

# **Integrative Therapists' clinical experiences of personal blind spots: An Interpretative phenomenological analysis.**

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## **Abstract**

This study uses Interpretative Phenomenological Analysis to explore integrative psychotherapists' lived experience of recognising a personal blind spot in their therapeutic work. The five female participants aged between 42-60 years have between two and twenty years clinical experience. Each participant was interviewed on two separate occasions, with a period of one month between interviews. The inductive approach of IPA sought to capture the richness and complexity of participants' lived emotional experiences. Given the methodological challenges uncovering the implicit domain of participants' blind spots, researcher reflexivity served as a secondary but integral data source and provided the experiential context from which meaningful findings emerged.

Three superordinate themes and seven subthemes emerged from the interviews: Feeling under pressure, Facing a Blind Spot and finding the missing piece, and Holding my own. Theme one explores participants' loss of self-awareness when personal vulnerabilities are triggered by client work. It also describes maladaptive coping skills such as avoidance, employed to cope with feelings of vulnerability and shame. Theme two describes the process of facing a personal blind spot where participants recognise the impact of their personal needs and history on their therapeutic work. Theme three describes how self-compassion helps participants develop an expanded sense of self-awareness and capacity to be emotionally responsive to their clients despite their personal difficulties. The findings suggest that when shame is hidden and unacknowledged, it impacts on therapists' ability to be emotionally responsive to their clients' concerns. Furthermore, unacknowledged shame is a primary cause of therapeutic ruptures in their clinical work. The study recommends that continued research be undertaken into resilience towards shame in order to prepare and protect therapists against the normative force of subjective negative self-appraisal when they experience feelings of incompetence in their therapeutic work. Some aspects of these findings can be found in previous research on countertransference with participants of varying experience and varying therapeutic modalities. Given the centrality of the therapeutic relationship as a vehicle for successful therapeutic outcome, research that furthers our understanding of therapist emotional resilience and personal efficacy can help guide training and supervision.

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**A note on terminology:** The term 'therapist' as used throughout the study refers to counselling psychologists, psychotherapists and psychoanalysts. Terms such as 'client' and 'patient' are used interchangeably except when a particular discourse denotes the specific use of a term (i.e. psychoanalysis).

# Chapter 1

The aim of this study is to explore integrative psychotherapists' experiences of recognising a personal blind spot through their therapeutic work. It seeks to understand how therapists' limitations and vulnerabilities impact on their ability to be emotionally present and responsive in their clinical work. It also seeks to explore the transformative effect of recognising a blind spot and the impact it has on them personally and professionally.

## 1.1 Introduction

I have always enjoyed reading therapy books describing how other therapists' work, particularly the clinical vignettes and case histories describing the ups and downs of their therapeutic practice. There is always something new to learn! One of the harder parts of being a therapist is feeling repeatedly distorted and misunderstood in the service of the client's needs to process negative intense feelings (Casement, 1990; McWilliams, 2013). Perhaps even more challenging is learning that there is sometimes a large grain of truth when clients point out our blind spots to us. When I read and hear about therapists' accounts of personal therapy, I am struck by how many of them have learned from their therapist what *not* to do. Psychoanalyst, Nancy McWilliams reminds us that these lessons are also an important source of professional knowledge. Furthermore, given the amount of time, money, energy and hope we all bring to therapy, these hard won lessons require the strength to face loss and disappointment with honesty (McWilliams, 2013, p. 625). This is essential so that we can keep our minds and heart open to our clients' suffering as we accompany them on their journey to find meaning and hope.

A vital part of therapeutic presence is a therapist's ability to be fully in the moment on a multitude of levels, physically, emotionally, cognitively, spiritually and relationally (Geller & Greenberg, 2002, 2012). Often this requires an ability to tolerate intense affect and move outside one's comfort zone (Bridges, 2005). Foremost here is the therapist's capacity for non-defensive reflection that can offer opportunities for new



insights and greater intimacy through negotiation of misunderstandings (Mitchell, 1988). This can be particularly challenging when a therapist's personal vulnerabilities or sensitivities are triggered by her client's struggles. Inevitably therapists can feel pulled back into maladaptive patterns of coping, they thought they had long outgrown. How do therapists experience the personal sense of risk, exposure and vulnerability during these moments? I introduce my study exploring therapist blind spots by offering a personal practice-based illustration of how the defensive strategies of both therapist and client become manifest in a therapeutic relationship. The story is conveyed in the present tense in order to convey the intensity and complexity of the experience. The vignette also creates a bridge from my experience of practice-based learning into this research-based thesis.

*The client is a student therapist who has embarked on a second chapter of therapy to support her personal development while in training and beyond. Over a period of six months there is an uneasy fit between the therapist and client that is apparent to both. The therapist is concerned and tries to understand. For the client, there is something about the pace and the sense of rhythm that 'jars' and she struggles to find a form of words that won't offend her therapist. What she really wants to tell her therapist is that she feels frustrated; there is too much interpretation and not enough space to share thoughts and feelings in a way that builds trust between them. She explains to her therapist that she feels the work is 'moving too fast' and that she would like things to 'slow down a little'. She tries to 'help' her therapist by offering her own interpretation - she is an introvert and maybe the therapist is an extrovert as she's got lots to say. She also adds that she wishes she could think on her feet. She thinks this might 'soften the blow'. Although this feels incongruent and uncomfortable, for some reason, it seems necessary. Her therapist inquires if she feels envious of her ability to think on her feet. The client is dumbfounded yet she also knows that she has not been candid with her therapist. She feels embarrassed and guilty and she wants to avoid a difficult encounter.*

*At the next session, the client tells her therapist that the therapy is not working between them and that she would like this to be their final session. The therapist is upset and tries to persuade her to wait a month reminding her that this is not a*

*professional or respectful way to end their work together. The client is aware that she is transgressing normal professional protocols that are there to protect the work, however she also knows that any fragile sense of trust between them has now been broken. Her therapist's reaction has provided her with the information she needs. It's time to leave! The sense of personal exposure and embarrassment in the room is palpable. The client has not been able to share her struggles with candour. She also knows she has 'broken the rules' around working towards endings that have been discussed during her training. Her therapist is hurt and angry. This is apparent in the way she confronts her client, 'Is this the way you leave all your relationships?' There is nothing to say - a deafening silence hangs between them. The client asks the therapist if she wants her to leave. The therapist replies 'yes'. The client puts the fee on the table and walks out. She feels free.*

*In the aftermath that follows the client tries to make sense of her experience. It is one that she finds difficult to put into words. It seems as if shame clouds her ability to think. Much later, she recognises her experience in the words of Donald Winnicott (1896-1971), British paediatrician and psychoanalyst:*

*'It is a joy to be hidden but a disaster not to be found' (Winnicott, 1965).*

This is my account of an experience of a rupture that occurred with my therapist over fourteen years ago. The personal and professional ramifications of this rupture provided valuable learning for me and continue to influence my development as a psychotherapist. This is explored in a reflexivity section at the end of the chapter.

How can we begin to make sense of the complex emotional entanglements when both the therapist's blind spot and the client's wound lead to an impasse or a therapeutic rupture? Why might it feel necessary for a client to *protect* her therapist by trying to flatter her despite legitimate feelings of frustration and discontent? According to Miller (1997) children who are highly sensitive to their caregiver's emotional needs often experience their own painful reactions to parental misattunements as treacherous and a defective failure in respect of their sense of selfhood. Such early developmental experiences can leave their mark as a

propensity for shame when their own needs and longings come to the fore. The experience of shame can leave one feeling as if there is something to be ashamed about and one feels compelled to hide (Kelly, 2012). In the process of trying to navigate a sense of confusion and loss, a disjunctive accommodation is reached between the desire to be invisible and the longing to be seen.

Also for the therapist, there is inevitably an element of emotional bruising during these difficult interpersonal transactions. Unexamined negative emotional reactions can lead to feelings of incompetence or inadequacy that arise from process issues in the therapeutic relationship or when the therapist's personal wounds become triggered (Thiériault & Gazzola, 2006, p. 324). Many terms have been used to describe these moments including transference-countertransference enactments, empathic failures, and misunderstandings.

Although moments of interpersonal tension between patient and therapist are almost inevitable in therapy, they are regarded not as obstacles but opportunities for therapeutic change (Safran & Kraus, 2014). Indeed Rousmaniere (2014, p. 89) describes how disagreements are so predictably common in therapy, entire research programs and models of therapy of therapy focus on navigating therapeutic ruptures (e.g., control mastery therapy, Weiss, 1993; alliance- focused training, Eubanks-Carter, Muran & Safran, 2015). A useful way of conceptualising a problem before it has been brought into full awareness is that of a *therapeutic rupture* (Safran & Muran, 1996). Safran and Muran define therapeutic ruptures as, 'patient behaviours or communications that are interpersonal markers indicating critical points in therapy for exploration' (Safran & Muran, 1996, p. 447). These transactions are broadly classified as either *withdrawal* ruptures or *confrontation* ruptures – each with its own characteristic patterns and resolution. Both patterns are evident in the rupture I describe with my therapist in the clinical vignette. In a withdrawal rupture patients tend to deal with difficulties and misunderstandings in the therapeutic alliance by becoming overly compliant to the therapist's recommendations, falling silent, or suddenly changing topic to an unrelated matter. By contrast, in a confrontation rupture the patient (or therapist) may directly express anger, resentment or unhappiness with some aspect of the treatment, often in a demanding or blaming way (Safran & Kraus, 2014, p. 382). Whatever the behaviour manifests as withdrawal

or confrontation, the therapist's ability to detect and work constructively with alliance ruptures and negative therapeutic process has become a focus of clinical attention and on-going research (Safran & Muran, 1996; Safran et al, 2005).

In terms of our understanding of the processes and mechanisms that underlie the therapeutic relationship, contemporary thinking and research suggest that the relationship between a therapist and her patient is co-constructed, existing within a shared intersubjective field of reciprocal mutual influence (Orange, Atwood & Stolorow, 1997). There is a heightened interest in the therapist's ability to negotiate the alliance in general and therapeutic impasses in particular (Safran & Muran, 2000). Indeed Safran and Muran (2000) suggest that much of the therapist's success involves their 'inner growth' when they take responsibility for their part in misunderstandings and ruptures in the therapeutic relationship.

Still the problem remains, as argued by Rizq (2005), that therapists have difficulty thinking about how their most vulnerable and subjective parts come to be sought out and explored by clients. One reason may be that these parts will often be 'blind spots' or 'no-go' areas for therapists that exist at the periphery of consciousness and are not yet available to reflective thought or verbalisation (Merleau- Ponty, 2003). Various schools of thought in the fields of psychoanalysis, cognitive science and infant research refer to this ground of experience in terms such as: 'implicit relational knowing', 'unformulated experience', 'embodied knowing', 'horizons of experience', 'subsymbolic process' and 'the unthought known' (Preston, 2008, p. 347). Each of these concepts provides a perspective on this vital domain of experience.

In the current study, 'Blind spot' is a dynamic concept that may be said to refer to conscious or unconscious biases or vulnerabilities that compromise therapists' ability to maintain a therapeutic stance with their clients. An important aspect of therapist personal and professional development is learning to recognise when she feels 'triggered' so feelings can be managed or used as a source of insight to further the therapeutic work (Gelso & Hayes, 2002). This sounds fine in theory however therapists have reactions to their clients that register at both a conscious and unconscious level. There is also the question of degrees of self-awareness and what one is willing or indeed able to know about oneself. Although the unconscious nature

of blind spots (at least partially) makes them elusive and difficult to grasp, it is vital that therapists are open to exploring them. As Marie Adams (2009, p. 49) points out, 'sometimes we may be able to recognise the signs that things beyond our grasp are at work'.

Furthermore, argues Adams:

'It is our recognition of this that may determine our worth as therapists with those patients who speak so profoundly to the unresolved and unknown aspects of ourselves' (Adams, 2009, p. 49).

An important starting point for therapists is recognising what they bring into their relationships with their clients in terms of their personality, strengths and limitations and how these various elements have influenced their motivations for entering the profession. According to Sussman: 'These are what have brought the therapist into the relationship with the patient, and they will inevitably shape all subsequent interventions' (Sussman, 2007. p. 7).

There is an on-going literature that explores the complex motivations and particular sensitivities that lead therapists to become therapists. Psychoanalyst Alice Miller (1997) draws on her numerous analyses of analytic candidates, which she either conducted or supervised, to suggest that the therapist's 'powerful antennae,' acute sensitivity and empathy indicate a childhood of putting the needs of others first as indicative of a narcissistic injury that leads to development of a 'false self'. She warns that therapists need to acknowledge their own needs and what they have sacrificed in terms of their 'true self' in order to practice psychotherapy in a way that is not compelled by their unconscious need for gratification and love. Sussman (2007) questions the naïve illusion that therapists' motivations to become therapists are based on the purely altruistic wish to understand and help others. Furthermore, according to Sussman, such a stance is dangerous and anti-therapeutic:

'It is only when the practitioner's unconscious motivations are discovered and understood that their destructive potential can be held in check' (Sussman, 2007, p. 4).

Sussman also warns of the danger of professional 'burnout' for therapists when underlying motives remain unexplored. For those reluctant to consider the 'shadow side' of their seemingly 'pure' intentions, Jungian analyst Guggenbühl-Craig underlines the danger of uncritical self-regard:

'But there is a great danger that the more the case worker pretends to himself that he is operating from purely selfless motives, the more influential his power shadow will become until it betrays him into making some very questionable decisions' (Guggenbühl-Craig, 1971, p.11).

Adams (2014, p.14) argues that the notion of pure and impure motives reduces our internal complexity to 'good and bad'. This kind of binary thinking polarises experience where people tend to react defensively and opportunities for critical reflection and transformation are lost. An interesting observation by Bager-Charleson is that often when therapists describe going to personal therapy as a result of a 'crisis' in their adult life, they regard the 'crisis' in a positive sense, like an 'eye-opener' or transformative experience that has inspired them to train in psychotherapy (Bager-Charleson, 2012, p. 22).

Unfortunately, there is also a tendency towards binary thinking about therapists in the wider culture. Many portrayals of therapists on English-speaking television shows have historically been of the unrealistically skilled and humorously incompetent (Von Sydow & Reimer, 1998). On the one hand therapists are depicted as self-obsessed and neurotic (e.g. Frasier; Wanderlust) or behaving in an unethical manner talking about their clients outside the session or even having sex with them (The Sopranos; In Treatment). At the other extreme therapists are represented as having an almost 'magical' ability to read people and solve complex cases very quickly, often by helping the client to recover traumatic memory (Gabbard, 2001). These stereotypes may account for the various reactions of fascination, apprehension and bewilderment I sometimes encounter socially, when I tell people that I work as a psychotherapist. Notwithstanding the above, more than a few students have told me that they were inspired by the TV character 'Cracker' to enter the field of psychology. Cracker is a classic antihero: alcoholic, foul-mouthed, manic, obese, addicted to gambling and yet an absolute genius in his speciality: criminal psychology.

Even within the profession, stereotypes abound ranging from the notion of the 'sorted' therapist to therapist as 'wounded healer'. Historically the primary aim of personal therapy throughout training was *resolution* of the therapist's issues (Freud, 1937/1964), perhaps leading to the unrealistic expectation of the 'sorted' therapist. This notion has negative implications in terms of power dynamics where the patient is positioned as the one carrying all the problems and the analyst carrying all the knowledge and power to 'fix' their patients. Guggenbühl-Craig (1971) has expounded eloquently on the problems that arise when the therapist or doctor feels himself to be the archetypal strong healer while repressing any sense of personal vulnerability, illness or woundedness:

'He develops into a physician without wounds and can no longer constellate the healing factor in his patients. He becomes only-a-doctor and his patients are only-patients. It is no longer the wounded healer who confronts the ill and constellates their inner healing factor' (Guggenbühl- Craig, 1971, p. 92).

The original concept of the 'the wounded healer' refers to a person whose personal experience of illness or trauma has left a legacy in the forms of lessons learnt that later serve her in ministering to other sufferers (Jackson, 2001). Others have put more emphasis on the therapist as 'wounded healer', with *on-going* emotional struggles that are addressed through reflection and supervision, as the therapist progresses on their journey towards integration (Aponte, 1994; Martin, 2011; Sedgwick, 1994). Given that 'culture saturates subjective experience' (Dimen, 2011, p. 4), it is important that therapists pay explicit attention to the impact of both the expectations and responsibilities they take on in their role as therapists (both real and imagined) as well as the extent to which their own needs and histories influence their therapeutic work throughout their professional lives. The 'truth' according to Adams, is that therapists, like their patients may need to revisit earlier trauma throughout their life as different chapters in their life bring new elements to the fore (Adams. 2014, p. 11). What seems more important is the therapist's stance towards their wounds and limitations. Cozolino maintains a realistic and hopeful stance

'A good therapist is not perfect but simply a person dedicated to on-going self-discovery and lifelong learning. We continue to live and grow within and through our limitations' (Cozolino, 2004, p. 7).

### **1.1 The person of the therapist.**

It has long been recognised that neither years of professional training, discipline or years of experience can consistently predict psychotherapy process and outcome (Beutler et al., 2004; Goldberg, Rousmaniere et al., 2016). Much more relevant are therapists' personal and interpersonal qualities, facilitative interpersonal skills (Anderson et al, 2009; Wampold & Imel, 2015), and their capacity to be emotionally responsive, empathic and genuine in their work with a diverse range of clients (Bohart, Elliot, Watson & Greenberg 2011; Lambert, 2013). Another important skill is therapists' ability to manage their countertransference reactions (Hayes, Gelso, & Hummel, 2011) as well as tensions and relationship ruptures with clients (Safran, Muran & Eubanks-Carter, 2011). It is likely that these therapeutic qualities and relationship skills enable therapists to embody the treatment in a way that may explain why the manner in which a treatment is delivered is more significant to therapeutic outcomes than the treatment offered (Wampold & Imel, 2015). Given this background, there is a lack of research exploring how aspects of professional and personal characteristics interact in contributing towards professional growth and development in therapists.

### **1.2 Statement of the problem**

The development of the person of the therapist is one of the most potent but neglected variables in psychotherapy research (Crits-Christoph & Mintz 1991). There is a lack of understanding about how therapists' personal and professional functioning may impact professional role performance. Yet research shows that the quality of personal relatedness is a key factor in either strengthening or limiting the impact of therapeutic procedures (Orlinsky & Rønnestad, 2005). There is a need for more understanding about how therapists live and grow within and through their



personal limitations with their clients. The findings might illuminate what Elkind (1992) sees as a major challenge facing the profession of psychotherapy, namely, 'finding constructive ways of including the vulnerabilities of psychotherapists, without discrediting their capacity to help patients' (p.3).

Psychoanalyst, Darlene Ehrenberg offers a relational perspective on blind spots, highlighting the therapist's responsibility to consider them:

'There are ways in which we permit or preclude certain kinds of emotional contact with our patients, and this is something that must be addressed explicitly, because this often defines the level of analytic work that will be possible' (Ehrenberg, 1996, p. 276).

Maroda gets closer to asking the thorny question,

'How do therapists know when they are primarily meeting their own needs and when they are primarily meeting their clients' needs, and how much do these two sets overlap?' (Maroda, 2007).

These are not questions that can be easily answered. However opening this area for deeper enquiry is necessary so that we can understand processes that both facilitate and undermine therapists' ability to be emotionally responsive to their clients' distress.

### **1.3 Reflexive exploration in qualitative research.**

An important undertaking in any piece of qualitative research is reflecting on one's motives for doing the research. Postmodernism challenges the notion of the psychological researcher as a neutral, passive and objective observer of phenomena (Gergen, 2001). Qualitative researchers increasingly recognise the importance of acknowledging how researcher subjectivity contributes to the construction of the material gathered and interpretations that emerge (Goldstein, 2017). Indeed some degree of self-reflection is needed to establish procedural integrity (Morrow, 2005) and adds to the trustworthiness of the research (Yardley, 2000; Willig, 2013).

Reflexivity means more than acknowledging personal 'biases'; reflexivity encourages us to reflect on how our reactions to the research context and the data actually make possible certain understandings (Willig, 2013). It also involves acknowledging how the research has impacted or even transformed us as people and researchers. Willig suggests that reflexivity in qualitative research might be analogous to how psychoanalytic psychotherapists use 'countertransference' - the therapist's emotional response to the client's behaviour- in order to gain a better understanding of the client (Willig, 2013, p. 25).

Although it is considered good practice to think critically on how one's personal biases and agendas are likely to influence the findings, identifying these processes, especially those that are not readily conscious, presents a challenge that is difficult to resolve (Bishop & Shepherd, 2011; Finlay, 2002). Furthermore many question how reflexivity is practiced and challenge the extent to which it benefits the research (Finlay, 2002; Probst & Berenson, 2014). Although reflexive procedures are generally incorporated into qualitative research, some qualitative researchers highlight the potential for ethical problems when researchers use reflexivity as a means to claim objectivity while failing to acknowledge the difference between observer interpretations and the actual experience of those being observed (Bishop & Shepherd, 2011; Finlay, 2002). Indeed Goldstein (2017) emphasises how engaging reflexivity to identify and isolate researcher biases in an attempt to neutralise their potential impact (a practice known as bracketing), may run counter to the epistemological principles that underpin qualitative endeavours (Morrow, 2005; Ortlipp, 2008).

Despite these concerns, reflexive procedures are often incorporated in an effort to achieve the impossible task of separating the researcher from the data (Bishop & Shepherd, 2011) which could suggest an inadvertent adherence to a positivist paradigm in which sterilized results are perceived as more accurate' (Goldstein, 2017, p. 150) and given the impossibility of managing or controlling researcher bias, perhaps a more interesting question is how reflexivity can add more understanding about the phenomena of interest than what it takes away.

In addition to personal reflexivity, qualitative research also stresses the importance of epistemological reflexivity. Willig describes how epistemological reflexivity invites us to consider a number of important questions:

‘How the research questions defined and limited what can be ‘found’? How have the design of the study and the method of analysis ‘constructed’ the data and findings? How could the research question have been investigated differently? To what extent might this give rise to a different understanding of the phenomenon under investigation?’ (Willig, 2013, p. 10)

While qualitative researchers differ in the emphasis they place upon reflexivity in their research, this study employed reflexivity as a tool throughout the research process. I believe that sustained reflexivity must be integral to a study that proposes to illuminate participants’ blind spots. By making my process as transparent as possible, the reader is able to observe my biases and to assess how I arrive at my interpretations (results). This process is documented throughout each stage of the study in a reflexive account. For clarity it is presented in demarcated sections at the end of each chapter.

#### **1.4 Why I ask the question.**

My personal history and experiences in therapy have contributed to my sense that exploring the origins of psychological conflicts, including problematic relational patterns that lead to ruptures or stalemates in the therapeutic relationship, is a significant component of psychotherapy. I align myself with contemporary relational perspectives that emphasize psychotherapy as a shared interpersonal exploration in which two subjectivities merge and exert mutual influence (Atwood & Stolorow, 2014) rather than as a “one way street” (Benjamin, 2004, p. 6). Within this theoretical experiential context, it seems important to me to be as transparent as possible about my experiences of personal blind spots and the extent to which I engage with them *or not* throughout the process of this study. Shaw succinctly describes my stance:

'By engaging in reflexivity, that is, proactively exploring our *self* at the start of our research inquiry, we can enter into a dialogue with participants and use each participant's presentation of self to help revise our fore-understanding and come to make sense of the phenomenon anew' (Shaw, 2010, p. 235).

The rupture with my therapist described at the beginning of this chapter situates my interest in exploring therapists' experiences of personal blind spots in their clinical work. My reflections on the drama that unfolded between us strengthened my understanding about how some clients come slowly into relationships and need to experience a sense of mutuality and trust before letting their guard down. It's possible that because I was a 'mature' student therapist who had already experienced a chapter of therapy, my therapist expected a higher degree of openness and readiness to engage with the therapy from the start. With hindsight, I see how I may have also projected these assumptions onto her. The truth is that my belief that I 'should be more sorted' made it difficult for me to talk about wounds that she recognised in me, vulnerabilities that I had not fully acknowledged and which had only come to the fore as I faced a new chapter in my life. This was why I needed to 'slow down'. I struggled to reconcile myself with a sense of shame that was difficult to articulate. I suspect my therapist recognised this however she needed to earn my trust.

What jarred with me most was how she hid behind Kleinian theory with a look of concern as she offered her interpretations. I experienced her behaviour as both defensive and intrusive. At the same time, I could see she was well intentioned and felt slightly protective of her. The personal conflict I experienced around trying to express my needs while looking after hers reflected a history of self-reliance where I was used to occupying the role of a 'caretaker' from a young age in a large family. It feels sad to recall the avoidant and deceptive ways I tried to hide my dissatisfaction with her style of working. In trying to protect her from my truth, I hurt us both in the end.

On a professional level, I am now more able to recognise defensive, self-protective coping strategies that therapists and their clients can fall into when feelings of shame

get triggered in their therapeutic work. I have learned how to listen with purpose for the subtle and nuanced communications that point to deeper wounds in both therapist and client. This has enhanced my work as a therapist and supervisor.

I have also learnt to question the expectations I put upon myself in my work as a psychotherapist. A tendency towards being over-responsible for the care of others was born of a catholic upbringing in sixties and seventies Ireland, where the female role was one of service to others. A convent education reinforced by messages from the wider culture upheld self-denial and self-sacrifice as values to uphold. Although I am conscious of it, this desire 'to help' can put me too much in confluence with the suffering of others. When in the grip of it, I have noticed a pull to 'rescue' people from difficult feelings rather than allow space for the feelings to borne and processed. This can manifest in avoidance of exploring painful feelings and a pull towards giving advice. Reflecting on these processes, I am reminded how 'taking responsibility' in its crudest form can default to the 'controlling caregiving' strategies of the parentified child (Liotti, 2011). Left unacknowledged, these needs can play out in collusions, idealisations and impasses in my clinical work. An important personal insight involved understanding how well intentioned motives obscured unfulfilled longings and losses from my past. This learning has enabled me to respond to clients from a more secure place based on self-compassion and humility where I can acknowledge my vulnerabilities and use them in service of my work:

'I have that quality of attention so that I may be with you, alongside you, empathizing with you: and yet not losing myself in confluence with you because the dialogue between us both bridges and preserves our differences' (Reason, 1988, p. 219).

The objective of this research study is to promote awareness so that therapists can recognise how sometimes their own needs to influence their clinical work obstruct the work despite their best intentions. I hope this will enable therapists to respond more quickly and honestly when their perceptive clients see their blind spots more clearly than they do themselves.

## Chapter 2

### Literature Review

The aim of this review is to critically explore literature that illuminates how therapists' blind spots and vulnerabilities manifest in their therapeutic work. It also explores some of the methodological challenges involved in examining a domain of experience that can only be apprehended indirectly due to its implicit nature. Given the pre-eminence of the therapeutic relationship within Counselling Psychology, a relationship valued above any one theoretical model or doctrine, I will draw on literature consonant with a relational integrative framework from a range of disciplines within psychology including, social psychology, developmental psychology, and relational psychotherapy. I aspire to offer a readable synthesis that is useful to clinicians and fellow researchers.

**2.1** In the first section of this chapter I offer an integrative conceptualisation of therapist blind spots by exploring them through the lens of narcissistic vulnerability. This is followed by a discussion on countertransference, a trans-theoretical concept that is intrinsically linked to the concept of therapist blind spots. Some of the debates and challenges conceptualising this ambiguous phenomenon are reviewed. Next, I consider research developments in attachment and affective neuroscience that highlight the importance of exploring the implicit domain. The following section evaluates the contribution of both qualitative and quantitative research while highlighting the methodological difficulties involved in researching implicit processes that exist at the periphery of consciousness (Merleau-Ponty, 2003). In the final section of this chapter, I offer my rationale for the current study by identifying the research gap this study hopes to fill, and what it may contribute to the field of therapist development, training and Counselling Psychology. I conclude the chapter with my personal reflections on the project.

I concur with Danielian and Gianotti (2012) that everyone struggles to overcome or compensate for some degree of injury to the self and that 'none of us is immune from areas of vulnerability that colour our ability to be completely objective or neutral' (p.21). As a phenomenon, they suggest that narcissistic vulnerability refers to a spectrum of narcissistic injury that occurs in all levels of personality functioning and people. Accordingly, narcissistic injury is a dynamic concept best viewed on a continuum:

'Variations along the continuum of narcissistic injury range from minor wounds that don't appear to compromise much of the personality, all the way to major injuries that result in more rigidified attempts to compensate for and recover from more severe degrees of trauma or deprivation' (Danielian & Gianotti, 2012, p. 21).

Thus, all persons carry within them a wound or psychological issue that is core to their experience of vulnerability, influencing their ability to regulate their emotions. Given the role of shame in a wide range of mental health issues including self-esteem issues, depression, anxiety, addiction and eating disorders (Dearing, Stuewig, & Tangney; Nathanson, 1997; Tangney & Dearing, 2002), it is crucial that therapists acknowledge their personal vulnerabilities and learn to master the influence of maladaptive or defensive coping strategies so that they can relate more effectively to their clients (Aponte & Kissil, 2012, p. 4).

