, similarity and multiple clinical understandings of phenomena such as countertransference, projective identification, primary identification, empathy and role responsiveness. It is shown that these constructs are elastic concepts, each without a singular definition. These arguments are used to introduce the notion that, when viewed together, the constructs mentioned form a theoretical continuum that may be used to explain the dyadic interaction between the psychotherapist and her patient. The relationship between this understanding and psychoanalytic relational theory is then briefly explored. A link between countertransference phenomena and the development of a professional identity is then suggested before the few studies using a similar sample, approach or means of analysis are presented.

A chapter on the study's methodology follows. The study's sample and method of data collection, including comment on the semi-structured interviews, begins the chapter. A synthesis of Cartwright's (2004) and Crossley's (2007) suggestions informs the study's approach to analysis. These suggestions are stated and explored. Comments on reflexivity and my reflections upon my possible influence upon the study follow. A section detailing the study's ethical adherence ends the chapter.

In the fourth chapter, the research results are presented in a narrative that answers the research questions by presenting, linking and relating the psychotherapists' experiences, the sense that the psychotherapists made of their experiences and the psychotherapists' development of a sense of professional identity. Three different types of countertransference experiences were prominent in the interviews: experiences of feeling stuck, experiences involving strong (and unthought) reactions, and experiences of confusion between patient and psychotherapist. The psychotherapists made sense of their experiences of countertransference by either: (a) trying to place the cause of their experience in either themselves or the patient, (b) feeling inadequate as psychotherapists, or (c) making use of a third presence (either the psychotherapist's supervisor, psychotherapist or myself as

researcher) as an aid. The psychotherapists' negotiation of this process was found to influence their development of a sense of professional identity. The idea of professional identity development was noted as a process of growth in relation to which the countertransference-type experiences and the therapists' understanding of these experiences could be understood. The relationship between professional identity and countertransference in newly practicing therapists is stated as an area for future research.

The fifth and last chapter, the *Discussion,* compares the project's findings to existing literature. It suggests that an experiential model may benefit current understandings of countertransference and the processes involved in negotiating countertransference experiences in the moment of their occurrence. It further suggests that an experiential model may provide a clinical grounding to the multiple meanings associated with current theoretical constructs while capturing the alive and elusive nature of countertransference events. The development of a sense of professional identity in beginning psychotherapists was found to be a topic worthy of further research. In addition, the development that beginning psychotherapists undergo and the experiential basis of countertransference are suggested as areas for further research.

Chapter Two: Literature Review

Historical and Conceptual Overview

Perspectives on countertransference

Countertransference has a complex and varied usage within the psychoanalytic literature. The idea that the psychotherapist can influence the process and content of a psychotherapy was first suggested by Sigmund Freud in 1910 (Marchon, 2006). He stated that ". . .no psychoanalyst goes further than his own complexes and resistances permit. . ." (Freud, 1910, p. 141-2 in Jacobs, 1999 p. 576). Given this reasoning, Freud prescribed self-analysis as a remedy to this perceived disturbance to analytic work. In 1912, however, Freud extended his first observation when he recognised that the psychotherapist's unconscious may be skillfully used to communicate with the unconscious of the patient (Jacobs, 1999). This significant amendment was largely overlooked for close to forty years subsequent to Freud's comments; with the exception of a few contributors (Jacobs, 1999), countertransference was a topic little discussed (Heimann, 1950; Racker, 1957). The theoretical focus during this period was upon the patient's psyche, and within this ethos any thought on the psychotherapist's subjectivity (beyond that of facilitator to the analytic process) was not enthusiastically received. Gabbard (2001) cites adherence to this ethos as the "narrow perspective" to countertransference, as it considers countertransference a hindrance to effective psychotherapy. The narrow perspective is thus closely aligned with Freud's first observation and his consequent prescription. Countertransference is understood within this perspective as the psychotherapist's experience of the patient as an object representative of key figures from the psychotherapist's past (Reich, 1960).

A challenge to the narrow perspective emerged with Winnicott's (1949) depiction of countertransference as an objective reaction to the dynamics of the patient rather than as a phenomenon individual to the psychotherapist. This idea was elaborated by both Heimann (1950) and Racker (1957, first read in 1953) who viewed countertransference as informative of the functioning of the patient's unconscious. Little (1951), who supported Winnicott, Heimann and Racker by taking a position in favour of the study of countertransference, described the (then still prevalent) avoidance of speculation on the subjectivity of the psychotherapist as "paranoid or phobic" (p. 33). She further identified both the psychotherapist's and the patient's minds as worthy of simultaneous study. Thus, while the period preceding Winnicott's (1949) contribution adhered to the narrow perspective, Winnicott, Heimann, Little and Racker introduced a view towards the phenomenon that focused on Freud's second assertion; that of countertransference as a means to

understanding the patient. For the purposes of this project, Winnicott, Heimann, Little and Racker's collective contribution will be referred to as "the objective view" of countertransference. The collective contribution of these authors has not been named in the countertransference literature and has been named above for ease of reference. Nevertheless, "the objectivistic view" is intended to indicate the assertion of Winnicott, Heimann, Little and Racker that there is an aspect to countertransference that is independent of the therapist's subjectivity and representative of the patient's unconscious communication. The word "objectivistic" is not intended to suggest that Winnicott, Heimann, Little and Racker's perspective is more correct or scientific than the other views/perspectives outlined in this section.

Subsequent to Winnicott's (1949) amendment, an understanding of countertransference, allied to the objectivistic view, emerged from within the Kleinian school (Gabbard, 2001). Jacobs (1999) cites Fairbairn (1952, 1963) and Guntrip (1961) as key Kleinian authors who viewed countertransference as the psychotherapist's entire, or "total response", to the patient. Their understanding is similar to the objectivistic view to the extent that it views the psychotherapist's thoughts, emotions and behaviour in the psychotherapy as representative of the patient's unconscious (i.e the patient's mind). However, in contrast to the objectivistic view, the total response concept rejects the idea that countertransference may be independent of the patient and individual to the psychotherapist (i.e. as best explained by the narrow perspective at particular times). In other words, the total response concept encompasses all of the psychotherapist's responses to the patient all of the time. It does not describe the psychotherapist's responses to the patient in particular and definable circumstances only, as the narrow perspective and objectivistic view do. Gabbard (2001) has accordingly termed the total response concept the "totalistic view" of countertransference due to its all inclusive definition.

Further concepts of interaction

Key to the totalistic view is the idea of projection; the mechanism that structures the mind in such a way that unwanted aspects of self (e.g. feelings of frustration, aggression or anxiety) are viewed as though they belong to other objects (Klein, 1946). Melanie Klein (1946) extended the scope of this mechanism in her concept of projective identification. This new concept allowed Klein to speculate that the patient may unconsciously project his unwanted aspects of self *into* the psychotherapist and through these aspects believe himself to control the psychotherapist from within. Wilfred Bion (1957a, 1957b) and Thomas Ogden (1979), amongst others, extended the scope of projective identification from an intrapsychic phenomenon that occurred only within the patient's mind to an

interpersonal phenomenon involving both the psychotherapist and patient (Gabbard (2005) also cites Rosenfeld (1952) and Money-Kyrle (1956)). Before this theoretical extension, countertransference had been the only tool available to psychotherapists in their attempts at understanding their influence upon a psychotherapy. The conception of projective identification as an interpersonal phenomenon broadened the range of constructs available to psychotherapists for this purpose. The concept extended the totalistic and objectivistic views on countertransference by linking, in particular circumstances, the psychotherapist's thoughts and feelings to the patient's unconscious intent. Ogden (1979) and Sandler (1993) suggest that the concept of projective identification is differentiable from these perspectives as it is conceptualized as a particular and specific type of interpersonal interaction, rather than as a way of understanding the psychotherapist's general reactions to the patient.

While Bion and others were developing the utility of projective identification, Joseph Sandler (1976, 1983) was developing his own means to understanding interpersonal events. In 1976 he suggested the construct of role-responsiveness. The idea represents events in which the psychotherapist unconsciously responds to a role assigned to her by her patient (Sandler, 1993). The patient perceives and responds to the psychotherapist as though the psychotherapist embodies a particular role (transference) and the psychotherapist in turn unconsciously responds to this role in a way that is congruent with her own personality (Sandler, 1976). Role-responsiveness was thus a concept that bridged the narrow and totalistic views of countertransference; it was a response to the patient's unconscious "prodding" (a subtle, often non-verbal, pushing) of the psychotherapist towards enacting an assigned role and yet simultaneously a product of the psychotherapist's own character (Gabbard, 2005). Sandler's (1976) conceptualization foreshadows many contemporary views on countertransference as a phenomenon that is co-constructed by both psychotherapist and patient. The active, enacting and behavioural aspects of role responsiveness are also significant, as these characteristics underlie the contemporary construct termed countertransference-enactment. Ivey (2008) describes the concept as the behavioural expression (or the inhibition of an expression) of the psychotherapist's impression of the patient.

While projective identification was conceptualised as a specific and discrete phenomenon, countertransference-enactment was not. Explanations of the construct do not consider whether the psychotherapist's behavioural expression is (a) evoked by the patient, (b) derived solely from the psychotherapist's mind, or (c) best understood as a co-constructed dynamic between patient and psychotherapist (cf. Ivey, 2008). This lack of specificity means that the construct can potentially be

applied to a whole number of phenomena that may also be categorised more specifically. In order to demonstrate the difficulties inherent in such a "loose" definition, consider the contrast between this vague approach and Sandler's (1993) method. He emphasises the difference between empathy, sympathy, primary identification (also termed resonance-duplication) and projective identification *based upon the processes in operation*. For Sandler, primary identification refers to an unconscious, recurrent and spontaneous boundary-blurring between one's unconscious understanding of one's self and the other[1]. Empathy refers to a boundary-blurring with a concomitant recognition of the origins of the affects (the other's person), while sympathy by contrast is a boundary-blurring without the recognition or boundary-resetting (Sandler terms this process "disidentification"). Sandler's (1993) projective identification requires an unconscious intent within the patient, whereby he wishes for the psychotherapist to feel his disavowed aspects of self. Thus, while Sandler (1993) differentiates between primary identification, empathy, sympathy and projective identification based upon processes that are occurring (or failing to occur) within either the therapist or the patient, any of these constructs may result in countertransference-enactment as it is defined above. To label a phenomenon or a complex series of psychic processes occurring between patient and therapist "countertransference-enactment", requires only that the therapist express his reaction or impression of the patient in action. This reaction may be as a result of either empathy, sympathy, primary identification or projective identification as Sandler (1993) has defined them. Thus, at the moment of the therapist's action, all these terms in some sense become synonymous as they are then represented by the single term countertransference-enactment. The point here is that the same clinical phenomena have been described from different perspectives, while this difference in perspective (and the possible confusion that may occur) seems to remain unacknowledged.

The dilution of meaning

Complicating the differences in approach or perspective is the variety of meanings that many of the concepts have come to embody. This was demonstrated above with respect to the many uses of countertransference; a notion seconded by Mills (2004): ". . .the question, nature, and meaning of countertransference continue to be among the most heavily contested theoretical and clinical phenomena" (p. 468). Similarly, in his 1993 article, Sandler cites Cooper (1989) with the recognition that projective identification (as Sandler puts it) ". . .refers to a broad spectrum of processes, and has often been used in an extremely imprecise way, as a synonym for a whole variety of mechanisms" (p. 1104). Garfinkle (2005, 2006) and Lubbe (1998) support this sentiment, and the

[1] This understanding of primary identification is shared by Arnold (2006), Elliot (1995) and Grotstein (1980).

idea is echoed by Ivey (2008) in reference to countertransference-enactment in the following statement:

> . . .controversies regarding the specific scope, nature, prevalence, relationship to countertransference experience, impact on the analytic process, role played by the psychotherapist's subjectivity, and the correct handling of [countertransference] enactments abound. (p. 19).

With respect to empathy, Hinshelwood (1999) describes how Money-Kyrle (1956) understood empathy as the result of a cycle of the patient's projection and the psychotherapist's introjection. This conception tacitly refers to the presence of boundaries, yet evokes an understanding of them as always present but permeable. Hinshelwood (1999) further describes a depiction by Pick (1985) whereby a patient's projection sparks a primitive response within the psychotherapist. In this case the same mechanisms are involved, namely projection and introjection, yet Pick refers to this occurrence as countertransference (and no longer as empathy). In this latter case there are always present, permeable boundaries but what exists within the psychotherapist's boundary is now significant to the construct in operation. Both Money-Kyrle and Pick's descriptions are in contrast to Sandler's (1993) description of a blurring and re-establishment of personal boundaries. Sandler illustrates that an unconscious intent at affective evocation (in the psychotherapist) is required for projective identification to be present, yet he does not describe what would be necessary for the designation of countertransference. The point here is that similar to the cases above, although there is agreement about the existence of constructs such as empathy and countertransference, there is little agreement as to the exact clinical phenomena that these terms denote.

Countertransference as a continuous phenomenon

The above presentation leads one to consider the observations made in three separate articles. The first is that of Vaughn et al. (1997) who caution that without clinical grounding a concept may lose its exact definition and become replaced by a number of definitions that inevitably expand the range of phenomena to which the concept refers. As a consequence, the concept may end up being best defined as a scale or continuum. The second article is that of Sandler (1983) in which he introduces his ideas of *concept elasticity* and *meaning-space*. Both terms refer to a similar occurrence whereby a concept comes to denote a number of slightly different phenomena concurrently due to a lack of consensus within the discipline. Concept elasticity refers to the contextual dependence of much psychoanalytic concept usage, for example, a South American psychotherapist may mean something quite different to an English psychotherapist even though they are both naming their idea countertransference or projective identification. Sandler's (1983) idea of meaning-space refers to

the particular meaning that a concept may hold for a group of psychotherapists (with the implication that it is possible to have multiple meaning-spaces for a single concept). He is suggesting that a group of therapists working together may use a particular term (e.g. countertransference) to describe a clinical phenomenon that they witness together, and the meaning they have assigned to the construct may differ to that held by another group even though both groups practice within the same context. In other words, Sandler (1983) is stating that the meaning that concepts hold is partly determined by experience, subjectivity and interpretation. Both Sandler's (1982) ideas are further supported in the following account:

> . . .we cannot. . .fix "enactment" in one place forever. It is not possible to establish permanently the meaning of any psychoanalytic term. . .Meanings evolve in psychoanalysis as they do in law: terms take on meaning as they are processed and decisions rendered; to begin with, they are virtually empty vessels waiting to be filled and refilled by a more or less changing history of usage and challenge [p. 77] (Schaffer, 1999 in Holder, 2005, p. 166)

Given these observations, and the range and flexibility of phenomena under discussion, it is suggested that primary identification, sympathy, empathy, projective identification, countertransference and countertransference-enactment together represent an elastic concept (or perhaps a continuum or meaning-space) related to the phenomena that occur during the intersubjective interaction between patient and psychotherapist. This elastic concept is referred to as "countertransference and related phenomena" or "countertransference-type" experiences/phenomena.

There are three points that support the suggestion above. The first is the ephemeral nature of the processes or phenomena in operation during the analytic encounter, which are difficult to measure or precisely define. Much countertransference is subtle in nature and most of the processes theorised are (at least initially) unconscious in nature (Rosenbloom, 1992). The second point is perhaps a product of the first point. Given the ephemeral nature of countertransference phenomena much of the theorising that occurs (if not all of it) is speculative. Increasing levels of abstraction are used by authors in order to make their positions both clear and useful. The result is an inevitable divide between how phenomena are theoretically described and how they are experienced. The third point refers to the added complexity introduced by the contemporary debates about: (1) the relevance of (postmodern) perspectivist philosophy to psychoanalysis (cf. Marzi, Hautman & Maestro, 2006), and (2) the validity of Renik's (1993, 1998) *irreducible subjectivity*. The two debates are somewhat related, with the second falling under the heading of the first. They are separated in

order to depict specific concerns about the interaction of psychotherapist and patient, and the psychotherapist's subjectivity/objectivity respectively.

The first debate refers to the relational (also termed inter-subjectivist) theoretical perspective that views meaning as co-created and the interactions between individuals as central (Marzi, Hautman & Maestro, 2006). Ogden's (1994) *analytic third* and Gerson's (2004) *relational unconscious* are examples of concepts that refer to phenomena that exist only in the interaction of the psychotherapist and patient. The inter-subjectivist position has been criticised for moving analytic focus away from the patient (Marchon, 2006). This critical perspective argues that the focus of any therapy is the patient and that the therapist is a facilitator rather than someone co-experiencing the therapeutic process. The second debate refers to Renik's (1993, 1998) claim that the psychotherapist is incapable of overcoming his own psychology and is thus destined to enact it within the psychotherapy (Louw & Pitman, 2001). If the psychotherapist is unable to view anything objectively, then the accuracy of his perception of the patient becomes highly suspect. Renik's position is criticised for its negation of the possibility of an objectivity that takes the subjectivity of the psychotherapist into account (Louw & Pitman, 2001). In other words, Louw and Pitman (2001) suggest that the therapist is capable of being functionally objective despite the limits that her inevitable subjectivity entails; a middle ground position. Given the extra constructions of countertransference phenomena that are possible in light of the above debates, it is put forward that their presence strengthens the concept elasticity of the phenomena that occur during the therapist-patient interaction.

One person and two person models

The debates and developments described in the section above have had far reaching impact upon the way in which psychotherapy is contemporarily understood (Marzi, Hautman & Maestro, 2006). Cassorla (2005) distils the influence of the debates and theoretical developments mentioned into two categories. He cites Balint's (1979) ideas of *the psychology of one person* and *the psychology of two people*, one- and two- person models, as terms that categorize the evolution of psychoanalytic theory. One person models denote a theoretical position in which the focus in psychotherapy lies upon the patient's functioning. While this standpoint acknowledges the interaction involved in psychotherapy, it attempts to define the interaction discretely (Dunn, 1995). The narrow perspective, the objectivistic view and the totalistic view of countertransference may be described as one person models. By contrast, two person models place the interaction of the patient and psychotherapist's psychologies at the forefront of their theory and describe this interaction as

complex, mutually created and difficult to capture (Cassorla, 2005). Two person models may thus depict a relational understanding of clinical events.

Two ideas complicate such a discrete classification. The first is Dunn's (1995) suggestion that one- and two- person models illustrate two different yet related ways in which the mind operates. As such, rather than representing the same clinical phenomena in different theoretical forms, the models may in fact be describing distinct psychic functions. A second complication pertains to the historic development of the theory presented. While concepts such as the *analytic* and *subjugating thirds* (Ogden, 1994) and the *analytic field* (Baranger et al., 1983; Ferro & Basile, 2008)[2] are clear two person constructs, concepts like role-responsiveness (Sandler, 1976) and projective identification (Klein, 1946; Bion, 1957a, 1957b; Ogden, 1979; Sandler, 1993) are not as easily categorized. While the focus in Klein's (1946) projective identification lies distinctly upon the functioning of the patient's mind, the focus in Ogden's (1979) use of the term is not as clear. His version of projective identification emphasises an interpersonal pressure whereby the patient attempts to force the psychotherapist to act in accordance with his projections in order to feel understood, protect himself from unwanted aspects of self, and benefit from the psychotherapist's reaction to his actions. With this advent of the interpersonal, the concept is no longer understood in a way that singularly focuses upon the patient. It nevertheless does not quite reach the mark of a *co-created* phenomenon; for while it requires the psychotherapist's unconscious response to the patient, this aspect of the interaction is markedly under-emphasised (see Ogden, 1979).

Thus, as the meaning attributed to countertransference-type constructs shifts (as depicted in reference to projective identification above), so may the model that underlies the construct. As the constructs change, the models seem to mix or blend. This is seen in Ogden's (1979) depiction of projective identification. Although no longer a one person construct, it is not classically a two person understanding either. It thus may lie midway between the two models, incorporating particular aspects of each one. This suggested occurrence is implicitly supported in literature that traces the development of a two person psychology (e.g. Lichtenberg, 2005), as the use of one-person constructs within two person models may render distinctly two-person models few in number. In linking existing theory to the clinical phenomena under investigation, knowledge of the conceptual model (i.e. a one person or two person model) underlying the construct that is used to explain the phenomena experienced (e.g. countertransference or projective identification) is necessary given Dunn's (1995) suggestion that the one and two person models may in fact be describing distinct

[2] Mills (2004) cites Beebe, Jaffe and Lachmann's (1992) *dyadic system* and Stolorow and Atwood's (1992) *intersubjective field* as further examples.

psychic functions rather than the same clinical phenomena in different theoretical forms. If psychotherapists are found to make use of a particular model in explaining particular kinds of lived experience, then practical and theoretical implications may result.

Contextualising Countertransference-type Phenomena

This section centres on the psychotherapist's experience of (and during) psychotherapy. It is self evident that in order to be involved (or present) within the therapeutic hour (and thus the therapeutic relationship), the psychotherapist must relate to the patient: to participate in a dialectic. Evoking the concept of countertransference-type phenomena developed above, this participation inevitably involves therapist-patient interaction; in other words, phenomena that lie upon the primary identification, sympathy, empathy, projective identification, role-responsiveness, countertransference and countertransference-enactment continuum. This statement is made with the idea in mind that when therapist and patient participate within a dialectic, unconscious communication occurs between them. This unconscious communication may be understood to occur at various levels of interruption in a psychotherapy; an idea expanded by Ferro and Basile (2004) below. It may also be understood to manifest in various forms. These two ideas are represented in the concept of the continuum of countertransference-type phenomena above, namely that unconscious processes will inevitably occur and manifest in any intersubjective interaction. The form and intensity of the manifestation, as felt by the psychotherapist in a psychotherapy setting, has been documented in the various concepts named countertransference-type phenomena in this project. The term "therapist-patient interaction" is shorthand for the interaction of therapist and patient, recognising that this interaction involves the communication of their own unconscious processes, the manifestation of this unconscious communication, and the various forms of their own awareness of the unconscious processes in operation.

Marchon (2006) emphasises this inter-subjective nature of the analytic setting by drawing attention to instances when the psychotherapist finds herself stuck in an un-involved silence for fear of imposing her own subjective perspective upon the patient. He describes such a situation as inevitably influential to the patient in itself, as the very "act" of the therapist's non-involvement is significant to the patient's experience. This idea is further supported by Ferro and Basile (2004). They suggest that countertransference is omnipresent in psychotherapy at various levels of intensity. They conceptualise these levels in a range from 0 to 4, where level 0 is a psychotherapy functioning optimally and level 4 represents a state of affairs in which the analytic function has broken down to the extent that work (or thinking) is no longer occurring. Thus both Marchon (2006)

and Ferro and Basile (2004) recognise that the unconscious communication occurring between therapist and patient can be manifest in various forms (e.g. an uninvolved silence) and at various levels of interruption to the therapeutic process – Ferro and Basile's (2004) levels 0-4. The links between countertransference and the ability to work therapeutically (as evident in Ferro and Basile's suggestion) are taken up later on in this section.

This project aims to build a combined narrative of the sampled psychotherapist's experiences that lies at the level of lived experience. This involves describing phenomena and events as they were experienced. Towards this end, the BCPSG's (2007) innovative concept of the *local level* is used. The BCPSG (2007) describe the local level as: "All things that are the stuff of the interactive flow, such as gestures, vocalizations, silences and rhythms, constitute this moment-to-moment exchange, which we refer to as the local level" (p. 844). They further state that the local level is the interactive space in which intrapsychic experiences are formed. This is a reversal of classical psychoanalytic theorising in which events occurring at the interactive level were understood to have intrapsychic origins (e.g. the enactment of an ego defence). Within the BCPSG's (2007) model, the enacted event (e.g. an ego defence) is the origin of the intrapsychic event and not vice versa. Stating this differently, one may say that an affect, conflict or defence originates as it is experienced within a relational matrix and only after this initial occurrence can the same affect, conflict or defence be (metaphorically) "placed" within an individual's mind. This process may be illustrated with reference to the occurrence of an ego defence as follows: the defence would occur at the local level, and thus as an enactment of the patient that incorporates the psychotherapist as object and guards the patient against experiencing a subjectively anxiety-provoking situation, before being incorporated intrapsychically as a part of the patient's internal world. Thus, within this model all interaction involving the blurring of boundaries, given the reliance of such interaction upon countertransference-type phenomena, is understood to occur at the local level. This level of interaction is the primary level of study or focus within this project.

It is suggested that for the purpose of this research project, all countertransference-type phenomena be placed within an experiential context. This is provided by the psychotherapist's subjective experience of the therapeutic process. Baranger, Baranger and Mom (1983) provide the beginnings of such a framework through their concepts of "field", "bastion" and the "second look" (definitions to follow). Their concepts, as depicted here, are interpreted from a phenomenological perspective. The field may be understood as the psychotherapist's experience of the analytic encounter in which a sense of meaningful progress in the relationship is felt to occur (this is the

analytic or therapeutic process). Stated differently, the field may be understood as the therapist's perception of the "space" of relational interaction between therapist and patient while in psychotherapy. It is the psychotherapist's experience of a psychotherapy in progress. Ferro and Basile's (2004) idea of countertransference as omnipresent may be seen to support and extend both this understanding and Marchon's (2006) idea of non-process, as all these authors recognise that unconscious communication is omnipresent in therapy and that it either amounts to a therapeutic process or a hampered/"stuck" process. Elaborating this idea, when the therapeutic process is equated to Ferro and Basile's (2004) levels of countertransference, the therapeutic process may be conversely conceptualised as a sense of progress that exists at various levels of stagnation (i.e. as a process that may become "stuck", in various intensities of "stuckness"). Baranger et al. (1983)'s idea of the bastion relates very closely to this converse understanding of the therapeutic process. The bastion may be conceptualised as a felt experience of stagnation or paralysis in place of a sense of progress within a psychotherapy. Alternatively, Ferro and Basile (2004) may describe a bastion as a level of countertransference greater than 0. A bastion is thus an impediment to the therapeutic process that may take the form of one of a number of countertransference-type phenomena. The second look is Baranger et al.'s (1983) solution to the predicament of the bastion or non-process. It is the therapist thinking about the therapeutic relationship and the therapeutic process in a way that seeks to identify the dynamics responsible for the sense of "stuckness" or non-progress. This form of thinking, the second look, focuses upon the role that the therapist's own thoughts, feelings and behaviour are assuming in the relationship.

The therapeutic process, and the expression of countertransference-type phenomena within it, has been described in other ways that are in agreement with the ideas presented in this section thus far. Cassorla (2005), for example, describes his conceptualisation of the therapeutic or analytic process in the following statement: "I believe that the analytic process as a whole can be described as a continuum of normal and pathological enactments" (p. 709). He thus views the entire analytic encounter as a series of jointly created enactments. Cassorla (2005) has also developed a model depicting the interaction of therapist and patient that is based upon the theatre. This model emphasises the active, lived aspect of interaction (enactment); a view that supports the BCPSG's local level. In addition, and in support of the Baranger et al. (1983)'s bastion, Cassorla (2005) describes the idea of the *non-dream*, a breakdown or impediment to the therapist's ability to think about the psychotherapy in an unobstructed or free way. Within Cassorla's (2005) model, the psychotherapist's enactments (actions) may be experienced by both psychotherapist and patient as either beneficial or harmful to their sense of progress (the analytic process). Note the congruence

between Cassrola's (2005), Ferro and Basile's (2004), Baranger et al.'s (1983) and Marchon's (2006) ideas as presented in this section. There is thus a strong theory base behind the contextualisation of countertransference-type phenomena in the therapeutic process.

Building upon the ideas presented thus far, Cassorla (2005) makes suggests that countertransference may derive in psychotherapist, patient and in a combination of patient and psychotherapist and all be present at different layers of consciousness. This understanding suggests that psychotherapists may have difficulty differentiating both what is happening and which concepts apply in any given situation. An experience-near investigation may provide information about how psychotherapists negotiate such a potentially complex sense-making process.

Complementary to the above and in reference to the resolution of non-process, bastions and non-dreams, Parsons (2007) introduces the idea of the "internal analytic setting". It is an alternative approach to the second look. Parsons (2007) describes the internal analytic setting as a space that may be cultivated within the psychotherapist's mind where the psychotherapist is ". . .able to be however he finds himself internally needing to be" (p. 1445). It is an internal space with the characteristics that define the analytic setting for the patient, namely an unwavering acceptance and a freedom to experience that which one most sorely needs.

Somewhat related to Parson's (2007) idea, Scialli (1982) describes the development of the *observing ego* in the patient through a process of identification with the psychotherapist. He defines the term as the capacity for the patient to observe himself without recourse to judgement. Given the similarities in the concepts, Parson's notion may possibly depict a burgeoning development within the psychotherapist, while in the role of psychotherapist, that is comparable to the development of the observing ego within the patient.

In the perspective outlined in this section, countertransference-type phenomena have been contextualised within a framework that remains close to the experiences of the psychotherapist. By noting the concepts of the second look and the internal analytic setting within the experience of the therapeutic process, theory depicting the relationship between countertransference-type phenomena and their resolution (or working through) has been noted. Through the theories of Baranger et al. (1983), Ferro and Basile (2004), Marchon (2006) and Cassorla (2005), the concepts of the therapeutic process and countertransference-related phenomena have been related in a way that also depicts the experiences (or attitudes) involved in the resolution of therapeutic stalemates.

An experiential exploration may provide information about the lived difficulty involved in differentiating between the different concepts in the countertransference-continuum. This information may be particularly useful in designing concepts that aid psychotherapists in understanding therapeutic interactions at the beginning of treatment when the patient's transference and the psychotherapist's response to the patient is not yet well known.

The Identity-Countertransference Dialectic

Psychotherapists' understanding of their role as therapists is expected to undergo change (Gibson, Dollarhide & Moss, 2010; Kaufman & Schwarts, 2003; Rosenbloom, 1997). This change is expected to happen throughout the course of one's career but is thought to be particularly prevalent during the beginning years of practice (Hazler & Kottler, 1994). In addition to this characteristic expected of a sample of beginning psychotherapists, it was anticipated that the changes in understanding referred to would emerge in the current study owing to the study's focus on the sampled psychotherapists' experiences of countertransference-type phenomena. This was because the sampled therapists were trained to reflect upon the role that they played in such experiences. This section is intended to situate the sampled therapists' experiences of countertransference-type phenomena within the context of their ongoing development as therapists, as well as in relation to their developing awareness of their role as therapists and the development of their professional identity.

The authors to follow all support the notion that a sense of professional identity in beginning psychotherapists is subject to development. Rizq (2009) discusses professional identity in reference to the unconscious dynamics that are often prevalent in trainee psychotherapists. She suggests that a psychotherapist's professional identity is subject to growth that is influenced by the psychotherapist's training, didactic and clinical experiences. Rosenbloom's (1992) description of Fliess' (1942) *work ego*, as the capacities of self that enable the psychotherapist to handle the requirements of her professional interactions, evokes similar support in his description of its capacity for growth and development. Eagle, Haynes and Long (2007) refer to the role of supervision in aiding trainee psychotherapists to integrate their hard-felt therapeutic experiences into a form that is both consciously processed and meaningful. They further refer to a shared trainee experience, of a "childlike" or regressive form, wherein ". . .primitive anxieties, of persecution, annihilation, narcissistic injury or contamination, can become specifically related to the experience of the unfamiliar[3]" (p. 145). They link the trainees' progression from experiences that are characterised as stated in the previous sentence to capacities of confidence, resourcefulness and

[3] By the unfamiliar, they mean differences of culture, social setting and lived experiences between the world of the psychotherapist and that of the patient.

self-reliance, to a process of containment and reflection. As Eagle et al. (2007) refer to the intersubjective quality of the trainees' experiences, the childlike qualities quoted above may be feasibly described as having resulted from countertransference-type phenomena; an assertion partly supported by Eagle et al.'s (2007) reference to over- and under-identification. This is significant in the sense that Eagle et al. (2007) describe a personal transformation that results from the trainees' conscious processing of, and reflective attitude towards, their experiences.

Kaufman and Schwarts (2003) present an idea of professional identity development based on Erik Erikson's developmental model. In their article, they do not define professional identity and refer to the facilitation of professional identity development through effective models of supervision only. Gibson, Dollarhide and Moss (2010) describe profession identity development in relation to the professional community. Although they refer to "intrapersonal" and "interpersonal" aspects to the development of professional identity, they do not detail ideas similar to countertransference-type phenomena in either category. Neither study refers to the effect of experiences of countertransference-type phenomena upon professional identity development directly, or offers definitions of professional identity that may be of use in understanding the extent to which experiences of countertransference-type phenomena influence the development of psychotherapists' professional identity.

While all of the above accounts support the notion of professional identity-development, they either refer to ideas that are similar but not focussed upon the psychotherapist's understanding of her role as therapist, or they fail to define the professional identity construct in adequate depth. Thus for the purposes of this project, it is suggested that the construct combines the ideas of *analytic identity* (Hinshelwood, 1999), *analytic style* (Kantrowitz, 1992; Rosenbloom, 1997), and *personal and professional development* (Donati & Watts, 2005; Rosenbloom, 1992). This synthesis is articulated below.

Hinshelwood's (1999) analytic identity incorporates the qualities of curiosity and dynamic interaction (qualities that partly characterize a psychotherapy) into the psychotherapist's sense of self. It is an idea that attempts to capture a psychotherapist's identification with the role that she need assume in the process of psychoanalysis/psychotherapy. Kantrowitz's (1992) description of analytic style refers to both the manner in which the psychotherapist interacts with her patient, and to the psychotherapist's own personal way of working. Rosenbloom (1997) defines analytic style as a change in the way a psychotherapist works psychotherapeutically, a position congruent with

Kantrowitz's (1992). Although he refers to countertransference experiences as a possible factor influencing change in analytic style, he does not focus upon this possibility to any extent. The concepts of personal and professional development highlight two distinct, yet overlapping processes of growth that occur in the psychotherapist as a result of her continuous goal towards an ever increasing self-awareness; itself a requirement for effective therapeutic work (Donati & Watts, 2005). While personal development refers to an increasing complexity of the psychotherapist's person, professional development refers to the maturation of the psychotherapist's professional self-awareness, theoretical expertise and interpersonal skills. Rosenbloom (1992) also refers to a loosening of a psychotherapist's *psychoanalytic work superego* through her development of her own way of doing psychotherapy and being a psychotherapist. This idea thus supports Donati and Watts' (2005) suggestion of a concurrent personal and professional development. Defined as the amalgamation of the ideas outlined directly above, a psychotherapist's professional identity may be seen to depict the psychotherapist's dynamic experience of self within the clinical setting.