The therapeutic alliance literature testifies to the extent that the personality and the vulnerabilities of individual therapists are implicated in therapeutic disjunctions such as ruptures, stalemates and collusions (Safran & Muran, 2000). Arguably these intersubjective contexts arise when client material interacts with the therapist's unresolved issues and blind spots. Indeed Elkind (1992) concluded that many impasses are the results of primary (developmental) vulnerabilities on the part of both the therapist and client, reflecting the power of disjunctions to touch core aspects of self-experience.

There is a large body of literature devoted to helping therapists make sense of their vulnerability in order to generate insight into patient issues and to plan future interventions. Within the Humanistic therapies, terms such as personal or dialogic resonance, congruence and incongruence are used to illuminate how client material interacts with a therapist's subjectivity (Mearns & Schmid, 2006). Within the psychoanalytic literature, terms such as projective identification (Klein, 1997) and transference and countertransference (Freud, 1910) are tools of the trade. While much of this literature focuses on the impact of the client on the therapist's subjectivity, not enough explicit attention is given to the impact of the *therapist's* blind spots on therapeutic process and how therapists reflect on the vicissitudes of their emotional experiences when their personal issues become triggered.

## **2.2 An integrative approach to understanding how blind spots manifest in relationships**

Recent developments integrating theory from neuroscience, child development and psychoanalysis highlight the value of an interdisciplinary focus on the mind, the brain and human relationships (Siegel, 2010; Schore, 2012). Schore's neuro-psychoanalytic contributions emphasize the intersubjective nature of mutual affect regulation between therapist and patient and the primacy of affective processes that lie at the core of the implicit self. Here, Stern's schema of 'ways-of-being-with' is a neuropsychologically valid model of the representation of interpersonal experience (Stern, 2004) informing transference phenomena. In the broader field of social cognition, research offers strong evidence that mental processes are relatively automatic and implicit and that meaning is made on the spot as people try to make sense of their current experience (Miranda & Anderson, 2010).

Within psychotherapy, transference refers to the ways in which the patient's experiences in relationship to the therapist are influenced by early childhood experiences, especially those with one's parents (Holmes & Lindley, 1998). The role of expectation involved in transference is analogous to how we deal with the blind spot where the optic nerve exits the eye (Solms & Turnbull, 2003). Despite the 'gap' in the visual field, we fill in the hole based on what we *expect* to see in a way that



feels natural and familiar. Countertransference on the other hand, comprises therapists' emotional responses to their clients.

### **2.3 Countertransference as a perspective on therapist blind spots.**

#### **Conceptual issues and biases**

The term countertransference is intrinsically linked with the phenomenon of therapist blind spots. Both concepts are evocative but elusive and can cover a multitude of therapist reactions where one's personal biases and conflicts impact on one's ability to understand and empathise with a client. The history of countertransference highlights the professional challenges involved in conceptualising and operationalizing it. It is briefly described here.

Countertransference was originally conceptualised by Freud (1910/1959) to describe the analyst's emotions, complexes and resistances which interfered with their capacity to be neutral with a patient. Freud viewed countertransference as detrimental to therapeutic work, although he believed these limitations could be overcome through further psychoanalysis (Gabbard, 1995). Over the past fifty years, as psychoanalytic theory evolved, countertransference has become a key concept in the field of psychotherapy and debates have ensued about how to understand it and use it to understand the client's problems better (Gabbard, 1995).

Today, there is a convergence of opinion amongst most schools of psychotherapy that countertransference is inevitable and even useful to the extent that it can facilitate the therapist's understanding of interpersonal dynamics in the therapeutic relationship. Despite the various perspectives on the construct, countertransference is considered to be trans-theoretical and to occur across all therapists regardless of theoretical orientation and whether they label it as such (Hayes, 2004). A common view is that it represents the therapist's *total* emotional reaction to the patient, involving contributions from both the therapist's past and what is evoked by the patient (Gabbard, 1995).

Although this view captures the current prevailing consensus that the therapeutic relationship is co-created, there is still a lack of agreement around the extent to

which countertransference is rooted in unresolved conflicts and issues within the therapist or includes therapist emotional responses that are 'natural reactions' to what the patient is pulling for (Winnicott, 1994: Gelso & Hayes, 2007, p. 30). According to Gabbard the relative weight attributed to the client and the therapist's contributions 'is simply a difference in emphasis rather than in substance' (Gabbard, 2001, p. 988). Elsewhere Hayes (2004) argues that the psychodynamic literature does not pay sufficient attention to the influence of therapists' unresolved issues on the therapeutic relationship. Accordingly there is still considerable ambivalence accepting the substantial impact therapist personal factors can have on therapeutic process. The seminal Vanderbilt studies show that therapeutic influence can manifest in subtle ways but with substantial effects where even low levels of disaffiliative process can be detrimental to treatment outcomes (Strupp, 1993).

In a review of the literature, Gelso and Hayes (2002) argue that the 'totalistic' use of the term 'countertransference' to encompass all therapist reactions may render the concept meaningless as it makes countertransference indistinguishable from therapists' reactions in general. While they agree that all therapist reactions are significant both clinically and empirically and therefore worthy of investigation, it is helpful to distinguish the various causes and kinds of therapist reactions, e.g. projective identification (Klein, 1997) and Sandler's (1976) concept of 'role responsiveness' to client reciprocal reactions. Gelso and Hayes propose an alternative integrative conceptualisation labelled the "countertransference interaction hypothesis" in which countertransference is defined as "the therapist's internal or external reactions that are shaped by the therapist's past or present emotional conflicts and vulnerabilities" (Gelso & Hayes, 2007, p. 25). Such reactions are said to be *triggered* by specific attitudes, sentiments, behaviours or attitudes from the patient that touch the therapist's 'blind spots' (i.e. unresolved conflicts or vulnerabilities). This integrative definition clearly locates the therapist's reactions to the client as residing in the therapist and encourages therapists to take responsibility for their reactions and attempt to understand and manage them (Hayes, 2004). In this way, countertransference is seen as a potentially useful phenomenon.

Elsewhere, relational psychoanalyst Lewis Aron (1991) also challenges the lack of attention in the literature to the impact of the therapist's subjectivity. He locates the source of the problem in the concept of countertransference. In a seminal paper titled 'The Patient's Experience of the Analyst's Subjectivity', Aron argues that the term 'countertransference' perpetuates the view that therapists' experiences are always in reaction to their patients as opposed to something that originates from their own subjectivity (Aron, 1991). As such, the concept obscures the impact of the therapist's behaviour on the transference by omitting to include what the patient may perceive about the therapist that the therapist does not know about himself. Furthermore, argues Aron, it is crucial that therapists are genuinely available to accept their patients' experience of them and to explore it with them in a non-defensive way:

'I find that it is critical to ask the question with the genuine belief that I may find out something about myself that I did not previously recognise. Otherwise, it is too easy to dismiss the patient's observations as distortions' (Aron, 1991, p. 37).

This two-person approach is central to a relational sensibility. Implied in this model is an increased vulnerability in the therapist. Alongside the potential for self-exposure and scrutiny by the patient, there is also the pervasive threat of countertransference self-protectiveness (Greenberg, 1991). Much of this has been theorised in the relational literature describing countertransference enactments.

#### **2.4 Therapeutic enactments.**

The term 'enactment' developed out of a two-person psychology and the inevitability of the therapist's intersubjective participation (Mann, 2009). The term is still emergent and developing as a concept and as such is burdened by a multiplicity of meanings. Jacobs (1986) was instrumental in introducing the term as a way of understanding subtle instances of interlocking transference-countertransference dynamics (Gabbard, 1995, p.478). Enactments have become a major focus of clinical attention in the relational and interpersonal schools. Relational psychoanalyst Lewis Aron describes the tension between viewing all therapeutic interaction as a manifestation of unconscious mutual influence where therapeutic process is turned 'into one huge enactment', and seeing enactment as limited to discrete episodic

events (Aron, 2003, p. 623). However a convergence of opinion amongst different approaches is the goal of transforming what has been enacted into an experience that can be symbolically represented in a meaningful way (Bromberg, 2006).

From a relational psychoanalytic perspective, the work of Stern et al (1998) and Lyons-Ruth (1998) has been pivotal in drawing our attention to 'implicit relational knowing'. Drawing on clinical and developmental observations, Stern and colleagues propose that interactional processes from birth onward give rise to a form of procedural knowledge regarding how to be with others. This form of 'knowing' is distinct from the dynamic unconscious and usually exists outside reflective awareness. Such sub-symbolic or implicit memories are phenomenologically communicated through relational patterns, physiological tensions, tone of voice, and undifferentiated affects that can stimulate physiological and affective resonance in the therapist (Erskine, 2015). According to Lyons-Ruth and colleagues from the Boston Process of Change Study Group the construct 'implicit relational knowing' encompasses normal and pathological knowings, integrating affect, fantasy, behavioural, and cognitive dimensions (Boston Change Process Group, 1998). In terms of the therapeutic relationship, the Boston Change Process Group conceptualise the 'real relationship' as the intersubjective field constituted by the intersection of the patient's and the therapist's implicit relational knowing. Here the intersubjective field extends beyond the transference- countertransference domain to encompass authentic personal engagement and reasonably accurate sensings of each person's current 'ways of being with' (Boston Change Process Group, 1998, p. 285). While traditional theory postulates interpretation of transference- countertransference dynamics as the semantic event that helps the patient reframe her understanding, Stern et al (1998) propose interpersonal transactions involving 'now moments' (present moments of truth) and 'moments of meeting' as pivotal to change processes. To clarify further, when 'now moments' are managed by patient and therapist so as to achieve a 'moment of meeting', the implicit relational knowledge of each partner gets altered by creating a new and different intersubjective context between them. This change in the intersubjective field by virtue of the moment of meeting is experienced at an implicit level and does not require verbalisation or narration to be effective and lasting (Stern, 2004).

Alternatively an enactment takes place when emotionally fraught 'now moments' result in misunderstandings and division as opposed to moments of meeting. In conclusion - 'there is a polarisation, a distinct lack of any warm or generative feeling of togetherness, and a sense that the alliance has fallen apart and become painfully disorganised' (Boston Change Process, 2013, p. 737). The relationship has reached an impasse (Elkind, 1992).

More recent theorising emphasises the role of enactments as discrete clinical events. Writers such as Donnel Stern (2003), Bromberg (1998), Davies and Frawley (1994) convincingly relate enactments to dissociative process. This conceptualisation should be distinguished from the on-going enactment that is said to constitute all psychoanalytic process (Aron, 2003). While all therapeutic process is of interest to therapists, including Stern's (2004) dynamic conceptualisation of 'now moments' and 'moments of meeting', arguably the concept of discrete enactment is valuable for exploring dissociative processes in relation to trauma. Trauma is particularly prone to expression through enactment (Mann, 2009). During therapy with traumatised clients, the therapist becomes a witness and in transference-countertransference enactments sometimes even part of the past dramas of the client (Davies & Frawley, 1994).

The relational clinical literature refers to enactments as symbolic interactions between client and therapist, where personal issues of both members of the dyad become unconsciously entwined (Mann & Cunningham, 2009). Relational psychoanalyst James McLaughlin captures well the essence of therapists' struggles to be fully conscious in their clinical work with the following:

'When at work we bumble, stumble, and get lost, we know we are into mixes of not yet knowing (our dumb spots), not being free to know because of acquired biases and preference for theory and technique (our hard spots), or having lost, for reasons of intra-psychic conflict, our hold on what we know or thought we knew (our blind spots)' (McLaughlin 2005, p. 188).

McLaughlin's concept of blind spots as knowledge that was once 'known' or 'lost' can be usefully situated within the clinical literature on enactments. In their aptly titled book, 'The Past in the Present,' Mann and Cunningham (2009) present a range of clinical case histories from different therapeutic modalities, suggesting that enactments occur in all kinds of therapies regardless of the therapist's theoretical orientation. Emphasizing the unconscious nature of mutual influence Mann adopts a view from the wounded healer paradigm suggesting that 'the patient's material finds a place in the therapist's blind spots' (Mann, 2009, p.8). Maroda (1998, p. 520) highlights the affective dimension to how they interlock: 'Enactment is an affectively driven repetition of converging emotional scenarios from the patient's and the analyst's lives'.

Although not drawing on a psychoanalytic conceptualisation, Elkind (1992) concludes that many impasses result from areas of primary (developmental) vulnerability on the part of both therapist and client. She describes the importance of recognising and understanding the mutual impact of these vulnerabilities on each member of the therapeutic dyad in order to prevent the derailment of the therapy. Enactments are often experienced as a crisis in the therapy and are particularly evident with clients who have experienced some kind of trauma in the past. However they also mark a potential turning point, whose outcome can have a benign or malign effect on the therapy (Mann & Cunningham, 2009, p. 1).

From a relational perspective therapeutic enactments provide a therapeutic context for understanding unconscious processes in therapy as they affect *both* participants. In this regard, therapists must recognise that they will be drawn into various roles in the course of therapy and also how their own needs and vulnerabilities might be triggered in their clinical work. This requires a high degree of self-awareness and acceptance about how our unwanted, less savoury parts will be present in our clinical work despite our best intentions. Furthermore managing one's reactions with awareness is work in progress for all therapists throughout their career. As McLaughlin maintains:

'Acknowledging this truth, we can be more ready to see how our needs suffuse all that we are and do in the work and how we must endlessly be self-observing to discipline and optimize these tendencies that are both our strength and our weakness' (McLaughlin, 2005, p. 179).

Gabbard (2001) reminds us that despite the mutual vulnerability of patient and therapist to transference, there is always a power differential and that countertransference optimally should be contained and discussed in supervision. Unprocessed countertransference affects can be harmful resulting in promiscuous self-disclosure of feelings and behaviours that may result in therapeutic ruptures or boundary violations. Ethical practice requires that practitioners remain alert to their clients' psychological wellbeing; that they attempt to understand such reactions and not inflict harm because of their personal problems. Therapists are expected to seek supervision and personal therapy so clients are not negatively affected by their problems (Corey, Corey & Callanan, 2014).

Notwithstanding the above, the literature on therapeutic enactments highlights how despite one's best intentions, a therapist's conscious and unconscious intent may be at odds with one another (Gabbard, 2001; Mann, 2009). In a review of two hundred cases featuring sexual boundary violations, Celenza and Gabbard (2003) observe that a common misunderstanding about the transgressor was the assumption of psychopathy, and the likelihood of multiple offenses whereas most of the offenders were one-time transgressors. Furthermore, typical characteristics of therapists who engage in sexual misconduct were presented and discussed as qualities that are to some extent present in therapists in general. According to Celenza and Gabbard (2003), a vulnerability to sexual misconduct is often marked by a slippery slope of self-deception and vertical splitting where there is a tendency to deny the universal vulnerability that all therapists have to behaving in ways that enact their unconscious processes. Crucial here is a therapist's ability to adopt a curious and non-defensive attitude to her potential blind spots. To the extent that enactments can be made conscious, they offer a window on important tasks of therapy. To the extent that they unfold outside awareness, 'they may function as barriers to insight and new experience' (Wallin, 2007, p.181).

## **2.5 Attachment Theory and Affective Neuroscience: How therapists' blind spots obstruct their ability to offer a secure relationship to their clients.**

Attachment theory provides a broad and far-reaching view of human functioning that has the potential to change how we think about and respond to clients and the therapeutic relationship. An attachment-based clinical approach highlights the unconscious nonverbal affective domain more than conscious verbal cognitive factors as the essential change process to psychotherapy (Schore & Schore, 2008). Attachment research also demonstrates that one's ability to generate a secure attachment relationship will be profoundly influenced by one's attachment history (Mikulincer et al., 2013). Given that a therapist's attachment security is linked to a capacity for reflective function (Fonagy, 2001), it is evident that for those with a history of insecure attachment, emotional dysregulation is likely to impair one's mentalizing capacity (Fonagy et al., 2004). In terms of identifying potential blind spots, it is crucial therefore to consider what emotions one was able to integrate through one's developmental history as well as what one needed to dissociate in order to maintain attachment security to significant caregivers. Inevitably this will impact on one's ability to understand patient behaviour in light of underlying mental states and intentions (Fonagy, 2001). Wallin describes how a therapist's capacity for reflective function influences her clinical work:

'To the extent that we make it possible for patients to mentalize, we strengthen their ability to regulate their affects, to integrate experiences that have been dissociated, and to feel a more solid coherent sense of self' (Wallin, 2007, p.4).

Wallin's stance echoes an observation by relational psychoanalyst, Harold Searles that speaks to both therapist and client alike:

'One does not become free from feelings in the course of maturation or in the course of becoming well during psychoanalysis; one becomes, instead, increasingly free to experience feelings of all sorts' (Searles, 1979, p. 35).



With regard to therapist blind spots, Attachment theory alerts us to ways in which the therapist's view of the patient can be skewed by what the therapist is unable or indeed unwilling to know about himself (Wallin, 2007). Research suggests a tendency in avoidant adults to assume they are *different* and *distinct* from others obscuring a bias towards seeing their own projected unwanted traits in others. In contrast, anxious adults are prone towards seeing (projected) evidence of actual traits of their own in others and assume others are *similar* to them (Mikulincer & Shaver, 2003). It is likely that these tendencies impact on therapeutic processes limiting a therapist's ability to empathise with her client or see herself from her client's point of view. Inevitably, this can lead to impasses, collusions or ruptures in treatment arising out of the therapists' need to keep at bay unbearable, and hence dissociated experiences of self or other (Goldbart & Wallin, 1996). By way of explanation, Wallin highlights that a history of relational trauma often marks the developmental history of therapists and draws on attachment research to describe the collusions, ruptures and impasses that take place when the therapist's vulnerabilities interlock with those of the client (Wallin, 2007, 2014).

Elsewhere the work of Giovanni Liotti (2011) describes the defensive role of controlling caregiving strategies in those with a history of disorganised attachment, helping us understand the compulsion to help experienced by some therapists, especially those who were parentified as children. A particular feature of relational trauma is a 'constriction and narrowing of the horizons of emotional experiencing' (Stolorow, 2007, p. 4). In the clinical setting, developmental histories of relational trauma have a significant impact on the patient's expectations and emotional availability to explore their difficulties with the therapist. In a similar vein, the therapist's developmental history will influence her capacity for non-defensive reflection. Indeed Safran and Muran (2000) suggest that much of the therapist's success involves their 'inner growth' when they take responsibility for their part in misunderstandings and ruptures in the therapeutic relationship.

## **2.6 Emotional blind spots and the nonverbal realm.**

In accord with a relational model of psychotherapy, recent developments in affective neuroscience highlight the value of attending to the nonverbal realm and implicit

relational knowledge (Schore, 2003). Schore proposes 'a model of right-brain interactive affect regulation as a fundamental process of both psychological development and psychotherapeutic treatment' (Schore, 2003, p. 279). This new paradigm is challenging the 'dominance' of the left hemisphere due to its capacities for explicitly processing language functions. According to Schore:

'More so than conscious left brain verbalisations, right brain-to-right brain visual-facial, auditory - prosodic, and tactile-gestural subliminal communications reveal the deeper aspects of the personality of the patient, as well as the personality of the therapist' (Schore, 2014, p. 391).

Within this paradigm, transference-countertransference transactions represent non-conscious nonverbal right brain-mind-body communications. Accordingly, Schore asserts that a relational perspective of professional development requires that 'the continuously evolving psychotherapist frequently reflects on the subjective experiences of *being with* patients, including not only *the patients'* unique personalities, but also *their own* conscious and especially unconscious intersubjective co-participation in the therapeutic process' (Schore, 2014, p. 394, emphasis in original). Schore raises a central concern here, 'when the therapist's wounds are hit, can she regulate her own bodily based emotions and shame dynamics well enough to be able to stay connected to her patient?' (Schore, 2015, p.131).

Clearly, such a therapeutic stance is emotionally demanding, requiring a level of stamina and risk for therapists. Not only are therapists expected to regulate and process their own intense feelings which might be stirred in the work in order to gain insight into the relationship dynamics and plan future interventions, they also need to be affectively present with the client who may also be in a dysregulated state. It demands core skills such as empathy and the ability to track the shifting intensity of affective charge as well as offering containment. Critically according to Schore, 'all other techniques and skills sit atop this essential substratum' (Schore & Schore, 2014, p. 189). While the literature and its associated clinical vignettes is unambiguous about what is required of the therapist in terms of attitude and

technique, relatively less attention has been given to how therapists actually experience their sense of vulnerability in the here-and-now when in the grip a personal blind spot and how this impacts on therapeutic process and outcome.

## **2.7 Research on Countertransference.**

Despite continued disagreement over the definition of countertransference, most empirical studies have employed a definition that implicates the therapist's unresolved conflicts as the source, often with patient characteristics as the trigger (Gelso & Hayes, 2007). Within this paradigm, research has examined either internal or external manifestations of countertransference. Countertransference can manifest affectively, cognitively and through behaviour. In terms of affective manifestations, anxiety is one of the most common reactions when a therapist's unresolved issues are stimulated (Fauth & Hayes, 2006; Hayes et al, 1998). Cognitively, countertransference may manifest in therapists' inability to recall therapy-specific events that touched on their own issues and misperceiving patients as overly similar or dissimilar to themselves (Cutler, 1958). These internal reactions are viewed as natural and inevitable and do not necessarily harm the therapeutic process and can ultimately offer important insights into how the therapist is affected by the patient. Accordingly, countertransference can be used as a therapeutic tool and lead to positive effects when these inner experiences enable the therapist to develop deeper insight into both their own issues and those of their client. Clearly the greater the resolution of the therapist's personal issues, the more likely it is that he or she can reflect on their experiences to benefit the patient. This is the archetypal definition of the wounded healer (Groesbeck, 1975; Sedgwick, 1994).

On the other hand, when these internal reactions are not managed, therapists act on the basis of their own needs rather than those of their patient. The nature of countertransference behaviours can have a powerful influence on the process of therapy. Therapist issues, particularly countertransference, are cited as contributors to impasse by many clinical authors (Elkind, 1992; Safran & Kraus, 2014). Findings from a qualitative study exploring highly experienced therapists' retrospective recall of impasse in long-term psychotherapy indicated that most therapists implicated their own personal issues (countertransference) in the impasse (Hill, Nutt-Williams,

Heaton, Thompson & Rhodes, 1996). Research that improves our understanding of therapists' ability to detect, attend to and manage personal issues that become triggered in their interactions with clients is crucial to ensure clients receive the best care possible.

## **2.8 Types of Countertransference Behaviours.**

In an early naturalistic study Cutler (1958) examined therapist response quality to patient material related to their personal 'blind spots' (which were identified by close associates). Audio recordings of therapists' verbal utterances were coded in terms of the therapist's task and ego-orientation. By definition, task-oriented behaviour was any behaviour by the therapist that tends to facilitate a flow of therapeutically relevant conversation, while ego-orientation involves therapist behaviour that departs from this task. The implication was that avoidance was a way in which therapists protected themselves from the threat represented by their patient's material. Cutler found that when faced with material related to their own conflicts, therapists tended to offer ego-oriented, avoidant responses rather than task-oriented responses. As a self-serving, or ego-oriented response to the client, countertransference can be construed as an attempt by the therapist to meet his or her own needs (Cutler, 1958). In this way, uncontrolled countertransference can result in the therapist neglecting the patient's needs in service of playing out his or her personal conflicts, resulting in counter-therapeutic behaviour. This finding proved highly significant in that countertransference was operationalized as 'avoidance behaviour' (e.g. disapproval, silence, ignoring, mislabelling and changing the topic) and established an important foundation for further studies (Hayes & Gelso, 1993; Rosenberger & Hayes, 2002).

Most research that followed Cutler's (1958) classic piece examined therapist withdrawal and avoidance in relation to various client characteristics. These studies found support for a variety of hypotheses such as: therapist gender moderates the effects of countertransference. For example, male therapists withdraw when they are anxious (Hayes & Gelso, 1991); female therapists withdraw only with dependent clients; therapist homophobia predicts avoidance behaviour with gay and lesbian clients (Hayes and Gelso, 1993). However this early research was based on analogue studies and lacked ecological validity. When considered alone, client

characteristics fail to predict how countertransference will manifest. On the other hand, research on the manifestations of countertransference suggests that anxiety, avoidance and distorted perceptions are the most common countertransference reactions (Gelso & Hayes, 2007). Much of research therefore, has focussed on developing measures to describe how countertransference manifests.

Due to its flexibility and trans-theoretical underpinnings, one of the most popular measures is the Avoidance Index (AI; Bandura, Lipsher, & Miller, 1960). Bandura et al (1960) originally developed the AI to study the effects of therapists' anxiety on their in-session client hostility. Avoidance reactions were identified as those that were intended to inhibit, discourage, or divert hostile session content, whereas approach reactions were intended to encourage continued exploration of hostile session content. Approach reactions featured the following responses: approval (e.g. explicit agreement, exploration (i.e., requesting elaboration), instigation (e.g. redirection towards hostility), reflection and labelling (i.e., labelling hostile feelings as such). The following reactions were classified as avoidant responses: disapproval (e.g. critical of client's hostility), topical transition (changes the topic from hostile to a non hostile topic), silence (no response for four or more seconds), ignoring (responding to the content but not hostile affect), and mislabelling (therapists labels hostile feelings as non-hostile). Although the AI is one of the most widely validated CT manifestation measures, it has several limitations. Firstly, the inter-rater reliability has been suspect at times (Fauth, 2006). Fauth argues that there is also an overly narrow focus on the verbal content of therapists' interventions at the expense of the implicit and nonverbal content. Arguably, tone of voice and body language reveal important aspects of non-conscious countertransference behaviour (Gelso & Hayes, 1998). Furthermore, a significant problem is that some of the AI categories are arbitrary and simplistic. For example, any silence of four or more seconds is coded as an avoidance response. Conceivably, silence paired with appropriate nonverbal cues can also be an appropriate response in certain therapeutic contexts. The approach responses themselves (i.e. approval), may, in excess, represent countertransference and lead to collusions and avoidance of material that touches on the therapist's issues.

Most early research was based on analogue studies lacking ecological validity and without a theoretical framework, so it was difficult to organise and integrate findings. Hayes (1995) proposed a structural model of countertransference consisting of five main components; origins, triggers, manifestations, management and effects. *Origins* relate to unresolved conflicts within the therapist. *Triggers* are therapy related events that provoke the therapist's unresolved issues. *Manifestations* refer to the therapist's cognitive, affective, behavioural and visceral reactions to these events. *Effects* describe the subsequent results of these manifestations on therapy process and outcome. Finally, *management* refers to therapists' ability to regulate their countertransference manifestations (Hayes, 1995).

Rosenberger and Hayes (2002) attempted to evaluate the model using a case study design where all five components of the models were operationalized and measured. A single therapy dyad was followed for 13 sessions and client verbalisations predicted to trigger countertransference reactions were studied in relation to their possible consequences. The potential moderating role of countertransference was also explored. Rosenberger and Hayes (2002) found that when the client talked about issues related to the therapist's unresolved issues, the therapist tended to respond with less avoidance and the working alliance was rated as stronger. However, the therapist judged the sessions to be smoother and shallower and felt less attractive and trustworthy the more the client talked about conflict-relevant topics. Hayes (2004) speculates that client and therapist colluded in a positive countertransference and that the therapist responded to potentially threatening material by approaching rather than avoiding the client. It may be that some therapists meet their needs by drawing closer to a client rather than withdrawing. In retrospect, the assumption that avoidance would be a reaction to conflictual material was influenced by findings from earlier studies in which the participants were predominantly men (Peabody & Gelso, 1982; Yulis & Kiesler, 1968). Hayes (2004) suggests that gender may influence whether a person exhibits countertransference behaviour by approach or avoidance. This study contributed to methodological advances in operationalizing countertransference and the inclusion of Hayes's (1995) integrative model of countertransference.

Researchers have assessed each of the five dimensions and the relationship amongst them with mixed success. Findings suggest that countertransference behaviour is a low-frequency event. This poses challenges for researchers in establishing acceptable estimates of inter-rater reliability because reliability scores are usually low for a low-frequency event (Hayes, 2004). It may be that quantitative methods fail to capture the more subtle aspects of countertransference behaviour. Therapist self reports are subject to the influence of social desirability and limited by conscious self-awareness. Furthermore, rater observations are restricted to overt displays of countertransference. Rather than focus on the incidence of countertransference, it seems more important to focus on examining its impact. Research suggests even minimal displays of countertransference can influence the depth of therapeutic process (Rosenberger & Hayes, 2002).