It is suggested that the process of psychotherapists' identity formation may be accessed through narratives of personal experience of intersubjective interaction that may be identified via stalemates, in-authenticities or stereotypy in the therapeutic process (Baranger et al., 1983). In other words, through the psychotherapist noting difficulties in the therapy that she may identify through markers such as: the therapy not progressing, the therapy progressing in a purely stereotypical way or the therapy progressing in a way that feels inauthentic to the therapist. Although Eagle et al. (2007) may be seen to more-or-less support the presented thesis of professional identity formation, it is asserted that further study with a specific focus upon the interaction of professional identity and countertransference-type phenomena (the identity-countertransference dialectic) may further their presentation. The role of the identity-countertransference dialectic in the research project is that of aiding in the description and depiction of the countertransference experiences and sense-making process central to the study's aim.

Chapter Three: Method

Research Questions

One

What are the sampled psychotherapists' countertransference-type experiences?

Two

How did the sampled psychotherapists make sense of their countertransference-type experiences?

Three

How did the sampled psychotherapists' understanding of their countertransference-type experiences affect their sense, and the development of their sense, of professional identity?

Research Approach

The study follows a qualitative approach to research. It is concerned with the participants' words, the way in which they made or found meaning in their experiences, the development of their self understanding and the ways in which they conveyed this knowledge in a focused, brief and transitory interaction with me. The study did not seek to quantify, categorize or explain particular, pre-defined variables. It sought instead to describe, acknowledge and understand the therapists' experiences of countertransference and related phenomena. Specifically designed semi-structured interviews and a generically psychoanalytic narrative analysis (Cartwright, 2004; Crossley, 2007) were the methods of investigation.

In line with the study's experience near focus, the participating therapists were invited to reflect upon their experiences of countertransference-phenomena. This experience-near approach resulted in a depiction of the psychotherapists' countertransference-type experiences that captured their lived dynamics and avoided the abstraction prevalent in current theory. Although I did not witness the experiences described by the therapists, it is suggested that it is the way in which data is perceived, theorized and depicted in its written form that creates an experience-near account. It is further suggested that as parts of experience are inevitably unconscious, an experience-near account is best elicited by a third party to the experience; a position in line with psychoanalytic assumptions (e.g. the centrality of the unconscious in psychic functioning and the disguised nature of all unconsciously derived content).

A narrative-analytic approach was chosen as the research is concerned with how participants story their countertransference-type experiences. The method matched the study's emphasis on the resolution of countertransference experiences, as both stories and countertransference-resolutions unfold over time. The secondary focus upon the therapists' sense of professional identity is intimately related to the narrative approach, as the research aimed to investigate how the participants tell their story, make sense of it and place (characterize) themselves within it. These are all aspects that may be understood as indicative of an underlying sense of identity.

The congruence of the narrative approach and the current study is further depicted by the following narrative assumptions. (1) Any change in personal meaning is understood to affect the content and form of an individual's narratives (Avdi, 2008; Crossley, 2007). (2) These narratives are further understood as representative of the individual's expression of affect, immediate cognitions and self-reflections (Crossley, 2007). (3) Narratives are also simultaneously understood as the mode through which individuals are able to find sense in their experiences.

With regard to the congruence of the psychoanalytic perspective, the psychoanalytic subject is understood to have an intrapsychic investment in the narration of their own experience (Frosh & Baraitser, 2008). This investment can be delineated in terms of a conscious and unconscious reasoning that underlies all motivated behaviour. A psychoanalytically viewed subject can be discerned via her relations to objects and her emotional investment in interpersonal interactions (Cartwright, 2004). Interpersonally enacted defensive processes are also understood to depict aspects of an individual's intrapsychic operation (Frosh & Baraitser, 2008). It is suggested that these processes are observable in narrative descriptions (Cartwright, 2004; Frosh & Baraitser, 2008).

Of primary importance to knowledge construction in the project is my role as the researcher, particularly my subjectivity, within the research process (Frosh & Baraitser, 2008). Intersubjective theory understands all knowledge to be a co-construction or joint creation between researcher and participant. This narrative knowing is fixed with respect to its temporality and interpersonal context (Frosh & Baraitser, 2008). There is, however a current debate about the researcher's use of his subjective feeling state as knowledge pertaining to the research subject. Authors such as Marks and Mönnich-Marks (2003) refer to these feeling states as countertransference-reactions, while Hook (2008) critiques the use of psychoanalytic ideas outside of the clinical setting. The utility in noting this debate is in highlighting that while my subjectivity is part and parcel to the final knowledge product, there are debatable limits to the extent of my personal involvement. The safeguards of reflexivity (stated in the *Method* chapter) are crucial to this limit setting.

In light of the above, the study is language-based, making use of interview narratives that will be analysed in their existing storied form. This process is interpretative in nature in the sense that the researcher reflected upon the interview content, in a manner informed by psychoanalytic theory, towards an understanding that connects presented and underlying meanings. The therapeutic context of the experiences described by the sampled therapists acts as the background to all meaning-making, while the narratives provided are understood to represent only a particular account or presentation of each therapist's subjectivity. This approach is in line with Avdi's (2008) descriptions of language-based analyses and highlights, as Avdi (2008) suggests, the congruency of the underlying philosophy of the narrative and psychoanalytic approaches. The notion of reflexivity plays a central role throughout this study's research process.

Sampling

Six psychodynamically trained therapists within their first three years of practice were interviewed for this study, five of whom comprised the final sample. This sample was chosen, as it was reasoned that countertransference related experience will be more intense during this initial period than at a later stage of more experienced praxis. It was further reasoned that the processes related to the development of a therapist's sense of professional identity will be more formative at this early stage of experience.

To obtain the sample, I contacted therapists who graduated out of the Clinical Psychology programme at the University of the Witwatersrand (Wits) and were in or just out of their community service year (their second year of full time practice). The graduates' contact details were sourced from the University's Department of Psychology (see *Ethics* section below) and contacted via email. The email asked for therapists who were in their own personal psychotherapy and willing to participate in the study. The email also provided information on the study's broad aims, particulars of participation and ethical assurances (see *Appendix A* for further detail).

The study followed a simple sampling strategy common to qualitative research , namely non-probability sampling (Neuman, 1997), in which the therapists were asked to volunteer their participation. The sample size obtained is small (comprising five volunteer therapists), allowing for a more in-depth and detailed analysis of the research subjects than is usually possible with most quantitative forms of research (Neale, Allen & Coombes, 2005). In addition, as the qualitative study of countertransference usually takes the form of a single case study, a sample of five therapists

would enable a relatively broader scope of inquiry. Given that the study asked for (1) participants who were new to practice (and people of varying ages are selected into psychology masters degrees), (2) in their own personal psychotherapy (which is a practice common amongst beginning therapists), (3) volunteer participants (and there is no apparent reason to suspect that therapists of one demographic group will be any more likely to volunteer than therapists of another), it was anticipated that the participating therapists would have varying demographics.

The original interviewees consisted of five female therapists and one male therapist. In order to protect the male therapist's anonymity, all the therapists have been referred to as though they are female and have been given pseudonyms to protect their real identities. Four of the therapists were in their second year of full time practice while two were in their third year. One interview was accidently recorded at very poor quality and as a result was inaudible, and excluded from the sample. A replacement interview was not conducted at this point as it was decided both that the data obtained was sufficient for a meaningful analysis, and as data saturation, defined by Marshall (1996, p. 523) as the point at which "new categories, themes or explanations stop emerging from the data", had been reached. The final sample thus consisted of four female therapists and one male therapist. Four were in their second year of practice and one was in his/her third year of practice.

Other variables such as age, race, gender and context (both historical and political) were not taken into account in the analysis of the interviews; that is, the age, race and gender of the therapists was not utilised in the narrative, and the context was not given significance in the analysis. While these variables may have had an effect upon both the nature of the data obtained and the therapists' experiences with their patients, their examination was beyond the scope of the current paper and thus not included.

Method of Data Collection

The semi-structured interview style is defined as an interview with a designated, predetermined schedule of questions and with scope for additional questions elicited from the dialogue (DiCicco-Bloom & Crabtree, 2006). This style was chosen for its ability to guide and orient discussion around specific topics while still allowing space to explore particular aspects of the interviewee's disclosed content (Britten, 1995). This choice thus allowed for both the depth required for analysis and the focus required to answer the research questions posed (DiCicco-Bloom & Crabtree, 2006).

The interviews ranged between 66 minutes and 96 minutes in duration. They were conducted at either the therapist's place of practice, the therapist's place of residence or my consultation room at the university, according to the preference of the interviewees. All the interviews were private and uninterrupted. Appointments were made at times convenient to both myself and the participant. I began the interview by asking each participant to complete and sign consent forms both for participation in the interview and for the audio recording of the interview (see *Appendices C and D*). I then reassured the participants that their identities and the identities of their patients would remain confidential. Following Cartwright's (2004) suggestions, I explained to the interviewees that it was their lived experience of both the countertransference events and the *post hoc* thoughts and feelings associated to them that was sought in the study.

All participants were emailed the interview schedule prior to the interview in order to facilitate their recall of key experiences. It was felt that via this method the narratives would have sufficient depth without placing participants in any unnecessary discomfort. Five of the six therapists interviewed had read the questions prior to the interview. The interview excluded from the sample was one in which the therapist had read the questions beforehand.

The semi-structured interview schedule (see *Appendix B*) began with a broad question, asking the therapist to describe an incident of her own experience in which countertransference feelings were present. Questions two to six asked for the description of incidents in which specific countertransference-like phenomena were felt or experienced; for example, question two asks for an experience contrary in nature to the first, question three refers to countertransference enactment, question four to projective identification and questions five and six to empathy/over identification. Following each description, the interviewee would be asked about the resolution of each dilemma and the meaning which the interviewee may have made of the experience. Questions connecting all the disclosed experiences followed, beginning with those asking whether the therapists attributed any collective sense or any collectively induced self-discovery to all the experiences described. This global theme was continued into questions about the therapists' sense of professional identity and understanding of emotional boundaries. A question about the influence of theory, training experiences and advice upon the sense and self-discovery processes each therapist may have described concluded the semi-structured interview schedule.

Although the interview questions were used as a guide, the therapists' knowledge of the research questions allowed the interview to focus upon and explore the therapists' most meaningful

encounters. During this process, I had the task of providing a professional, ethical and reflexive space. This was aimed for through professional conduct, an open and self-aware attitude, and an empathic stance that had the goal of understanding the interviewee's experience.

The interview ended with two invitations: (a) for the interviewee to ask any questions on her mind, and (b) for the interviewee to comment on her perception of my influence upon the content that was disclosed. All interviews were recorded on an audio tape recorder. This material was transcribed into written format, directly by me, subsequent to each interview.

Method of Data Analysis

In line with a psychoanalytically informed approach to analysis, a feel for both the interviewee's intrapsychic world and unconscious motivations was aimed at. Towards this end, a synthesis of the recommendations of Cartwright (2004) and Crossley (2007) was followed. While Cartwright's (2004) recommendations are focused on eliciting the narrative's latent content and the interviewee's intrapsychic dynamics, Crossley's (2007) recommendations are method-focused, outlining the process behind the construction of the final (combined) narrative. An outline of the considerations used in the analysis follows.

To begin, Crossley's (2007) first four steps will be discussed as they provide a structure that Cartwright's recommendations can then elaborate. Crossley's (2007) first step involves the researcher familiarising himself with the data by reading through the entire transcription five to six times. Step two is the identification of concepts to be used in guiding the analysis. Crossley (2007) suggests the three "principal elements" identified by Mc Addams (1993), namely narrative tone, imagery and themes. Narrative tone refers to the way in which the story was told, for example with sorrow or concern. It is judged through the content and diction of the narrator's story as well as through her non-verbal body language. Imagery refers to the interviewee's use of images, metaphors and symbols. The origin of the imagery may be cultural, familial or individual and is usually used particularly when the interviewee is describing another's character, a particular atmosphere or a nuance. Themes refer to patterns of particular constructs.

As Crossley (2007) recommended Mc Addams' three *principle elements* in step two; his further steps proceed accordingly. Step three is the identification of narrative tone, both overall and in relation to each sub-narrative, in each transcript. Similarly, step four is the identification of narrative themes

and images. Crossley (2007) notes that the links between, and overlapping of, images can hint towards the presence of particular themes.

Cartwright's (2004) first step, "attention to feeling states and corresponding thoughts and perceptions", is a global consideration that began prior to the first interview and continued until the final write-up. The step requires the researcher to reflect on his own motivations for conducting the research, to monitor and note his own feeling states during the interviews themselves, and ultimately to grapple with the implication of his own emotive experiences with respect to the interview content and research process. This step is thus akin to the topic of reflexivity to be covered below. The step elaborates Crossley's (2007) process by incorporating the researcher's person.

Cartwright's (2004) second and third steps, "the search for core narratives" and "the exploration of identifications and object relations", supplemented Crossley's (2007) identification of tone, themes and images. Core narratives refer to particular narrative components (scenes and plots) that have reference to the phenomena under investigation. Cartwright (2004) further deconstructs these components as follows:

> I have come to understand the scene as comprising two principal elements: the characters in the story and the underlying atmosphere. The plot refers to the actions and motivations of characters identified in the narrative. I see these as guiding themes that aid the interviewer in searching for and building coherent narratives that stand out in the interview. (p. 228)

Thus, Cartwright's (2004) second step complements Crossley's (2007) third and fourth steps as they each encompass different approaches with the same outcome: the identification of useful themes. Cartwright emphasises the importance of always referring to the entire transcribed text, a point that works well with Crossley's (2007) initial six readings prior to a more direct engagement. Cartwright (2004) understands core narratives to be coherent when they fit with the researcher's understanding of the co-constructed emotional content present at each stage during the interview. A further test of the narratives' significance is the extent to which they were subtly repeated (perhaps in different forms) during the same, or across different, interviews. Again, this complements Crossley's (2007) note on the links between images.

Cartwright (2004) delineates his third step, "the exploration of identifications and object relations", as follows:

> The analysis of the narrative at this point is not unlike the way one listens to analytic material in the therapeutic context, allowing it to impress on the listener different hypotheses about how the individual locates him or herself through various forms of identifications and object relations. (p. 232-233)

It is the task of Cartwright's (2004) third step to use the core narratives identified earlier to hypothesize the composition of the interviewee's internal world. The narratives are assumed to reflect the operation of the interviewee's psyche including her appraisal of events. This assumption is not different to the BCPSG's (2007) proposal that intrapsychic dynamics are lived and understood at the interpersonal (or local) level, in other words in inter-subjective relations. Of fundamental interest to the researcher during this step was the way in which the interviewee positioned herself in relation to other narrative objects.

Thus, through Cartwright's (2004) third step, and Crossley's (2007) third and fourth steps, the phase of narrative construction was reached. This is depicted by Crossley's (2007) fifth step, which involves combining all the elements so far identified into a coherent story that is demonstrably supportable by the interview data. The story needed to incorporate all congruencies and discrepancies between interviewee narratives, and be able to demonstrate the meaning of the experiences collected. This step was thus central to the validity of the research process. The story that is presented did not need to be portrayed with a clear conviction of its veracity, but should rather aim to portray a well founded, coherent argument that demonstrates the sense in its construction. These concerns echo Cartwright's (2004) first two (key) validity criteria: *internal consistency and coherence*; and *comprehensiveness*. The third, *external consistency*, requires that reference to alternative explanation is pursued in case the final account has been unintentionally skewed in favour of the researcher's theoretical preferences. The fourth criterion, *independent validation,* refers to the consistency of the account across interpreters of the same theoretical approach. As my supervisor, working within the same theoretical approach, was actively involved in assessing the (research) analytic process, it is suggested that the results obtained demonstrate a consensus across more than one interpreter, and thus a consistency of the account. As such, this criterion has been deemed adequately accounted for.

Crossley's (2007) sixth and final step is the compilation of the final research report. Crossley (2007) notes that analysis continues even into this final stage in the research process. This is in line with Cartwright's (2004) emphasis on the circular nature of the entire analytic endeavour, in which the researcher's task is one of ". . . perpetually correcting and refining preunderstandings" (sic)(p. 232).

I read through each interview twice once I had finished transcribing it. From the first reading I began to consider concepts that may guide the analysis and I met with my supervisor to discuss each interview individually. In this way, I synthesised Crossley's (2007) first two steps. Through a collaborative discussion, my supervisor and I decided, already at this stage, that the narrative tone of the interviews would guide the development and contextualisation of the imagery and themes. The tone was a poignant contrast between a vulnerable, anxious and exposed communication and a helpful and explorative curiousness. Cartwright's (2004) first step, "attention to feeling states and corresponding thoughts and perceptions", was integral in the identification of the narrative tone. The feeling states of both the therapist and myself in each interview were considered. Similarities and contrasts between my own experience and that portrayed by each therapist, as well as between the therapists themselves across interviews, were borne in mind.

After this initial joint-impression that had been arrived at once all the interviews had been discussed, I read through all the interviews consecutively twice more. From these readings and further meetings with my supervisor a number of themes were identified. The three core narratives presented in the results section were outlined at this point. Cartwright's (2004) third step, "the exploration of identifications and object relations", were then explored in a further reading of key moments in each of the interviews. The ideas gained from this reading were used to assess the validity and applicability of the three core narratives across the interviews. Through this reading and further supervision, Crossley's (2007) step of narrative construction was reached. This phase of the analysis involved the delineation of the eight narrative themes presented in the *Results* chapter, as well as their interrelated or linked nature. This step was in many ways the most complex and challenging in the process. The challenge of capturing the relationship between the ideas presented by each theme, while portraying these ideas in a logical narrative was a creative process. Of note in the process described, was that the narrative themes developed out of the narrative tone rather than through the delineation and combination of narrative images. The object relations of each therapist, to the extent that they could be identified, helped to develop the narrative tone into the narrative linking the eight themes. This was a process of refinement and validity checking, wherein the links being stated between themes were matched with the object relations and narrative tone that existed within a number of interviews. True to Crossley's (2007) sixth step, the analytic process continued into the final write up. During the write up, the narrative themes were adapted, so as to best depict the "feel" of the interviews and experiences described. The relationship between the three core narratives (the main sections of the *Results* chapter) and the eight themes was also adapted during the write up, as through the focus that was placed upon the

final (meta) narrative at this stage, particular themes were found to best be portrayed in relation to particular core narratives. To this extent, Cartright's (2004) task of "perpetually correcting and refining preunderstandings" was fulfilled.

Evident in the six steps above is the extensive use which this form of analysis makes of the researcher as analytic tool. I was responsible for finding meaning in the data and I was required to utilise theory in order to determine a data-supportable final narrative. Given my key role, it was both a moral and a professional requirement for me to make a concerted effort to remain as true to the data as possible; I thus employed an attitude of reflexivity. This attitude is both a methodological and an ethical imperative. My reflections are noted in the section below.

Reflexivity and Reflections on the Research Process

The principle of reflexivity is particularly pertinent to the study, given my participation in each interview, the use of me as tool during the analysis, and the topic under investigation, namely countertransference. My own influence, presence and identity as researcher upon the interview content and the research process itself was tracked via self-reflections, the use of a diary for recording the researcher's emotional states and impressions, an invitation for feedback from the interviewee at the end of the interview, and my consultations with my supervisor (who assisted as a party indirectly involved, and thus more objective to the research process) (Frosh & Baraitser, 2008). The objective of the reflexive process is a perspective that recognises and acknowledges the researcher's influence upon the final narrative depicted in the final report. This attitude is portrayed in the following:

> The researcher's analysis should be presented, not as a privileged account, but as conditioned by a certain perspective that should be made as explicit as possible. This leaves room for participants and readers to interpret the narrative in their own terms subsequent to publication. (Smythe & Murray, 2000, p. 333).

As a Clinical Psychology masters student, I have my own experiences of countertransference and my own developing sense of professional identity. This has undoubtedly shaped the way in which I interpreted the data, and the extent to which the results reflect my own experiences is uncanny. As my own experiences during the research interviews were included in the study as data, the reader may want to bear this similarity in mind.

As someone new to qualitative research, I have felt vulnerable, exposed and fallible at many points throughout the research process. As these feelings were one of the themes elicited, the possible

influence of my own subjectivity upon this result is best held in mind. My own experience and awareness of self in relation to the study's participants was somewhat contradictory. As researcher, interviewer and data-interpreter I experienced a position of power in relation to my participants, while my position as student in relation to their status and experience as qualified therapists simultaneously placed me in a less knowledgeable position. These dynamics left me both very aware of the vulnerability involved in the therapists' disclosure and sensitive to the therapists' attitudes towards me as researcher. As such, the emphasis in the project upon the elusiveness of the therapists' experiences may in part represent my own efforts to both normalise the therapists' experiences of vulnerability in relation to me and portray the therapists in a way that reflects my experience of self in relation to them.

Ethical Considerations

The ethical principles of informed consent, duty of care, confidentiality, anonymity, reflexivity and reciprocity informed all conduct in the proposed study. This is in line with the ethical guidelines of the Health Professions Council of South Africa (HPCSA), as stated in the *HPCSA booklet 6*[4], and the University of the Witwatersrand's (Wits) Human Research Ethics Committee (HREC), as stated on the Wits website[5].

Informed consent refers to the disclosure of all information relevant to participation prior to participants partaking in the study (Smythe & Murray, 2000). In the study, the therapists invited to participate were informed of the study's focus, parameters and intentions in an email prior to them giving consent to being interviewed (see *Appendix A*). Additional, written consent was obtained at the interview for both the tape recording of the interview and the interviewee's participation itself, prior to the interview commencing (see *Appendices C & D*). All participation was purely voluntary and all interviewees were informed of their right to withdraw from the research process at any time. Smythe and Murray (2000) extend this criterion to a responsibility of the researcher to initiate a discussion about the participation of any subjects that become distressed by their disclosure. As the disclosure of countertransference feelings and enactments was potentially distressing to participants, this criterion was accounted for in two respects: Firstly, only therapists in their own personal psychotherapy were requested to participate; and secondly, given that the sample comprised psychology professionals, it was assumed that the volunteers were able to judge their own suitability for participation.

[4] It can be downloaded at the following URL: http://www.hpcsa.co.za/downloads/conduct_ethics/rules/generic_ethical_rules/booklet_6.pdf
[5] Found at the following address: http://web.wits.ac.za/Academic/Research/Ethics.htm#herc

Consent from the University of the Witwatersrand's (Wits) Human Research Ethics Committee (HREC) was obtained prior to any contact with the potential participants (see *Appendix E*). The email addresses of the potential participants were obtained from the university's Psychology Department, with the department's permission. My supervisor contacted all possible participants via email with an invitation to participate. These individuals were asked to contact me directly should they wish to take part in the study. In this way, my supervisor was not aware of the identities of the participants. This was important for ensuring the participants' confidentiality.

Concerning the confidentiality of interviewee disclosed content, all recorded material was securely and confidentially kept by me during the research process and it will be destroyed once this process is concluded. Only I have had and will have access to the recorded material at any stage during or after the research process. A summary of the final research report will be emailed to all the psychotherapists who participated in the study. I had student and intern registrations with the HPCSA, registration numbers *PS S 0111015* and *PS IN 0123811,* by which I was formally bound to the body's ethical principles.

While the identities of the participating therapists are known to me, confidentiality in report of both the therapists' identities and the disclosure of their client identities (or information that may be used in identifying them) was assured. In addition, the identities of the participating psychotherapists were not known to my supervisor, as stated above. She assisted the researcher using anonymous transcripts of the interview recordings. Confidentiality in the final write up has been achieved through the use of fictitious names and the absence of any information that would potentially allow for the identification of any of the participants.

Chapter Four: Results

Introduction

This chapter presents an analysis of quotations from the transcribed interviews that have been grouped into three core narratives, which comprise eight narrative themes. The first three themes, grouped in the section *Countertransference-type Experiences* provide examples of the therapists' experiences of countertransference-type phenomena. Themes four, five and six are encompassed into the second core narrative, *Making Sense of Countertransference-type Experiences.* The way in which the therapists processed and made sense of these experiences is presented in the fourth theme and the difficulty and discomfort that the therapists experienced as a result of their countertransference-type experiences is portrayed in the fifth. The therapists' use of a third or additional perspective in negotiating an understanding of their experiences, both of countertransference-type phenomena and the discomfort associated with them, is presented in the sixth theme. The final two themes are grouped in the core narrative of *Development of a Professional Identity* and present quotations that illustrate a process in which the therapists described moving from feelings of difficulty and discomfort to a more definite understanding of themselves in their roles as therapists. These two themes are presented in a narrative that links the therapists' experiences of countertransference-type phenomena to the development of their professional identity as psychotherapists.

An aim of the results chapter is the depiction and summation of the interview content in a way that acknowledges its intangible, alive and elusive quality. The three quotations below, two of which were sourced from one of the research interviews, expand this idea:

> When one has 'figured out' the meaning of a dream, one has lost touch with the aliveness and elusiveness of the experience of dreaming; in its place one has created a flat, bloodless decoded message (Ogden, 1992a, p. 521).

> . . .it [countertransference] has a sort of nebulous quality to me. Kind of what is it, what exactly is it? What exactly does it mean? (Caira)

> . . .I think there's this aspect to it [countertransference] that's, that's quite intangible, that's hard to kind of lay your finger on. (Caira)

Ogden suggests that a result is best achieved when "the aliveness and elusiveness" of an experience, definable as such, remains after the analysis of the experience. He thus links the idea of aliveness with the idea of *the experience* of a phenomenon. His statement indicates that experience itself is elusive; that there is an aspect to experience that is beyond capture. It is this element that he seems to suggest is lost in the "figuring out" of an experience. While Ogden refers to dreaming in his statement, the same ideas will be applied to the sampled therapists' experiences of countertransference.

Caira in turn describes countertransference in a way that is both alive and elusive. The sense she appears to make of the term is that it is difficult to capture both in words and in her mind. She is perhaps saying that there is more to the term than its academic definition. As a clinical phenomenon it evades her sense-making capacity. Similarly, the analysis of countertransference in this text is difficult because of the alive and elusive quality of the data. The accounts of countertransference in the data shared the intangibility that Caira described. The narrative begins with the first theme below.

Countertransference-type Experiences

Experiences of feeling "stuck"

In the extracts below, Becca became "stuck" within the interview while in dialogue with me:

> . . ya I'm quite stuck with him [her patient]. I think that that you can see. . .Um because I'm quite stuck with him. . .I can't see, I can't see it. (Becca)

> I'm stuck, I'm kind of stuck and that is definitely, ya that is definitely the case. (Becca)

> Ugh he's a, he's a (laughs). I do feel very stuck with him. . .Ya. (sighs)(laughs). Even just talking about him makes me, makes my mind whirl. . . (Becca)

Becca describes being "stuck" with her patient. She also became "stuck" on this patient, and on the description of her encounters with him, during the interview. In this sense, she has replicated her "stuckness" with the patient in the interview. She was in this way expressive and active in the manner in which she recounted her experience with her patient in the first quotation. The repetition of the statement that she feels "stuck" and the phrase "I think that you can see. . .", that she directed towards me, appear to convey this sense.

In the second quotation, Becca seems to feel more confident of her mind state. She appears able to make sense of her experience to the extent that she can now describe the experience in a way that defines it, although her definition is without reference to the dynamics at play between herself and her patient. As with Caira's sense-making above, Becca is able to describe, and partially capture, her experience in such a way that it remains out of reach (and even out of description).

In the third quotation above, Becca is unable to describe her patient, laughs at her inability to do so, repeats the sense-making statement that she feels "stuck" with him, sighs, laughs again and then describes that he makes her mind whirl. She appears to have lived her experience of being with her patient in the research interview in a way that was direct and observable. Her assertion that talking about her patient makes her mind whirl perhaps attests to the strength/power of the emotions that are triggered by Becca's attempts at describing the events of her experience.

In the sequence depicted below, Emily and I engaged in an event in which the theme of feeling "stuck" was lived within the interview in a way that is comparable to Becca's experience above:

Emily:	. . .I ask about how she [Emily's patient] feels about coming and speaking about the same, it's the same things every week. And she says ya well it's, it's hard because she realizes that she's stuck (laughs). We are stuck (laughs). We are we're stuck but that's we, we get unstuck at times ya.
Me:	I, I think it's really interesting because it's almost like we're stuck here, now on the same patient.
Emily:	Ya. It is (laughs). We are stuck on this patient, there's no one else that comes to mind or, ya.

Emily first depicts her patient as "stuck". She then amends this to her and her patient being "stuck". I then add that Emily and I are "stuck" within the interview and Emily confirms this suggestion. As above, the phenomena described are acknowledged by the vague and unspecific label "stuck". No more is said in either case and sighs, laughter and a "whirling mind" accompany the indefinite description. The experiences described thus appear to be alive, elusive and to some extent indefinable. These characteristics are further represented in the quotations of the next section in slightly different form.

Experiences involving strong reactions

In the quotation below, Avril associates feeling "frazzled" with feeling "stuck":

> . . .like usually when I get stuck with something, I read, like that's my go to, like I'll get frazzled and pick up a book and try and get like. . .it contains me, um and helps me think again. . . (Avril)

Her last five words, "and helps me think again", suggest that when she feels "stuck" she has difficulty in thinking as she does when she is not "stuck" or frazzled. Avril thus presents a slightly expanded description of being "stuck" to that discussed above. She did not become "stuck" within the interview, instead giving a description of how she manages her experience. She nevertheless describes an experience in which she had a strong reaction and she described this reaction using the words "stuck" and "frazzled", as well as a reference to an inability to think. The following three quotations share this strength of reaction to a session's events:

> . . .you know I hated her, um and I felt after that session, like you know. There had been times where I'd been gritting my teeth like literally gritting my teeth. In the weeks before and after that session I went through a phase of about twenty minutes where I couldn't unlock my jaw, it was just so like, like it was a rage in me. . . (Faye)

> It was like a jolt of a, it felt like white rage ah which was strange for me because usually I'm quite like calm and collected and you know, reasonably contained, and it was like fury!. . .but it was a strange experience to get such a strong like blind, hot feeling; like bodily and, um, emotionally. (Avril)

> . . .we had a session and it got into a lot of his childhood sadness stuff and, um, and suddenly as he was speaking I got completely dizzy, like, like really dizzy, so much so that I was thinking like OK what should I do because I was going to fall off my chair, how do I control this nicely, and, and then after probably about two minutes it just lifted completely and went away. And I didn't really understand it then. . . (Caira)

In the first quotation, Faye described feeling hate and rage, gritting her teeth and being unable to unlock her jaw as reactions to a particular patient. In the second quotation, Avril referred to feeling a jolt of white rage, fury and a strong "blind hot feeling". She described this experience as her reaction to a particular event within a group therapy session. In the third quotation, Caira referred to an experience in which she felt particularly dizzy and in which she was worried that she might fall off her chair. Each description represents an experience in which the therapists felt a particularly strong reaction to something within the session. Of note in each description is the direct, immediate and powerful quality of each therapist's reaction. The therapists were left without recourse to reflection, instead forced into action and later redress and recovery. This was evident in the first quotation in

the section where Avril turned to reading in order to recover her ability to think. Faye describes the effect of the interaction that she described above:

> . . .I had a crap weekend after it [the session] finished um. I felt really depressed afterwards actually, like I um, like it actually, you know I actually became depressed. (Faye)

Caira referred to the immediacy mentioned in the last seven words in her quotation, "and I didn't really understand it then". She describes feeling left without any knowledge as to the meaning behind her experience of being dizzy. She further described the following in reference to this same experience:

> . . .it's almost like the dizziness in itself is fulfilling to some extent because it's a kind of expression of an emotion [laughs while she says emotion] even if I'm not expressing it verbally or intellectually. . . (Caira)

Of note in the above is her understanding of the dizziness as the "expression of an emotion". She thus equates her dizziness with an affect but she also recognises that she was unaware of this link in the moment of the experience. This post-experiential insight throws light on the theme itself: there is something both elusive and alive in the *experience* of countertransference phenomena. The aliveness of the experiences was discussed earlier in terms of experiences of feeling "stuck". This quality may be said to exist in the instant, overwhelming and often somatic nature of the experiences depicted in this section. The elusive quality is similarly discernable by the absence of an immediate sense of understanding in the experiences presented. In the moment of their occurrence, there appears to be something that is missing, omitted from the therapist's awareness and perhaps disguised in somatic form or otherwise. Faye describes her understanding of such a quality:

> . . .you often only get a sense of what's happening with a patient when you do enact something, so you, you find yourself saying something and are like why did I say that. . . (Faye)

> . . .often you're going to be dipping into sort of enacting and it's about trying to, trying to pick up when you, when you have done that and, and, and how the patient's reacted to try and give you a clue. (Faye)

Faye gives the impression that she has recognised the inevitability of doing something that she is unaware of doing in the actual moment that it is done. In the section that follows, an aliveness and elusiveness is present in a yet alternate form; the section depicts experiences in which there is confusion between the persons of therapist and patient.

Confusion between therapist and patient

> . . .you know from the beginning of my therapy with this lady, um, my therapy with her, her therapy with me [laughs], um I made some fundamental mistakes. (Faye)

Faye initially phrases her statement as though she was being treated by her patient. She at first describes the therapy as though it is her therapy ("my therapy with this lady"); with her as the patient and her patient in the role of the therapist. The significance of this role reversal is evident in Faye's sudden awareness of her phrasing, her repetition of it, her correction (to "her therapy with me") and her laughter. As in the examples in the section above, and Faye's understanding of enactments, she was unaware of her error/role reversal until she had spoken the words.