In order to examine how therapists perceived the influence of countertransference on their clinical work, Hayes and colleagues used a consensual qualitative research strategy to explore their experiences of countertransference (Hayes, McCracken, McClanahan, Hill, Harp & Carozzoni, 1998). Countertransference was reported in 80% of their sessions, highlighting its ubiquitous presence. Bear in mind, this figure does not account for the countertransference that was unconscious and not detected by the interviewers. In addition, participants were seasoned therapists with between 5-42 years of postdoctoral experience, and had been identified by their peers as highly competent thus challenging the notion that countertransference is related to lack of experience.

A noteworthy finding, in keeping with Cutler's (1958) now classic piece, was how the content of client material frequently elicited countertransference reactions in this group of therapists. While some triggers might be considered as objective and factual (e.g., interruptions to structure of therapy, discussions about death), most triggers were the result of therapists' subjective perceptions. Examples include, therapists' phenomenological evaluations of the progress of therapy, appraisals of the client, and perceptions of a level of emotional arousal in the client or therapist (Hayes et al, 1998, p. 478). This highlights the influence of the therapist's subjectivity on clinical

process. Therapists make decisions in terms of their values, needs and goals while also taking into account those of their clients (Fauth, 2006).

Next to fairly cognitive manifestations involved in treatment planning, most countertransference reactions seem to affect the emotional distance between therapists and client. As one would expect, some reactions, such as identifying or empathising with the client, draw client and therapist closer together, while other reactions increase the sense of distance between therapist and client (e.g. boredom and misunderstanding). Noteworthy was how the category 'negative feelings' was unpredictable. Negative feelings were defined as therapist emotions that were difficult to tolerate (e.g., anger, frustration; sadness; inadequacy; anxiety; guilt) and were unpredictable in their effect on the distance between therapist and client. This may be because therapists deal with discomfort in different ways. While some therapists may react to their anxiety by withdrawing from the client (Hayes & Gelso, 1991), others might respond by increasing their involvement with the client (Gelso et al., 1995). Although it was not possible to determine the effects of countertransference manifestations on outcome in this study, the findings were informative in terms of highlighting the challenges involved in making accurate generalisations about the effects of most CT reactions and the importance of contextual information to establish whether their reactions were adaptive or maladaptive.

Cutler (1958) first formulated the idea of a maladaptive approach in his description of countertransference as a case of perception influenced by need suggesting that therapist ego-orientated behaviour also occurred when therapists overemphasised patient material that actually related to their own conflicts. McClure and Hodge (1987) describe how over-identification makes the therapist unable to remain separate from the client's material while dis-identification leads to distancing behaviours by the therapist. Friedman & Gelso (2000) argue that empathically engaged therapists can lose their objectivity when client material touches an area of unresolved conflict. Here, the identification process can result in withdrawal or over-involvement, where the therapist takes on an over-supportive stance with the client, which could lead the therapist to lose his or her objectivity. Hayes (2004) suggests



that avoidance may be a way in which therapists protect themselves from the threat represented by the client's material.

In order to scrutinise a therapist's inappropriate behaviour more comprehensively, Friedman and Gelso (2000) developed the Inventory of Countertransference Behaviour (ICB) with a view to describing over-involvement and withdrawal of involvement. The ICB has demonstrated concurrent validity with the Countertransference Index (CT Index; Hayes, Riker & Ingram, 1997) and the Countertransference Factors Inventory (Van Wagoner, Gelso, Hayes & Diemer, 1991). Withdrawal was theorised to reflect behaviours that seemed negative (e.g., being critical of the patient) while seemingly supportive behaviours (befriending the patient) were theorised to reflect over-involvement.

The factors that emerged from Friedman and Gelso's (2000) study did not reflect the approach/avoidance paradigm theorised in the research questions. Instead, findings suggested that whatever the manifestation of countertransference feelings (over-involvement or withdrawal) therapists were avoiding client issues when their behaviour serves their own needs. A significant feature of avoidance therefore, is that it can have positive or negative valency. Within this model, Friedman and Gelso defined negatively valenced CT as therapist behaviour that is disapproving or avoidant (e.g., critical of the client during the session, apathetic, frequently changing topic), while positively valenced countertransference reflects therapists' behaviour that seems supportive (hence positively valenced) but has an enmeshed or dependent quality (e.g. offering advice and too much support; befriending the client). These findings highlight the complex nature of countertransference phenomena. Excessively positive emotions characterised by excitement and a sense of connection with a client may obscure deeper fears about loss and difference and indicate enmeshment and collusions. Rupert and Morgan (2005) found over-involvement with clients to be positively related to emotional depletion and depersonalisation but also to personal accomplishments in therapists.

Research on countertransference underscores the importance of affect regulation and mentalisation in promoting positive therapeutic outcomes. This is reflected in the

frequently expressed premise that therapists who have difficulty accepting certain feelings and experiences in themselves will have difficulty empathizing with these experiences in their patient (Safran & Segal, 1996, p. 84).

A recent qualitative study exploring therapists' subjective experience of countertransference in successful and unsuccessful cases showed how therapists with successful outcomes described experiencing more unpleasant feelings and problematic cognitive reactions than did therapists with unsuccessful outcomes (Hayes, Nelson & Fauth, 2015). Hayes and colleagues speculate that therapists with successful outcomes were more aware of their countertransference reactions, and also willing to discuss their reactions with clients. Furthermore, therapists whose outcomes were successful also managed their covert reactions so that they were not acted out with their patients. This is consistent with previous research that awareness of countertransference reactions is associated with better psychotherapy outcomes (Gelso & Hayes, 2007). Although the design of the study did not permit causal inference in terms of the effects of therapists' countertransference, the findings do provide important information about therapists' perceptions of the effect of their personal issues on their work, for good and for ill.

## **2.9 Identifying therapist blind spots**

Although there has been significant progress in developing the quality and variety of countertransference measures, conceptual issues around the construct still pose a huge obstacle to researching countertransference phenomena. As Hayes (2004) argues, in order to study countertransference meaningfully, one needs to be sure that therapist reactions stem from areas of personal conflict and not other phenomena. How can one reliably differentiate reactions that might be rooted in therapists' unresolved conflicts and vulnerabilities and other responses to the patient? Intense feelings such as plain dislike may provide insight into patterns the patient evokes from significant others. This distinction is important. How one manages feelings of dislike for a patient that is based on the patient's presenting attributes and behaviour (i.e., narcissistic personality disorder) is very different from dislike that originates from one's personal unresolved issues. Here recent research drawing on a *totalistic* conceptualisation of countertransference can illuminate.

In order to capture the specific characteristics of therapist's involvement, Drew Westen and colleagues designed the Countertransference Questionnaire (Betan, Heim, Conklin, & Westen, 2005). This instrument assesses a wide range of cognitive, affective and behavioural responses to their patients. The research group was particularly interested in studying the relationship between patient 'personality pathology' and countertransference reactions in order to test clinically derived hypotheses. Results describe a factor structure offering a complex picture of countertransference reactions that can be applied to a range of diagnostic and clinical populations. For example, factor analysis identified an overwhelmed/disorganised pattern of countertransference response, characteristic of clinicians' response to primarily Axis II cluster B patients. This group of patients share problems with impulse control and emotional regulation and includes patients diagnosed with conditions such as borderline personality disorder, narcissistic disorder, histrionic personality disorder and antisocial personality (American Psychiatric Association, 2013). In addition, the authors reported on prototypes of "average expectable" countertransference to patients with a personality disorder. Delineating the specific content and domains of countertransference may help therapists to understand and anticipate their reactions towards patients (Kächele et al., 2015). Furthermore reflection on the 'average expectable' countertransference can help therapists distinguish how their personal issues impact on perception and judgement.

## **2.10 Managing Countertransference**

A fundamental concept in the literature is that therapists need to manage their reactions or use them to further self-understanding and to progress the therapy (Hayes, 1995). The wounded healer literature emphasises how therapists use their wounds to help them understand their patients from a place of mutual shadow that promotes healing for both members of the therapeutic dyad (Sedgwick, 1994; Martin, 2011). Sedgwick provides a phenomenological account of his experience describing his use of dreams to illuminate countertransference phenomena from a Jungian perspective.

More research is required to understand the phenomenology of countertransference from an integrative perspective. Much research has focussed on therapist factors that facilitate management of countertransference. The findings from a recent meta-review provided by Hayes, Gelso and Hummel (2011) emphasises the role of managing countertransference and its role in enhancing the success of psychotherapy. All studies used a version of the Countertransference Factors Inventory (CFI) (Van Wagenor, Gelso, Hayes and Diemer, 1991); CFI-D (Gelso, Latts, Gomez & Fassinger, 2002) and CFI-R (Hayes, Riker & Ingram, 1997). All three versions of the CFI contain five subscales reflecting therapist attributes believed to be important to successful CT management: self-insight, self-integration, anxiety management, empathy and conceptualising ability. The meta-analysis found that countertransference factors studied to date play little to no role in actually attenuating countertransference reactions ( $r = -.14$ ) but that they are strongly associated with positive therapy outcomes ( $r = .56$ ; Hayes et al., 2011). According to Fauth (2006);

The primary limitation of the CFI is that it does not directly assess the actual strategies or behaviours that therapists implement to manage their countertransference manifestations, but rather, therapists characteristics that are *theorized to facilitate* countertransference management. (Fauth, 2006, p. 26. original italics)

Research on the role of self-awareness in managing countertransference has also had mixed results (Hayes, Gelso & Hummel, 2011). This is not surprising; the reason that countertransference phenomena create blind spots is that it takes effort and discipline to become aware of one's personal biases. Indeed Hayes and colleagues speculate that often when therapists experience an intense response as a *natural* response to the patient, the therapist's unresolved resolved conflicts are implicated (Hayes, Gelso & Hummel, 2011, p. 90). To further complicate matters, research from social cognition shows that although people recognise the existence and influence of many of the biases that affect human judgement and inference, they often lack recognition of the role these same biases have in influencing their own judgements and inferences (Pronin, Lin & Ross, 2002).

The term 'bias blind spot' originally conceptualised by Pronin and colleagues, attempts to describe an 'introspection illusion' as the meta-cognitive bias where individuals see the existence and operation of cognitive and motivational biases much more in others than in themselves (Pronin, Lin & Ross, 2002). It seems that people often rely on conscious introspections when seeking self-understanding, even when the processes they seek to understand occur outside their awareness (Nisbett & Wilson, 1977). Introspection plays a vital role in how therapists use their mental states to develop insight into themselves and their client work. However the work of Pronin and colleagues highlights the importance of reflective practice (Schön, 1984) and critical reflexivity (Etherington, 2004) in order to develop awareness about how personal biases shape experience.

Arguably the emphasis on countertransference 'management' may obscure more nuanced countertransference related phenomena; intersubjectivity, enactments and identifications that are part of therapists' experience of countertransference. For example, although enactments are often experienced as a crisis in therapy, they can also mark a potential turning point, which may have either a benign or malign effect on the therapy (Mann & Cunningham, 2002, p. 1). Fundamental here is how a solid working alliance characterised by mutual liking, can serve as a buffer in allowing difficult transference feelings to be expressed and resolved (Gelso, Hill, Mohr, Rochlen & Zack, 1999).

In a review of the definitional and measurement barriers inhibiting countertransference research, Fauth (2006) concludes that despite the progress researchers have made in increasing the quality and number of measures, we have yet to capture the 'full richness' of countertransference manifestations because they are displayed in such a 'myriad' of ways (p.26). Fauth proposes an idiographic approach in order to capture the idiosyncratic nature of countertransference manifestations.

A conclusion reached by Hayes and colleagues based on a qualitative analysis of therapists' experiences of countertransference indicates the need for *an*

*interpretative phenomenological* exploration of therapists' experience of recognising personal blind spots. They conclude:

'Most triggers were the results of therapists' perceptions... Thus, the lenses through which therapists saw the world largely dictated whether and when countertransference was stimulated' (Hayes et al, 1998, p. 478).

## **2.11 Similar Research**

I will now describe the empirical research most closely related to the current research study: that which has explored therapists' experiences of difficult and upsetting sessions. The research relevant to this study refers to experiences where qualified therapists might experience upset, helplessness and incompetence when clinical material touches on their personal issues. Both these studies use grounded theory.

de Oliveira and Vandenberghe (2009) explored the upsetting, in-session experiences of four psychotherapists (two behavioural and two psychoanalytic) in therapy with clients. Grounded theory analysis of therapists' experiences yielded some key themes, in particular, a sense of helplessness and insecurity relating to therapist effectiveness. A significant finding was that therapists related failures in dealing effectively with upsetting experiences 'to personal biases and difficulties' (p. 243) pointing to a need for greater understanding of how therapists overcome these challenges. In terms of therapist resilience, the study suggests that although opening up to distressing experiences puts clinicians at risk of further distress, using these experiences to benefit treatment promotes therapist resilience. It seems that there is also a need to understand how therapists integrate their understanding of their personal biases into their personal and professional self in a more experience-near way.

Thiériault and Gazzola (2005) used a Grounded Theory approach to explore feelings of incompetence amongst eight therapists, with between 10 and 29 years of experience. Thiériault and Gazzola's study resulted in a continuum model for feelings of incompetence, which they claimed was qualitatively different as a function of experience. The most intense, uncomfortable and damaging forms of feelings of

incompetence were the emotions that arose from personal issues where the nature of the self-doubt targeted core elements of the self. Incompetence triggered by the *reliving in-session* of wounds/historical wounds was the most painful experience of feelings of incompetence for many participants. Furthermore when the client's style of relating or issues were similar to either recent or past painful experiences of the therapist, the latter reported "loosing all their ways" (Thiériault & Gazzola, 2005, p. 325). Research that explores the phenomenology of these experiences will enable us to better discern the different layers, nuances and subtleties of these experiences so trainers and supervisors can support their supervisees better.

In another important context, therapist blind spots are a personal development issue for supervision; yet research suggests that therapists withhold or distort aspects of therapy cases including their errors at moderate to high frequencies (Yourman & Farber, 1996). In a further study exploring an association between non-disclosure and therapist shame, Yourman (2003) concluded that the exploration of material that may lead therapists to view themselves or appear to others as less competent, is likely to produce a sense of shame and in turn, less disclosure to supervisors. Dalenberg (2004) describes reluctance in therapists to disclose hostile, passive-aggressive or defensive practice. One is left wondering how therapists' fears of vulnerability influence therapeutic process and outcomes.

Brown (2006) argues that the best way to develop shame resilience is to talk about one's difficult experiences with others who have shared similar experiences. While training courses and supervisors encourage therapists to talk about their personal issues, this can also be a shame inducing experience (Tangney & Dearing, 2002). The clinical literature needs to reflect the experience of therapists in their clinical work. What are the conflicts, contradictions, hopes and fears that therapists experience as they try to maintain a therapeutic stance during a challenging interaction with a client, especially when they describe situations where they feel as if they are 'loosing all their ways' (Thiériault & Gazzola, 2005, p. 325).

## **2.12 Summary**

The literature review has considered a limited but growing number of published studies that describe how the therapist's subjectivity is implicated in their work. The countertransference literature describes the conceptual and methodological challenges researching the implicit domain: how it can only be apprehended indirectly, by examining behaviour and the nonverbal realm. Evidently different methods need to be employed to create a multi-faceted understanding of this complex phenomenon. The focus on examining countertransference behaviour such as avoidance does not give us sufficient understanding of the feelings that motivate the behaviour (Kelly, 2012). I concur with Fauth (2006) that therapists' appraisals are subjective and emotional in nature and embedded within each unique relational context. Accordingly, a research focus on personal meaning and emotion could illuminate the phenomenology of countertransference and make it more clinically relevant.

The clinical literature on therapeutic enactments, and research integrating studies from attachment and affective neuroscience emphasise the central role of affect regulation and attending to the implicit nonverbal as crucial to change processes. From this perspective, therapists are required to participate in an often intense, emotional relationship while simultaneously observing repetitive features of this relationship that might reflect the client's issues. At the same time, therapists need to be curious and become aware of how their own unconscious processes and blind spots may be hindering the work. Such a stance involves a level of risk and personal exposure for therapists, an experience that is emotionally demanding. The personal effect of this approach on the therapist is missing from the clinical literature describing what is required of the therapist to achieve full therapeutic impact (Frankel, 2006).

Apart from the wounded healer literature that describes how therapists use their wounds in service of their therapeutic work (Sedgwick, 1994) and clinical anecdotes appearing in the enactment literature, there is no empirical research exploring how therapists perceive the experience of 'being caught in the grip of a personal blind spot'. Although the enactment literature comes close, it does not produce a fine-grained account of the transformative phenomenology of the therapist: instead, using



an anecdotal approach, it addresses the two-way frustrations of impasse and rupture, usually from a meta-position of theory.

As Ehrenberg (1996) argues there is a need for more understanding about how they therapists limit their capacity to be emotionally available to their patients. While the literature review highlights how this manifests in conscious or unconscious avoidance, more understanding is needed about the motivations and emotions that might lie behind this behaviour. This emotional landscape is fertile for further exploration and I choose to make it the focus of this study.

### **2.13 Primary research questions**

The current study seeks to shed light on how therapists' personal blind spots impact on their ability to be emotionally available to their clients. I aim to address the following questions:

1. What are therapists' experiences of a personal blind spot that impacted on their client work?

The word 'what' is used in order to elicit participants' accounts; how they experience their sense of involvement with a client when 'in the grip' of a personal blind spot and the effect it has on them in the here and now.

2. What helps therapists to recognise their blind spot? The word 'recognise' is designed to draw out therapists' experience of coming to 'know' their blind spot

3. What do participants learn from their experience?

## 2.14 Reflexivity

An important part of a literature review is the process of immersion. It would be fair to say that my process was one of submersion where I felt as if I was drowning in a vast sea of literatures that could offer a perspective on therapist blind spots.

Furthermore, rather than rest and take time to gather my energy, I would double my efforts by following new paths of inquiry into different literatures. My desire for certainty became conflated with perfectionist tendencies and I could not let go! I woke up to this when a recurring dream provoked me to take stock. I dreamt I was on an airplane that couldn't take off due to the weight. This mirrored a parallel process with difficulties achieving a sense of lift off with the literature review. It was also reflected in my writing where my sentences were overburdened with too many ideas. My over reliance on theory for answers triggered obsessive thought process that became ruminative rather than explorative. How curious it was that my conundrum was underlined by a message from my unconscious through a dream.

Important here was re-establishing my regular mindfulness practice, which helped restore my sense of equilibrium. I decided to explore more deeply the literature that I find most helpful for helping me to reflect on potential blind spots in my work as a psychotherapist. Alongside regular supervision, what I have found most useful is the literature that illuminates implicit processes; the countertransference literature; the literature on affect regulation and therapeutic enactments. These theories and research inform my *personal equation* (Samuels, 2014, p. 224) and invigorate my therapeutic stance by keeping me curious as I monitor my capacity for therapeutic presence (Geller & Greenberg, 2002, 2012).

In my clinical work, I have noticed that the most useful and informative moments in my relationship with a client are when I experience a strong emotional reaction that elicits my own feelings of vulnerability. Most significant in these moments is my stance towards experience (Wallin, 2007). When I am receptive and curious about what's happening in the intersubjective space, there is often the opportunity for 'a moment of meeting' (Stern, 2004) and development of new insights which are

mutually transformative. For me, this is when therapy is at its best! Alternatively when my defences are triggered, reflection on action (Schön, 1984) has taught me how strong feelings that seem familiar and therefore *normal* indicate that I might be losing perspective and getting over-involved with a client's issues. At times this has manifested in a temporary loss of a therapeutic stance where I found myself experiencing a strong pull to give advice or colluding with a client.

Reflecting on these moments, I have often asked myself, what is being avoided? What is not being spoken about? The literature review surfaced my frustration at the lack of attention to the emotional demands on therapists as they strive to be emotionally present to their clients. Not only are therapists expected to regulate and process personal feelings that might be stirred in the work in order to gain insight into the relationship dynamics and plan future interventions, they also need to be affectively present with the client who may also be in a dysregulated state. While the literature and its associated clinical vignettes is unambiguous about what is required of the therapist in terms of attitude and technique, the process of carrying out the literature review confirmed my belief that that more attention needs to be focussed on the inner world of therapists as they go about the tasks of being helpers. This is vital so that we can prepare and protect therapists against the normative force of subjective negative self-appraisal when they experience a sense of inadequacy/incompetence in their therapeutic work (Thiériault & Gazzola, 2006).

## Chapter 3

### Methodology and Method

In this chapter I begin by outlining the nature of the qualitative paradigm central to this study and my philosophical perspective. The chapter then engages a more specific focus on the epistemological and methodological concerns of hermeneutic phenomenology in general and IPA specifically. This is followed by a description of the methods used in the study, including those relating to participant recruitments, data collection and analysis. Next, consideration is given to quality assurance and ethics. The final section of the chapter explores the use of reflexivity, both personal and methodological, throughout the study.

#### 3.1 Rationale for a qualitative approach.

The literature review highlights the inevitability of biases and schema that operate at an unconscious or implicit level and help to organise our experience of the world. These beliefs, attitudes and meaning systems (Dweck, 2000) are said to form schemas that give meaning to people's worlds. Our personal theories may be held consciously or they may exist at the 'periphery of consciousness' (Merleau-Ponty, 2003) in which case they may be described as implicit knowledge. The implicit nature of a blind spot means that it needs to be made visible before it can be subjected to scrutiny. This represents a challenge for research methods as before blind spots can be subjected to examination they have to be made visible to the researcher (Carpenter, 2009). An important consideration for this study therefore is how both researcher and participant come to *know* and understand a phenomenon that is difficult to put into words.

#### 3.2 Epistemological position

A fundamental part of any research project is deciding what its objectives are and what kind of knowledge it claims to generate so that it can be evaluated in a meaningful way. Qualitative research draws on a variety of epistemologies. Epistemology is a branch of philosophy concerned with the theory of knowledge. According to Denzin and Lincoln epistemology poses the question:

“How do I know the world?” “What is the relationship between the inquirer and the known?” Every epistemology (...) implies an ethical-moral stance towards the world and the self of the researcher (Denzin & Lincoln, 2005, p. 183)

This underlines the importance for researchers to be aware of the frameworks they use, the assumptions on which they are based, and the possibility of logical inconsistency (Bateson, 1972). Given that the focus of the current study is to examine the *lived experience* of recognizing a personal blind spot, researching this phenomenon will involve exploring the dynamic emotional, physiological and psychological dimensions of the experience. As the research aims to go beyond a description of the phenomenon to the evocation of a deeper, more visceral level, one in which the texture and meaning of the phenomenon can be explored, a qualitative research approach is deemed appropriate. Qualitative methods are concerned with a naturalistic description and interpretation of phenomena in terms of the meanings these have for the people experiencing them. In contrast, quantitative methods are concerned with counting the amount of the phenomenon or some aspect thereof (Langdrige, 2007). A qualitative approach is particularly useful in providing insights into the underlying reasons and motivations *behind* an experience as well as providing *contextual* information. This approach seems pertinent to a study that seeks to describe implicit processes that manifest in personal blind spots for therapists as well as therapists evolving sense of meaning as they recognise them.

By and large qualitative research can be divided into experiential approaches which are concerned with understanding how people make sense of their world and discursive approaches, which focus on how language is used to construct particular versions of reality (Reicher, 2000). The difference in epistemological positions can be conceptualised on a spectrum that positions naïve realism at one end of the pole, and a radical constructionist position on the other (Madill, Jordan and Shirley, 2000). Somewhere between these poles is a contextual constructionist position. Naïve realism assumes that it is possible to reveal an objective or direct reality by the use of appropriate methods. Critical realism, on the other hand operates from a more tentative and cautious perspective with its proposition critical realism that the data needs to be interpreted in order to further our understanding of the underlying structures that generate the phenomena. This places it closer to a contextual

constructionist position, which assumes that all knowledge is context specific and imbued with subjectivity (Lyons & Coyle, 2015). This approach chimes with my light constructionist stance (Eatough & Smith 2008), which is underpinned by a philosophy of symbolic-interactionism (Blumer, 1969). Symbolic interactionism offers a theoretical perspective that posits that people act on the basis of the meanings that things have for them and that meanings emerge through processes of interaction between people. Thus meanings are modified and constructed through an interpretative process that is subject to change and redefinition (Blumer, 1969).

### **3.3 Rationale for a Phenomenological Approach**

Phenomenology encompasses both a philosophical movement and a variety of research approaches. As a philosophical approach, phenomenology originated with Edmund Husserl and was later developed by Martin Heidegger as a way of exploring our lived experience and the way things are perceived and manifest to consciousness (Smith, Flowers & Larkin, 2009). More than a method, Finlay describes how phenomenology 'invites us to slow down, focus on, and dwell with the 'phenomenon'- the specific qualities of the **lived world** being investigated' (Finlay, 2011, p. 3). The emphasis is on full and detailed descriptions rather than any kind of explanation or theorizing in order to understand how meaning is created through embodied perception. Phenomenology contributes to deeper understanding of lived experiences by revealing taken-for-granted assumptions about these ways of knowing (Sokolowski, 2000).

A central tenet of phenomenology is that every experience is a 'consciousness of something' or an object of consciousness that is referred to as 'intentionality' (Langdrige, 2007). It is this specific relationship with the world - our intentional relationship - that phenomenologists seek to describe when researching lived experience (Finlay, 2011, p. 37). Here a focus on the lifeworld involves a return to phenomena as they are lived pre-reflectively. Finlay describes it thus:

'As we act in the world - doing, being, experiencing- mostly we do not reflect on what our experience means as we are in the '**natural attitude**'. Lifeworld just happens, it unfolds' (Finlay, 2011, p. 125).

This 'natural attitude' can be contrasted with a phenomenological attitude whereby we reflect upon the natural attitude (Sokolowski, 2000). Thus phenomenologists need to study both acts of consciousness or the manner of being aware (noesis) as well as the objects of consciousness/awareness (noema) as one experiences them (Finlay, 2011). Noteworthy here is the extent to which consciousness is to be understood not as limited awareness, but in a wider sense that also includes preconscious and unconscious processes (Giorgi & Giorgi, 2008). Finlay highlights how we live our body-world interconnection **pre-reflectively**, without thought with the body having its own wisdom and memory (Finlay, 2011, p. 31). In terms of the current study, it was envisaged that the experience of being caught in a blind spot (natural attitude) and then recognising it (phenomenological attitude) would occur at multiple levels some of which would be implicit (Carpenter, 2009).

While a fundamental principle of phenomenological inquiry is that experience should be examined in the way that it occurs, and in its own terms, the challenge for research is translating philosophy into research methodology. There is significant debate on a wide range of approaches to empirical phenomenological research, however Kvale describes what unites all approaches:

'A phenomenological perspective includes a focus on the life world, an openness to the experiences of the subject, a primacy of precise description, attempts to bracket foreknowledge and a search for invariant essential meanings in the description' (Kvale, 1996, p. 38-9)

Although all phenomenology aims to describe rather than explain experience, arguments revolve around the appropriate way to undertake phenomenological research. Phenomenological approaches to knowledge generation range from descriptive approaches to interpretative or hermeneutic varieties. These follow the broad philosophical traditions of Husserl and Heidegger, respectively (Finlay, 2011). For Husserl and descriptive phenomenologists, dwelling *with* the phenomenon and 'bracketing' habitual ways of seeing the world minimize interpretation allowing the researcher to focus on 'that which lies before one in phenomenological purity'

(Husserl, 1931, p. 262). This means that for Husserl and descriptive phenomenologists, 'description is primary and interpretation is a special type of description' (Giorgi & Giorgi, 2008, p. 167). In contrast, interpretative phenomenologists do not separate description and interpretation. Instead, drawing on insights from the hermeneutic tradition, they argue that all description constitutes a form of interpretation (Willig, 2013). I concur with Heidegger's existential, hermeneutic philosophy that interpretation is an inevitable, basic structure of our being-in-the-world and that no observation or description is exempt from the influence of the observer's experiences, prejudices, presuppositions, and projections (Moran 2000). Given my position that it is not possible to observe an objective, direct reality, my focus of interest in this study is the phenomenal reality of *how* participants experience is constructed, socially contextualized and subjectively experienced. Such an exploration requires a combination of insights from both phenomenology and hermeneutics.

Hermeneutics is the theory of interpretation. Historically, hermeneutics represented an attempt to provide a more solid foundation for the interpretation of biblical texts (Smith, Flowers and Larkin, 2009, p. 21). For Heidegger, hermeneutics or the study of meaning was an important prerequisite of phenomenology (Shinebourne, 2011). There are meanings to what is experienced which are concealed or hidden by the manner in which the phenomenon manifests in consciousness (Howitt, 2016, p. 317). This clearly links phenomenology to hermeneutics. Smith et al succinctly capture this inter-connection, 'without the phenomenology, there would be nothing to interpret: without the hermeneutics, the phenomenon would not be seen' (Smith, Flowers & Larkin, 2009, p. 37). For Heidegger, phenomenology was partly about the manner in which the phenomenon manifests in consciousness and also about the meaning underlying this manner of appearing. Therefore, phenomenology must reveal what is hidden by the appearance of the phenomenon (Howitt, 2016).