In the quotation below, Avril uses the term identification in reference to her patient:

> . . .I think sometimes it's an identification like with, with the fragile patient. And um maybe it's that, you know protecting myself in an identification (laughs as she says the last three words). Ya. (Avril)

She seems to be saying that she, as herself, can relate to the idea of being fragile. She then takes this further by suggesting that when she protects one of the patients that she perceives as fragile, she is also protecting herself "in an identification". These last three words thus convey how Avril has made sense of the experience after the fact. They appear to suggest that there was a confusion in her mind, at the time of the experience that she refers to, between herself and her patient to the extent that both her and her patient were felt by Avril to be fragile. Avril's laughter may be said to attest to the feeling (perhaps of vulnerability) in her description. Caira also refers to an experience that she initially terms "over-identifying":

> . . .I get this completely somatic response of getting completely dizzy. . .I think it was probably over-identifying with the patient, but not so much identifying as just meeting that emotional state, right then. (Caira)

In the extract, Caira amends "identifying with the patient" to "just meeting that emotional state, right then". She is referring to her experience of feeling dizzy, presented in the section above. It appears that the sense she has made of her somatic experience is that it occurred because she met an emotional state that her patient was feeling in that moment. By meeting her patient's emotional state, Caira may be suggesting that they felt the same affects in the moment of her dizziness. As Caira experienced this meeting so powerfully, it may be said that in the moment of her dizziness,

there were two patients in the room, or perhaps one patient in two bodies. Emily sketches this idea below:

> . . when she talks about feeling lonely, I don't know whether it's me or her who's lonely. I mean it feels like one, feels like one thing. . . (Emily)

She too refers to a sharing or meeting of affect. In this experience, it is the feeling of being lonely. Emily first refers to not knowing whether it is her patient or herself who is lonely when loneliness presents in the session. She then extends this observation by saying that "it feels like one" and "it feels like one thing". In these words, Emily may be saying that the difference between her feeling lonely and her patient feeling lonely is experientially indistinguishable. The idea of two bodies and one mind, suggested above, once again appears to be an applicable description. The quotation below describes Emily's experience of a sameness of thoughts:

> . . .I still don't know sometimes (laughs), whether her thoughts are my thoughts or whether my thoughts are her thoughts. (Emily)

This description takes the idea of one mind beyond an emotionally based phenomenon and into the realm of thought. Emily describes not knowing to whom the thoughts present in the session belong. She appears to struggle in these moments with where her and her patient's minds begin and end. With this in mind, it may be said that there is an indefinable quality to the experience in the moment of its occurrence. The aspects that define her and her patient's separateness/distinctness appear to be lost. Emily describes this theme in her statements below:

> . . .it just feels so, it feels so close to home, and that's the only way to put it, it feels so, so close to home that you don't have distance from it. (Emily)

> It's difficult, ya, but it just feels um, too close, ya, to yourself. (Emily)

She describes her experiences as "so close to home", without "distance from it" and as feeling "too close. . .to yourself". Her use of the words "close" and "distance" perhaps suggest an inability for her to differentiate herself in these moments. "It", the experience or phenomenon, eclipses Emily's individuality or separateness. She refers to an inability to separate herself from her patients in the quotation below:

> . . .you just can't see it yourself always. You can't. You can't always separate yourself from some of your patients. Others you can but sometimes you can't. (Emily)

It appears that these experiences are describable and yet they depict an experience that is indefinable for the therapist in the moment that it is experienced. The therapists' laughter and their manner of considering and revising their statements while speaking, attests to the aliveness of the experiences even within the interview. In the section that follows, the process of distinguishing to whom particular psychic phenomena belong is discussed by the therapists. This sense-making process will be seen in light of the confusion, elusiveness and indefinability depicted thus far.

Making Sense of Countertransference-type Experiences

Attempts at untangling the confusion

In the quotation below, Avril describes what she does when she becomes aware that she is feeling difficult feelings:

> . . .um well the instance where it [her feeling difficult feelings] comes up and I realise it in the room then I'll like think about: what does this mean?, is it mine?, is it the patient's?, is it both? What can it be linked to? Why now? All of those kinds of things, um sometimes with like when I just feel left with it then I'm just left with it for a while. It's like um, sort of like waiting it out until the time comes when it gets a bit more processed. Ya, and sometimes it will happen in like a therapy session; in my own therapy or not, at another point in the day when I'm doing something else or er ya. . . (Avril)

She separates how she manages these feelings according to whether she becomes aware of them in the session itself, or only once the session has ended. When she becomes aware of the feelings while in the session, she describes reacting by going over a number of questions in her mind. The form of her response in this scenario attests to the nature of the experience: she becomes aware of feelings that are already felt and then she works backwards by trying to reason as to why they are present. Any understanding that she may reach about the feelings that are felt is arrived at after the fact. In the second scenario she described having become aware of the feelings after the interaction had ended. Her response in this case was to wait out the feelings "until the time comes when it gets a bit more processed". Avril's ability to make sense of her experience was in both scenarios temporarily elusive. For this period however, the experience remained alive with unnamed meaning.

Within this alive and temporarily intangible moment, Avril described turning to the following questions: "is it mine?", "is it the patient's?" and "is it both [mine and the patient's]?" (amongst

others). These questions represent an attempt at differentiating her feelings from those of her patients *by understanding in whose mind the feelings originated.* This too is a process of working backwards and seems to rest on the assumption that the feelings *began* in one mind before engulfing both the therapist's and patient's minds into something shared, elusive and inseparable. This process of sense-making is described by Emily:

> . . .it [her experiences of feeling stuck and inseparable from her patient] was definitely happening because it was my stuff (R: OK) that these people[6] were hooking into, definitely. I mean that's where these strong feelings came out of nowhere or the difficulty in working with these people. Um and also, I mean I didn't realise it also until I went to supervision um that a lot of stuff was being projected onto me as well, particularly with my female patient. And I couldn't do (laughs). I didn't realise it. Um I thought also at one point that it was just because we were so similar and I wasn't thinking clearly about her stuff and separating her stuff from my stuff. That it was confusing. But I actually, one of her biggest problems was this kind of feeling of worthlessness and so I always used to feel she came to see me, I was like this worthless therapist that couldn't help her because I couldn't think about her stuff, but we. . . when I went to supervision it was actually pointed out to me what like a massive projection that actually was. And when I realised that I don't really, I don't feel like a worthless therapist anymore (laughs) with her. Ya. (Emily)

She begins by stating that she understands the countertransference events to have occurred because her patients were "hooking into" her "stuff". In this initial understanding, Emily describes having thought that her confusion and "stuckness" was a result of her not "thinking clearly about her [her patient's] stuff and separating her stuff from my stuff". She then describes how this understanding shifted into considering the possibility of the "projection" of "a lot of stuff" onto her, and that her feeling of worthlessness was "a massive projection". She describes acknowledging the projection of "stuff" and then her worthlessness resolving.

Emily's initial understanding was that she had "stuff" (feelings that were similar to her patient's) that was evoked by her patient's similarity to her. Incorporated in this understanding was the idea that she was worthless because she would get caught up in this evoked stuff and that she was thus unable to separate herself from her patient. Her shifted understanding included the recognition that her patient felt worthless and had induced this in Emily. In her initial understanding, when she believed herself to be responsible for the experience, there are two separate people and one (Emily in this case) is reacting to the other's experience. In her developed understanding, in which she refers to projections, her initial understanding is not ruled out and the idea that her reaction is a

[6] She appears to refer to a number of cases simultaneously and yet to only a single case – that of the patient that she felt similar to.

response to her patient's state of mind is added. The ideas do not appear to conflict and it appears as though Emily's worthlessness resolved only once she considered both her and her patient's roles in the interaction. In this understanding, the feeling of worthlessness has occurred in the minds of both participants, but is understood to have originated in the mind of Emily's patient. By tracing this origin, Emily appears to have understood the worthlessness to have been originally induced by her patient. Avril describes a similar understanding:

> . . .the other danger which I've experienced quite a bit in therapy is like, like that feeling of openness to stuff. Like I think I tend to take a lot and then I sit with quite difficult feelings that aren't always my own or um ya, ya. It can be quite distressing or um ya, so it's like a, like a delicate balance again. Sometimes it's good to do that and sometimes I suppose you have to have a point where you say I'm not going to hold that for you, you need to hold it or work on it or um. Ya, sometimes I think I take a little bit too much of projections or, you know? (Avril)

In her phrase "difficult feelings that aren't always my own", she describes experiencing feelings that she understands to belong to her patients. Towards the end of the quotation she states that she at times takes "a little bit too much of projections". Avril seems to be saying that she understands the feelings that she understands as belonging to her patients. This understanding appears to be due to a thought process that assigns feelings to the person that felt them first. In the quotation below, Becca describes her experience of struggling with a similar sense making process:

> . . .sitting with that kind of raging anger, it made me uncomfortable. It just just didn't feel right, it didn't sit nicely um and I found it difficult to sort of process and to figure out was it his stuff, was it my stuff um how much of it was his stuff, was any of it my stuff. So I struggled with that kind of boundary of of figuring out where it was coming from. (Becca)

She refers to a process of "figuring out" the degree to which the raging anger that she felt was her patient's "stuff". She describes this process as "figuring out where it was coming from" and she refers to a boundary. Becca thus gives the impression that she is describing a similar process of reasoning about to whom a feeling belonged. Her reference to a boundary implies that the feeling is a product of both of their minds. She reiterates this process in her statement below:

> . . . because it's [countertransference], I feel such an important part of what's figuring out what's your stuff and what's their stuff, where that boundary lies, which can obviously be blurred. . . (Becca)

She refers to the blurring of a boundary, suggesting that the differentiation of the therapists' and the patients' "stuff" is not always possible. She nevertheless describes a process in which she attempts this differentiation. Her use of the term "boundary" sets up a sort of continuum along which it is theoretically possible to situate her interaction with her patient. This continuum may range between understanding the interaction or phenomenon as evidence of the patient's psyche only, the therapist's psyche only or as some form of shared product of both their psyches. Below she refers to an understanding of the role that her own "stuff" plays within an interaction:

> . . . so I think again it relates to the excesses of me as a therapist in being kind of, you know able to contain my, my stuff you know. (Becca)

Becca refers to her excesses and her ability to contain the phenomena of her own mind. Her own mind and her ability to manage its affects are important to her role as therapist. Of note in this quotation, as in many of the quotations in this section, is Becca's use of the word "stuff", which often referred to the workings or products of either their or their patients' minds. That the therapists used "stuff" and did not elaborate what they meant by the term may signal either a felt reluctance to discuss, or a difficulty in discussing, the intricacies of the experiences that they described. The difficulty in discussing such elusive, indescribable and alive experiences has been noted a number of times thus far. The therapists' possible reluctance – either conscious or unconscious - in discussing their countertransference-type experiences is explored indirectly in the sections that follow.

This section focused on how therapists, in response to intangible or indifferentiable phenomena, seek the origin of the phenomena experienced. In contrast to this process of thought and exploration, the section to follow presents excerpts in which the therapists describe feeling either inadequate or vulnerable as a result of the types of experiences depicted thus far.

Experiences of inadequacy and vulnerability

In the extracts below, Caira describes her understanding of her countertransference experiences:

> . . .I think my countertransference experiences make me critique myself as a therapist definitely quite a lot, um. . .then some; ya when they critique they make me wonder if I am fit to be a therapist sometimes. . . (Caira)

> . . .[negative countertransference] challenges or shakes something about my world, like even my sense of security or my sense of myself as a person that can be patient and understanding, or even like whether I am fit to be a therapist if I can't control those feelings. . . (Caira)

> . . . it feels like a gap in my ability to be a therapist, um that countertransference experience. (Caira)

In the first quotation, Caira describes a link between her experiences of countertransference and her experiences of self-critique. She also questions her adequacy as a therapist. In the second quotation, she speaks of a challenge to her sense of being in the world and how this causes her to question her sense of adequacy as a therapist. In the third quotation, Caira refers to a countertransference experience as a gap in her ability. At this moment she does not seek the origin of the phenomena that she experienced but rather finds fault in herself. Emily describes a similar sense of inadequacy below:

> . . .I felt like maybe I was doing something wrong (laughs) in the sessions that we weren't making any progress. . . (Emily)

> . . .at those times I imagine that I'm not being helpful. That's what I imagine, that I'm not being a good psychologist. That that more than anything is what goes through my mind. (Emily)

In referring to her experiences of stagnation (described above as "stuckness"), Emily doubts her own ability. This is apparent in the first quotation in her thoughts about whether she was "doing something wrong" and in her second quotation in her fantasy that she is "not being a good psychologist". This is perhaps a result of her considering her own "stuff" before considering her patient's contribution, as described in the section above. Faye and Avril describe their experiences of inadequacy as follows:

> . . .you know I look back and I actually feel foolish, you know because of the way I thought in those first two sessions. . . (Faye)

> Um, ya so for the rest of the group I was feeling quite like eee, shaky and um I think ashamed as well for having ah put her [her patient] down. (Avril)

In the first quotation, Faye describes feeling foolish as she considers her thoughts in a moment of countertransference in the past, while in the second Avril describes having felt ashamed of her misdemeanour. While Faye refers to a way of thinking, Avril refers to a feeling. In Avril's instance,

she was unable to trace the feelings that she had had in the encounter, as she was unaware of them until they were enacted. Knowledge of the feelings was elusive to her in the moment of action. This knowledge arrived after the fact, resulting in her reactions described. Faye, by contrast, appears not to have considered the origin of her thoughts and this had perhaps resulted in her feeling foolish. Consider the following quotations from the interview with Becca:

> . . .and then I found out that he was lying and I got, I didn't get angry with him but when I found out I was extremely angry with him for manipulating me. I was cross with myself for falling into that "trap" so to speak, um for believing him and I was so cross with him. (Becca)

> . . .initially just feeling stupid for believing him and then just you know, being so cross with him for manipulating me like that. . . (Becca)

> So it felt like a failure on my side that I hadn't figured this out and I think that was my, why I got so cross. It wasn't that he'd lied to me, it was that I had believed him. (Becca)

> Um, I think it's the failure, it's that feeling that I, that I have, I had failed to "get" him. (Becca)

In the first quotation, she stated that she "didn't get angry" with her patient and then immediately said that she was "extremely angry" with him. She then described feeling "cross" with herself and "so cross" with her patient. In the second quotation, she described feeling stupid and in the third quotation, referring to the same incident, she spoke of feelings of failure leading to her anger. It appears as though Becca struggled to admit that she felt angry and that once she had traced the origin of her anger, she found that it was due to her feelings of failure. This sense of failure is perhaps hard to bear, hence her unwillingness to say that she had felt angry. Admitting as much places the origin of the experience within her mind. As this may be the conclusion of a reasoning process that seeks the origin of a phenomenon, and Becca appears to use such a process, her reactions perhaps indicate a feeling of inadequacy induced by this thought process. In some of the experiences described by the interviewees, feelings of inadequacy were supplemented by a fear of judgement and/or persecution that often left the therapists feeling vulnerable to criticism:

> Ya, like with therapy, it's quite exposing to talk about your experiences um and how they might look and eeeee, eek (laughs). Ya. (Avril)

The aliveness of Avril's experience is evident in her communication of distress and her laughter. She seems to fear being judged by me after having described experiences that possibly leave her feeling

vulnerable. This may be due to their alive, felt, lived nature. The anxiety that this elicits is evident in the quotation below:

> . . .maybe it's an anxiety I have like ah how are you going to interpret the responses or um the things that you ask me further questions about what hooks on your mind, um but there's so much to like each experience. Feels like I haven't really given the, a whole picture or the picture as I see it and that's just the point: there isn't (laughs) um ya. (Avril)

Avril spoke to me about our researcher-participant relationship directly. She referred to her anxiety about how I was going to understand everything she had said during the interview. She further referred to my influence upon what was said during the interview, conveying her worry about the limited exploration of each experience and her understanding of each experience. Near the end of the quotation, Avril struggled to describe her worry, or perhaps she decided not to voice what was on her mind. She does not complete her sentence, laughing instead. Although the points that Avril raised in the quotation are both realistic and valid concerns about the validity of the research findings given the qualitative nature of the research project, her concerns appear to have left her feeling vulnerable in the interview. It is possible that this was because she feared the experiences that she had described, and feared that I would judge her or misinterpret her experiences. In the excerpt below Emily describes fears that were evoked in her work with suicidal patients:

> . . .probably just my need to be responsible for people and um maybe a fear of punishment or (laughs), repercussions, ya just the, um a fear of feeling responsible for someone else losing their life ya, ya. (Emily)

In the quotation above, Emily describes a "fear of punishment" and then laughs. She describes her fear as being related to a feeling of responsibility for her patient. Her "fear of punishment" thus appears to be related to her role as therapist and to the judgement of her actions in relation to her suicidal patient. She may feel vulnerable because of her patient's suicidality and to perhaps experience this as a fear of punishment from an "other". The role of therapist and its implications was further evident in the interaction between Emily and I:

Emily: Ya, I do feel responsible. I can add on it; probably overly responsible to the point where, I mean even now I really need a holiday. And I was sick two weeks ago but I didn't cancel any appointments because I feel responsible to these people (laughs). Now there's something to take to my, to therapy on Monday (laughs), ya.

Me: Cool.

Emily: Cool.

A vulnerability that is felt to be beyond professional appropriateness seems to have been felt and responded to by both parties. Emily mentioned taking her feeling of responsibility to her own therapy and laughs. I responded only with an affirmative comment and we then moved onto another topic. Evident in this excerpt is that the inclusion of the personal within the professional realm is potentially discomforting, uncomfortable and exposing. I experienced a sense of vulnerability at this moment that I have attributed to the discussion of Emily's own psychotherapy within the research interview. I seem to have avoided further exploration of the topic as a result.

The quotations in this section presented instances in which the therapists had felt a sense of discomfort. This discomfort took the forms of an exposed vulnerability, feelings of inadequacy as therapists and a fear of persecution. These forms were at times related to the understanding that the therapists had reached regarding past countertransference experiences, while at other times they appear to have resulted during the therapists' interactions with an "other". In the section that follows, the beneficence of a third presence to the therapist and his or her patient is described.

An "other" as guide

In contrast to Avril's discomfort evoked in the interview, Caira, Becca and Emily experienced the interview as a helpful space in which they were able to think further about themselves in relation to their patients. In all of these instances, the interviewer was a presence external to the therapist-patient couple and was experienced in a particular way during the discussion of therapist-patient dynamics. The theme of an external presence acting as a guide to the therapists is explored in this section. In the quotation below, Becca describes an experience involving a person other than me:

> . . .it was through supervision that I was able to really kind of talk it out and work through it. It wasn't something that I could do. I needed that that external sort of objective something to help me um figure out that it actually wasn't me, it actually wasn't my stuff. (Becca)

Becca refers to the help that she found in attending supervision. She described needing "that external sort of objective something". By placing the words "external" and "objective" together, Becca suggests that with distance (or removal) from the therapist-patient couple, greater objectivity is achieved. This objectivity, even when present in someone other to Becca's self, was found by her to be helpful in tracing the origins of particular feelings. This position was also suggested by Emily:

> Just kind of like taking the stuff to my own therapy and to supervision, I kind of realised that um (laughs) again it's my own stuff. . . (Emily)

In the statement, Emily refers to an experience of speaking about her countertransference experiences in her own therapy and supervision and how this helped her to realise that her "own stuff" was present in the experiences that she described in these sessions. This is not necessarily a process of tracing the origin of a phenomenon but nevertheless may be an acceptance of the role of her own mind while in the role of therapist. In the quotation below, Avril describes her own development while in the role of therapist:

> . . . in some ways it has like um I think the more I've had like therapeutic encounters and um experiences the more, the more I've been able to like observe rather than just feel. (Avril)

She describes the development of her capacity to observe herself in interaction with her patients. In her development of this capacity, she seems to have herself taken on the role of the supervisor. Her use of the word "observe" may suggest her capacity for a position of distance from the interaction between herself and her patient. Reference to a presence external to the therapist and patient was evident in the last two sections. This theme as well as the idea of the therapists' self development within their roles as therapist will be explored in the section that follows.

The Development of a Professional Identity

Developing personal ways of working

> . . .sometimes I wonder like, you know do I have to punish myself so much for that time that I said, or I laughed, or I made a joke or something. Like how free can you be? (Avril)

In this first quotation, Avril questions how much of herself may enter the therapy. She is grappling with the intersection of her professional and personal selves. This idea is furthered in her statement below:

> . . .what's um you know when is that not alright, when it's not alright for me to be gratified by the intimacy of the space? (Avril)

She refers to her own gratification within a space (or interaction) in which she holds the role of therapist. She once again grapples with a question that involves the intersection of her own enjoyment and her role as therapist. She seems to ponder the extent to which it is acceptable for

her to include herself in her work as a therapist. In her statement below, she describes her sense of the results of her pondering and grappling:

> Like it is a, a developing something. I'm not sure what yet if that makes sense? Like um I think I've learned more about um like the principles we learned about, like about therapy and things like the frame like what, how it's become more personalized for me. Like what. . . how does it um, how do I understand it or use it as a tool and rather than like a set provision of like it must be like this, this and this. Like rather than rules, it's more like a philosophy really if that. . . ya. (Avril)

In the quotation, she initially refers to "a developing something". She then describes how her understanding of psychotherapeutic principles has "become more personalized" and her understanding of them "a philosophy. . .if that". These statements retain an elusive quality, as if the development that they describe is still being lived by Avril. The development of a position that incorporates a personal and professional fusion appears to be in evidence. Furthermore, this position is perceived in relation to a norm or standard position in opposition to ". . .a set provision of like it must be like this, this and this" and then to "rules". This stated, the quotation below suggests, as above, that Avril did not simply arrive at the position described, but rather that she grappled with ideas that led her towards the indefinite, lived statement:

> Is it alright to try something new and maybe sit back a little bit more and let things be? Um ya. (Avril)

Avril seems to be seeking permission to be more personal and more herself within therapy. She seems to feel that sitting back may be beneficial, yet there is the hint that something within her stops her from doing so. The questioning nature of her statement suggests that she is asking the question of herself, yet seeking external reassurance. Becca suggests a similar idea in the quotation below:

> . . .I work a lot on instinct, and I, I don't know whether that's good or bad. I don't think it is good or bad, I think it's it's my way of working. (Becca)

She describes "on instinct" as her mode of working. She then states that she is unsure of the validity of her way of working before correcting herself and re-asserting it without the suggestion of judgement. There is a definite sense that Becca has developed her own personal way of working, yet it is something that she doesn't automatically herself accept. In her statement below, Becca elaborates an idea of identity:

> . . . [her own personal therapy] has also helped me to, to understand myself better when responding to things. Which I think also adds to me being the therapist that I am becoming. (Becca)

Becca describes "being the therapist that I am becoming"; knowledge of herself has helped her in her professional development. Her statement evokes a process of development and an emergent sense of professional identity. In the section that follows, quotations that describe an acceptance of fallibility and personhood are presented. This is a theme that develops the idea of an integration of roles already discussed.

Acceptance of fallibility/personhood

> . . .[it] doesn't feel right as a as a therapist to be angry with a patient but human, humanly we, it is and and that's also the using the this idea that I'm a therapist but also that I'm human is a new thing for me as well. (Becca)

Becca introduced the idea that she is both therapist and human, and named it as such. This seemed to reflect a blossoming awareness of personhood within the role of therapist, or alternatively, an integration of the personal and professional parts of herself. She developed this idea as follows:

> So it's that kind of that chicken-egg. So is it the reaction that's the egg and the fact that I'm a therapist first; I am me as a therapist that means that I respond in that way in the therapy to certain things, or is it the fact that I'm responding in that way that makes me the therapist that I am. (Becca)

Becca describes an idea that occurred to her after reading the research questions prior to her interview. She names this idea "that chicken-egg": did the therapist or person come first? She is unsure whether she is a therapist before she responds therapeutically to a patient, or whether her therapeutic response is what makes her a therapist. By reference to the "chicken-egg" aphorism, she implies that these two positions are indistinguishable; that she is a therapist by training and at the same time a therapist by her doing. Her words "the therapist that I am" suggest that when she is responding to a patient therapeutically, she is simultaneously her own person. The two ideas described above appear to co-occur with a development in Becca's self-acceptance within her role as therapist:

> I wonder if what I'm trying to say is that the more experience I get the more able I'm work, the more able I am to work with the countertransference, for it not to feel like a failure or a negative or a or a scary thing. (Becca)

Becca describes her countertransference as becoming less of a "negative" or "scary thing" as she gains experience. She appears to accept her capacity for fallibility. She is both a person like any other and a therapist by her training. If she is human, then by extension, she will make mistakes. If she is more accepting of her humanity, then she is more accepting of her mistakes. Emily describes a very similar understanding in the quotation below:

> Um, I'm like, I can make a mistake hey. I can do things wrong. I'm not always going to do the right thing. I'm fallible (laughs), ya. It's possible to have like moments where you, ya I can just make a mistake and not be helpful, um and in a way I think it's OK, um and I think in a way if it does happen, it's kind of to ya realise where you're going wrong, so moving forward you can try not to do the same stuff again. But it happens, you make mistakes. (Emily)

She seems to describe a new acceptance of herself within her role as therapist. She is "fallible" and she is likely to make mistakes. Her new acceptance seems to allow her to accept these ideas as reasonable rather than as a failure and as evidence of inadequacy. She elaborates her new understanding as follows:

> . . .ya it happens. It happens. And it is hard and I do feel bad, but um I feel in a way that that's kind of like the way it is as well. That you can't always be perfect, you can't always say the, exactly the right thing, ya. (Emily)

Emily describes the co-existence of feeling a failure and her acceptance of the inevitability of her mistakes. She creates the impression that she experiences both positions at once; although she accepts the inevitability of her mistakes, she still feels bad about them. In the quotation below, she describes her struggle to trust herself within sessions:

> . . . I put a lot of pressure on myself to make things better for these people, make it happen. And I learned ya that I just need to like trust this process that's happening more than trying to make it happen or trying to um or sort of feeling helpless in myself or despondent because things are not going anywhere. (Emily)

Emily refers to a "process that's happening" in the relationship between herself and her patients. She describes feeling despondent and hopeless in herself and juxtaposes this with the knowledge

that she needs to trust that the process of the therapy will happen without her having to put pressure upon herself. This perhaps speaks to the difficulty of accepting a position of fallibility. Avril describes an allied process of development:

> I think I maybe assumed (laughs while saying last word) that everyone else was the same. Um, that that's the way we are (laughs). (Avril)

Avril describes having assumed that all therapists were as she is. This is the assumption of a way of being as a therapist. In her statement below, she explains her new insights on this topic:

> . . . how I am, like quite. . . the person I am as the therapist I am, like as kind of trying to get to grips with that. I suppose embrace it in some ways rather than try and be that kind of therapist who I think is brilliant but a, it's not me, I can't be like that um, ya. (Avril)

She describes being herself and being a therapist and this combination defining her as a therapist. This is sketched in contrast to the kind of therapist who she thinks is brilliant and to the way in which she had previously aspired to be ("the way we are" in the previous quotation). "The person I am as the therapist I am" appears to be an understanding of self in which she is both a therapist and a person simultaneously, and where each role defines the other. The laughter in Avril's previous quotation attests to the aliveness and relevance of the discussion topic.

Conclusion

This chapter has presented the sampled therapists' experiences of countertransference-type phenomena. Although having already occurred, the therapists at times lived aspects of the elusiveness of their experiences in the research interview. This made for an alive and engaging sense that continued into the therapists' reflections upon their understanding of the events they described. This understanding was shown to include a method of "untangling" the experiences, potent feelings of discomfort and the development of an objective, non judgemental frame of mind. The therapists' understandings of their experiences were related to thoughts about their way of working as therapists and the extent to which their professional conduct could include their character or personal self. This process appeared to result in a sense of identity in which the therapists experienced themselves as both a therapist and their own person at the same time.

Chapter Five: Discussion

Introduction

The study's first research question required the exploration of the sampled psychotherapists' lived experiences of countertransference and related phenomena. These experiences were presented in the results section in three themes. The first theme depicted experiences in which the therapists had felt as though their ability to think about a therapy was "stuck" or hampered. The second theme described events in which the therapists had felt or enacted their reaction to a situation within a therapy. In the third theme related to this research question, a feeling of confusion regarding the distinction between the therapist and patient was shown to occur in particular moments during some of the therapies described. These themes all portrayed an elusive and alive quality that linked the diverse experiences within them. It is suggested that there would be benefit in the development of an experiential model that is able to capture the alive and elusive nature of these experiences.

The second research question called for an investigation into the nature of the psychotherapists' understanding of their countertransference-type experiences. This understanding was presented in the results section in three themes supplementary to those described above. The thought processes used by the therapists in their attempts to describe their experiences, was the first theme related to this research question. The second theme explored the therapists' encounters with their own sense of inadequacy and fallibility. The third theme depicted the helpfulness that the therapists attributed to an objective view of the events that they had experienced. When viewed together, these three themes showed how the therapists attempted to make sense of events that were elusive to them, encountered a sense of fallibility related to this sense making, and experienced the beginnings of a process through which they could accept their fallibility. The need for further research into the relationship between a feeling of fallibility in beginning therapists and their countertransference-type experiences is noted. The process of the acceptance of fallibility in beginning therapists and the relationship of this process to countertransference-type experiences is called for.

The third research question suggested that the influence of (a) the sampled therapists' experiences of countertransference-type phenomena and (b) the therapists' methods of meaning making, upon the development of their professional identity be explored. The therapists described their exploration of the possibility of the inclusion of their idiosyncrasies and preferences within their role as therapist. This exploration appeared to be accompanied by the acceptance of their personal fallibility as therapists. Each of these is explored below.

Countertransference-type Experiences

Experiences of feeling "stuck"

This first theme presented quotations from the research interviews in which the sampled therapists described their experiences of feeling "stuck" with their patients within the therapy session. The power of the emotional content evoked in the therapist-patient interaction was such that it left the therapists feeling "stuck" when describing this relationship in the research interview. This manifestation of the "stuck" dynamic within the research interview attested to the alive or lived quality of the therapists' experience, even though the experience referred to an interaction between the therapists and their patients and thus to one not physically present in the research interview. Given the prominence of the "aliveness" within the interviews, it is important that it be retained in the analysis of the data for three related reasons: (1) the power of the experiences appears to lie in their alive or lived quality, (2) the meaning of the experiences seems to be contextualised within the "aliveness" of the moments described, and (3) theorising countertransference-type experiences at the BCPSG's (2007) local level[7] perhaps requires that any unnecessary abstraction, reification and loss of meaning is avoided. It is thus important to the aims of this project that the aliveness of the interview content be both acknowledged and retained in the synthesis of the data.

The therapists' difficulty in describing their experiences in the research interview was evident in their experiences of "stuckness" and even in their use of the word "stuck". As the word "stuck" explains little more than the absence of the therapists' ability to understand the particular experiences they described, it appears to convey the elusive and indefinable quality of the experiences. This experientially indescribable quality is seemingly beyond thought or explanation and as such may be said to illustrate the influence of the therapists' system unconscious. As the experiences pertain to the interaction between therapist and patient, this idea may be extended to the interaction of the therapist's unconscious and the patient's unconscious. This phenomenon of the interlocking of psychic processes that are beyond the therapists' and patients' awareness has been discussed within the psychoanalytic relational tradition (cf. Charzanowski, 1979; Ehrenberg, 1982; Stern, 2004; and Wolstein, 1959, 1975 in White, 2001). The experiences depicted in this theme thus support existing relational premises; a finding that may have implications for current understandings of countertransference outside of the relational tradition. This idea is elaborated in later themes.

[7] The level of relational interaction rather than the level of psychic processing – see the *Contextualising Countertransference-type Phenomena* section in the second chapter of this report.

Ogden's (2004) concept of the *subjugating third* describes a stagnation in the psychotherapeutic process due to the presence of interpersonal, unconscious phenomena. This stagnation remains until the presence of these phenomena is recognised and acknowledged by the patient and therapist. Similarly, Baranger et al.'s (1983) concept of the *bastion* captures a felt experience of stagnation or paralysis in place of a sense of progress within a psychotherapy. Both the bastion and the subjugating third are forms of impediment to the therapeutic process that may be described as one of a number of countertransference-type phenomena. In addition, Cassorla's (2005) concept of the shared *non-dream* is a breakdown or impediment to the therapist's ability to think about the psychotherapy in an unobstructed or free way. These three concepts thus specifically conceptualise the therapeutic impasse described in the therapists' experiences of being "stuck". All three concepts recognise the co-creation and the felt presence of "stuckness" in this obstacle to therapeutic work. As Ogden (2004), Baranger et al. (1983) and Cassorla (2005) recognise the unconscious nature of these events, they appear to *implicitly* acknowledge the elusive and indefinable nature of such an experience. However, these qualities are arguably actively absent from their concepts. This is an important note as, while the above mentioned concepts provide some understanding of how and why the event occurs, they fail to wholly capture the here-and-now experiential nature of the event.

Experiences involving strong reactions

While retaining the "aliveness" and elusiveness present in the experiences of feeling "stuck", this theme portrayed events in which the therapists were better able to describe the moment in which the experience of "countertransference" occurred. In each of the moments described, the therapists were left unable to think and they instead expressed their reaction to the patient or encounter through their soma, actions or general mental state. As a result, redress for the loss of the therapists' objectivity and the recovery of their reflective capacities appeared to happen only after the moment of "countertransference". An absence of awareness in the moment of the experiences, as well as the instant and overwhelming nature of the therapists' responses, suggests the presence of the system unconscious. In each case, it was unclear whether the therapist's response was due to her own personality, the patient's unconscious communication or prompting of the therapist, or some combination of the two. Caira described understanding her dizziness as the expression of an affect and Emily spoke about the inevitability of the therapist enacting in the session. These descriptions may suggest that they understood their responses as a function of their own personality (countertransference as defined in the "narrow perspective", which is the perspective that views countertransference as a hindrance to effective analytic work (Gabbard, 2001)).

The concepts that may be applicable to the reactions in this theme, namely *role-responsiveness* (Sandler, 1976), *projective identification* (Bion, 1957a, 1957b; Ogden, 1979) and *countertransference-enactment* (Ivey, 2008), require information about the relationship between therapist and patient that is absent in the accounts. For example, assigning the label projective identification to any of the experiences described would require there being some suggestion that an interpersonal pressure was exerted from the patient on to the therapist. The absence of this knowledge about the relationship between therapist and patient may be viewed as a limitation of the research project. Alternately it may suggest that the therapists themselves were, even after the fact, unable to reliably classify their experiences in terms of these concepts. This may be due to the brevity of the therapies in which the experiences occurred, the group setting of some of the experiences, the relative novelty of such situations for the therapists, or perhaps because the therapists' grasp of the encounters they described have, for whatever reason, remained elusive. If the last point is considered, it may suggest that the existent theoretical concepts are unable to adequately capture the experiential nature of the events described. As a result, they may be insufficient in providing an understanding of the phenomena experienced. As suggested above, a more experiential model that captures the uncertainty, unawareness and elusiveness of the moment may be helpful in beginning a process of exploration; a *second look* (cf. Baranger et al., 1983).