An interpretive phenomenological approach seems uniquely suited to a project that aims to describe therapists' lived experiences of recognising a personal blind spot in their clinical work as offered by the participant and understood by the researcher. Merleau-Ponty (1968) proposed that what appears in experience has a layer of the



invisible - that is the reality of the experience. Thus the process of making manifest what is hidden can be conceived as a matter of interpretation (Howitt, 2016). Previous experience will inevitably have an influence on experience. The phenomenological literature describes how interpretation is based on what has gone before in terms such as fore-having and fore-conception. Gadamer (1975) spoke of this in terms of 'the fusion of horizons between subject and object' highlighting the importance of making ourselves more transparent. This requires being aware of our social situatedness; that we experience and interpret the world from a particular perspective and we never completely escape this subjectivity (Shaw, 2010). It is from our understanding of this involvement that we begin to interpret the meaning of the phenomenon (Howitt, 2016, p. 317).

Schleiermacher (1998) developed the concept of the 'hermeneutic circle' to show that whenever something is interpreted, the interpretation will be founded on fore-conceptions. Accordingly, an understanding of the part requires a grasp of the whole and an understanding of the whole requires a grasp of the parts. Not only is the movement circular, it is endlessly illuminating. Thus understanding develops through a circular process where presuppositions are examined in the light of evolving meanings and modified accordingly. Therefore, according to Willig:

'Instead of attempting to bracket presuppositions and assumptions about the world, the interpretative phenomenological researcher works with, and uses, them in an attempt to advance understanding' (Willig, 2013. p. 86).

This interpretative process also provides a 'method' for understanding the text and thereby interpreting its meaning. Ultimately, for hermeneutic philosophers and Heidegger, understanding relies on recognition of our pre-understandings and historicity, and our primary task is to give priority to the new object. This echoes Merleau-Ponty's interpretive attitude where he describes how 'enquiry is a continuous beginning' (1945/1962). In other words, in interpretation, priority should be given to the new object rather than one's preconception (Smith, Flowers and Larkin, 2009, p. 25).

Interpretative phenomenologists acknowledge the inevitability of biases, preoccupations and assumptions when conducting research. Following Gadamer, they aim to engage with them fruitfully for the purpose of understanding (Eatough & Smith, 2017, p. 195). Smith and Osborn (2003) describe how the researcher is involved in a double hermeneutic whereby the researcher is trying to make sense of the participant trying to make sense of what is happening to them. As a result, the insights generated by such research are very much a product of the relationship between the researcher and the data (Willig 2013, p. 86). I concur with Willig's assertion that this does not mean that the research is 'biased', "rather, it means that knowledge is only possible through the application of initial categories of meaning which the researcher then modifies through the process of interacting with the data" (Willig, 2013, p. 86). I also agree with Finlay's proposition that the researcher's values and assumptions should be explicitly acknowledged and worked with reflexively:

'Our understanding of 'other-ness' arises through a process of making ourselves more transparent. If we do not examine ourselves, we run the risk of letting our predilections and prejudices dominate our research findings' (Finlay, 2011, p. 114).

As with descriptive phenomenology, there are several versions of interpretative phenomenology including Van Manen (1990), Langdrige (2007) and Smith, Flowers and Larkin (2009). Of the different phenomenological approaches available, IPA seemed most appropriate to meet the aims of this study. It is an experiential approach to research that owns explicitly the interpretative activity of the researcher.

### **3.4 Interpretative Phenomenological Analysis.**

Interpretative Phenomenological Analysis (IPA) is a specific hermeneutic version of phenomenology developed by Jonathan Smith (1996) who saw a need for an experiential approach to research that could enter into dialogue with mainstream psychology. What makes IPA phenomenological is its' concern with the detail of human experience. The aim of IPA is to examine experience in a way that enables the experience to be expressed in its own terms as far as possible, rather than

according to predefined category systems (Smith, Flowers & Larkin, 2009, p. 32). This is what makes IPA phenomenological and links it to key phenomenological philosophers discussed in the preceding section. According to Smith and colleagues:

‘Interpretative phenomenological analysis is an approach to qualitative, experiential and psychological research that has been informed by concepts and debates from three key areas of philosophy of knowledge: phenomenology, hermeneutics and idiography’. (Smith, Flowers & Larkin, 2009, p.11).

Firstly, by engaging in a reflective focus on personal experience, IPA assumes a model of a person as a sense-making creature. As such, the meanings of participants’ lived experience are taken into consideration and include embodied, cognitive, affective and existential domains. IPA is influenced by the phenomenological and existential perspectives of Heidegger, Merleau-Ponty, and Sartre, which consider the person as embodied and embedded in the world in a particular historical, social and cultural context (Shinebourne, 2011, p. 18). The works of these philosophers complement each other and collectively inform a theoretically rich and holistic phenomenology (Tuffour, 2017). Heidegger draws on the original Greek etymology of the term ‘phenomenon’, meaning ‘to show itself’ ‘to bring to the light of day, to put in the light’ (Heidegger, 1962, p.51). This involves making manifest what is hidden and engages the question of interpretation. On a similar note, Merleau-Ponty (1964) states that, “the proper essence of the visible is to have a layer of invisibility... which it makes present as a certain absence” (p.187). In Sartre’s work, human nature is more about *becoming* than being, the individual has freedom to choose and in that sense is responsible for their actions. Altogether, these diverse theoretical touchstones inform a phenomenological perspective that seems particularly responsive and sensitive to a dialogue with processes that may be involved in participants’ experiences of recognizing a blind spot.

Next, while IPA shares the aims of other phenomenological approaches to data analysis with its focus on describing the quality and texture of individual experience, it is recognized that such experience is never directly accessible to the researcher.

Following Heidegger's persuasive views that phenomenology is a hermeneutic enterprise, IPA recognizes researcher reflexivity as an essential activity. IPA always involves researchers' own interpretations as they try to make sense of what is being said while remaining grounded in the interview text. This hermeneutic commitment is captured in its use of the 'double hermeneutic' (Smith & Osborn, 2003, p, 51).

In order to achieve understanding, IPA research aims to hold the tension between both an 'insider' and 'outsider' perspective through a stance that employs both a hermeneutics of empathy and a hermeneutics of 'questioning' (Smith, Flowers & Larkin, 2009). On the one hand, the IPA researcher is trying to 'see what it is like from the participant's view, and stand in their shoes' (Smith et al, 2009, p. 36). At the same time interpretation can be critical and questioning 'in ways which participants might be unwilling or unable to do themselves' (Eatough & Smith, 2008, p. 189). Crucial here, is that interpretations are grounded on a reading from *within* the terms of the text that the participant has produced. (Smith, Flowers & Larkin, 2009, p.37).

Idiography and its concern with the particular comprise the third theoretical foundation of IPA. An idiographic approach aims for an in-depth focus on the particular and commitment to a detailed micro-analysis of participants' experiences that is less feasible in nomothetic research studies which focus on aggregated data (Smith, 2004). Its objective is not to make generalizable claims but to make informed speculations about the studied phenomenon (Smith & Osborn, 2003). An emphasis on the particular requires cautious and careful analysis and therefore, usually draws on a small number of participants or a case study. Some of the task may involve exploring similarities and differences between each case. Although Smith and colleagues contend that individuals can offer a unique perspective on their engagement with phenomena, they also agree that the details of a single case can help us understand what we have in common by virtue of our shared humanity (Smith, Flowers & Larkin, 2009, p. 32).

In terms of the current study, research, IPA provides a clear theoretical and methodological framework with which to explore the experience of recognizing a blind spot for a small number of individuals. It aligns with my epistemological stance

and is particularly appropriate to address my research question. As a novice researcher, it also provides me with a structured process of analysis, which also allows for a certain amount of adaptation to meet the challenges of whatever this research produces (Smith, Flowers & Larkin, 2009).

### **3.4.1 Limitations of IPA**

The strength of IPA lies in its ability to identify meanings and develop understandings through sustained interpretative engagement (Finlay, 2011). Like all forms of phenomenological research, IPA suffers from both conceptual and methodological limitations. Willig (2013) identifies the role of language and the suitability of accounts as well as the question of explanation versus description.

IPA has been criticized for not giving sufficient recognition to the integral role of language and the extent to which language constructs, rather than describes reality (Willig, 2013). Although IPA recognizes the action-oriented nature of talk and how meaning-making takes place using certain kinds of resources (narrative, discourse, metaphor, etc.), this represents only a partial account of what people are doing when they communicate. For IPA, a primary focus is with understanding lived experience through the *expressive* function of language (which is enmeshed with language and culture). It is strongly influenced by Heidegger's description of language as 'The house of Being' and his assertion that 'our interpretations of experience are always shaped, limited *and* enabled by language' (Smith, Flowers & Larkin, 2009, p.194).

Questions have also been raised about whether IPA can accurately capture the experiences and meanings of experiences rather than opinions of it. Following the hermeneutic turn, IPA does not claim to uncover 'pure experience' which Smith and colleagues (2009) view as wholly inaccessible. Instead the aim is to get 'experience near' accounts by focusing on the sense-making process and attending to subtleties and nuances both in what is said and what is unsaid. As in most qualitative studies, IPA research is limited by participants' capacity for self-expression. This was less of a concern with the current study as all participants were familiar with sharing their personal and professional experiences at therapy and supervision.

In addition to criticisms about the ambiguous role of language in IPA, Willig (2013, p. 95) asserts that although phenomenological research describes and documents the lived experience of participants, it does not further our understanding by attempting to explain it. Smith et al (2009) have argued that IPA uses hermeneutic, idiographic and contextual analysis to understand the cultural position of participants. They address this argument when illustrating how IPA conforms with Yardley's (2000) yardstick of sensitivity to context (one of Yardley's principles for assessing the quality of qualitative research). This is expanded upon later.

Another criticism levelled against IPA concerns the extent to which its concern with accessing participants' cognitions runs counter to the aims of phenomenology (e.g., Willig 2001; Langdrige 2007). Willig (2013) maintains that Smith's (1999) version of the phenomenological method invokes a Cartesian conceptualization of the mind with the aim of research being explication of these internal processes. Furthermore, according to Willig, such an approach is incongruent with phenomenological philosophy and the notion of intentionality, which emphasizes the fact that consciousness is not something *internal* to a person but something that occurs in the relationship *between* people. These criticisms may be based on a misconception that IPA researchers claim to be investigating cognition *directly*, or, simply to be "doing" cognitive psychology (Larkin, Eatough & Osborn, 2011, p.13). From the perspective of IPA, like phenomenology more broadly, cognitions are not isolated separate functions but are intricately connected with our engagement with the world. They are 'dilemmatic, affective and embodied' (Smith, Flowers & Larkin, 2009, p. 191). Furthermore, they are accessed indirectly through peoples accounts and stories, through language, and ultimately, meaning making (Smith et al, 2009). It is here that relational phenomenologists focus their attention in the belief that much of what we can learn and know about one another emerges within the intersubjective space between researcher and participant (Finlay, 2009).

### **3.5 Alternative methodologies**

Several qualitative methods including Grounded theory, Discourse analysis and Narrative approaches were considered and are briefly outlined here to contextualize my final decision to use IPA.

The first approach considered was grounded theory, a very popular method and often seen as the main alternative method for someone considering IPA (Smith et al, 2009). Grounded theory (GT) was originally developed by Glaser and Strauss (1967), and is concerned with generating a theoretical-level account of a particular phenomenon by comparing individual accounts of personal experience. Although Grounded Theory is used to address a number of different types of research questions, its principle concern is with social and social psychological processes (Charmaz, 2006) rather than individual experience. Thus, it is probably more appropriate for questions about influencing factors and the social processes that underpin a particular phenomenon (Braun & Clark, 2013, p.186). Furthermore its central aim of generating theory is at odds with the aims of this study: to access experience-near accounts of the phenomenon of interest in order to uncover the essence of 'what it is like,' to have a particular experience.

Also considered was Discourse analysis (DA), which can be classed as a social constructionist approach to research. Fundamental to the approach is how language is represented not as reflecting psychological and social reality but as *constructing* it (Lyons & Coyle, 2015, p. 183). Here the focus is exclusively on discourse itself; how it is constructed, it's functions, and the consequences, which arise from different discursive organization (Potter & Wetherell, 1987, p. 178). IPA shares some common ground with discursive psychology; it recognises the action oriented nature of talk and that people want to achieve a range of objectives with their talk such as save face, persuade and rationalize (Eatough & Smith, 2017). It also recognises that reality is contingent upon and constrained by the language of one's culture (Willig, 2003). However for IPA this only represents a *partial* account of what people are doing when they communicate and that missing from such accounts are the private, psychologically impactful, rich and often indefinable aspect of emotional life (Eatough & Smith, 2017, p. 22). Discourse analysis does not attribute motives to participants and therefore does not assume that their words reflect experiences that participants may or may not be aware of (Lyons & Coyle, 2015). Indeed discourse analysis has been criticised for 'a lack of a person' (Langdrige, 2004, p. 345). Although Foucauldian discourse analysis (FDA) does offer insights into the relationship

between discourse and subjectivity, it does not provide the researcher with the tools to study non-linguistic dimensions of experience (Willig, 2013, p. 179).

In contrast, IPA assumes that the researcher *can* access motives and understandings that the participant finds difficult to express or is not aware of (Smith et al, 2009). Given my interest in understanding the dynamic nature of persons' *experiencing* and the idiographic dimension of first-person meaning making, discourse analysis was deemed unsuitable.

Narrative analysis refers to a family of qualitative methods for making sense of 'storied' data and was strongly considered for the current study. Like IPA, narrative analysis focuses on a small number of individuals or a group in order to offer insight into lived experience (Bruner, 1990). IPA has a particular affinity with those approaches, which view narrative as an interpretive feat (Bruner, 1987, p. 13). Although narrative analysis is to some extent phenomenological with its interest in narrative as a mechanism for understanding life experience, the focus is on how participants construct meaning and make connections between the past and the present, and how this may shape their experience today.

In terms of the person of the participant, narrative analysis refers to concepts such as 'self' and 'identity' primarily in relation to the narrative. Narrative analysis might contribute a reflection on the role of language and sequencing in meaning making, by showing how the experience of recognising a blind spot has been structured to become part of the participant's life story. Furthermore, its focus on the social and psychological consequences of the stories people tell and how these stories shape their lives did not seem to provide sufficient scope to elicit the 'what is there' element that was sought in this study. While this approach may help us draw conclusions about *why* an experience is as it is, it cannot tell us what actually happened to our participants and how these events affected them at the time of their occurrence. Indeed this is a limitation of all interview methods as a description of past events cannot be taken as equivalent to the reality of events as they occurred. Howitt succinctly describes the difference between both approaches: 'the contrast is simple - the lived life of experiences or the storied life of the narrative' (Howitt, 2010, p. 329).



In order to access how the events in the narrative are *experienced* rather than what the narrative has to say about identity (Howitt, 2010, p. 382), a phenomenological approach was deemed more appropriate.

Another important consideration in choosing the methodology for the current study was deciding what approach might best generate data with participants who might find it difficult to put their sense of vulnerability into words. Sometimes we feel vulnerable precisely because we find it difficult to make sense of our suffering. It's what we both know and *don't know* that becomes manifest through behaviours and attitudes rather than words. Terms such as "implicit relational knowing" (Lyons-Ruth, 1998), the "unthought known" (Bollas, 1987) and "the felt-sense" (Gendlin, 1981) offer different perspectives on this realm of embodied situated cognition. Given that embodiment is an inescapable presence in the lifeworld, it was envisaged that phenomenological research could engage with it through bodily empathy, embodied self-awareness and embodied intersubjectivity (Finlay, 2006. p.19). Here the challenge for the researcher was to arrive at a position where interpretations could be made about constructions that in a sense lie beyond articulation, and yet are reliant on language to reveal them (Carpenter, 2009, p. 4).

Given that the objective of qualitative research is to describe, to understand and to sometimes predict, it would seem that qualitative research and *interpretation* share a concern with making sense of experience and developing understanding (Willig, 2012, p, 22). However the process of interpretation can generate very different types of accounts, and therefore different kinds of knowledge ranging from apparently 'descriptive' translations of surface meaning to a deeper meaning which 'get to the truth of the matter' (Willig, 2012, p. 10). Generally speaking, these two different orientations to 'analysis' represent interpretation driven by 'suspicion' and interpretation driven by 'empathy' respectively (Ricoeur, 1970). Suspicious interpretation is similar to detective work where the aim is to find out what 'really happened.' They are explanatory to the extent that the aim is to generate an account that can *explain* a phenomenon by referring to its underlying meaning (Willig, 2012). One example of such an approach is the Free Association Narrative Interview

technique (FANI), an approach that draws on psychodynamic theory to understand (interpret) participants' psychic defences (Hollway & Jefferson, 2013).

On face value such an approach might seem suited to a project that seeks to understand therapists' blind spots and the realm of implicit, unconscious knowledge. However, its epistemological concerns did not fit with my epistemological stance that prizes present centred empathic immersion as a way of developing understanding. Clearly the type of interpretation employed depends on the researcher's epistemological position. Other factors such as the researcher's ethical, political and intellectual commitments also influence decision making. In terms of my values, my approach to research is similar to how I work as a therapist, I believe in the potential of empathic immersion and phenomenological inquiry as a means of developing understanding and new insights. An empathic approach seeks to elaborate and amplify the meaning that is contained within the material that presents itself (Willig, 2012). Following this approach, it was envisaged that empathic interpretation had the potential to shine a light on what might be absent (thus leading to blind spots) in participants' accounts.

In IPA both 'bottom up' descriptive analyses and 'top-down' theory-driven interpretations have a place in the analysis. However the dual reading is always stimulated and rooted in the participant's personal experience (Smith et al, 2009). Equally important in this hermeneutic enterprise is the researcher's attention to the intersubjective space and that this is explored reflexively. Finlay describes how analysis of the emergent dynamics within the research relationship can offer a window on the 'creative adjustments' or the defensive strategies a person has developed in order to cope (Finlay, 2009, p. 2). In the current study this was envisaged as a secondary but integral source of data from which meaningful findings could be found.

### **3.6 Method**

In this section I begin by presenting the research design for the study followed by the criteria used to select participants and the recruitment process. This is followed by a

description of data collection and procedures followed by the process of analysing the data. Next, I provide details of how the study addressed a range of ethical and evaluation considerations. A section describing procedural reflexivity concludes the chapter.

### **3.6.1 Design**

This research was carried out according to the principles of IPA (Smith, Flowers & Larkin, 2009). This design values the relationship dynamic between researcher and participants and views the data collected from each participant as emerging out of the shared intersubjective space between researcher and participant (Finlay & Evans, 2009).

IPA is associated with a small, purposive, homogeneous sample where the emphasis is on depth rather than breath of data. The data was gathered by semi-structured interviews, which were then transcribed verbatim. Transcripts were then subjected to detailed qualitative analysis in order to elicit key experiential themes in the participant's talk (Smith, Flowers & Larkin, 2009; Finlay, 2011). This provided an idiographic account of each participant's experience before moving on to the development of a subsequent microanalysis of similarities and differences across cases. The collective data was then systematically organised into superordinate and subordinate themes, which appeared to capture the essence of the participants' accounts

### **3.6.2 Selection and recruitment of participants.**

Five participants were recruited in accordance with guidelines for a small sample size deemed appropriate for IPA. A primary concern of IPA is with obtaining a detailed account of individual experience, therefore IPA studies usually benefit from a concentrated focus on a small number of cases (Smith, Flowers & Larkin, 2009, p.51). Participants were selected on the basis that they could offer a perspective on the phenomena under study. The objective was to recruit a sample that satisfied the criteria for homogeneity associated with IPA's inductive principles (Smith et al, 2009). It was decided to recruit integrative psychotherapists or counselling psychologists who subscribe to contemporary integrative relational approaches. These

perspectives stress the mutuality of the therapeutic process as a co-construction between therapist and client. This 'two person' approach is in line with current ideas within contemporary relational psychotherapy such as intersubjectivity theory, which emphasizes the concept of 'reciprocal mutual influence' (Stolorow & Atwood, 1996, p.181). The common factor between these therapists is their focus on relational processes, which meant they met the criteria for homogeneity. Less important in terms of homogeneity, was the therapist's treatment modality. Within the integrative paradigm, the therapist's use of self, the techniques used, views on transference and countertransference and self-disclosure can vary widely.

Another important factor was that participants were qualified therapists who had experienced personal therapy and if necessary, access to further therapy to deal with difficult issues that might arise through participating in the research. Personal counselling is a mandatory part of training for both UKCP Integrative psychotherapists (160 hours) and counselling psychologists (40 hours). Arguably it supports therapists' resilience and capacity to reflect on their psychological processes so that they can be 'emotionally available' for their clients. Regular consultative supervision is also important in this regard (Carroll, 2009; Carroll, 2010) and is considered an essential part of good, ethical practice by both the UKCP (2019) and the British Psychology Society (BPS, 2017).

In terms of participants, a fairly homogenous sample (Smith et al, 2009) was sought that met the following criteria:

- Participants are qualified practicing integrative psychotherapists (UKCP registered) or counselling psychologists (HCPC registered) and are currently practicing relational integrative psychotherapy
- Participants are currently seeing individual clients and are in regular supervision.
- Participants have access to personal therapy if necessary.

**Exclusion criteria:**

The decision to exclude therapists who work mainly with specialist clinical populations (e.g. eating disorders; addictions) was made after the pilot interview. This decision is explored in the section describing the Pilot Study. Also excluded were therapists such as clinical psychologists (HSBC) and counsellors accredited by the British Association of Counselling and Psychotherapy (BACP) for whom personal therapy is not mandatory during their training.

Participants were initially recruited using a snowballing sampling method commencing with colleagues and supervision network who were asked to distribute the study's approved printed information sheet through collegial networks (Appendix 1 and Appendix 2). The first participant who came forward took part in what proved to be the Pilot Study. This is described below. One month later, a further three more participants who met the selection criteria came forward from collegial networks.

After several weeks, no further prospective participants came forward so it was decided to advertise with the British Association of Counsellors (BACP), the United Council for Psychotherapy (UKCP), London Counselling Psychologists and the British Psychological Society (BPS). All agreed to display a copy of the advertisement on their Facebook and Twitter pages (Appendix 3). Four prospective participants responded to the advertisements. From this group, two therapists met the inclusion criteria and two were excluded on the basis that they were clinical psychologists who had no experience of personal therapy and therefore did not meet the selection criteria (one male and one female).

Of the five participants chosen to participate in the study, four were white, middle class women, aged between 42-62. The fifth participant described herself as 'mixed race'. Two of the participants grew up in the UK and three were from outside the UK. All participants had post-qualification experience ranging from 2- 18 years. One participant was an integrative psychotherapist (UKCP) and the remaining four were counselling psychologists. All participants worked in private practice and three of the

four counselling psychologists also worked in mental health units in hospitals. (See Appendix 4 describing Participant Characteristics)

### **3.6.3 Interviews**

Semi-structured, one to one interviews have tended to be the preferred means for collecting data in IPA studies (Smith et al 2009). This form of interviewing allows the participant and researcher to engage in a dialogue whereby initial questions are modified in the light of participants responses and there is sufficient flexibility for the researcher to explore any areas of interest that arise. Smith and colleagues emphasise number of interviews (rather than participants) of “between four and ten” for professional doctorates (Smith et al, 2009, p.52).

Participants were interviewed on two occasions. The decision to interview participants twice was made on the basis that a second interview would facilitate exploration of themes developing from the first interview within the context of a deeper, and therefore more trusting relationship between interviewer and participant (Roulston, 2010).

The first interview schedule comprised of questions designed to capture the chronological sequence of recognising a blind spot. This involved constructing questions that would facilitate participants to describe the temporal dimensions of their lived experience. In the first instance, the focus was on obtaining a retrospective account of the participant’s unfolding lived experience *before* they recognised their blind spot. The purpose of this line of inquiry was to acquire data that might capture the participants’ implicit theories while they lacked awareness of their blind spots. Next, participants were invited to describe how they became aware of the blind spot and finally, the subsequent meaning and consequences the experience carried for them. The second interview took place approximately one month later to allow time for new insights to develop and potentially other blind spots to be discovered as participants expanded their relational knowledge. Here the interview schedule consisted of two questions designed to elicit participants’ further reflections on their experiences of recognising personal blind spots and talking about them with the researcher.

### **3.6.4 Journals/ Diaries**

Participants were invited to keep a journal or diary between the first and second interview in order to record their thoughts, activities and feelings in relation to their experience of recognising a personal blind spot. They were also encouraged to bring this information for further discussion at the second interview. The decision to use journals/ diaries was based on a couple of factors. Willig (2013) suggests that diary entries avoid problems associated with retrospective reporting of events that can be influenced by the participant's present circumstances, retrospective interpretation of events or tendency to forget the details. Diaries also facilitate access to data that can provide a chronological sequence of how events unfold prospectively in real time (Willig, 2013, p. 34). In the current study, the journal was not prescribed as a method of data collection per se, i.e. where the journal is collected and text analysed by the researcher after the interviews. Instead it was envisaged as a tool that might encourage the participants to continue to reflect on their experience of recognising a blind spot between interviews and a means to note further insights and new experiences that might be shared with the researcher at the second interview. It was anticipated that participants might be more reflective about potential blind spots as a result of the first interview (raised awareness) and available to share their developing insights (based on developing trust). No demand was put on participants to maintain a journal, nor were guidelines offered in terms of structure or frequency.

### **3.6.5 Information and Consent**

Once participants made contact with me, they were sent an information sheet and consent form (Appendix 6) to be discussed and signed at the interview. The information sheet included my contact information and that of my supervisor, so participants could get in touch regarding any additional questions or clarifications (Appendix 2). Due to the possibility of the interview eliciting unanticipated sensitive material, participants were also sent a copy of the interview schedule prior to giving consent (Appendix 5).

### **3.7 Pilot study**

The first participant 'Chris' provided what proved to be the pilot interview for the study. Chris volunteered to participate when he read about the study on a leaflet

distributed through my collegial network. After considering the information, Chris completed and signed the consent form prior to the interview, which took place at his consulting rooms. The interview lasted 75 minutes and was then transcribed. This interview was dwelt upon in considerable detail, however it was not subjected to IPA, as it did not sufficiently address the research question. A review of the interview transcript indicated that the research questions needed to have a clearer focus on exploring the actual *lived experience* of recognizing a blind spot, as opposed to obtaining a description of blind spots per se. This was not clearly understood by the first participant whose account focused on descriptions of therapist blind spots in general and blind spots that he used to have, rather than his *lived* experience of recognizing one through his therapeutic work. This misunderstanding may have been partly based on how the questions were constructed although this was not apparent when I discussed the questions with colleagues and supervisors when designing the interview schedule.

On reflection, I noticed how throughout the interview Chris adopted a pedagogical role with me. This might have been related to his job as a psychosexual therapist working with sexual addiction where psycho-education comprises a large component of his work. As a result of the pilot interview, it was decided to exclude therapists who mainly work with specialist populations (e.g. eating disorders and addictions). This also served the purpose of creating a more homogenous sample for the study. I also took great care to ensure that prospective participants understood the focus of my inquiry was on obtaining 'experience near' accounts of recognising a blind spot as well as a description of how their blind spots became manifest in their work. I emphasized how this might involve describing sensory perceptions as well as mental phenomena (thoughts, memories, associations, fantasies) and, in particular, their interpretations (Pietkiewicz & Smith, 2014). This was an important clarification in terms of mapping the terrain I wanted to explore. Questions were subsequently adapted to ensure a focus on participants' 'lived experience'. For example, after participants were asked to describe what happened when they became aware of a blind spot (Question 7: Appendix 6), they were invited to retrospectively describe their experience on a physical, emotional and cognitive level in as much detail as possible as if it was occurring in real time.



### **3.8 Procedure**

Semi-structured interview questions were printed on an interview schedule for use by the researcher and used to elicit participants' experiences of recognising a blind spot through their therapeutic work (See Appendix 6). Interviews were held at the participants' workplace or home, subject to their convenience. The first interviews lasted between 60-90 minutes and included a review of the study information and consent procedure as detailed in the pilot interview. A second interview lasting 30-60 minutes was conducted approximately one month later. Participants were also encouraged to keep a journal recording any experiences or insights that came to light between the first and second interview.

#### **3.8.1 Data collection**

A crucial factor at the beginning of an interview is establishing a rapport with the participant. Mindful of my position as a researcher (and the power inherent in that), I employed empathy to promote dialogue and shared with the participants my personal interest in the topic; how my own personal blind spots had led to ruptures or collusions in my clinical work. My intention here was to somehow equalise the power dynamics between us and to promote a collegial atmosphere. At all times I strove to be mindful to the sense of vulnerability and potential shame that can be triggered when one feels exposed or embarrassed.

All interviews were recorded and transcribed with all identifying information removed from the transcript. Once this task was complete, the recordings were destroyed.

#### **3.8.2 Data analysis**

IPA analysis is iterative, inductive, fluid and emergent although Smith and colleagues (2009, p. 79) offer a helpful six-stage approach outlining 'common processes' for analysis, which are described below. I transcribed the interviews myself and listened to each interview several times, noting hunches and intuitions in my reflexive journal. After this, I set about the task of analysing each participant's contribution. My supervisor encouraged me to adopt a flexible approach to data analysis and to allow time for dwelling with the data to allow different levels of meaning to emerge.

### **Step 1. Reading and re-reading**

As I read through each participant's transcript, I noted initial musings about words or phrases that seemed particularly thought provoking or pertinent. By immersing myself in the text, I sensitized myself to participants by familiarizing myself with their modes of expression and tone. I noted questions and thoughts that came to mind and recorded them in my reflexive journal alongside the notes I had made about my experiences during the research interviews.

### **Step 2. Capturing 'Descriptive Themes'.**

A 'Descriptive Theme' capturing the semantic content of each line of the transcript was noted in the margin of the text (Appendix 7). Each description had a 'clear phenomenological focus' that captured the participant's core concern (Smith, Flowers & Larkin, 2009, p.83). This step reflects a stage in the process of the hermeneutic cycle where the emphasis is developing an empathic understanding of the participants' concerns.

### **Step 3. Developing 'Emergent Themes'.**

The data was reduced into a smaller number of 'Emergent Themes' (Appendix 8) that related to the research questions. These themes recorded the essence of the participants experience together with my interpretation of this, a process that marks the juncture between description and interpretation (Larkin, Watts & Clifton, 2006).

### **Step 4. Searching for connections across emergent themes**

In order to map out how the various themes fitted together all the themes were listed in chronological order and then rearranged into groupings that captured how they related to each other. I repeated this exercise with a colleague to gain a fresh perspective and to reduce the data further.

### **Step 5. Moving to the next case**

After working through the first participant's transcripts and organizing a table of potential themes, I repeated the process for the remaining participants. In keeping with IPA's idiographic commitment, I endeavoured as far as possible to bracket ideas

emerging from preceding cases so that I could 'meet' each participant's experience on its own terms.

### **Step 6. Looking for patterns across cases.**

The next stage involved looking for patterns across cases. I became aware of strong connections between themes in certain areas and weaker links in terms of others. In some cases this stimulated a reconfiguration and labelling of themes. Regarding the themes through a more conceptual lens enabled me to deepen my analysis and draw on higher order concepts to describe what individual cases share. This resulted in the identification of three superordinate themes and five subthemes, which are explored in the next chapter.

A chart was drawn up to illustrate the progression towards the development of final superordinate themes through the process described above. All the analysis was carried out by pen and paper before it was typed out for presentation in the appendices (Appendix 9).

### **3.9 Ethical considerations**

Throughout the research process, attention was paid to key ethical principles related to duty of care, informed consent and confidentiality. From the outset, all participants were informed they could withdraw from the research process at any time up to the writing up of the thesis.

From the outset, I was aware that talking about these experiences might evoke distressing feelings such as embarrassment and shame or stimulate the recurrence of old wounds. In order to minimize the impact, one of the preconditions for being a participant was having access personal therapy for support if needed. All participants were experienced therapists who had experienced therapy during their training. Indeed two of the participants were in therapy at the time of the interviews although this was not stipulated as a requirement. I also prepared a list of local therapists that participants could refer to if required.

Participants were sent a copy of the semi-structured interview so that they would have an opportunity to consider and reflect on the questions before doing the interview and prior to giving consent. Even with these safeguards, there are limitations to informed consent. While participants had consented to taking part in the research, there was no way of knowing until the interviews took place what impact disclosures might have on a them.

Participant accounts of personal blind spots have the potential to elicit unethical conduct (such as sexual misconduct, inappropriate personal disclosure or extra-therapeutic relationships). In order to minimize this, a number of strategies were put in place. Firstly, the information sheet included a paragraph stating that the researcher is not interested in grossly unethical practice. This information was reiterated in the consent process, immediately prior to the interview. Participants were advised what measures would be taken should they disclose such violations so they were aware of the consequences (e.g. informing my supervisor, contacting appropriate safeguarding bodies).

Throughout the interview process, I drew on my sensitivity, empathy and therapeutic skills to monitor how the interview was affecting each participant. I also checked with participants throughout the process to ensure they were not unduly upset. Time was allowed at the end of each interview to discuss any concerns that may have arisen through taking part. Participants were also given both my contact details and that of my supervisor if they wanted to discuss any matters or problems arising from the interview.

The proposal for this research was granted full ethical approval by the Metanoia Ethical Committee and guided by the ethical codes of the British Psychological Society (BPS) (Appendix 10). In practice, ethical research involves cultivating an ethical sensibility where monitoring and reflection underpin the whole research process. As mentioned previously, all participants were provided with a 'Participant Information Sheet' and completed a 'Research Consent Form' that reiterated their right to withdraw from the research project at any point.

All audio- tapes and transcripts were kept in a locked cupboard. Typed transcripts were kept in secure computer files and names of each participant and any clients, places of work or identifying features related to training institutions were changed to preserve anonymity. After each interview, participants were offered the opportunity to receive a copy of the transcript in order to change or remove any identifying features. Only one participant requested a copy of the transcripts for both her interviews in order to remove some details that she thought might compromise her anonymity.

### **3.9.1 Validity and Quality.**

A number of guidelines for assessing quality or validity in qualitative research have been produced. Smith et al (2009) favour approaches by Elliot, Rischer and Rennie (1999) or Yardley (2008) due to their “sophisticated and pluralistic stance” (p.179). The current study has sought to comply with all four of Yardley’s (2008) guidelines for assessing validity and quality in qualitative research.

The first principle is ‘sensitivity to context’ which can be established in a number of ways (Yardley, 2008). I undertook a thorough literature review around the subject of blind spots as well as its relationship to psychological therapy and therapists in order to contextualize this study. In order to show sensitivity to my participants’ accounts, my analysis and interpretation employed an idiographic focus on each individual participant’s context. Semi- structured interviews were carried out in such a way as to encourage narratives to flow naturally. Due to the sensitive nature of the subject matter of the research, each participant was interviewed twice in order to allow a rapport to develop between researcher and participant. Throughout this process, I communicated empathy, transparency and rapport to foster dialogue and to equalize as far as possible the power relations between my participants and myself. This transparency was also employed by my use of reflexivity in order to assess my influence on the research process.

Yardley’s second broad principle is ‘commitment and rigour’ (Yardley, 2008). My commitment is shown by my immersion in the research process and my use of reflexivity, an important component of any interpretative study, at every stage of the project. Rigour is evidenced by the thoroughness of the study, my attention to

sampling, the quality of the interview and the completeness of the analysis undertaken (Smith et al, 2009).

The third broad principle is 'transparency and coherence.' I have described in detail the different stages of the research process. This is shown in the use of appendices to demonstrate the logic of the iterative stages followed in the research. This process was overseen by my supervisor's on-going monitoring, in particular in relation to the transcripts and the extraction of themes. I also attended regular IPA meetings with peers at the Tavistock Clinic in Belsize Park, in order to discuss my research process and findings and to ensure I was following the principles of IPA in terms of method and methodology.

Finally, Yardley (2000, p. 223) argues that a piece of research should be judged by its impact and significance, since "it is not sufficient to develop a sensitive, thorough and plausible analysis, if the ideas propounded by the researcher have no influence on the beliefs of anyone else." I have endeavoured to connect my findings with the wider literature in the field of psychology and therapy. However the extent to which this fourth principle has been achieved, can in some part, be judged by the reader when reading the implications section of the discussion chapter. Since carrying out this research, I have trained as a clinical supervisor for therapists and have been actively promoting its findings.

### **3.9.2 Independent audit**

In addition to Yardley's (2008) four criteria, Smith and colleagues (2009) discuss the value of an independent audit in contributing to validity in qualitative research. One way of doing this is filing all the data in a way that allows the research to be 'tracked' by providing a trail of evidence from initial notes through to the final report (Yin, 1989). This procedure allows an independent researcher or supervisor to check the paper trail between data and interpretation.

The current study demonstrates congruence with the goals of independent auditing through provision of appendices that demonstrate and document every stage of the

research process. It was also aided through dialogue with my Supervisor and peer researchers at the IPA meetings I attended at the Tavistock Clinic.

### **3.10 Personal and Methodological Reflexivity**

At the beginning of the beginning of this chapter, a number of epistemological issues were considered; e.g. assumptions about the type of knowledge this research seeks to generate and ontological assumptions about the world and how these might influence the research. In this final section I engage in personal and methodological reflexivity as a way of processing the various influences on this research study (Finlay, 2009).

### **3.11 The impact of the personal interview**

Before the research proposal was submitted, a colleague was invited to interview me about my personal experiences of encountering blind spots through my clinical work. The interview enabled me to gain greater clarity about my personal beliefs and assumptions. These were discussed with both my research supervisor and clinical supervisor and are described in the reflexivity section in the introduction chapter to this study.

During initial discussions with my research supervisor, I realised how I related most of my experiences of being caught in a blind spot to patterns of behaviour connected to childhood scripts (e.g. being productive, being responsible, self-sacrifice). My supervisor reminded me of the wider context of blind spots which may simply arise out of stresses in a therapist's current situation such as problems in his/her personal life. Perhaps more significant in telling my story to my colleague and supervisor, was the sense of personal exposure and vulnerability I experienced while sharing my experiences of personal blind spots with a person who was not sharing theirs with me! The sense of embarrassment I experienced was both a revelation and surprise to me as I'm familiar with talking about my vulnerabilities during therapy and Supervision. Important here was recognising the different context of these professional relationships. In therapy and supervision there is an opportunity for trust and intimacy to develop over time as bonds are forged and strengthened through rupture and repair (Safran & Muran, 1996). Notwithstanding the above, Herman

(2011) observes that the individual therapy relationship is to some degree inherently shaming because of the power imbalance between patient and therapist, and because the patient exposes his or her more intimate thoughts and feelings without reciprocity. Given that the focus on therapist blind spots encourages an inward focus on self – especially the problematic and even feared aspects of self, I was very aware of the power dynamics between researcher and participant. In order to promote a greater sense of mutuality and trust, I decided to share with them my motives for doing the research i.e. how my experiences of personal blind spots had led to collusions and ruptures in my clinical work. I hoped that by exposing my vulnerabilities (with its accompanying risk of judgement and shame) my participants might non-defensively join me in exploring this emotional landscape in a spirit of self-compassion and curiosity. It was also decided to interview participants twice to allow time for a deeper and therefore more trusting relationship to develop between interviewer and participant (Roulston, 2010).

*Out beyond ideas of wrongdoing and rightdoing, there is a field. I'll meet you there.*

(Rumi 1995, p. 36)

### **3.12 My presence in the interview process.**

An important consideration in qualitative research is considering the extent to which participants' accounts may have been influenced by my presence during interviews. Along with knowing I was a on a counselling doctorate training, participants were also aware that I was an experienced psychotherapist. I believe this contributed to them seeing me as an 'insider' as opposed to an 'outsider' and facilitated the interview process as we explored the phenomenology of being caught in a blind spot together. There were moments throughout the interviews when the participants seemed to develop fresh insights about a personal blind spot and all of them expressed gratitude for the opportunity to participate. I also believe I managed to make the interviews therapeutic without becoming therapy (Willig, 2013).



### **Intersubjectivity and the research relationship.**

A relational approach to qualitative research emphasises how data emerges out of co-created, embodied, dialogical encounters between researchers and their participants. Particular attention is paid to exploring the participant's *being-in the world*, including his or her 'creative adjustments' or what one might describe as the defensive strategies the person has developed in order to cope (Finlay, 2009, p. 2). Finlay (2003) describes how the researcher's attention moves between the phenomenon being researched and the research relationship as it unfolds in a particular context. In the current study an exploration of the specific interpersonal therapy events in which participants' personal blind spots became manifest assisted in the development of contextualised hypotheses about each participant. The goal of attaining a deep and empathic understanding of each participant's experience of blind spots in a therapeutic relationship was further supported through the use of reflexive processes. Here my attention was guided by attending reflexively to the body and embodiment through three distinct, though connected, layers: bodily empathy, embodied self-awareness and embodied intersubjectivity (Finlay, 2006, p. 19). Here I drew on my therapeutic skills to attend to the non-verbal domain: what Jungian analyst Mario Jacoby describes as 'that which partly reveals itself by the intonation of their voice, the expression of their face, their body-language, their kind of vitality, harshness, softness, warmth or lack of emotion or whatever' (Jacoby, 1995, p.81). As tentative hypotheses were formed, I was excited at the thought that these intuitions might illuminate aspects of a blind spot that could not be 'spoken' but which were lived out through the participants' attitudes or forms of engagement with the phenomenon of inquiry. I also noted signals of developing countertransferences that held the potential for deeper analysis. These burgeoning intuitions began to form from the moment I met a participant and inevitably shaped the evolution of the intersubjective in each individual encounter. Immediately after each interview, I recorded my emotional responses, intuitions and observations about each participant in a reflexive journal in order to make transparent potential biases that might obstruct or inform my understanding of the participants' meaning making when I analysed the texts later.

Throughout the interviews, my attention to participants' body language enabled me

to empathise and build a rapport with them quite quickly. During the initial interviews I struggled to carry the role of 'researcher', which for me meant using a slightly 'cooler' and more formal register of communication. It felt somewhat counterintuitive to the warm demeanour that is more natural for me both personally and professionally in my work as a therapist. I managed this tension by reflecting on my role as a researcher, a role I inhabited with greater confidence as I gained experience. Outlining my personal assumptions and epistemological framework in earlier sections of this report enabled me to hold my ground as a researcher rather than get pulled into the role of a therapist.

On the other hand, the fact that I was *not* engaged in a therapeutic or supervisory relationship with participants made me uncomfortable about inquiring more deeply into what seemed to me, their patent sense of personal exposure as they shared their experiences with me. Their vulnerability was evident not only in their accounts but also in *how* they spoke; for example self - deprecating comments and moments of confusion or quickly changing the topic. Finlay suggests that attention to participants' bodily gestures are a way of accessing a person's lived experience. Not only is tone and gesture reflection of a person's subjective feelings – they are the feelings (Finlay, 2006, p. 23). At these times I was very aware of participants' sense of embarrassment and on occasion, guilt and I was wary of causing further shame by asking about behaviour that might be considered curious or questionable but not shameful. Noteworthy here is how my fear of coming across as judgemental about behaviours that the participants themselves came to regard as poor judgement triggered shame processes in me. In hindsight, as I reflect back on my process, I wonder to what extent the participants sensed my fear of shaming them. Perhaps by my avoidance of the proverbial elephant in the room, there was an implication that their behaviour was shameful. Throughout the analytic process that followed, I became more aware of the impact of my presence on what transpired during the interviews and how my fear of shame and tendency to avoid it was a significant blind spot for me. Although the interviews were productive and therapeutic, I am left with a sense that my fear of shaming the participants may have led to a collusion between us as they too sought to avoid the feelings of shame that were evoked.

### **3.13 Procedural reflexivity**

The pilot interview raised my concerns about the extent to which participants understood the aims and focus of my research. Clarifying the research question with participants was important for making sure I did not waste their time. The pilot interview also helped me to clarify group homogeneity with greater rigour. Most of the participants who came forward were educated (At least masters level qualification) middleclass women similar to myself. Three of the participants were from overseas but worked in London (one mixed race and two white). The other two participants were white English. This multinational demographic profile seems to reflect London as a whole. All participants were of middle age (42-62) perhaps reflecting the degree of maturity and life experience it takes to volunteer to talk about one's blind spots with a sense of equanimity. I believe the fact that the participants were 'older' contributed to the study in terms of showing that the process of developing critical awareness requires on-going self discipline and is never complete. On the other hand, a limitation of the study is a lack of diversity in terms of the range of participants. It would be interesting to include the voices of a wider range of participants, for example, men, different ethnic groups and a younger age range.

Although all of the participants were invited to keep a journal to record their reflections between the two interviews, none of the participants concurred. One of the participants referred to notes that she had written beside the interview questions in preparation for the first interview. Willig (2013) argues that the diary method suffers from poor recruitment due to the high demand it puts on participants. Clearly keeping a diary or journal requires considerable motivation and commitment. Although no demand was put on participants in the current study to maintain a journal, it is possible that with more encouragement and guidance by the researcher, there may have been more compliance. I decided to leave it up to the participants to make their own decisions about what data to bring. An important touchstone as I navigated the process of data collection was embodying the attitude of a curious fellow traveller rather than a detective:

‘The IPA researcher aims to enter into the lifeworld of the participant rather than investigate it: to move between guiding and being led: to be consciously naïve and open; and to be receptive to change and ambiguity’ (Eatough & Smith, 2017, p. 30).

My interview schedule for the second interview (Appendix 5) involved only two questions as I was relying on new data being brought based on reflections activated by the first interview. On reflection it may have been more effective to study the first interview and mark out themes that I could follow up in more detail at the second interview (Hollway & Jefferson, 2000). With the benefit of hindsight, I can see how this might also have alerted me to how fear of triggering shame in my participants might impact on the interview process. It would also have been beneficial to explore this topic in supervision as it may have encouraged me to address the topic of shame with participants during the second interview.

The second interview was important in providing significant new data. Arguably the request to keep a journal was not necessary. All participants described the therapeutic benefits of talking about their blind spots and how it had stimulated new insights. Only one participant talked about how the experience of talking about her blind spots during the first interview had evoked unexpected feelings of shame afterwards. However this was significant in alerting me to possible shame processes in other participants that were *not* spoken about. Another participant described a *new* experience of recognising a blind spot that happened during the month between the first and second interview. Given that in the first interview, this participant was unable to share an experience of recognising a personal blind spot since her student training twenty years previously, this was a significant event. It seems that the process of raising awareness in the first interview and the development of trust between us provided the conditions for this disclosure.

### **3.14 Analytic process.**

In this section, an example of reflexivity is described in considerable detail to show how it provided a secondary but integral data source and became the experiential context from which meaningful findings emerged. Also highlighted is Smith’s (2011)

concept of the 'gem' and its capacity to illuminate and enhance interpretation and understanding. Of particular significance in this study was the concept of the 'suggestive gem' where meaning is less manifest and the researcher needs to work harder to disclose the meaning, moving repeatedly around and within the hermeneutic circle (Smith, 2011).

The most challenging part of the analysis was developing codes that captured the participants' lived experiences of being in the grip of their blind spots. This task involved uncovering the participants' implicit theories (blind spots) while they lacked awareness and at the same time uncovering my own implicit theories about what I might find. Following IPA's idiographic approach (Smith et al, 2009), initial findings suggested that different dimensions of a particular blind spot manifest on various levels both between individuals and within individual accounts depending on context. Furthermore, all participants' accounts contributed to revealing the complexity of the phenomena. Their experiences *converged* in how they shared 'avoidance' as a way of coping with feelings of vulnerability. Although these initial findings highlighted the value of IPA's idiographic approach, I was conscious that I was only scratching the surface and that something was missing from my analysis of their accounts. The overwhelming threat of 'the swamp', a realm wherein meanings become confused by excessive layers of analysis (Finlay, 2002) pervaded this phase of this study.

As I moved deeper into insular self-analysis, I found myself 'in the grip' of ruminative cycles of self-doubt about whether I was pursuing a fruitful line of inquiry. At times, this triggered feelings of incompetence and self-criticism reminiscent of childhood experiences that originated in a shame-based education system. Finlay (2002) suggests that a secondary level of self-awareness may be required when practicing reflexivity in order to critically evaluate the reflexive process itself in order to avoid falling into the 'swamp of interminable deconstructions' (Finlay, 2002, p. 209). In my efforts to climb out of the 'swamp,' I endeavoured to regain and redirect my reflexive focus towards my lived experience of sitting with each of the participants. This involved revisiting my reflexive notes describing the intersubjective space and re-reading the transcripts. Writing up pen

portraits for each participant enabled me to recall and reconnect with the whole person. This enabled me to regain my perspective and reflective capacity (Fonagy et al, 2004).

On reflection, the experience of 'feeling stuck' made sense when I noticed a parallel process between the subject matter of the research and my process. It was as if my rumination was mirroring processes that might be part of the experience of being caught in a blind spot; confusion, lack of control and anxiety. Reflecting on how rumination can function as a way of managing uncertainty enabled me to recognise it as a form of avoidance. What was I avoiding? Furthermore, what were the participants avoiding when they found themselves in the grip of a personal blind spot?

The words 'vulnerability', 'exposure' and 'shame' loomed large as I reconnected with both the participants' accounts and my experiences of the intersubjective space. What puzzled me most was that only one of the participants mentioned the possibility of 'shame' in relation to her lived experience of being in the grip of a personal blind spot. My attention focused on an extract where this participant described her sense of vulnerability as she encounters her client at a bus stop after completing the last session of therapy before a holiday break. Through careful navigation of different layers of interpretation this passage revealed itself as a 'gem' that illuminated the larger corpus in which it was embedded.

**Interviewer:** So what was happening- if we can just pause slightly there? What was happening for you do you recall in your body?

**Participant:** I remember I felt quite uncomfortable. I thought oh dear, I don't really want her seeing me, but I needed to get into town. I remember feeling uncomfortable a little bit unsure about how to handle it, um you know.

**Interviewer:** It's a difficult situation

**Participant:** *Yes, I felt a bit embarrassed, I felt a tiny bit ashamed, I don't know*

*why. Perhaps um, I don't know whether that's quite the right word, but I did sort of feel a little bit that it would be better if I wasn't there or she wasn't there sort of thing. So yeah. So what happened was that she had spotted me and she got on and I got on and I hadn't actively turned away from her, I don't think, but I hadn't made eye contact with her. I think I went upstairs or something like that, but anyway you know.*

The hermeneutic circle encourages researchers to work with their data in a dynamic and non-linear manner, examining the whole in the light of the its parts and the various contexts from which the whole and parts are embedded from a stance of open inquiry as to what the data might mean (Eatough & Smith, 2017, p. 12). A snapshot of this process is described in order to offer the reader a window on how different interpretations of the data involved a synthesis of the participant's sense making during the interview and that of the researcher during the analysis.

Returning to the above extract (written in italics) there are several interpretative possibilities in the extract that could illuminate what is happening for the participant. Taking the account at face value and holistically, one understanding is that the participant feels awkward at meeting her client at the bus stop and is trying to rationalise feelings of embarrassment and possibly shame if she doesn't handle the situation properly. There seems little to dispute here, one can easily imagine oneself in a similar situation and the feelings of awkwardness as one thinks about how best to manage it. A more critical interpretation might be that the participant is overwhelmed by embarrassment and anxiety about her ability to handle the situation and wants to save face. One might also infer that the participant feels embarrassed about the fact that she simply doesn't want to face dealing with her patient when she is off work and she wants to attend to her own needs. Bearing in mind that the participant completely avoided her client and did not reflect on the potential impact of her behaviour on her client at the time, I suspected that either of these interpretations might capture an aspect of the participant's experience in a way that she was unable or unwilling to do herself (Eatough & Smith, 2017). This process of moving between parts and wholes is an essential part of the hermeneutic process and enables the researcher to decipher meanings from the

material, which can themselves be examined and amplified (Smith et al, 2009).

Noteworthy here is how my own assumptive framework around shame processes prevented me from trusting the more critical interpretations. Initially this led to a rather surface reading of the texts where the main focus was a theme of avoidance.

An important part of developing my understanding of the data was confronting my own implicit theories about what I might find. These unconscious biases came to light throughout the analytic process and were recorded in my reflexive journal. Firstly, there was an assumption that experienced therapists would have a greater awareness of shame processes and recognise when it manifested in their relationship with a client. Furthermore, I believed that even if they hadn't acknowledged their feelings at the time, they would have recognised them with the benefit of hindsight and opportunities for reflection at supervision or during the research interviews. Implicit here are personal assumptions around levels of awareness that experienced therapists *should* have developed *and* be emotionally available to share with me. Noteworthy also is my belief that in a similar situation, I would have spoken about my sense of shame. It was difficult for me to believe that they would not have acknowledged it. A significant personal historical- cultural piece is that I am familiar with talking about shame despite the sense of vulnerability it evokes. Sensitivity to shame is part of the legacy of my catholic upbringing where nuns encouraged students to offer painful feelings up to God as a way of processing pain. Back then I took this as a mark of strength. And now as I studied the present extract, echoes of that same familiar feeling of shame clouded my ability to think and to decipher what belonged to my past; what I might be projecting on to the participant; what actually belonged to her and what was a product of the relationship that developed between us as she shared her experiences with me!

From an ethical perspective, given that the participant still retrospectively questions whether embarrassment or shame is 'quite the right word' during the interview, I was deeply concerned about over- interpreting the data and the importance in a phenomenological account, of staying close to the text (Willig, 2012). Some of my



concerns reflected my cultural situatedness as a professional psychotherapist who was also a student carrying out research towards a doctorate in counselling psychology. At an anecdotal level the expression 'be careful about shaming the client' became a mantra during my therapy training. I share these findings to contextualise my reflexive process around shame processes; how anxiety around naming shame in others or projecting my shame on to them seemed like a shameful activity. These ruminative thought processes formed a double bind that became an obstacle to further exploration. Suffice to say at this stage of the analysis I avoided discussing the possibility of shame processes in the initial report of my findings to my supervisor. With hindsight, I see how this behaviour embodied how shame compels us to hide. Little did I realise the extent to which the process of analysis itself, was bringing the phenomenon to life. A significant breakthrough occurred when I shared my work with my supervisor; she indicated that the findings were difficult to get hold of!

Compelled by her response I decided to trust my intuition about the presence of shame and threw myself into exploring the shame literature. A particular passage by Morrison (1994) struck a chord leading to a revision of my fore-understandings and thus transforming my understanding of the data:

'Of human emotions and affects shame settles in like a dense fog, obscuring everything else, imposing only its own shapeless, substanceless impressions. It becomes impossible to establish bearings or to orient oneself in relation to the broader landscape. Like fog, shame distorts vision and influences what is seen. But more. Shame also feels like a weight, a heaviness, a burden, pressing down often at the top of the back, forcing the body into the characteristic posture that Tomkins (1962-1963) described- shoulders hunched, the body shoulders hunched, the body curved forward, head down, and eyes averted... Shame induces a wish to become invisible, unseen, to sink into the ground or to disappear into the thick soupy fog that we have just imagined' (Morrison, 1994, p. 19)

I believe this understanding enabled me to appreciate with greater sensitivity what

may have transpired in the therapeutic relationships described by the participants as well as more about my own reactions to them (Goldstein, 2017). Once I recovered my ground, I was able to proceed with my explorations with a sense of curiosity. This enabled me to engage with the ‘reductive –reflexive dance’ as described by Finlay:

“The researcher makes interpretative revisions and the ground is re-covered. And the “dance” steps begin one more...” (Finlay, 2008, p. 17).

Important here was maintaining a more critical and probing attitude to the texts. As Kearney argues, ‘it is not sufficient simply to describe meaning as it *appears*; we are also obliged to interpret it as it *conceals* itself’ (Kearney, 1994, p. 94). This time, by attending to paralinguistic cues to shame and how it expressed itself in ‘confusion of thought’ (Gilbert, 2011) and a ‘shrugging off that covers embarrassment’ (Greenberg & Iwakabe, 2011), I was able to see how shame was concealed in the participant’s language. Returning to the last line in the above extract: *‘I think I went upstairs or something like that, but anyway you know’*, might be understood as an expression that adds to our understanding of shame processes. Without this systematic approach, the surface of the data may have only been touched without a full understanding of the obvious and hidden gems buried within it (Goldspink & Engward, 2019)

IPA conceives of cognition as ‘dilemmatic, affective and embodied, and intricately connected with our engagement with the world’ (Smith et al, 2009, p. 191). In a similar vein to Social Cognition, IPA shares a concern with unravelling what people think (cognition), say (account) and do (behaviour) (Smith, 1996). Through a systematic process of critical engagement with these different interpretative layers, it became apparent to me that both the participants and I were disclosing our shame processes through an attitude of avoidance. Here we see how phenomenology reveals what is hidden by the appearance of the phenomenon (Howitt, 2016).

The more reflexively I worked with the data, the more I began to understand and

accept the presence of 'me' as an analytic instrument (Smith et al. 2009). With revised fore-understandings and a renewed sense of confidence, I was able to recognise shame and its paradoxical presence as both showing the way forward and yet also potentially barring the way. Important here was holding a dialectical perspective:

'Our nature or being as humans is not just something we *find* (as in deterministic theories), nor is it something we *make* (as in existentialist and constructionist views); instead, it is *what we make of what we find*' (Richardson, Flowers & Guignon, 1999, p. 212).

# Chapter 4

## The Findings

**4.1** I begin this chapter by introducing my five participants. Each participant presents an overview of their opinions and attitudes to personal blind spots in their clinical work followed by a personal account(s) of a blind spot. These accounts describe how participants' vulnerabilities become manifest in their clinical work. Introducing the participants in this way enables the reader to see the uniqueness of each participant and how they present themselves in their lived world; the meanings they make and the meaning I am making of their meaning-making. This is fundamental to the process of the hermeneutic cycle.