Confusion between therapist and patient

The quotations in this section referred to the therapists' experiences of sameness between themselves and the patient. This appeared to involve both a partial loss of a sense of self and a sense of partial joining or merger between therapist and patient. This sameness was experienced in the moment as an inability to separate one's self from the other; as a loss of differentiation between therapist and patient with respect to an aspect of their (now partly joined) psychology. The therapeutic space appeared to, in some respects, consist in these moments of two bodies and one shared mind. All sense of individuality, with respect to the shared aspect of their psychology (either thoughts or feelings) seemed to be lost and replaced by a sense of un-differentiation. As in the themes presented above, these experiences were partly indefinable and beyond the therapist's understanding in the moment in which they occurred.

The concept of *primary identification* (Arnold, 2006; Elliot, 1995; Grotstein, 1980; Sandler, 1993) may best capture the confused and shared mental state described by the therapists. Primary identification is a sympathetic position in which the therapists were without the capacity to stand apart or separate themselves from their object; a capacity that is needed in states of empathy

(Sandler, 1993). This state may also be understood as a failure of the boundary setting function that mediates a process of primary identification between momentary states of merger and separation (Sandler, 1993). The therapists' accounts suggest that the process of *disidentification* (cf. Sandler, 1993), the separation and differentiation of self from object, did not occur with respect to the aspect of the patient's and therapist's minds that was experienced as though it was shared.

In considering the therapists' use of primary identification, the following possibilities emerged. Firstly, the therapists' use of the phenomenon may suggest that they were unconsciously pulled into the role of mother in the patient's mother-infant phantasy. If this is the case, the concept of role-responsiveness may further characterise the interaction as the therapists would have unconsciously responded to a role placed upon them by their patients. Alternatively, the phenomenon may be understood as the therapists' unconscious response to feelings of anxiety that were triggered by something within the therapeutic interaction. This possibility is based upon Carlson's (1961) suggestion that primary identification may be used as a means of escape from anxiety by merging with the other. Arnold (2006) also describes Freud's views on primary identification as both a derivative of love and as the ego's absorption of the other. Considering that the patient's perspective in the relationships referred to is unknown, together with the hypothesis that a beginning therapist is in a process of developing her professional identity, the therapists' use of primary identification may be understood as a result of the therapist unconsciously developing her professional identity via the unconscious absorption of her *relationship* with her patient. What is perhaps significant to the above is the myriad of ways in which the therapists' experiences may be understood using this single theoretical concept. While consideration of these possibilities is useful, this process may be supported by an experiential model which allows for a common, unified or global concept that, as a result of its experiential base, does not become reified or diluted into multiple clinical meanings. In addition, this experiential model may aid in the therapist's recognition of unconscious processes of identification and merged parts of self in the moment of experience. As above, this recognition may enable a starting point for thinking: the beginning of a *second look* (cf. Baranger et al., 1983).

The occurrence of "primary identification as a function of the therapist's mind" does not, in my knowledge, appear to be documented in either the countertransference or primary identification literature. The documentation of such experiences thus contributes to existing literature, and advocates further research in this area.

The first three themes addressed the first research question by depicting the variety of countertransference-type experiences that the therapists described. The therapists appear to have experienced events in which they felt "stuck" and unable to resolve this dilemma, experiences in which they expressed their reaction to the patient/encounter through their soma, actions or general mental state and experiences in which they were unable to distinguish between themselves and their patients with respect to an aspect of their psychology.

Making Sense of Countertransference-type Experiences

Attempts at untangling the confusion

This theme grouped experiences in which the therapists made sense of what happened in the moment by reflecting on the moment's events at a later time. Of note was the therapists' apparent difficulty, or perhaps reluctance, in discussing the intricacies of the experiences they described in the research interview. This difficulty builds on the observation that the therapists were temporarily, in the moment, unable to find any understanding in their experiences. It suggests that the therapists' difficulty in making sense of their experiences may not only be temporarily elusive but indefinitely out of their reach. The elusive, indescribable and alive character of the therapists' experiences, as discussed in the first three themes, may provide some explanation for the difficulty. This predicament of elusive, indescribable countertransference phenomena is recognised implicitly, but not directly, in concepts such as the *second look* (Baranger et al., 1983) and the *third position* (Fukumoto, 2001). Baranger et al. (1983) describe the second look as the therapist thinking about the therapeutic relationship and the therapeutic process in a way that seeks to identify the dynamics responsible for the sense of "stuckness" or non-progress. This form of thinking, the second look, focuses upon the role that the therapist's own thoughts, feelings and behaviour are assuming in the relationship. Fukumoto's (2001) third position is a very similar idea, in which the psychotherapist assumes a perspective from which she can mentally view her relationship with her patient, rather than being caught up in a particular role within the relationship. While both concepts recognise the need to "untangle" countertransference-type experiences, the concepts do not suggest an approach that begins a process of sense making *in the moment* that the experience occurs. This may be because the second look and the third position do not incorporate (a) the therapist's "in the moment" realisation of countertransference phenomena and (b) the process of making sense of the experience, in a single step or single conceptual tool. This may be because the concepts are not experiential and that they as a result miss the possible simultaneity of these steps. The above critique is based upon the idea that an experiential concept may allow therapists to identify instances of countertransference phenomena as they occur and in this acknowledgement already

have begun a process of thinking about the event. If an experiential model is able to capture the "feel" or lived experience of a "countertransference" moment, then as soon as the therapist becomes aware of her "feeling" she is already thinking conceptually, with theory to help guide her working through. The feasibility of these ideas requires further investigation.

The quotations presented in the theme refer to feelings exclusively. The therapists appeared to attempt to make sense of their feelings by determining in whom they originated. This process thus appeared to assume that the feelings began in either the therapist or the patient before becoming shared by both therapist and patient. Specifically, Emily and Avril appeared to have made sense of their experiences by understanding their feelings to have originated in the patient's mind before having become shared; while Becca used the idea of a boundary to make sense of her experiences. Thus while Emily and Avril appear to have described a single origin to the feelings that were felt, Becca appeared to refer to a continuum of possibilities that included the idea that the origin of feelings may at times be unclear. The therapists, including Becca, nevertheless attempted to uncover the origin of their feelings (the feelings that they felt) in all the experiences presented.

As above, in the therapists' attempts at uncovering the origin of the feelings experienced, they appeared to either trace this origin to the therapist's or the patient's person. Considering the latter possibility, it may be that the therapists assigned the feelings to their patients because they unconsciously experienced themselves as their patient (as was depicted in the theme of *confusion between therapist and patient*). Alternatively, the therapists may have assigned the feelings to their patients because of the sudden onset of the feelings experienced and the indefinable quality of the experiences themselves. The indefinable quality may have in part been due to the therapists' inability to think in the moment and in part due to the unconscious nature of the experiences described. As a result, the feelings may have felt foreign or unusual to the therapists and they may have, based upon this, reasoned that the feelings did not begin in themselves. Further explanations likely exist and may be the subject for further research.

The ideas discussed above indicate the therapists' use of a model that may lie closer to a one person than a two person understanding, in order to decode, understand and make sense of their countertransference-type encounters. Even when the idea of a blurred boundary was suggested as explanation, the origin of the feeling had initially still been sought. Becca's suggestion of the blurred boundary perhaps alludes to the difficulties experienced by the therapists in using relatively one-person concepts to understand phenomena that appear to be inevitably shared or jointly created. It

is suggested that, although elusive due to their unconscious nature, the experiences described perhaps in part *remained* elusive to the therapists because their efforts at understanding their encounters did not make use of two person concepts.

Experiences of inadequacy and vulnerability

This theme explores the therapist's awareness of their fallibility. It grouped quotations in which the therapists questioned their adequacy as therapists. Caira did not attempt to make sense of her feelings but appeared to find fault in herself resulting in her feeling a sense of hopelessness. Similarly, Emily appeared to doubt her own ability rather than to attempt to understand the encounter. Faye and Becca appeared to feel inadequate as a result of an analysis that placed the origin of their feelings within their own minds. Feelings of inadequacy were also accompanied by a fear of judgement and/or persecution. In addition, there may have been a feeling of discomfort about the inclusion of the personal within the professional realm. This was felt by me, as the researcher, and this idea is thus partly based upon my experience while conducting the interviews. The idea of inadequacy builds upon the notion that the therapists felt reluctant to explore the intricacies of their experiences in the research interview (introduced in the theme above). Feelings of inadequacy, the fear of persecution and feelings of discomfort that appear to co-occur with the discussion of countertransference phenomena may explain the therapists' reluctance to fully explore their experiences in the research interview. This occurrence perhaps speaks to a vulnerability that is triggered in beginning therapists that may result in a tendency for them to doubt their adequacy as therapists. This in turn alludes to the close link between the personal and the professional within the psychotherapy profession. As this has implications for the management of therapists within the profession, this may be an important topic for future research.

The therapists' use of a relatively one person model, discussed in the preceding theme, may be better understood given the feelings of inadequacy suggested in this theme. These feelings suggest two further possibilities that were not discussed in the preceding theme. In considering the therapists tendency of assigning feelings to an origin within the patient, it may be that the therapists felt inadequate and assigned the feelings to the patient in order to gain some sense of adequacy/empowerment in an (imagined) other's eyes. Considering the therapists' propensity to consider the feelings as originating within themselves, their feelings of inadequacy may suggest that beginning therapists have a propensity to self blame or find fault in themselves and thus a tendency to ascribe the origin of feelings to themselves. This notion suggests that beginning therapists may thus make use of *the narrow perspective* and concepts such as *projective identification*, one person

constructs, as these ideas may match their experience of the countertransference. In order to be substantiated these ideas may require further research.

An "other" as guide

In this theme a third presence was described as helpful in resolving the therapists' experiences of countertransference phenomena. This third presence included the therapist's therapist, the therapist's supervisor, and me as the researcher. The therapists appeared to imply that with distance from the therapist-patient dyad, objectivity was achieved and that this objectivity was found to be helpful in both tracing the origin of feelings and in facilitating the therapists' acceptance of the inclusion of their own mind within the therapy. This capacity to be objective was also described as having developed within the therapist's own mind where it seems to relate to the therapists' ability to develop the capacity to observe themselves as therapists. They describe the development of this function within themselves in a way that parallels accounts within the literature of the development of a self observing capacity within the patient (cf. Scialli, 1982). This idea may suggest that there is an aspect in the therapists' training that parallels the development of the self observing function that occurs in analysis. Eagle et al.'s (2007) reference to supervision as an aid in the development of this capacity appears to be supported by the quotations grouped under this theme. Furthermore, the literature links identity processes and the development of this function (Scialli, 1982). This idea relates to the final two themes to follow and may relate to potential avenues for further research.

Cassorla's (2005) model of the *theatre of analysis* and Parsons' (2007) idea of the *internal analytic setting* refer to a specific attitude or approach towards both one's self as therapist and the dyadic encounter, that incorporate the idea of objectivity. These ideas appear to go beyond the capacity for observation alluded to by the therapists within the interviews. This may be because these ideas represent capacities that take many years to develop, because of the relative novelty of the papers or due to the poor resonance that the ideas hold for beginning therapists who are involved in work that is different to traditional analysis. Further investigation into the development of the capacity for the resolution of countertransference phenomena within beginning therapists and into the development of their ability to make use of the various functions of their own minds within their role as therapists, may provide knowledge useful to supervisory relationships.

The sampled therapists appear to have made sense of their countertransference-type experiences through the use of relatively one person models and a presence "other" to the therapist-patient

dyad. This sense making appeared to at times remain elusive, at times result in feelings of inadequacy and at other times to allow the "countertransference" to feel resolved. Viewed together, these three themes show how the therapists attempted to make sense of events that were elusive to them, encountered a sense of fallibility related to this sense making and experience a process in which this fallibility could be accepted

The Development of a Professional Identity

Developing personal ways of working

Avril's grappling with the intersection of her personal and professional selves through a number of reflexive questions introduced this theme. Her questions demonstrated the emerging intersection of her person and her role as therapist. She wondered about the extent to which it is acceptable for her to include herself in her work as therapist. Becca wondered about her role as therapist and she initially described two distinct possibilities: either she is a therapist by doing or she is a therapist by her being. As she spoke, she developed these ideas into an acceptance of herself as a therapist by both her being and her doing. Through her discussion, Becca appeared to describe an experience of development resulting in a position that encompasses a personal and professional fusion. Both therapists' accounts appeared to evoke a comparison to an imagined norm and the questioning of whether differentiation is acceptable or permissible.

The personal and professional fusion referred to, acknowledges Donati and Watts' (2005) idea of overlapping personal and professional areas of growth. Both Avril and Becca appeared to question the validity of the inclusion of themselves within their role as therapist and the inevitable differentiation and personalisation of their work that would result. This process of the "entwining" or fusion of the therapists' personal and professional selves challenges the exclusivity and differentiability of the areas of personal and professional development described by Donati and Watts (2005). The increase in complexity of the therapist's person, to which Donati and Watts refer, seems to develop in a process indifferentiable from the therapist's growth in theoretical expertise and interpersonal skills. That is, one's growth as a person and one's growth as a professional are inextricably linked and cannot be untangled.

The therapists' process of differentiating their therapeutic attitude from an imagined norm, the development of their personal way of working, appears to match the idea of *analytic style* proposed by Kantrowitz's (1992) and referred to explicitly by Gabbard and Ogden (2009). In addition, Eagle, Haynes and Long's (2007) description of a personal transformation resulting from the trainees'

conscious processing of, and reflective attitude towards, their experiences captures the developmental process described above. The therapists' experiences depicted in this theme thus find some support in the existing literature.

Acceptance of fallibility/personhood

The quotations presented in this theme represented the therapists' experience of the integration of their personal and professional parts of self. The therapists seemed to describe an acceptance of their capacity to make mistakes and through this process, the acceptance of their humanity. Their comfort in the role of therapist thus may have happened through their recognition of their personhood. The gradual incorporation of their person within their roles as therapist followed. This did not seem to be an easy position for them to accept as even while accepting her fallibility, Emily described feeling bad about a mistake that she had made. The therapists described their acceptance of fallibility replacing their feelings of inadequacy, yet feelings of inadequacy and acceptance also appeared to co-occur. Overall, an understanding of self appeared to have emerged, through a process of questioning perceived norms, in which each therapist felt as though he/she was both therapist and person simultaneously. This indicated a position in which each role defined the other.

Both the therapists' voluntary inclusion in the project and the thought processes that they communicated in the interviews suggest that the therapists are adept at being both reflexive and curious about the dynamic interaction that they had experienced with their patients. Hinshelwood's (1999) concept of *analytic identity* incorporates the qualities of curiosity and dynamic interaction (qualities that partly characterize a psychotherapy) into the psychotherapist's sense of self. It is an idea that attempts to capture a psychotherapist's identification with the role that she need assume in the process of psychoanalysis/psychotherapy. The concept of analytic identity thus appears relevant to the therapists sampled.

Kantrowitz's (1992) description of *analytic style* refers to both the manner in which the psychotherapist interacts with her patient, and to the psychotherapist's own personal way of working. Rosenbloom (1997) defines analytic style as a change in the way a psychotherapist works psychotherapeutically, a position congruent with Kantrowitz's (1992). The therapists' described change in their way of working therapeutically and in their manner of interacting with their patients, through the integration of their personal and professional senses of self, both match Kantrowitz's (1992) and Rosenbloom's (1997) ideas of analytic style and mark a change in this style since the therapists first began practicing.

The concepts of *personal and professional development* highlight two distinct, yet overlapping processes of growth that occur in the psychotherapist as a result of her continuous goal towards an ever increasing self-awareness; itself a requirement for effective therapeutic work (Donati & Watts, 2005). While personal development refers to an increasing complexity of the psychotherapist's person, professional development refers to the maturation of the psychotherapist's professional self-awareness, theoretical expertise and interpersonal skills. Rosenbloom (1992) also refers to a loosening of a psychotherapist's *psychoanalytic work superego* through her development of her own way of doing psychotherapy and being a psychotherapist. This idea thus supports Donati and Watts' (2005) suggestion of a concurrent personal and professional development. The sampled psychotherapists described an experience of development that incorporated the integration of both changes in their understanding of self and changes in their understanding of themselves as therapists. Their growing acceptance of their capacity to make mistakes may be taken to represent an increasing complexity in the therapists' understanding of themselves, Donati and Watts' (2005) idea of personal development, as persons both capable of achievement and mistakes. An increase in the therapists' self-awareness was represented by their increase in understanding of themselves as therapists, and their increasing ability to make sense of their interpersonal interactions with patients depicted a maturation of their interpersonal skills and understanding. This growth areas support Donati and Watts' (2005) idea of professional development. The concurrence of the therapists' personal and professional development support Donati and Watts' (2005) idea that these processes are concurrent. It appeared that both forms of development were necessary for the sense of integration of therapist and person to occur. The psychotherapists' growing ability to accept their own fallibility and humanity amidst often concurrent feelings of inadequacy speaks to the loosening of the psychotherapists' psychoanalytic work superegos that Rosenbloom (1992) described. The feelings of inadequacy represent a self-perception of self-criticism (a superego function), while the ability to accept one's fallibility while feeling inadequate suggests a position of flexibility in which one's self-criticism is not so severe that fallibilities cannot be seen or accepted. The applicability of both Rosenbloom's (1992) and Donati and Watts' (2005) ideas reinforces the concurrent nature of their perspectives.

Given the application above, the relevence of Hinshelwood's (1999) *analytic identity*, Kantowitz's (1992) and Rosenbloom's (1997) *analytic style,* and the apparent indifferentiability of Donati and Watts' (2005) *personal and professional identities* supports a process of amalgamating a dynamic personal sense of self in relation to the "other". Rosenbloom's (1992) suggestion of a loosening of a psychotherapist's *psychoanalytic work superego* through her personal development also appears

applicable to this process. This sense of professional identity appeared to incorporate the therapists' ideas of self, their feelings of inadequacy/vulnerability and the models that they used in making sense of their countertransference-type experiences. It appeared to include reference to an imagined norm and an understanding of their interpersonal interaction with their patients. To this extent, what may be described as the therapists' sense of professional identity seem to more-or-less confirm the ideas suggested by Eagle et al. (2007). An experiential rendering of Eagle et al.'s (2007) ideas may aid in providing a compact understanding of the experiential process of professional identity development. This may be achieved through a description of the core dynamics that beginning therapists experience and struggle to master in their first few years of practice. This description could state the dynamics in an experiential form that is compact but able to be elaborated and described until it is understood and internalised. This rendering may possibly be able to incorporate the difficulties involved (experienced) in the process of the beginning therapists' professional identity development. Such a model may help in making the process more accessible to beginning therapists and may perhaps be used for training or didactic purposes.

As the concept of professional identity development is supported by the data in this study, only very marginally represented within the literature in relation to countertransference phenomena, and of apparent theoretical use in understanding a number of processes occurring in the maturation of beginning therapists, it may well be a strong topic for future research. The relationship between a sense of professional identity and the self observing function, introduced in theme of *an "other" as guide* above, may be a further topic for future research. This is particularly so given the likely role that identity processes may play in the development of each psychic function.

These final two themes show how the sampled therapists appeared to develop their understanding of self as therapist through their experiences of countertransference phenomena and the resolution of these experiences. Their way of working as therapists appeared to in part be determined by their experiences of therapist-patient interaction and their sense of professional identity appeared to be determined by the therapists' capacity to accept their own fallibility. The degree of their acceptance appears to have determined the extent to which their personal and professional selves were integrated into a single sense of self as therapist.

Limitations of the Research Project

Demographic variables such as age, race, and gender, and contextual variables (historical, political and cultural) were not taken into account in the analysis of the interviews. These variables may have

influenced the content elicited in the interviews, yet the consideration of this influence was absent from the research project. However, the focus of the study, as well as time and scope constraints precluded the inclusion of these variables.

The project's limited sample size and the time constraints of the interviews perhaps limited the range of phenomena that were discussed. This also inevitably limited the depth to which the events of countertransference, and the therapists' understanding of these events, were explored. However, it must be noted that Marshall (1996) suggests that "[a]n appropriate sample size for a qualitative study is one that adequately answers the research question" (p. 523). As such, and given the data saturation discussed in the *Method* section, it can be argued that the sample size was adequate given the scope of the current study.

Given that the study utilised a small sample of relatively specific volunteers, the generalisability of the study's findings to other therapists and other historical, political and cultural contexts is unknown. However, generalisability, also termed external validity (Rosnow & Rosenthal, 1991) is often understood not to be a primary aim of qualitative research; this research is rather concerned with in-depth exploration based on generating personal, detailed and meaning-rich data (Myers, 2000). It is believed that the current study was able to provide the latter and, as such, its limits in generalisability may be forgiven.

Conclusion

This research project sought to provide a psychoanalytically informed, experience-near and narrative contribution to a subject under dispute yet central to the act of therapy. The experience-near aspect of the study relates to the intention of investigating "countertransference" qualitatively without engaging in unnecessary abstract descriptions. The study followed an approach that aimed to remain as close to the experiences depicted by the sampled psychotherapists as was possible. This was achieved by contextualising the psychotherapists' experiences of countertransference-type phenomena within the therapeutic process, and by understanding their defences, enactments and meaning-making to derive from the *local level* of interaction, an experiential and interactive rather than an intrapsychic focus (BCPSG, 2007). The narrative aspect of the study is linked to the storied nature of the data. A narrative analytic approach was chosen to examine the data presented. The depiction of the sampled psychotherapists' experiences of countertransference and related phenomena, and their understanding of these events, were together the research project's central

focus. A secondary concern in the study was the psychotherapists' development of an associated sense of professional identity.

The study's findings showed that the "alive" disposition of the therapists' statements emphasised the "lived" character of their experiences. The "elusiveness" of the experiences described appeared to depict the influence of the unconscious aspects of the therapist-patient interactions. Together, the "aliveness" and "elusiveness" related to a sense or tension of absence-presence in the experiences, as although aspects of psychic functioning were unconscious, and thus experienced as absent, they were still expressed or present in alternate forms. The alternate forms included the therapists' experiences of being "stuck", their strong reactions to situations, and experiences of indistinction between each therapist and patient. The experiences of being "stuck" provided support for concepts depicting countertransference phenomena as an obstacle to analytic work. These concepts are, as they are depicted in the literature, abstracted from the actual experiences that they describe. As an experiential model may be able to capture the lived and elusive qualities of the therapists' interactions with their patients, it may provide a theoretical stance that remains close to the clinical experience of countertransference and related constructs. This proximity to the "feel" of countertransference-type experiences may aid therapists in recognising the presence of countertransference phenomena in the moment of their experience, and through their recognition foster a "restarting" of their thinking in the moment of their "countertransference".

It was found that the participants tended to attempt to discover which thoughts and feelings were theirs and which thoughts and feelings were their patient's, before realising that the thoughts and feelings were inseparable. These experiences of the psychotherapists not being able to distinguish their minds from their patients' minds provides support for the application of the concept of primary identification to the therapists' experiences, in what appears to be a novel consideration. The prominence of this theme, *confusion between therapist and patient*, provides support for the conceptualisation of "relational interaction" as a continuum of exchange.

The therapists' were found to use constructs that were relatively "one person" in orientation, in their attempt to understand the events of their role relationships. As discussed above, it was suggested that an experiential model may facilitate processes of sense-making in the moment of "countertransference". Further investigation into the link between a felt sense of vulnerability and the interaction of the personal and professional within the psychotherapy profession was

recommended. The sampled therapists' tendency to use one person understandings seemed to in part be related to the sense of vulnerability that they experienced.

A number of the therapists were found to have developed an understanding of self, through their experiences as psychotherapists, in which they were simultaneously a therapist and a person. This understanding of self was found to be related to the therapists' development of a capacity for objectivity, and with it the acceptance of their human fallibility. The degree of their acceptance seems to have determined the extent to which their personal and professional selves were integrated into a single sense of self as therapist. Through the above, the suitability of viewing professional identity as a construct based upon Hinshelwood's (1999) *analytic identity*, Kantowitz's (1992) and Rosenbloom's (1997) *analytic style* and the combination of Donati and Watts' (2005) *personal and professional identities*, was apparent; while Rosenbloom's (1992) suggestion of a loosening of a psychotherapist's *psychoanalytic work superego* through her personal development also appeared applicable. Further investigation into the development of this conceptualisation of professional identity was suggested. In addition, the relationship between a sense of professional identity and the self observing function was noted. Future investigation into the influence of identity processes upon the development of each function was suggested.

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Appendix A

Draft email/participant information sheet

UNIVERSITY
OF THE
WITWATERSRAND,
JOHANNESBURG

School of Human and Community Development

Private Bag 3, Wits 2050, Johannesburg, South Africa

Tel: (011) 717-4500 Fax: (011) 717-4559

Email: 018lucy@muse.wits.ac.za

Dear Sir/Madam

My name is Rob Peers and I am currently in my M1 year of the Clinical Psychology programme at the University of the Witwatersrand. As a part of the requirements for my qualification, I am conducting a research study into how psychotherapists make sense of, and discover aspects of themselves in, their countertransference-type experiences. The broad focus is on countertransference-type experiences that were particularly difficult to negotiate, with an added emphasis on how these "dilemmas' were resolved. The extent to which these experiences may have contributed to one's sense of professional identity as a practicing psychotherapist is further considered. The study will use a psychoanalytic, narrative methodology; an approach that considers the influence of unconscious dynamics upon the sense-making and self discovery processes being explored. I invite you to participate in this research.

Participation involves your commitment to a single semi-structured interview of 45 to 90 minutes duration. It will be conducted at a time and venue both convenient and comfortable to you. I request your permission to audio record the interview, should you choose to volunteer your participation. Questions will be of an open ended and reflective nature; their content related to your personal experiences of countertransference-type dilemmas (for example, a therapeutic experience where your own feelings were particularly strong). Should you choose to participate, I will email you the questions that I will be asking in the interview prior to us meeting. I am not looking for well thought out accounts (although this would still work) but rather for those experiences that have stayed with you, even if they may feel irrelevant, or particular to yourself or a specific patient.

It is requested that only psychotherapists currently in their own personal psychotherapy participate. This request is due to the potentially distressing nature of the topic. Lifeline (011 728-1331 or lifeline@lifelinejhb.org.za) is a free 24 hour telephonic counselling service that may be contacted should you wish to have further counselling in addition to your psychotherapy.

I assure the confidentiality of both your participation and any disclosed content should you volunteer as an interviewee in the study. The interview will be transcribed by me alone into a written transcript. The transcript will be stripped of any identifying information (e.g. your age, name, graduating year etc.) before my supervisor will have access to it. At no point will any identifying information, in taped, transcribed or verbal form, be disclosed to my supervisor, to another member of the Wits department or to a third party not explicitly mentioned. Should you disclose any identifying information about one of your patients during the interview, the confidentiality of this information is similarly guaranteed. The confidentiality of your identifying information will continue into the final report and any possible publication through the continued use of fictitious names and absence of any identifying details (deleted prior to supervision). During the interview, you may decline to answer any questions without explanation and you may withdraw from the study at any time. All interview content, both taped and transcribed, will be securely kept during and after the research process (it will be destroyed/deleted six years after the project's completion).

Your participation would be significantly appreciated. Your interview will function as a space for reflective thought about your own growth as a psychotherapist since beginning your professional career. The research project aims to contribute to the existent, somewhat diverse, literature on countertransference; providing an experience-near understanding of the construct and its role in the formation of a sense of professional identity in beginning psychotherapists.

The research write up will be completed by end November 2011. I will gladly email summaries of the project to all interested participants. The full report will be available through the Wits library website (www.wits.ac.za/library) early in 2012. Should you require more information or choose to volunteer as an interviewee, please contact me via telephone or email (details below).

Kind regards

Rob Peers

(Training Clinical Psychologist)

Researcher:	*Supervisor:*
Robert Peers	*Carol Long*
*My Cell number**	*011 717 4510*
*My Email address**	*carol.long@wits.ac.za*

HPCSA student registration number: PSS0111015

*My contact details have excluded for privacy reasons

Appendix B

Semi-structured interview schedule

Included when sent to participants: We are looking for the experiences that have stayed with you, even if they may feel irrelevant, or particular to yourself or a specific patient .In responding to each question, it may help to visualize a particular session, moment or patient.

The researcher is to assure the interviewee of the confidentiality of their identity and of all information provided. Interviewees will be asked to keep the content of their answers as free of information that would allow one to ascertain the identity of any of their patients as possible. They will be assured that if something in this regard were to be mentioned, that the researcher will guarantee the patient's anonymity in all material beyond the interview and the interview recording itself.

One

(a) Can you describe an incident, or a number of incidents, of your own personal experience as a psychotherapist in which your own feelings were particularly strong?

[(b) Prompts on disclosed content]

(c) How did the situation resolve itself?

(d) How did you make sense of your experience?

(e) What did you discover about yourself?

Two

(a) Have you had an incident, or number of incidents, where your own feelings were of a positive/negative *[whichever type was not mentioned in answer to question one]* nature?

(b) Can you describe the incident(s) for me?

(c) How did this situation resolve itself?

(d) How did you make sense of your experience?

(e) What did you discover about yourself?

Three

(a) Have you had any experiences where you realized that you acted out your personal feelings in the therapy?

(b) Can you describe the experience(s) for me?

(c) How did this situation resolve itself?

(d) How did you make sense of your experience?

(e) What did you discover about yourself?

Four

(a) Have you had any experiences when you were unsure as to the origin of your thoughts and/or feelings, in other words whether they were your own or your patient's?

(b) Can you describe the experiences(s) for me?

(c) How did this situation resolve itself?

(d) How did you make sense of your experience?

(e) What did you discover about yourself?

Five

(a) Can you recall an incident, or more than one incident, in which you identified with a patient (or someone in your patient's life) to a degree that warrants the recall of that patient now?

(b) Can you tell me more about this incident/therapy?

(c) How did this situation resolve itself?

(d) How did you make sense of your experience?

(e) What did you discover about yourself?

Six

(a) Can you recall an incident, or more than one incident, in which you felt so attuned to the patient that you were unable to think about the patient as clearly as is usually possible?

(b) Can you describe the incident(s) for me?

(c) How did this situation resolve itself?

(d) How did you make sense of your experience?

(e) What did you discover about yourself?

Seven

Is there an additional countertransference-type experience beyond those mentioned that comes to mind?

(b) Can you describe the experience for me?

(c) How did this situation resolve itself?

(d) How did you make sense of your experience?

(e) What did you discover about yourself?

Eight

(a) If you had to reflect on all the experiences you've mentioned, is there some collective sense or theme of self-discovery that you can see in them?

(b) Can you describe how you came to this understanding?

Nine

(a) How have the experiences of which we have been speaking affected you in your development as a psychotherapist?

(b) Can you tell me more?

Ten

(a) As you developed as a psychotherapist, did your understanding of countertransference change?

(b) Can you tell me more?

Eleven

Have any of the experiences you have mentioned affected the way in which you view or understand the space or boundaries between yourself and your patient?

Twelve

How do you feel that the experiences you've mentioned have affected how you perceive yourself in your professional capacity?

Thirteen

(a)Was there any particular theory, training experience or advice that aided you in making sense of the experiences you have described?

(b) Was there any particular theory, training experience or advice that aided you in discovering more about yourself with respect to the experiences you have described?

The researcher will invite the interviewee to talk about anything she feels is important but was not discussed. The researcher will ask the interviewee what the interview was like for her and what her perspective may be on the researcher's influence upon all discussed. The interviewee will be encouraged to contact the researcher should any thoughts on further considerations or the researcher's influence arise. Following any discussion, the researcher will thank the psychotherapist for her time. This short conversation will conclude the interview.

Appendix C

Informed consent for participation

UNIVERSITY
OF THE
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JOHANNESBURG

School of Human and Community Development

Private Bag 3, Wits 2050, Johannesburg, South Africa

Tel: (011) 717-4500 Fax: (011) 717-4559

Email: 018lucy@muse.wits.ac.za

I _____consent to being interviewed by Robert Peers from the University of the Witwatersrand for his study on countertransference dilemmas and professional identity formation. I understand that:

(a) My participation in this interview is voluntary.

(b) I may refuse to answer any questions I would prefer not to.

(c) I may withdraw from the study at any time.

(d) No information that may identify me or any of my patients will be included in the research report.

(e) My identity, and that of any of my patients, will remain confidential to everyone but the researcher himself.

(f) Potential risks include the possibility of psychological distress.

(g) There are no potential benefits to participating in the research project.

(h) I may be directly quoted in the final research report.

Signed _____ Date_____

Appendix D

Informed consent for recording

UNIVERSITY
OF THE
WITWATERSRAND,
JOHANNESBURG

School of Human and Community Development

Private Bag 3, Wits 2050, Johannesburg, South Africa

Tel: (011) 717-4500 Fax: (011) 717-4559

Email: 018lucy@muse.wits.ac.za

I _____ consent to the audio recording of my interview with Robert Peers from the University of the Witwatersrand for his study on countertransference dilemmas and professional identity formation. I understand that:

(a) The tape content will not be heard by any person other than the researcher himself.
(b) The transcription of the tape content to a written format will be done by the researcher alone.
(c) The transcribed material will contain no identifying information of any of the participants or their patients.
(d) The anonymous transcribed material will be seen by the researcher's supervisor and parts thereof may be used in the final research report and/or any possible publication of the project.
(e) All audio recordings will be securely kept by the researcher for a period of six years after the research is completed (a professional requirement).
(f) No identifying information will be used in the final research report or any subsequent publications.
(g) This form will be kept by the researcher in a secure location and will only ever be seen by anyone other than the researcher on dispute of permission for consent in the recording of this interview.

Signed _____ Date_____

Appendix E

Ethics permission form[8]

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

HUMAN RESEARCH ETHICS COMMITTEE (SCHOOL OF HUMAN & COMMUNITY DEVELOPMENT

CLEARANCE CERTIFICATE	**PROTOCOL NUMBER: MCLIN/11/006 III**
PROJECT TITLE:	Beginning psychotherapists' experiences of countertransference dilemmas: An analysis of the sense-making and self-discovery involved in their resolution.
INVESTIGATORS	Peers Robert Erik
DEPARTMENT	Psychology
DATE CONSIDERED	23/03/11
DECISION OF COMMITTEE*	Approved

This ethical clearance is valid for 2 years and may be renewed upon application

DATE: 27 May 2011

CHAIRPERSON
(Professor M. Lucas)

cc Supervisor:

Prof C. Long
Psychology

DECLARATION OF INVESTIGATOR (S)

To be completed in duplicate and **one copy** returned to the Secretary, Room 100015, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure be contemplated from the research procedure, as approved, I/we undertake to submit a revised protocol to the Committee.

This ethical clearance will expire on 31 December 2013

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

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[8] The research project's title was changed and approved by the Faculty of Humanities after ethics clearance was obtained.