While this constitutes a necessary first step, it fails to take into account the unity and complexity of psychological functioning. Although the accounts contain verbatim quotes (*italics*), I have edited participants' accounts in a way that foregrounds what seems necessary to communicate to the reader, namely an understanding of how participants' unique responses and reactions unfold as themes. My personal reflections on my meetings with the participants are described in the reflexive section that introduces each pen portrait.

Following this, I describe the three main Superordinate themes that emerged from the analysis of the transcripts. **Feeling Under Pressure; Facing a Blind Spot and finding the missing piece, and Holding my own.** I then explore each theme and related sub themes in greater detail in order to show each participant's experience of recognising a personal blind spot in her therapeutic work.

## 4.2 Meeting the Participants.

### 4.2.1 Meeting Christine

For our meeting, Christine had prepared some examples from casework that show how her need to please and fears of causing harm manifest in her clinical work. Neither of these case examples had been shared in Supervision. At times she got tearful as she got in touch with some of her sadness around loss and the break up of her marriage and the toll this had taken on her professional self. During these moments I remember feeling touched by Christine's frankness and the depths of suffering she was willing to share with me. I also recall feeling a sense of frustration as I struggled to hold the tension between a pull towards using my counselling skills to help Christine explore her issues further and my task as a researcher which involved assuming a more detached demeanour and staying close to the research questions. I managed this tension by respectfully adhering to the agreement I made with my participant. My role in this context was as a researcher and if required, I could provide my participant with resources to access a therapist. However, I believe the fact that Christine knew I was also a therapist enabled her to feel safe that she would not be judged by me. It also helped me to relax and trust that I was sufficiently present for her to experience the compassion I felt for her as she shared her story.

Throughout our interview it seemed as if Christine was using the time to reflect more deeply on the personal and professional struggles she had experienced over the past few years. Indeed as we talked she made links enabling her to develop new insights and understanding about how *fear of being disliked* kept her stuck both personally and professionally. I imagined how 'fear of being disliked' might make a person more vulnerable to shame processes. I was also touched by the sense of guilt she described as a legacy of her strict catholic upbringing. I experienced a sense of heaviness and sadness as I related to what seemed like unhelpful binds from her childhood.

When we met for the second interview, it was clear that our explorations had enabled Christine to process some of her distress; she seemed more reflective and curious and expressed excitement and gratitude at the prospect of learning about her

growing edges. However, she also sought to protect me from any discomfort she imagined I might be feeling as a result of doing the interview- *here's me trying to protect you now, I don't want you to feel this has done any damage because it certainly hasn't, it's been good.* It seemed like her attempt to reassure me allowed her to express her fear of causing upset to others when she asserted her own needs. In response, I felt a need to reassure her, to relieve her of the burden of what seemed like misplaced guilt. Despite the new insights that Christine developed through participating in the interviews, I could see the challenges involved for her in relinquishing old ways of coping with her anxiety. It reminded me of an important distinction Christine made between knowing *about* her blind spot intellectually and knowing it emotionally. The latter she explained, was necessary if there were going to be new ways of behaving in the future.

### **Reflections on personal blind spots.**

Christine describes her blind spot as a tendency *to please people* and a *fear of doing harm*. She also describes a vulnerability to over identifying with patient's suffering. Christine first became aware of her blind spot through personal therapy. Her therapist once said that she had *empathy gone mad!* Christine's tendency to over-identify with patients results in her *feeling protective, feeling over-responsible*. She worries about challenging patients; *because if I challenge too much then- I think what it comes down to is, I really don't want to do any harm*. This can lead to a sense of feeling stuck in her therapeutic work.

Christine links her struggle to two formative experiences in her background. She grew up, as an only child in a devout Catholic family and was strongly influenced by messages in her environment such as *everybody else comes in front of you*. Another important influence was her on-going concern regarding her mother's ill health; her mother nearly died several times. As a child Christine believed that she needed to be with her at all times in order to *keep her alive*. Her mother reinforced this dynamic, and Christine believes it fuelled a sense of '*omnipotence*' at the time.

***I still grapple with pleasing people, making them feel totally understood, that I'm on their side, whatever it may be.***

Christine described a case with a middle-aged client with whom she has worked for ten years. Throughout the therapy Christine has felt overpowered by her client's need to idealise her and her own need not to disappoint. When Christine 'sniffs' any sign of fragility or anxiety in her client, her default is to step back and *make it all nice and fluffy for her again*. Christine describes a couple of seemingly benign interactions to show the sense of gridlock she experiences in their work.

At the beginning of each session, Christine feels under pressure to agree with her client about the state of the weather. *She almost looks to me to agree with her. If I said something like well actually I think it's a lovely day - that would disappoint her because she wants to feel we're in tune in the weather.* Christine describes a battle between her strong urge not to disappoint her client while knowing that she needs to disappoint her if the therapy is to progress.

Another example is Christine's reluctance to put the fee up for her despite the fact that the client benefitted from a significant inheritance in recent years. This has caused arguments between Christine and her husband who says she is not a *charity*. She feels like she has failed her patient, *because of my ego and my need not to disillusion her.*

#### **4.2.2 Meeting Cathy**

Cathy prepared a few examples to illustrate experiences where she recognized a blind spot at play in her work. As she talked I was struck by how carefully she had reflected on her cases and recalled the high value she placed on regular supervision. Quietly reserved, Cathy was generous with her examples while measured and precise in her descriptions and I got a strong sense of her professional persona. Recalling her psychoanalytic training, the 'neutral' persona that forms part of the approach and her tendency to 'retreat' behind a professional 'mask' when uncomfortable, I was sensitive to the potentially exposing aspects of our explorations. At one point during the first interview as Cathy recalled an 'embarrassing' situation with a patient, she became more confused and hesitant. I

sensed her vulnerability by the way she quickly dismissed potential feelings of guilt and embarrassment that she briefly alluded to. As I noticed her withdrawal, I sensed the shadowy presence of shame processes between us. This made me slightly more tentative and hesitant in my questioning. It felt intrusive to explore feelings with Cathy that she seemed to shy away from. On the other hand, Cathy also communicated a strong sense of confidence by the way she reflected on her mistakes and vulnerabilities and the interview felt very productive. This was also evident during the second interview when Cathy shared how she recognised a personal blind spot through a casual comment by her therapist when she was in personal therapy. The emotional resonance she experienced with her therapist was sufficient to provoke a change in her behaviour. In terms of developing insight, all she needed was a gentle *nudge* from her therapist, *I didn't even have to share it with her either - I just changed my behaviour*. This raised my awareness about the need to approach issues that might evoke shame processes tentatively and with a 'light touch' so that the defences to hide are not triggered unnecessarily.

### **Reflections on personal blind spots.**

Initially when Cathy tried to think about blind spots, she describes going *blank*. She explains: *It sort of like, it moves away from you when you try to rationalize it too much or try and understand it too much in a way*. Cathy was curious about how we might be defended against recognizing blind spots and how they often manifest around issues that one finds difficult to handle: *I've often found that if it's an area I'm not so comfortable with, I'm a bit more clumsy handling it. And then something happens to really challenge it and I'm forced to think about it and sort it out in my mind*. Cathy described how her psychoanalytic training and particularly the concept of 'countertransference' provided her with a way of reflecting on her blind spots.

One way that Cathy works with what she calls *areas of blindness* in herself is by listening closely, tracking the patient's responses and relating in a non-defensive open way while *having a clear sense of what's appropriate*. Learning from her mistakes has made Cathy more aware of her limitations and helped her become more sensitive so *that's now not such a blind area*.



***There was something in me, which was just not helping her.***

Cathy described a case with a patient where she experienced a lot of anxiety and eventually had to end the work because she felt she couldn't help; she describes feeling *flooded* by her patient. With the help of her therapist, she recognised the impact of experiences with her step- father *who could be quite controlling* and that her *very strong physical reaction* to her patient was a familiar response to feeling *bullied*. Cathy explains: *I don't think I work quite so well with, with that type of patient. It was a little while ago now and I haven't come across another one like that, so either I've developed in myself, in my capacity, because that was before I did my psychoanalytic psychotherapy training.*

***What was it about me that's not wanting you know - was having such boundaries which weren't helpful?***

Cathy described an incident that occurred with her patient when she encountered her at a bus stop shortly after a final session before a holiday break: *I felt a bit embarrassed. I felt a tiny bit ashamed, I don't quite know why.* In an attempt to ensure her patient's welfare by maintaining boundaries, Cathy avoided all contact with her client as they boarded the same bus. At the next session after the holiday break her patient describes her sense of hurt and rejection at not being acknowledged. Cathy explains, *I think I sort of over- was over firm in a way in my determination to avoid contact with her.* Cathy is also compelled to reflect on the meaning of her behaviour: *what was it about me that's not wanting you know- was having such boundaries which weren't helpful?*

**4.2.3 Meeting Zoe.**

Zoe had prepared for our interview by reading the questions I had sent her in advance and writing down her responses, which she referred to throughout our interview. As she talked, I felt as if I was in a tutorial as she laid down the theoretical foundations to her approach which she then drew on to describe how she conceptualised her blind spots. I was struck by the extent to which she made sense of her vulnerabilities through the lens of her various treatment modalities and was initially concerned that our explorations might be too abstract and experience distant. These reservations were soon dispelled through the heartfelt way Zoe described her

experience of feeling devalued by a client, and the way she tried to manage her feelings of anger towards her. A couple of times Zoe asked me if her story was *good enough*. This question seemed to communicate both her personal vulnerability around validation and in a wider context, the ubiquity of shame processes when potentially 'taboo' topics are explored. At times I struggled to find a balance between probing more deeply and staying on topic. This became apparent when Zoe shared a recent traumatic experience that deepened our understanding of the impact of unmet needs in her life. She did not want this included in the research; I turned off the tape for this part of our discussion.

When I met Zoe for the second interview, it felt as if I was meeting an 'old friend'. Zoe shared her gratitude for having the opportunity to talk in the first interview and the insights that she had gleaned from sharing what she spoke about when the tape was turned off. I wondered if the 'secret' we shared had promoted a greater sense of intimacy than I had experienced during the other interviews. It seemed as if at some level, the boundaries had been moved and tested between us.

When Zoe described her tendency to move towards something and then anxiously pull back, I recall musing how this dynamic might be playing out in our relationship. Although Zoe was very forthcoming and generous with her contributions, towards the end of the interview she became quite anxious about the detail of her descriptions. She became concerned about preserving confidentiality around her identity and that of her client. I was relieved when she agreed that I could send her our interview transcript for editing to make any necessary changes. This was vital to establish a sense of safety and trust between us and was an important step in acknowledging the importance of self-care for therapists and research participants alike when working at the edge of their comfort zone.

### **Reflections on personal blind spots**

For Zoe, blind spots are analogous to vulnerabilities and linked to a *childhood trauma*. She explains: *my vulnerabilities are around invalidation and that actually triggers anger and it's all around boundaries and you know when boundaries are crossed. So I know and I've worked with this a long time in my own therapy so I've*

*always known about the anger. In fact that's one of the reasons why I went into therapy because I was experiencing a lot of anger that felt quite inappropriate and you know over the top sort of stuff. Over the years, Zoe has come to understand the roots of her anger as really, really early stuff where my – I think my mother was a very anxious person. Zoe believes there is a healing for the therapist when therapists reflect on their blind spots in service of the work and relates to Jung's idea of the wounded healer.*

***I realised that I need to be a lot more careful when I talk about anger with my clients.***

Zoe described a case where she recognized how her fears of anger, both being angry and being confronted by someone else's anger provoked a misunderstanding in her relationship with a client. A problem arose around payment of fees when Zoe checked her bank account and noticed her client had missed a month's payment. Zoe's initial reaction was to feel 'bad' and then angry at the thought that she was being treated badly! She decided not to address the issue hoping the client would settle her account. When a second month went by without payment, Zoe raised the issue of missed payment with her. Her client settled the account only for the same thing to happen again two months later. This time Zoe decided to discuss the issue of money and mentioned in passing that she felt angry when she first noticed the missed payment. As she spoke she noticed a change in her client but did not process her client's reaction with her.

When her client cancelled the following session, the last one before a holiday break, Zoe recalled the emotional shift that had occurred in her client during the previous session. She decided to phone her. Pivotal to her decision was her recollection of how scared she used to get when her own mother was angry. She also recalled her client's fear of her mother's anger. Zoe felt compelled to phone her client and apologise to her without exploring her clients concerns: *I just kind of went straight in and said, this is what I want to say- I'm sorry, blah, blah, blah.* Afterwards, Zoe reflected on her reaction; how she had been in the grip of fear of rejection by her client. She recognised the importance of not making assumptions with clients about their experiences and the need to explore their perceptions first.

#### **4.2.4 Meeting Elena**

Elena had prepared a few case examples to illustrate her experiences; a couple manifested during her therapeutic work and another that came to light at supervision. As the interview unfolded I was struck by her openness and readiness to share her vulnerable moments with me. It was obvious she had given a lot of consideration to her vulnerabilities and her observations stimulated my interest in exploring her blind spots in greater depth. Although her interviews were much shorter than other participants, she took me to the heart of her struggles very quickly.

What seemed important for Elena was embracing opportunities for learning through reflecting on her blind spots. As she shared her experiences, I recall experiencing a sense of shyness and slight hesitancy between us that I came to understand more fully when we met for our second interview a month later. Elena disclosed that although she was keen to contribute to the research and had reflected on her case examples beforehand, she had not been quite prepared for the feelings of discomfort and embarrassment she would experience afterwards. Listening to Elena, I recall feeling a sense of vulnerability and embarrassment as I tried to grapple with my fear of provoking embarrassment or shame in my participants. For a few moments, the destabilizing effect of shame processes around personal exposure was palpable. I noticed my inner critic and recall reflecting on the ubiquity of shame; how even the anticipation of shame can evoke shame and that it can only be borne with humility and self-compassion. This experience furthered my resolve to bring these qualities to the task of making sense of my participants' contributions to my research while allowing their voices to be heard. The moment passed and our meeting was energized by the sense of sustained curiosity Elena brought to her experiences.

#### **Reflections on personal blind spots.**

Elena expressed fascination in exploring the topic of 'blind spots,' a phenomenon she describes as '*difficult to pin down*' but '*evocative and plural*' in how they might manifest. She described a blind spot around thinking about *feelings to do with loss and abandonment in her life* and how she sometimes avoids these feelings by *compartmentalizing*. Elena was particularly interested in grappling with how she might be alerted to a blind spot. She described a few cues that point to the possibility

that something is being missed. For example, moments of discomfort during sessions that involve unexpected changes in emotional intensity provoke her curiosity - *What's going on?* Sometimes there's recognition that one of her *buttons* has been triggered, which is not quite a blind spot, more what she describes as a *myopic spot* – an area of vulnerability where she needs to be particularly attentive such as erotic transference.

***As much as she needed me to receive, I perhaps needed to take. That was something I hadn't really realized in that way.***

Elena described a case with a client who she experienced as *very controlling* and how she struggled to end their sessions on time. Recently, for the very first time during their work together, her client *very uncharacteristically* paused five minutes to the end, a shift Elena recognized as *quite a breakthrough*. However, instead of finishing on time, Elena surprised herself by throwing another question at her. To her frustration, this added another five minutes to the session and made them finish late as usual. Afterwards Elena realised how she also had a need for her client to need her, something she had not been aware of before.

***Here the blind spot was more my tendency perhaps to compartmentalize.***

In this example Elena described an incident with a client who worried about running out of time at the end of the session. She agreed with her client that she would remind her when they were ten minutes from the end of the session and then again at five minutes so that her client could prepare herself for the ending. Towards the end of one particular session, Elena heard the bell ring in the hallway as another therapist and client arrived to use the room. At the sound of the bell, her client panicked and Elena recognized she hadn't warned her early enough, *we concluded in a bit of a state*. She felt angry for '*making a mess*' of the ending of the session, *I went to the loo and I slapped myself*.

Supervision enabled Elena to make a link with a *rushed ending* she was experiencing with *her* therapist who was about to go on maternity leave. Elena realized how upset she felt at the imminent break and her tendency to *compartmentalise* difficult feelings. She recognized also, how unacknowledged

feelings of anger at her therapist alongside her reluctance to address fears of loss and abandonment in her own life were affecting her therapeutic work.

#### **4.2.5 Meeting Jane**

When I first met Jane she mentioned that she was nervous about an exam the following day and also that she felt shy about being recorded. She characterised herself as having a *strong self-sacrificing schema* making me wonder if she might feel ambivalent about taking part in the research. Although it was clear she wanted to help, she asked a couple of times if she was giving me what I needed. I understood that with a self-sacrificing schema, she might be familiar with giving but might feel very uncomfortable getting in touch with her own needs and acknowledging her limits.

During the first interview, Jane shared an experience of recognising a blind spot when she was a student therapist over twenty years ago. She described her sense of shock and disgust when she realised a male client had a *sexual transference* towards her. As she talked, I felt disconcerted on two counts. Firstly, I experienced a sense of empathic shame for a client who had expressed attraction to an inexperienced therapist who did not know how to handle the situation. However, I also appreciated how exposing this might have been for Jane as a young and inexperienced student therapist. Secondly, I recall feeling confused and slightly bewildered about why Jane didn't have an example of recognising a personal blind spot in the two decades since she had qualified. For a few moments, my sense of disorientation left me feeling slightly 'spaced-out', as if I was needlessly exploring a phenomenon that does not exist in experienced therapists. I grappled with my need to explore in more depth while also trying to be reassuring by avoiding material that might promote too much discomfort. It seemed as if I was caught in a double bind with no way forward. I experienced the shadowy presence of shame and its reverberations in a sense of withdrawal between us rather than in anything that was said.

After the interview, Jane shared a comedy video clip of a psychotherapy session. Our mutual enjoyment of the clip seemed to dissipate any sense of awkwardness

between us. I recalled how Jane described humour as a way of protecting herself against the heavy toll of some of the casework she sees at the hospital:

*Jane: We are um sometimes asked to hold stuff that is so heavy and so outrageous eh it's like holding hot coals, you can't do it. You need to let it go in some way. An um laughter is maybe the only way to do it!*

When we met for a second follow up interview a month later, Jane was keen to share a recent transformative experience with me. I was deeply touched by her story describing how she had just become aware of the extent to which she had cut herself off from her vulnerabilities in order to survive in her work. Jane also described a recent discovery about how her body carried clues to feelings she experienced towards her clients. It seemed as if having the space to attend to her own fears and needs in the first research interview enabled her to acknowledge her needs without abnegation.

### **Reflections on personal blind spots.**

Jane described a blind spot around working with addictions because she cannot identify with *what it's like to need another hit whatever it is* especially when this need overrides any motivation for change. She finds it frustrating. She also characterises her tendency to *shut down* with histrionic patients or those presenting with hysteria as a blind spot. Jane believes that she gets triggered by stuff from her childhood and describes how she copes, *my attachment style can be quite avoidant quite a lot of the time in order to protect myself from what I'm hearing.*

### ***I have a limit. I didn't think I had a limit, but I do!***

During an assessment with a new patient with whom she feels a strong connection, Jane becomes shocked and deeply saddened when her patient shares her history of trauma. Shortly afterwards, still struggling to process what she has heard, Jane has to co-facilitate her regular group for other patients with traumatic histories. While sharing the burden of her 'shock' with the group, she notices a shift in her internal experience. She feels more emotionally connected to them and recognises their

mutual vulnerability. She is forced to confront the extent to which she *defends against* what she is told every day and wonders, *how much can I hold?*

## **Summary**

The narrative summaries above share some common elements. All participants are aware of patterns of relating that might impact on their therapeutic work such as a self-sacrificing schema, difficulties managing anger and patterns of avoidance. Most accounts contain categories of experience where participants experience a sense of 'being done to' by a client such as, being controlled; being bullied or being invalidated. An interaction with a client provokes them to reflect on how their own needs or unresolved issues contribute to misunderstandings and ruptures in their therapeutic work. Participants become aware of the need for a more disciplined focus on how their vulnerabilities and needs manifest within different intersubjective contexts. While analysing the data for the ten interviews a number of subthemes emerged which were then grouped together into seven sub- themes that appear to resonate strongly with the participants lived experience of recognising a blind spot. These are described in the next section.



### 4.3 Presentation of the Themes

<b>Superordinate theme 1</b>	<b>Feeling under pressure</b>
1.1	Feeling Vulnerable
1.2	In the grip.
1.3	Trying to cope.
<b>Superordinate theme 2</b>	<b>Facing a blind spot and finding the missing piece.</b>
2.1	Becoming a problem to myself.
2.2	Finding perspective.
<b>Superordinate theme 3</b>	<b>Holding my own.</b>
3.1	Gathering together
3.2	Taking responsibility

#### 4.4 Superordinate theme 1. Feeling under pressure

The first Superordinate theme provides the beginning of a narrative thread describing participants' experiences of a personal blind spot in their clinical work. Three subordinate themes seek to capture more nuanced aspects of this experience. Describing the various aspects of being caught in a blind spot enables the reader to see how the participant's experience is a moving, evolving dynamic. In essence it enables the reader to see the participant make very live attempts to avoid feelings of vulnerability when they feel exposed to the gaze of the other (whether actual or perceived).

#### 4.4.1 Feeling Vulnerable

All participants describe situations that provoke a state of vulnerability as parts of themselves not usually visible to their clients or even sometimes themselves become manifest interpersonally. The primary sources of their reactions are personal and professional. On a personal level, the experience of vulnerability occurs when unresolved issues from one's family of origin or a need to be liked are triggered. On a professional level, vulnerability is linked to a strong need to feel competent or a fear of causing harm by being inept.

The experience of vulnerability is accompanied by a sense of risk and danger and the potential to be wounded that connects participants to their sense of selfhood or self-concept. Here core emotions related to pride, embarrassment, guilt and shame manifest in subtle ways through the everyday language of discomfort, invalidation, fear and loss of control. These are feelings participants try to defend against as they attempt to restore a 'professional self.' Noteworthy here is how participant's ways of managing their vulnerability inhibits their capacity to be emotionally responsive to their clients.

When invited to describe a time when she recognised a personal blind spot through her therapeutic work, Christine describes the sense of vulnerability she experienced when working with clients when she was going through a difficult divorce:

*Christine: I can feel, talking about blind spots, I just didn't know what could be triggered and I was fearful of what could be triggered. I was fearful of material that would come up, especially if it was relevant to what I was going through in my own life.*

Christine's fear and anxiety seem so intense, she struggles to be available to her client's concerns. She describes a diminished sense of self that cannot cope: "I would think, what will that do to me?"

Notice how even the *thought* of being emotionally touched by client material is frightening and overwhelming. Central to Christine's experience is a loss of self-agency and control as she is taken to the limits of her capacity:

*Christine: I absolutely felt around this period that I'd lost my own identity. I felt a huge loss.*

In practice, it seems as if the depth of Christine's loss makes it difficult for her to separate her pain from that of her clients. However she also experiences a sense of pride in her ability to work at depth with her clients:

*Christine: I know I do go to a great depth with people because I felt such pain in the room at times and it has felt pretty unbearable at times to hear somebody's distress.*

Even now, there is no question in Christine's mind that the pain she experiences with her clients is a measure of the depth of her work with them. Paradoxically, in this account, her strong identification with her client's suffering has a merging quality that makes it difficult for her to be objective.

Elena describes a state of vulnerability when she felt 'seduced' by an attractive yet manipulative male client who could sometimes be 'dismissive' of her and therapy. She found it hard to take. She describes a powerful shift in self-awareness when he mentions having a drink with her:

*Elena: Um I felt very womanly, very girly. There was something in me that was responding, not at all as what I like to regard as my therapy stuff (...) and he moved on and I noticed then and refocused and went to the end of the session. But I still felt a little bit wobbly afterwards and a little bit doubting myself and whether I was actually in control in that relationship, who had control, who was actually keeping the boundaries for everyone, could I do that?*

What's striking here is the sense of destabilisation Elena experiences when she feels exposed by feelings of erotic transference. Despite her attempts to work with

changes in the 'tone' of the therapeutic relationship through supervision and personal therapy, the relationship ended a few sessions later. Whether the relationship might have ended anyway, for her part Elena believed she lacked experience and needed more personal therapy. She describes feeling 'wary'. Noteworthy here is how Elena experiences a sense of 'being done to' in some way:

*Elena: um there was something there that I felt I was being played on a bit. I know it's something that for personal historical reasons I sometimes find difficult. I'm quite sensitive to that.*

Elena describes a state of vulnerability that seems to trigger a sense of helplessness and anxiety around personal exposure, embarrassment or potential shame. Notice here how she seems to feel somewhat diminished by this experience:

*I was scared. I think it was hard for me to feel exposed like that, to feel like my own material was triggered so strongly.*

Fear of personal exposure is also pertinent to Cathy's account. She describes her discomfort when she encounters her patient at a bus stop after a final session before a holiday break:

*Cathy: I thought oh dear, I don't really want her seeing me, but I needed to get into town. I remember feeling uncomfortable, a little bit unsure about how to handle it.*

Central to Cathy's concern was how to maintain the professional boundaries so pivotal to her work alongside her own need to get into town. Cathy describes her state of mind: *'I felt a bit embarrassed. I felt a tiny bit ashamed, I don't quite know why'*.

Noteworthy but elusive in Cathy's account are feelings of embarrassment and an element of shame that seem difficult to grapple with even as she recalls her experience during our interview:

*Cathy: Perhaps um, I don't know whether that's quite the right word, but I did sort of feel a little bit that it would be better if I wasn't there or she wasn't there sort of thing.*

It seems that for Cathy her dilemma can only be resolved by avoiding any eye contact with her patient as they board the same bus:

*Cathy: It's clearer and better and less turmoil for her. I won't be unsettling her if she doesn't see me. That was my thought.*

There is a sense of reasonableness to Cathy's decision that resolves earlier feelings of guilt or embarrassment. There is also a restoration of professional pride in being able to maintain boundaries with her patient. Her decision to avoid her client seems to serve her patient's best interest while also protecting her from 'seeing' her patient. However her assumption also belies the fact that missing from her considerations are any other thoughts about possible consequences if her patient *does* see her.

As Cathy recalls the event, her tone and manner seem more restricted. I sense that something has been triggered leading to a return to concrete thinking. I wondered to myself if the feelings of exposure and vulnerability she experienced at the bus stop were resurfacing as she shared her experience with me. Feelings of embarrassment often result from self-consciousness when one feels exposed and there is a fear of being judged by others. They may also arise from the sense of guilt one carries when one falls short of one's ideals. Guilt can also lead to a sense of shame. Either way they lead to a sense of vulnerability that is destabilising due to fear about being judged by others.

For Zoe, the experience of vulnerability puts her in touch with early wounds and familiar defences:

*Zoe: My vulnerabilities are around invalidation and that actually triggers anger and it's all around boundaries and you know when boundaries are crossed (...) I've always known about the anger. In fact that's one of the reason why I went into*

*therapy because I was experiencing a lot of anger that felt quite inappropriate and you know, over the top sort of stuff.*

Zoe describes her immediate reaction when a bank statement showed that her patient has missed a payment for sessions: *My initial response when I noticed, I hadn't been paid by her was like, God, I really feel bad that she's treating me badly.*

Here, feeling 'bad' is an affect of alienation and inferiority that goes to the core of the self. Zoe also feels 'angry' about the perceived misdemeanour. In contrast to the deflating effects of shame, anger is experienced as empowering and energising, enabling Zoe to re-cover what has been 'violated.' However anger also feels destabilising as she lacks a repertoire of skills to manage it in a constructive way:

*Zoe: It's clunky because I didn't have the experience of being able to use anger in a positive and good way.*

Zoe *avoids* addressing this potential misunderstanding with her patient hoping the payment might be sorted the following month.

An important concern when participants feel exposed and vulnerable in relation to a client is experiencing a loss of their professional self. Of central importance therefore, is protecting their client work from a 'vulnerable self' that evokes feelings of embarrassment or shame.

An important priority for Jane when working with patients who have experienced trauma (many of whom self harm or have made suicide attempts) 'is not being shockable'. While on the one hand being reactive 'is not good for the patient', there is also a sense that Jane has witnessed so much trauma she is invulnerable to being shocked:

*Jane: You're hearing the same thing again and again and not being shockable, I think helps you to be able to work with people in that way.*

As Jane talks, there is an assumption that I too would find this a helpful way of working with trauma or that it is even possible to selectively dial down certain emotional reactions without it having an impact on other emotions. There is a lack of vitality in how Jane describes herself as hearing the 'same thing again and again'. It seems as if Jane inhabits the same 'self-state' in her role as therapist and has disconnected from her vulnerability. Indeed missing from her account is a sense of self - doubt or questioning that might put her in touch with her vulnerability and unacknowledged needs.

#### **4.4.2 In the grip.**

All participants describe experiences where personal frustrations manifest in anxious or confusing reactions to clients. Sometimes this behaviour calls their attention to assumptions or misunderstandings about a particular client-patient relationship that needs addressing. Also significant is how participants' unresolved personal issues become conflated with client material. Participants describe experiences that reveal a sense of 'self' manifesting in ways they struggle to control. Later this is recognised as a part of the 'self' that has been denied or rejected.

Zoe describes this part of the 'self' in theoretical terms: *It's all of the – 'not me' bits, the false selves, the bits that, the parts of ourselves that we don't like, that we hate.*

There is a sense in Zoe's account that the 'not me' bits are unacceptable parts that could evoke a sense of shame. In her therapeutic work, she is guided by the assumption that her experience of this inchoate uncharted terrain will reveal valuable information about the therapeutic relationship:

*Zoe: It's the not-me bits where I join in with the client with their not-me bits and then at some point I catch myself and realise we're in a little enactment, whether it's a collusion of some kind where there's an idealisation going on or any of these kinds of things. They tend to be around things like my boundaries and my anger and my invalidation (...). You know, the really early childhood hurts and slights.*

Significant in Zoe's account is a sense of critical self-awareness about personal vulnerabilities that influence her reactions *despite* her best intentions:

*Zoe: It's a known spot but sometime I just can't help myself. Paradoxically, although the experience feels familiar, it also carries an element of surprise indicating its uncanny nature: it's always different of course.*

The belief that the unfolding drama may cast light on dilemmas and conflicts that need to be addressed through the therapeutic relationship enables Zoe to tolerate uncertainty with a sense of humility and curiosity. She describes the pull:

*Zoe: I know I'm going into an enactment and it's just happening anyway and I'm like - I don't know if you know (laughter) 'Les Liaisons Dangereuses' where you go, this is beyond my control, that's me (joint laughter), I'm like, well I know what this is now.*

There seems to be a mild sense of self-deprecation in Zoe's account as she acknowledges her role in clinical enactments. Any tensions around personal exposure, embarrassment or shame are relieved through our shared laughter. Our laughter also seems to acknowledge the mutual vulnerability we share in our work as therapists.

This vulnerability is highlighted by Zoe's reference to the novel 'Les Liaisons Dangereuses' (de Laclos, 1979) which may be a metaphor for the tricky and exposing nature of enactments where therapist and client vulnerabilities interact in unforeseeable and confusing ways. Alternatively, the novel is also known for revealing the more shadowy, manipulative games that people play thus reflecting disowned, darker motives that may unconsciously drive our work.

Dissonance and confusion also feature in the sense of '*disconnect*' that alerts Elena to the possibility that something unforeseen is playing out between her and her patient:



Elena: *It's an overreaction or an under-reaction that says this- the emotional intensity of it is wrong; how it came out sounded out of place.* Like Zoe, Elena is provoked to consider what is *really* going on:

Elena: *um the fact that I'm feeling so uncomfortable around this particular session or this particular moment of a session suggests something was going on. And can that be the client's? Is that mine?*

Noteworthy in both accounts is how *sudden shifts* in emotional intensity and feelings of incongruence promote critical reflection about emotional entanglements that are difficult to name.

All participants describe situations where they perceive a sense of 'threat' from their client. Here 'the gaze of the other' evokes a sense of destabilisation suggesting the emergence of anxiety around shame processes. This manifests in behaviour participants struggle to control.

Elena describes a situation where an anxious client wanted five minutes notice before the end of the session in order not to have a rushed ending. When Elena forgets, her patient becomes flustered. Although they finish on time, Elena describes the sense of threat: *'it felt like something had been interrupted. I went to the loo and I slapped myself'*.

Elena's experience seems to be one where she loses her sense of awareness and the ability to see herself objectively in her own mind. The feeling of guilt or shame that emerges is clearly in the situation but it hasn't been said or exactly thought. However the 'slap' reveals her frustration and anger at herself for not managing the situation as planned:

Elena: *I was really, really angry with myself for making a mess of this ending of the session. I thought this is really bad. This is dreadful. Then I calmed down.*

Unable to make sense of her reaction by analysing the transference and countertransference, Elena feels confused and seeks support through supervision. When her supervisor inquires how her personal therapy is going, she describes another strong physical reaction: *'I burst into tears'*. This *surprising* reaction helps her make a link with her anger regarding a 'rushed ending' with her therapist who was about to go on maternity leave. Notice here how Elena's unacknowledged needs and subsequent anger about ending with her therapist come to a head in the 'rushed ending' with her client:

Elena: *I had completely put the whole conundrum of having to deal with this interruption to the side. I just didn't want to think about it.*

Most participants (4/5) describe a sense of wariness around certain client groups due to what is triggered in them. Noteworthy in their accounts are physical metaphors that seem to embody a sense of either 'fight, flight or freeze'.

Christine describes how her *'over developed sense of responsibility'* and desire *'to please people'* is powerfully evoked in her relationship with a longstanding patient who idealises her: *'It's such a strong urge not to disappoint her and that's almost why I think the therapy hasn't stopped'*.

The sense of conflict Christine describes as a 'battle' seems to polarize between an overriding need not to disillusion her client for fear of what it might provoke between them, versus an intuitive sense that this is also the only way to progress their work:

Christine: *Maybe it's that I don't want people to dislike me in any way for I would bend over backwards to accommodate.*

Not only does Christine fear disappointing her client, there is also a sense that she fears *being* disappointing. It seems that by accommodating to her client's wishes, she might also be protecting herself against intolerable feelings of guilt or shame about her own needs in the work.

Cathy describes how her experience of feeling bullied by a patient made her so anxious, she couldn't think. It manifested in '*a very strong physical reaction*' that she initially found difficult to put into words:

*Cathy: I felt floored with her. I couldn't gather things together or understand it in a way, which was helpful to her.*

She also relates her strong reaction to experiences from her childhood: *And um I didn't understand it at first but I did take it to my therapy and um I made a connection in my mind with my stepfather who could be quite controlling.*

For Jane, even the thought of working with 'histrionic people' is unbearable. The threat to self is powerfully illuminated through the metaphors and images she uses to describe what is evoked:

*Jane: I've not taken things forward a couple of times this year with people that I thought are just going to suck all the life out of me and so I've been able to say no and pass them on. I don't do well with hysteria.*

There is a strong sense of self-preservation in Jane's account as she describes in vivid detail her reaction to this client group who just 'suck all the life out' of her. A more reflective self uses self-deprecating language and humour to distance her from a vulnerable part that acts on instinct:

*Jane: I would never, but I just want to put a tape around their mouths or something like that (laughs) just to get, to get them off my back.*

The experience of being in the grip of an unbearable struggle is powerfully illuminated in how Jane describes her desire to escape: *Go away. Just leave me alone. I don't want to talk to you. It's just 'go away', which is completely counterproductive to therapy. I just shut off completely. I can't. I just shut down and I really do shut down.*

For Jane, even the thought of interacting with this client group is sufficient to trigger an aversive reaction during our interview. As she describes her experience, she becomes more animated. Her initial instincts are conveyed in the form of a rant while her more reflective, observing self sets her limits. There are four vulnerable pleas along the lines of 'go away' to the hysterical other, and four statements showing how overwhelming it is for her to be in the presence of histrionic processes:

*Jane: I really do shut down.*

All participants describe experiences where unresolved issues from their developmental years come to the fore in ways that make it difficult for them to maintain a therapeutic stance. They describe experiences of being overwhelmed by feelings they struggle to control. It is as if a needy, shamed, or humiliated part of them needs to be expressed if the previous awareness of self is to be restored.

#### **4.4.3 Trying to cope.**

All participants describe experiences showing how they managed stressful events with clients. Three of the participants, Cathy, Christine and Jane relate their way of coping to a kind of a professional persona that helps them manage stress. Elena describes how she turned towards psychological theories in order to cope with feelings of erotic transference. Zoe describes compulsive caregiving: *a lot of us I think are stuck in care giving mode*. Noteworthy in these accounts is the extent to which participants' repertoires of coping behaviour facilitate empathic connection with their clients or obstruct it.

Cathy's account describes how her professional persona can serve the work. It's something she retreats behind like a 'mask' when she feels uncomfortable. Notice how her patients comment on a change in her:

*Cathy: Most of my patients are really sensitive if I'm professional. They notice it straight away. (...) they say that, that - you're being professional.*

The fact that Cathy's patients share their observation that they see a change in how she relates to them when she is uncomfortable, indicates a sense of intimacy

between her and her patients; how they know her well enough to point out these shifts. Although Cathy is aware of her professional 'mask,' it does not seem to be something she *hides* behind. On the contrary, recognizing it facilitates further understanding and the promotion of authentic relating:

*Cathy: Well it's a defence basically um you know and I'm interested and curious. They're not always right but often they are, often I'm feeling you know a bit uncomfortable about something.*

Christine also alludes to a professional mask that helps her cope. She became aware of the power of it while going through a stressful divorce and her client made a comment about her having a happy life:

*Christine: It absolutely intrigued me that I could give off this aura of being calm when inside I felt wretched and really unhappy and upset.*

Rather than exploring or challenging her client's assumptions, in this extract, Christine uses it as a form of self-protection that enables her to 'save face,'

*Christine: In some ways it gave me confidence because I was in a particularly bad state that day, I remember it very clearly. And there was relief that I could sit there and that wasn't showing through at all from what she was saying.*

Christine's account shows how relying on a professional persona enables her to experience a modicum of security in the midst of overwhelming loss and anxiety. However there is a strong sense of disengagement and emotional depletion in her account where her professional persona functions as a barrier to authentic relating rather than a means to expand relational knowledge:

*Christine: I suppose it didn't really matter what I was feeling because she had projected this idealized life on to me.*

As Christine reflects back on this period in her life during our interview, her tone is one of guilt and regret. The depth of her struggle to manage her emotions and simply survive in her client work is evident in her strategy of avoidance:

*Christine: And if I'm really honest I don't think I wanted to go there. I was trying to deal with so much and keep my head above water with clients.*

As Christine talks, there is a sense of regret and possibly guilt and shame about her struggles to cope while going through a stressful divorce. Notice here how confronting authentic feelings of guilt and shame takes courage:

*Christine: But if I'm honest Paula, I was coasting. And that's a terrible thing to admit but it's the truth.*

Participant accounts indicate that an important goal of coping behaviour is achieving a sense of security when relationships come under threat. They also highlight how maladaptive ways of coping such as avoidance inhibit authentic relating and the development of trust.

Elena's account describes how this sense of trust was tested as she struggled to cope with feelings of erotic transference. She drew heavily on supervision, personal therapy and the literature on erotic transference. It seems that employing these strategies made her more defensive and exposed her fears even more:

*Elena: So I - and enlisting all those people and all those theoretical tools I created some sort of wall between us. Then surely my own lack of experience or need for more therapy was in evidence I felt. So something was lost.*

An important discovery for Elena is recognizing the personal work she needed to do in order to tolerate her feelings of vulnerability in the work:

Elena: *If I have to defend myself against the impact of the encounter, against possibly being touched too deeply, then it creates an interference. It becomes very difficult to keep the work fluid and responsive and open and authentic.*

All participants describe accounts where some form of withdrawal or avoidance is used to cope with feelings of embarrassment, shame or guilt. Cathy's account shows how avoidance is used when she has a surprise encounter with her patient at the bus stop:

Cathy: *And the anxiety which was evoked around that in terms of how to handle it so that the boundaries are kept and you know- but then I think, I was sort of over- was over firm in my determination to avoid contact with her.*

Cathy describes her sense of detachment: *'part of me was not in touch with her experience of rejection'*.

While maintaining boundaries is an important part of Cathy's practice, there is also a sense that her over-determined attitude in this instance might also be part of a strategy to cope with feelings of exposure. It seems as if the short-term relief of discomfort that is achieved through avoidance when she gets on the bus without breaking boundaries persists to influence an overall experience where any further feelings of discomfort are unavailable to awareness. As she put it: *'I didn't actually look for her again once I got on the bus so you know my shutting down was complete you might say in thinking of the blind spot in a way'*.

The use of emotional suppression as a coping mechanism is also present in Jane's account. She asserts the importance of being 'unshockable' when working with patients who have experienced trauma: 'you have to cut yourself off a little bit'.

This coping strategy seems to work until a strong emotional reaction to one of her patients provokes her to examine her beliefs:

*Jane: So I'm going merrily along working with people in this way and I think in the main, effectively. Then along comes somebody who blows it all out of the water.*

As Jane facilitates a therapy group for patients who have experienced trauma, she recognises the extent to which her way of coping disrupts her capacity for empathy with patients:

*Jane: But it's holding somebody's trauma like that, it made me realize all these other little traumas, smaller traumas are just equally as powerful. I'm not feeling them or picking them up.*

## **4.5 Superordinate Theme 2.**

### **4.5 Facing a Blind Spot and finding the missing piece.**

The second superordinate theme looks at the lived experience of being confronted by a personal blind spot. Participants describe a sense of disequilibrium as they are caught between old conceptions of the self that no longer feel 'true' and new ways of seeing themselves. All accounts show a process of change where participants are able to expand relational knowledge by making room for both their own subjectivity and that of their clients. Two subthemes describe different aspects of their experience.

#### **4.5.1 Becoming a problem to myself.**

This subordinate theme describes participants' experiences of seeing themselves in a new light as they recognise ways in which their unresolved personal conflicts have been impacting on their relationship with a client. The subtheme shows how participants' sense of self is mediated to them through encountering challenges to their self-concept in their client work. Equilibrium is restored as participants reflect on personal behaviour that now appears strange.

Elena's account describes a dynamic of personal becoming that is present to some degree in all participant accounts. This process is illuminated through an account



where she struggles to end sessions with a client she describes as ‘controlling.’ There is a sense of her reaching her limit:

*Elena: And so I’ve always felt I was struggling a bit to end the sessions on time. It was always something, I thought –ah I really wish I could do that.*

Noteworthy in Elena’s account is a loss of self- agency, as her client is perceived as powerful and in control of sessions:

*Elena: She always spoke. She always opened up a new topic. She used the usual techniques.*

A moment of *breakthrough* occurs when Elena’s client stops in good time and waits for her to end. Elena describes her reaction: *‘I threw a question at her. And I was very surprised by that’*. This intervention meant that they finished late as usual. Surprised by her behaviour, Elena is forced to consider her part in what happens between them:

*Elena: Then I really started thinking about that more and then tried to come to terms with the fact that as much as she needed me to receive, I perhaps needed to take. That was something I hadn’t really realised in that way.*

The experience of surprise combined with curiosity opens space for a new configuration of self to emerge. Noteworthy in Elena’s account is how her sense of herself as powerless is mediated by a surprising encounter with herself as an active agent asserting unacknowledged needs. The tension shifts from one where she struggles with a client who she experiences as ‘very controlling’ to one of internal frustration where she questions if perhaps *she* rather than her client is the ‘culprit,’ a term that connotes overtones of misdemeanour and guilt. Throughout this process, Elena seems to inhabit a perturbed state of mind. Preconceived views of herself as plaintiff are being left behind as she struggles to take possession of what up to now has been ‘other,’ the role of ‘culprit’ who seems demanding, needy, and controlling.

Amidst her frustration, there also seems to be a part of her observing her muddled state of mind:

*Elena: 'As I was doing it, there was a part of me saying, "What are you doing? What is that about?'*

As Elena searches for meaning, her 'inner supervisor' calls her attention to the professional task of ending the session with her clients. This time the tone is non-adversarial and instead reflective, indicating a renewed sense of self-possession:

*Elena: I again started thinking, gosh the next person's going to come. And how are we going to wrap this up in a way that doesn't feel abrupt and harsh and that's thoughtful?*

These dynamics of personal becoming through reciprocal mutual influence are evident in all participant accounts as they face new challenges to their self-concept. When Cathy's patient describes her sense of hurt about being avoided at the bus stop, Cathy describes her sense of surprise and confusion as she is confronted with the impact of her behaviour:

*Cathy: But when she told me that um and that she felt that I- it was something which was alien to me. And I, not alien to me, but didn't feel quite right. For she had interpreted it in a much harsher way than I had meant it to be. I had actually meant it to be- in my mind I justified it by thinking this is a boundary issue. It's clearer and better and less turmoil for her. I won't be unsettling her if she doesn't see me. That was my thought.*

The internal process of facing a blind spot is illuminated in this extract showing a self that seems caught between two opposing narratives. The sense of disorientation and destabilization is conveyed in Cathy's disjointed narrative as she tries to find the right words to express her experience. The journey towards greater self-possession manifests in how Cathy arrives at a more differentiated understanding of herself. This manifests through an internal process of negotiation between her patient's

representation of her which is initially considered as 'alien' to a position of realignment and recognition that her patient's view of her is understandable even if not exact; "*not alien to me, but didn't feel quite right*" (Cathy). The emotional tone seems to be one of angst and guilt as she reflects on behaviour that now seems over firm:

*Cathy: Would it have been so bad just to have acknowledged her and smiled and got on?*

In her search for meaning she is forced to question her behaviour, which now appears strange:

*Cathy: What was it about me that's not wanting, you know, was having such boundaries, which weren't helpful?*

Cathy's process of facing a blind spot involves navigating conditions of flux and ambiguity as she tries to understand her behaviour from her patient's point of view. There is a sense of emergence as Cathy recognises her behaviour as problematic:

*Cathy: So the blind spot really is just- is not- is being too much in myself really and not tuned in to her I suppose is one way I would maybe think about it. Um is that all right? (whispered)*

Christine's account also describes a moment of emergence as she envisages a more resilient self who could challenge a patient who she is afraid of disappointing. Here she describes her reaction to her patient's request to see her cat during the session:

*Christine: Anyway I did bring the cat in and em I didn't want to disappoint her by not showing her. I could have worked with that and I didn't. What would I have been like for me not to let the cat in?*

Salient in Christine's account is a sense of her entering a transitional space as she recognises a missed opportunity for more authentic relating with her patient. It is in

facing what will be required of her to change that she recognises how fear of rejection keeps her stuck:

*Christine: But it's made me think, am I as good a therapist as I could be or have I been short changing clients? That's a strange way of putting it, by not possibly challenging because my ego's got in the way about maybe being liked?*

Zoe's account shows how unconscious fears of rejection manifest through her impulsive behaviour as she rushes to apologise to her patient before exploring her patient's point of view:

*Zoe: rather than even asking the questions and I went- I just kind of went straight in and said this is what I want to say- I'm sorry, blah, blah, blah. I suppose what that helped me to understand was I am afraid when I see anger (...) because anger can be quite frightening as an emotion really.*

There is a quality of emergence in Zoe's account as she recognises how unconscious fear of anger drove her to apologise to her patient. It seems that by apologising to her patient rather than explore her patient's point of view first, Zoe was trying to forestall her own fears of an angry confrontation. Not only is she afraid of anger, she is afraid of *being* angry.

Most accounts show how the pernicious yet ambiguous presence of shame processes lead to avoidance rather than engagement with their client's issues. Furthermore, participants are not fully aware of these processes until they are confronted with what is 'other' in themselves through their surprising or frustrating behaviours.

When Jane is faced with how her efforts to be 'unshockable' have made her lose touch with her vulnerability, she struggles to come to terms with the extent to which she defends herself from her patient's suffering while also trying to help them:

Jane: *I'm still actually thinking about this, how much I can hold, um how much I defend against what I'm told every day and that, then, yeah, how much I can hold?*

Faced with her own vulnerability, Jane is challenged to re-evaluate her own needs and the importance of setting limits. As she recalls her experience during our interview, there is a sense of vitality as she acknowledges her blind spot with humour: *'I didn't think I had a limit but I do' (laughs).*

Jane's laughter captures both a sense of relief and irony at the absurdity of assuming she didn't have limits in the first place. Paradoxically, it seems that not acknowledging her limits has meant that they have operated outside her awareness in a defensive way keeping painful but significant feelings at bay.

#### **4.5.2 Finding perspective.**

The nature of a blind spot implies phenomena that lie outside awareness to a greater or lesser degree and that are not automatically available to reflective thought. In this theme the scope broadens from participants internal experience of recognising a blind spot to a broader description of attitudes and practices that support them to gain perspective on their vulnerabilities.

Cathy highlights the difficulty in uncovering blind spots and the importance of a non-defensive attitude in a relationship of trust:

*Cathy: I found it difficult to think of blind spots. Perhaps others are more able to point out our blind spots than we are ourselves. Patients, if you've got a close enough relationship with a patient and you are open enough, they obviously can point them out to you as well as hopefully supervisors can, in a safe way.*

Zoe also emphasises the embedded nature of blind spots and the need for another person to help develop perspective: *I suppose when you're in your own stuff you don't really- you don't have that analytical capacity as you do when you actually have access to somebody else's um prefrontal cortex if you like, because then they can make the links for you.*

For Cathy, the importance of time and space for personal contemplation: *It's good to just sit and think a little bit and reflect and put things together a bit more clearly sometimes. It begins to become a bit clearer in my mind and make connections.*

She describes the process as something akin to an 'incubation' period:

*Cathy: So something that might be half formed becomes you know a bit more formed.*

For Zoe talking in different contexts helps: *Even though I kind of knew about it, I think being able to speak about it and articulate it in that way in this context if you like, made me go 'hang on a minute'. It was like a kind of another shift or something.*

These accounts highlight how recognising one's blind spots is not a concrete all or nothing experience but a more fluid process of differentiation, where knowledge is synthesised and reconfigured in different contexts over time. This phenomenon is evident in all participant accounts as new insights come to light through reflecting and talking with me about their experiences in the research interviews.

Participants also describe Supervision as important for supporting their personal and professional development. Cathy emphasises its function both as a supportive relationship and as a discipline that helps her making sense of her work through her theoretical modality:

*Cathy: I had quite a Kleinian Supervisor so I was forced to work pretty - really thinking the transference. So that was very helpful to me, it's good training in a way of um focusing on the transference and counter-transference and staying with that and witnessing how helpful it was for the patient.*

Important also is being challenged by peers and supervisors to think outside her psychoanalytic perspective so that she can work in her patient's best interest:

*Cathy: It makes me think of things, which challenge me to think in different ways and not to stick to my pure psychoanalytic perspective, which often is not the most helpful for a patient always. It depends very much on what the patient brings, but to be flexible.*

While all participants cite the supervisory relationship as a resource for personal development, two of the participants highlight the importance of disclosing their concerns in a way that allows their supervisor get to know them better. Although Christine senses her supervisor is aware of her anxiety, she has never communicated it to her in a way that would allow her supervisor to support her more:

*Christine: I think my supervisor would know yes, you know, but no, I've never said that to her in that way for her to be able to work with it.*

This 'sense of reluctance' based on fear of personal exposure and being judged, is also alluded to in Elena's account when she describes her discomfort and embarrassment about sharing a little of the 'dark side' of what goes on in the room during our first interview:

*Elena: And it got me thinking about supervision and the times where there are things I don't want to discuss in supervision because I feel maybe I'm a bit shaky there and what does shaky mean? Does that mean I have a blind spot?*

Noteworthy in Elena's account is how allowing space for reflection and curiosity facilitates a deeper process of self- enquiry:

*Elena: Um am I afraid that things will be said that I'm not aware of or that my supervisor will see things in my work that I'm not aware of. How big is that fear? Is that interfering with the supervision? Does that mean I'm losing opportunities or wasting opportunities to learn about myself in the work?*

An important realisation for Elena is recognising that while in theory she felt comfortable about describing her blind spots for the research, she did not anticipate

the extent to which the experience of revealing her blind spots to me might evoke feelings of vulnerability and shame:

*Elena: That brings up feelings. That brings up a bit of shame and a fairly big bit of uncertainty as well as to- did I do the right thing?*

As Elena explores her fears, the focus of her inquiry becomes more critically reflexive:

*Elena: Does that say something about me as a therapist that I have those doubts or I, I realise those things about me that perhaps were not entirely positive for the client or could have been damaging. So it's the um the experience of discussing it with you has been I think quite valuable but interesting and also slightly uncomfortable*

Elena's account highlights how the capacity to be vulnerable in relationships is essential to the process of knowing and recognition on multiple levels; getting to know oneself and also allowing oneself to be seen by others so that one can become known. This requires courage. While the experience feels uncomfortable and even risky, it is a necessary step in the on-going process of developing awareness, resilience and an authentic sense of self.

Zoe also highlights the importance of a non-defensive attitude. She describes the importance of obtaining feedback from patients before acting on assumptions that may be based on personal blind spots, *'I need to check it out that it's okay to talk to them about that rather than just assume'*.

More difficult to square up to perhaps is feedback that is upsetting, and challenges one's view of oneself. Here one's capacity for critical reflection is important; the capacity to see oneself from the other's point of view while also empathising with the other. This process is captured in Cathy's account as she shares her experience with me during our interview:



*Cathy: So I step outside of my own experience and think and - think a bit more about her experience and you know - so where does that blind spot - so the blind spot really is just - is not - is being too much in myself really and not tuned in to her I suppose is one way I would maybe think about it. Um is that all right? (whispered)*

Pertinent to Cathy's account is a sense of personal exposure as she considers herself from her patient's perspective to face her human fallibility. The tone of her whisper conveys her sense of vulnerability. The relational context of our interview is significant in allowing what is emergent to be acknowledged and accepted. She enquires, '*Um is that alright?*'

All participants recognize the value of speaking about their vulnerabilities. While an important part of 'Finding Perspective' is having a witness or observer to help one identify one's blind spots, there is also a sense that having an interested and empathic listener promotes self- acceptance and well being.

#### **4.6 Superordinate Theme 3. Holding my own.**

This theme focuses on the personal and professional impact of developing insight into a personal blind spot. It describes how participants integrate new knowledge about themselves to inform a more (expanded) differentiated sense of self. It also describes what the experience means to them in terms of their development. Two subordinate themes were identified in relation to this.

##### **4.6.1 Gathering together**

All participants describe an expanded sense of self-awareness that becomes manifest on different levels of experience; cognitive, emotional and physical sensation. Participants describe how the act of speaking about their vulnerabilities enables them to making new connections and to put hitherto unformulated experiences into words. This requires a higher level of processing. At an experiential level, this involves a sense of collecting one's thoughts by reconciling knowledge from the thinking, feeling and sensory domains of experience.

Christine describes how 'speaking' about her fear enabled her to reflect on her experience that up to now has only been 'felt'.

*Christine: It's fear that's driven so much of my practice actually which is a difficult thing to really acknowledge but it has. It's been fear and that's a blind spot in itself because it's only in speaking it – I've felt it, but it's only in saying, that now I realize what's driven my practice, it's been fear. Whatever I do in the room the bottom line would be fear and that's not good.*

Zoe also describes how speaking about her fear of anger enables her to develop a firmer grasp of the ways it influences her behaviour. This enables her to come to a more differentiated understanding about how she relates to anger:

*Zoe: I think - and it goes back to something I said last time, which I didn't even appreciate until I said it even though I knew I was doing it, is that kind of thing. It was you know a lot of my clients have anger and they're afraid of it and what I didn't quite clock was, that there was a fear in me as well of getting angry or a fear of people who get angry.*

Noteworthy also in Zoe's account is how this implicit knowledge can be available on an intuitive level but not consciously registered:

*Zoe: And although I kind of knew it, I didn't know it if you see what I mean.*

Christine's account also captures the process of recognition where different levels of knowledge are integrated to inform a deeper understanding and expanded sense of self:

*Christine: I'm conscious of it so is that a blind spot? I'm only becoming more and more conscious of it now. You can know something on different levels can't you?*

Noteworthy here is how an expansion in self-awareness promotes curiosity and the potential for critical reflection. This process of reconciling different levels of

knowledge sometimes manifests on a physical level. Cathy describes how recognition can manifest as a physical shock:

*Cathy: So just think of the physical sort of experience I was having when she was telling me about it, it was like a bit of a shock, like a realisation that, I mattered to her even though I know that I matter to her.*

The 'shock' of recognition in Cathy's account indicates a point of integration and transformation where cognitive understanding connects with emotional insight, an important precursor to empathy.

These accounts show how the experience of recognising a blind spot isn't an-all-or-nothing phenomenon where information is simply registered at a cognitive or intuitive level. It also involves emotional processing which leads to insight and the growth of empathy.

Participants' accounts show how developing awareness is often a process of making sense of something that seems familiar but hasn't yet been explicitly formulated at a conscious level. When this occurs, participants describe a sense of expanded self-awareness and meaning as they make connections between their mind, body and in a poetic sense, heart.

The 'lived experience' of developing insight through connecting different channels of sensory information is powerfully illuminated in Jane's account as she notices physical manifestations of her emotional responses during our interview.

As she describes her tendency to 'shut down' when working with hysteria or histrionic patients, I notice how she put her hand on her chest over her heart:

**Interviewer:** It sounds the way you put your hand there it almost feels like a physical level?

**Jane:** Yeah, yeah, I just shut down. It just makes me, 'ah'. I can feel the tension in my body, the sense that I'm protecting myself from this. So- and that actually is quite interesting because I can now pick up the difference of how I respond to different

presentations. So people in pain, people who are depressed, people who have awful things happened to them, I am leaning forward in my chair. People who are presenting hysterically, whatever is going on, I lean back. I'm very- that's interesting, *I haven't thought of that before*. Yeah, so it's a completely- it's completely different, yeah how my body responds.

There is a nascent sense of self -discovery as Jane makes meaningful connections between her mind and body enabling her to differentiate physical reactions that correspond to discrete client presentations. A moment of emergence is signalled by the sense of surprise she experiences as she physically registers the tension in her chest while she imagines working with histrionic patients.

Jane's account highlights how the wisdom of the body can be harnessed to understand therapeutic process. It also shows how we bring our whole selves to our therapeutic encounters whether we are aware of it or not. As Elena puts it, *'you can't really compartmentalise'*.

The process of developing insight into ones vulnerabilities is marked by deeper level of understanding and engagement with what one brings to relationships. Participants describe a sense of relating to themselves and their client work with an enhanced sense of curiosity where they are willing to challenge their assumptions. This is evident in Elena's account:

Elena: *I mean I'm now very wary of any assumption that there's your life or there's your inner world and then there's the work, there's the relationship. Um I suppose I was a bit naïve there.*

She describes the importance of something akin to an 'internal supervisor',

Elena: *But there's always this little voice telling me, well careful here, because actually you're still there as well and it will come through in some way. So just try and think about that a bit.*

Participant accounts highlight how developing awareness requires a sense of curiosity and a conscious intention to be open to inner fluctuations in one's inner experience. Gathering together this information and articulating it in a way that feels coherent seems to promote an enlivened sense of connectedness and grounding. It also seems to support participants' capacity to be emotionally available to their clients.

#### **4.6.2. Taking Responsibility**

This sub-theme describes how participants respond to the insights they have gained through recognising their blind spots. This involves acknowledging what has been lost as well as taking responsibility for personal growth in order for change to occur. While this task means different things for each participant, what is evident in most accounts is a sense that fears need to be faced in order to develop a more authentic sense of self.

Christine explains how she needs to challenge her clients more but how fear of being disliked gets in the way: *'Maybe it's that I don't want people to dislike me in any way for I would bend over backwards to accommodate'*. She acknowledges how an important task for her is being able to assert herself in an authentic way while still acknowledging her client: *'I have to start being more challenging while still respecting the client'*.

The importance of being authentic is also alluded to in other accounts. When Jane recognises how she has defended against uncomfortable feelings by trying to be 'unshockable' in her work, there is a sense that in denying her vulnerability, she has also denied a tender part of herself that enables her to be emotionally 'touched' by her patients. By recognising her limitations, Jane is also able to claim what she needs without guilt or shame:

*Jane: I'm going to be good to myself, yeah, I'm not going to take it all because there's - I've got a really strong self-sacrifice schema um which is - most therapists do. I'm sure you do, which is doing for others and it's all right, it's not problem, I'm okay and all this, which isn't right.*

The importance of self-compassion when caring for clients rather than being 'driven' by one's own need to feel caring and acceptable is alluded to in other accounts. Christine acknowledges how an overdeveloped sense of responsibility impedes her work as a therapist: *'if I'm honest, I'm not as good a therapist as I could be (...) I feel very protective towards people. I'm very responsible'*.

Zoe alludes to this characteristic in therapists as a group: *'a lot of us I think are stuck in care giving mode'*.

Zoe describes herself as having a *'disorganised attachment style'*. Disorganised attachment is associated with compulsive caregiving and overly compliant behaviour, which may lead to suppression of difference in the therapeutic relationship. Often what's missing from this style of relating is a sense of trust that one's own needs for security will be met. Indeed it is likely that one's needs might be denied or unhelpfully enacted.

An important recognition for caregivers therefore is self-care. Zoe explains: *'It's not only just about care giving. It's care receiving'*.

The capacity to receive care acknowledges not only the mutual vulnerability of client and therapist but also the importance of self-compassion. It is a vital aspect of being emotionally responsive. As Zoe puts it: *'It's asking for care and being able to receive it when it arrives. It doesn't mean that it has to arrive in the way you want it to arrive in'*.

Not all participants gain an understanding of their motives when they behave in problematic or surprising ways. However, recognising that one's vulnerabilities have the potential to influence the therapeutic process outside awareness, promotes an attitude of humility and curiosity about how their needs influence their work.

When Cathy realises how she has hurt her patient by the way she avoided her at a bus stop, she becomes more self-reflective:

*Cathy: What was it about me that's not wanting you know- was having such boundaries, which weren't helpful?*

Like all participants, she is provoked to reflect on how she manages her anxiety and the negative impact it can have on her therapeutic work:

*Cathy: In future I need to be more aware of these sorts of things with patients in general and with her and not be so anxious about um these moments and that they can be handled in a way which is less rejecting.*

Elena also describes a more conciliatory approach to interactions around boundaries: *I think certainly it's given me food for thought and perhaps a slightly less adversarial approach to endings with clients who find it difficult.*

Noteworthy in all accounts is a tendency to be less self-protective. Elena describes a greater willingness to be known in supervision:

*Elena: I've noticed that in subsequent supervision sessions I've been perhaps a bit more open, which is, could be related a little bit, which is interesting, a bit more open and self-disclosing. I probably would say my supervisor knows more about me as a person as a result of that.*

She also recognises how self- acceptance and a willingness to be vulnerable in relationships will support her self-development:

*Elena: And so perhaps there was a sense in me that I did need help with my blind spots, perhaps more help than I realised, um and that it would be helpful to have someone who knew enough about me personally to help me spot them even better.*

#### **4.7 Summary**

The process of recognising a personal blind spot occurs in phases that share common characteristics. The initial sense that 'something is up' emerges out of an

intense emotional entanglement with a client where participants describe feeling 'triggered'. Participants describe a sense of exposure and vulnerability as they try to recover a sense of their professional selves. There is a sense of emotional destabilisation that is evoked by a situation that cannot yet be symbolised. The emergence of anxiety around personal exposure and potential shame leads to avoidance of one's own experience. A surprising encounter with an 'other' part of the self leads to a sense of confusion and a softening of defences as participants begin to see themselves in a new light. As new insights are assimilated, participants describe a sense of confusion, sadness, regret, hope, excitement and vulnerability. Alongside this expanded awareness, there is an ability to make room for both their own subjectivity and that of the client. This is accompanied by a sense of both self-compassion and empathy for the client. There is a sense of changing while remaining the same as previously 'known' blind spots settle in a new way that feels connected and enlivening

#### Personal Reflections.

One of the problems I struggled with when writing up the participants' accounts and themes is that the linear structure of an academic report imposes a sense that *the lived experience* of recognising a blind spot is a sequential process. In reality, participants experience different and often contradictory processes simultaneously. This is particularly the case where persons are caught up in a state of confusion and uncertainty while standing on the threshold of change. In the current study participants describe experiences where fear of personal exposure manifests in avoidance while at the same time, another part of them expresses unacknowledged needs. This revelation brings surprise, confusion and change that seems to come from nowhere. Indeed, the change has already begun to take place and there is a sense of the ground moving under their feet as they cross a threshold into a state of liminality (Turner, 1996). This threshold is not a simple boundary; it is *a frontier* that separates two different emotional terrains with different rhythms and atmospheres (O' Donohue, 2007, p. 65). At this threshold a mixture of complex emotions is evoked as one begins to leave behind the old and anticipates the new; hope, fear, loss, regret, confusion and vulnerability. There is a sense of uncertainty, of being betwixt and between as familiar defences soften allowing new possibilities to take



root. The process of integration can be seen as a movement through liminal space and time from disorientation to integration. According to Jungian analyst Bani Shorter, what takes place in the dark and confusing phase of liminality is a process of breaking down in the interest of making whole one's sense of meaning, purpose and sense of relatedness once more (Shorter, 2015.p. 73).

As I navigated the hermeneutic circle my own horizons of experience were altered as I sensitised myself to processes of shame by engaging deeply with the shame literature. Although my initial hunch was that shame lay behind participants' avoidant behaviour, I needed to anchor my understanding in a body of theory and research in order to ground my findings. I also needed the 'felt' companionship of fellow researchers who had studied shame, e.g. Tomkins (1962), Lewis (1971), Nathanson (1994), Morrison (2008), Scheff (1997) and Brown (2012). This new 'ground' enabled me to gradually uproot myself from old, ruminative patterns of thinking and to inhabit liminal space with hope and trust in what's emergent. It is challenging to capture this lived experience as much of what takes place, occurs in liminal space at an implicit level. Even so, change is hard. It requires vulnerability and vulnerability takes courage.

As far as you can, hold your confidence.  
Do not allow your confusion to squander  
This call which is loosening  
Your roots in false ground,  
That you might come free  
From all you had outgrown

What is being transfigured here is your mind  
And it is difficult and slow to become new,  
The more faithfully you can endure here,  
The more refined your heart will become  
For your arrival in the new dawn

(John O' Donohue, For the interim time, 2007, p. 135).

# Chapter 5

## Discussion

I begin this chapter by exploring the findings from this study and considering them in the light of current research and literature. Some of the literature has already been mentioned in the Introduction and Literature Review. However, as is the nature of IPA, the interviews and subsequent analysis have taken me into 'new and unanticipated territory' (Smith, Flowers & Larkin, 2009, p.113). Here I draw on new literature to frame my discussion. In the second section, I consider the strengths and weaknesses of this study. I then explore the implications of the findings for future research, therapist training and supervision. I conclude this chapter with some personal reflections.

### 5.1 Overview of findings

The current study seeks to shed light on how therapists' personal blind spots impact on their ability to be emotionally available to their clients. As argued by Ehrenberg (1996), it is crucial that the profession gives more attention to the ways in which therapists permit or preclude certain kinds of emotional contact with their clients because this sometimes defines the level of relational work that will be possible. An important part of this inquiry is developing an understanding of the ways in which therapists' needs influence their reactions in their client work. The findings in this study provide an important contribution towards answering this question.

In addressing the primary research question focusing on participants' experiences of recognising a personal blind spot through their therapeutic work, we see how they experience a wide range of both negative and positive impacts on their lifeworld (Ashworth, 2003). Findings indicate that *hidden shame* impacts on participants' ability to be emotionally responsive to their clients' concerns. Furthermore, lack of awareness of the impact of shame is a primary cause of ruptures that they experience in their clinical work. In the current study a therapeutic rupture manifests

as one that creates strain on the relationship or leads to deterioration as opposed to one that causes complete relationship breakdown (Safran & Muran, 1996).

Another finding is that the sources of participants' anxiety around shame are both personal and professional. On a personal level participants get triggered when client material touches on unresolved family of origin issues or current personal struggles. The study identifies common triggers from the past such as fear of rejection, feeling bullied, anxiety about personal exposure, fear of confrontation and fear of becoming emotionally overwhelmed. These themes reflect more about how participants experience themselves than represent distinct unrelated issues. For example, all of the themes might be conceptualised as a fear of being vulnerable due to unresolved personal conflicts. This is a common theme in all participants' accounts and reflects findings in the countertransference literature that implicates unresolved conflicts of the therapist as the source of misunderstandings in treatment (Gelso & Hayes, 2007, p. 25). On a professional level most participants describe situations where they experience feelings of incompetence or a sense of over-responsibility for their client's progress, or lack thereof. These findings correspond to three potential triggers for therapists that can occur in the context of treatment (Morrison 2008). We find the mutual *collusion to avoid* the consideration of shame; the intersubjective reverberation of shame between therapist and client; and the therapist's shame of *treatment failure* (Morrison, 2008, p.68). Here treatment failure refers to the experience of shame that a therapist may experience due to the notion that they are not helping the client therapeutically (Morrison, 2008; Klinger, Ladany & Kulp, 2012).

The findings also identify maladaptive *avoidant* forms of coping mobilised by the participants to defend against feelings of vulnerability and shame. In the current study avoidance manifests in behaviours such as, withdrawal, hiding behind theory or a professional persona, compartmentalizing feelings to do with loss and blaming the client for problems in the therapeutic relationship. Participants also describe a variety of avoidant behaviours that are embedded in relational patterns such as compulsive caregiving and a self-sacrificing attitude. Some participants relate these behaviours to 'a need to be in control' and the 'need to be liked.' Noteworthy is how

these patterns of avoidance mask feelings of vulnerability and fear of shame (Nathanson 1994; Morrison, 2008).

Shame is identified as a powerful mediating force that potentially blocks or, when accompanied by awareness, shows the way forward. When participants face their vulnerabilities and acknowledge how avoidant behaviours (i.e. implicit shame) impact on their therapeutic work, it leads to new insights and an expanded sense of self-awareness that is embodied and enlivening.

## **5.2 Hidden shame constrains therapists' capacity for therapeutic presence**

The lack of attention to the presence of shame processes by participants is a significant clinical blind spot that impacts on their sense of self-cohesion and how they relate to their client when they feel exposed. Tangney and Tracey (2011) locate shame as one of a family of 'self-conscious emotions' that are evoked by self-reflection and self-evaluation. These emotions include guilt, embarrassment and pride, emotions that may be consciously experienced or transpire *outside awareness*. Fundamentally these emotions consist of people's reactions to their own characteristics or behaviour.

A central problem with identifying shame is that it is a deceptive and elusive phenomenon, managed-out of awareness to maintain positive self-experiencing. As an emotional response to feelings of exposure, it compels us to hide, making it hard to recognize and readily access (Lewis, 1993). This is evident in participants' accounts where it seems to become the proverbial elephant in the room manifesting in behaviours such as withdrawal and avoidance (Nathanson, 1994). While this behaviour is in keeping with the literature describing the effects of shame as a negative emotional state, often characterised by feelings of deflation, exposure, inadequacy, helplessness and incompetence (Kelly & Lamia, 2018), it obscures the learning and insights that can be gained when shame is seen as a message that can guide the therapist (Kelly, 2012).

The fact that shame is present is not altogether surprising. In her seminal book, *Shame and Guilt in Neurosis*, Helen Block Lewis (1971) highlights how shame is

ubiquitous in clinical settings. This is also reflected in the views of seasoned therapists who try to address this issue in Dearing and Tangney's (2011) book, *Working with Shame in the Therapeutic Hour*. Other than this, therapist shame is rarely mentioned in standard clinical texts and articles (Dearing & Tangney, 2011). Why is this so? Perhaps therapists' aversion to their own shame has prevented them from looking at the role of shame in their professional lives. According to sociologists Scheff and Retzinger (2000), shame is the *master emotion*, an emotion that undercuts all other difficult feeling states. On the other hand, the 'taboo' nature of shame leads us behave as if it doesn't exist (Kaufman, 1989).

Therapist shame and embarrassment have rarely being investigated (Klinger, Ladany & Kupl, 2012) despite the fact that therapist shame and embarrassment are thought to have a significant effect on the therapeutic relationship (Pope, Sonne & Greene, 2006) and client outcome (Covert, Maddux, Tangney & Heleno, 2003; Pope, Sonne & Green, 2006). The findings in the current study support a number of observations in the literature that may explain the lack of attention to shame. Firstly, the elusive nature of shame makes it a confusing emotion and it can be difficult to recognize (Lewis, 1971; Wurmser, 1981; Scheff, 1988). Even when identified there is a natural tendency to avoid the painful feelings evoked and shame is *bypassed* (Scheff, 1988). In this case, individuals may distance themselves from the internal feeling of shame by projecting it outside themselves. Thus rather than speaking *about* the experience of feeling embarrassed or shamed, one might say the situation was embarrassing or awkward (Nathanson, 1992). Another example is when the client is blamed for being manipulative or controlling. Next the *recursive* nature of shame means that the experience of shame can evoke further shame making it difficult to acknowledge and talk about (Scheff & Retzinger, 1991; Sanderson, 2015). Each of these reactions to shame is evident during stressful situations with clients where participants describe fear of personal exposure. Fear of exposure manifests in participants' avoidant behaviours that obstruct or derail helpful communication with their clients despite their *conscious* intentions to help them.

### ***The different faces of shame***

The current study highlights the pervasive yet elusive nature of shame and how it features in the way participants describe their experiences of vulnerability in terms of feeling *invalidated, uncomfortable, ashamed, guilty, inept, triggered or embarrassed*. Here shame is *overt and undifferentiated* (Lewis, 1971). In this situation, the participant acts out the feeling but it is experienced as a diffuse negative emotion. Like *bypassed shame, undifferentiated shame* remains unacknowledged (Scheff, 2003).

Dearing and Tangney (2011) draw on the experience of seasoned clinicians to describe a common set of verbal, nonverbal and paralinguistic cues that may indicate the presence of shame processes. Examples are physical or emotional withdrawal (Morrison, 2008), avoidance of 'here-and-now' material (Shapiro & Powers, 2011), and going blank or talking around a topic (Gilbert, 2011). While most of these observations were related to clients, arguably they will also be true of therapists by virtue of our shared humanity. Herman (2011) notes that, 'the vocabulary of shame is extensive'. She deciphered code words for shame which include:

'ridiculous, foolish, silly, idiotic, stupid, dumb, humiliated, helpless, weak, inept, dependent, small, inferior, unworthy, worthless, trivial, shy, vulnerable, uncomfortable or embarrassed...'

Herman (2007, p.165) also builds on Lewis's (1971) clinical observations, and further identified paralinguistic cues for underlying shame including, 'confusion of thought, hesitation of speech, mumbled silences, stammering, long pauses, rapid speech or tensely laughed words'. These cues manifest in situations where participants feel out of their comfort zone with a client. For example, one participant struggles to comprehend her sense of discomfort when she encounters her client at the bus stop: *'I felt a bit embarrassed. I felt a tiny bit ashamed, I don't quite know why'*.

Other signs of shame processes are a sense of helplessness and humiliation in relation to another (Nathanson, 1994). Different categories of experience that support this conceptualisation are also evident in the findings. One participant describes 'feeling flooded' and unable to gather her thoughts with a client she perceives as a

'bully'. Another participant describes 'fear of loss of control' when she finds herself in the grip of erotic transference towards a manipulative male patient who is dismissive of her and therapy in general.

All participants describe exposing situations with clients that they find difficult to put into words other than anxiety or fear. Their narratives and difficulties differentiating their feelings seem to indicate that 'something more' than anxiety is at play in an unfolding drama with a client. Here Wurmser's elaboration of shame can illuminate:

'Shame in its typical features is complex and variable, a range of closely related affects rather than a simple, clearly defined one. It shades into moods on one side, into attitudes on the other. Moreover, it is clear that anxiety is a cardinal part of it. Yet evidently shame is more than anxiety, and anxiety is more than shame' (Wurmser, 1981, p. 17).

Wurmser's dynamic and fluid description of the phenomenology of shame speaks to the experience of vulnerability alluded to in participants' accounts. Crucially, it seems to capture participants' anxiety or fear of being shamed in their therapeutic work. However, as the literature suggests, fear of shame tends to promote the experience itself (Scheff, 1997). Thus the recursive nature of shame may explain why feelings of exposure, embarrassment or shame can interfere with social bonds and stop certain things being talked about (Sanderson, 2015). This is reflected in the current study where participants' maladaptive ways of coping with feelings of exposure manifest in a sense of strain and tension in a relation to a client. It may also be why participants did not talk about shame during the research interviews.

Herman (2011) notes that shame is frequently masked by other emotions, notably anger and rage, but also envy, contempt and expressions of grandiosity. These emotions are often evoked as a defensive reaction to initial feelings of shame in order to deal with the pain of shame. This is alluded to in Zoe's sense of invalidation when she notices that her patient has missed a payment of fees, 'I felt bad and then I felt angry'.

Shame is considered one of the most painful human emotions (Wurmser, 1981; Kaufman, 1989; Wheeler, 1997). It is often confused with guilt although they have different motivations and reactions. Lewis (1971) proposed a simple distinction to which most theorists continue to adhere:

‘The experience of shame is directly about the *self*, which is the focus of evaluation. In guilt, the self is not the central object of negative evaluation, but rather the *thing* done or undone is the focus’ (p.30: emphasis in original).

Here guilt seems to be a more adaptive emotion with the possibility of making amends for the actions that caused harm to another. Of course one might also feel guilt for experiencing shame or shame alongside guilt (Sanderson, 2015, p. 40). Morrison (2008, p. 68) highlights how despite their differences, shame and guilt are intimately related to one another by a natural *comingling* in a particular context, or through the causal link called the *shame-rage cycle* described by Helen Block Lewis (1971). Findings in the current study indicate a variety of shame experiences and functions. For example when Zoe notices her client’s missed payment, her initial reaction is to *avoid* clarifying the misunderstanding with her client. Sanderson (2015) describes how talking about fees and non-payment is typically difficult for therapists and how it can be hampered by feelings of shame:

‘Many practitioners feel embarrassed about making money from a client’s misery or distress and want to prove that their commitment and compassion is real, not just a paid-for service’ (Sanderson, 2015, p. 216).

It seems here that misplaced guilt might also be an obstacle to therapists communicating more congruently with their clients. Most theorists would probably agree that the nature of shame is to inhibit action and to focus the attention of the self inwards. The findings in this study are in keeping with Pattison’s (2000) suggestion that a major function of the normal reaction to shame may be a kind of protection of self and possibly others. As participants struggle with feelings of vulnerability, it seems that their main intention is to restore a sense of their ‘professional self’ so that they recover their therapeutic stance with a client. However



in many cases this leads to or exacerbates a therapeutic rupture. Significant here is how ruptures are often hidden and go unrecognised (Nathanson, 1992).

An important task for therapists is recognising when a rupture occurs between them and their clients (Safran & Muran, 2000). This is easier said than done as clients often display a reluctance to share negative feelings with their therapist. Furthermore, therapists also often avoid challenging material in a session when it relates to their personal issues (Friedman & Gelso, 2000; Rosenberger & Hayes, 2002; Hayes, 2004). Inevitably, this can lead to collusions or a sense of stalemate in the therapeutic relationship, which is characterised by a subtle yet pervasive undertow of shame. In the wider literature on relationships Kelly (2012) maintains that hidden shame is a major cause of rupture in once close intimate relationships. Although this might seem counterintuitive, Kelly suggests that this is due to the widely held belief that for most people the experience of shame means that one has done something to be 'ashamed of' (Kelly, 2012, p. 23). These speculations will be explored in relation to the findings in the discussion that follows.

### **5.3 The relationship between countertransference avoidance and unacknowledged shame.**

The need to self-protect and hide from personal exposure manifests in how participants attempt to hide behind a professional veneer, theory or over-strict professional protocols when they feel insecure or incompetent in their client work. Participants also describe other behaviours; numbing of feelings; avoiding challenging the client even when they know it would serve the work; trying to appease the client and forms of self-criticism. One participant describes a moment of frustration after a session where she slapped herself for not getting the ending of a session right. Wurmer's (1981) succinct conceptualization of shame as a feeling that *follows* the exposure of something one would prefer left private, speaks to the sense of vulnerability participants describe.

There is no doubt that feelings of personal exposure and vulnerability are uncomfortable and it is natural for a person to wish to avoid them. How one reacts to feelings of exposure depends on individual personality and intersubjective context.

Nathanson (1992) describes how there is moment of review when a version of the 'self' manifests in a way that one must accept or defend against. In the current study, participants' behaviours reflect findings by Tangney and Dearing (2011) that people tend to hide or withdraw when they feel vulnerable to shame. Participants describe a range of behaviours that can be captured by Nathanson's 'compass of shame' (Nathanson, 1992). Nathanson delineates four patterns of movement described as Withdrawal, Attack Other, Attack Self and Avoidance. Each position represents a style of behaviour that one might adopt for a specific situation, or it may become a defining character style informed by one's life script. In a similar vein, Karen Horney (1945) also describes three 'human tendencies' to manage shame anxiety: moving toward people, moving against people and moving away from people. Accordingly, the degree of rigidity is likely to reflect symptomatic thoughts, feelings and behaviours as well as degree of psychopathology (Danielian & Gianotti, 2012, p. 30). Temperament, developmental history and cultural conditioning are implicated in one's strategy of choice.

In terms of clinical practice, Wallin (2007) draws on attachment theory to explain how a therapist can be constrained by a vulnerability to shame and a defensive need to feel benevolent. Furthermore, these same needs may result in the therapist attempting unconsciously to project aspects of her shame onto the patient. Each of these theoretical approaches highlight ways that therapists might try to protect their sense of vulnerability while also trying to do what feels 'helpful'. Problematic here is how the defences we erect to protect us from shame *obscure* shame and hide from us the prevalence of shame in causing ruptures or the dissolution of relationships (Kelly, 2012, p. 14).

Shame as an emotional process (Nathanson, 1994; Tomkins, 1962) can be distinguished from shame as a recurring and recursive traumatic state, what we might describe as 'chronic shame' (Herman, 2011; De Young, 2015). In the language of affect theory, shame as a feeling or emotion is different to shame as *affect* (Nathanson, 1994; Tomkins, 1962). According to proponents of affect theory, shame is viewed as a 'modulator affect,' one that mediates or regulates the intensity of other affects, and particularly the affects Tomkins calls "interest-excitement," (Wheeler,

1997). As a biological signal, shame alerts us to breaks in interpersonal connection. When shame is exposed in an atmosphere of safety, its primary function is that it exists to inform and protect the self (Kelly & Lamia, 2018). Crucial here is the relational context of shame and the extent to which painful emotions can be borne so ruptures in interpersonal connection can be repaired. Here we can appreciate the generative function of shame; how it can promote understanding and intimacy when uncomfortable feelings can be expressed. On the other hand, dysregulated shame throughout one's developmental years can lead to a dispositional vulnerability to feelings of shame. One might envisage here how shame becomes part of the fabric of one's existence. Here shame as an emotional response to a trigger reflects the scripts one developed alongside the corresponding avoidant strategies to cope with feelings of vulnerability (Nathanson, 1994). Nathanson puts it succinctly: affect is biology, whereas emotion is biography (Nathanson, 1992, p. 50). It follows that therapists' ability to tolerate shame is largely related to the extent that their attachment history has enabled them to address distressing feelings *while they are actually feeling them* (Wallin, 2007, p. 82, italics in original). On the other hand, emotions that cannot be acknowledged will tend to be evoked in others, enacted with others, or embodied (Wallin, 2007, p. 247).

The level of self-awareness around shame that participants bring to their experiences varies both between participants and within participants according to their current state of mind and the intersubjective contexts in which they find themselves. Wurmser's (1981) three major *modes* of shame illuminate how shame manifests on different levels for each participant. The first mode is *shame proper* which is the *direct* experience of shame. The experience of *shame proper* can be an important sign that there is a misattunement or potential threat in a relationship (Steele, Boon & Van Der Hart, 2017). It also regulates the boundaries of socially acceptable behaviour helping us to navigate optimal levels of closeness and distance. In this way it has important social functions (Steele et al, 2017, p. 307). Shame is only acknowledged *directly* once by a participant when she describes her shame in response to unexpected feelings of exposure *after* she talked about her blind spot with me during our first interview. Here the participant, Elena was

provoked to reflect on the meaning of her experience of shame and the extent to which she avoided revealing her concerns in supervision. She explains:

*And it got me thinking about supervision and the times where there are things I don't want to discuss in supervision because I feel maybe I'm a bit shaky there, and what does shaky mean? Does that mean I have a blind spot? Um am I afraid that things will be said that I'm not aware of or that my supervisor will see things in my work that I'm not aware of. How big is that fear? Does that mean I'm losing opportunities to learn about myself in the work? (Elena).*

Here the experience of *shame proper* is generative to the extent that it provokes Elena to become more curious about uncomfortable feelings that previously might be disavowed or dissociated. Getting in touch with *shame proper* enables her to reflect on the extent to which she *allows* herself to *become known* in supervision. What might she be defending against or protecting herself from? Elena recognises that she needs help to reveal her vulnerabilities and decides to discuss the challenges she experiences around personal exposure in subsequent supervision sessions.

Next, *shame anxiety* refers to the experience of anticipating shame as an immediate danger (Wurmser, 1981). As we see from the findings, anxiety about the immediate possibility of shame is a common feature in all participants' accounts and usually stimulates aversive or avoidant defences such as hiding behind a professional veneer, blaming the client for problems in the relationship or colluding with the client and numbing feelings. While these ways of coping with shame are understandable and natural reactions to a sense of threat, they limit our ability to notice other feelings that could generate important insights about our therapeutic work.

Finally there is *shame as potential*. The potential for shame leads to the development of a character style meant to ward off shame, which is perceived as an ever-present danger (Jacobs, 1996). People whose core self-concept is *shame prone* tend to be overly sensitive to the potential for shame in all interactions. Hence they develop a character style or patterns of relating which are meant to counteract that possibility

(e.g., compulsive caregiving and self-sacrifice). Jacobs (1996) highlights a major problem with this relational style in that it usually operates outside awareness in order to avoid shame. These two modes of shame are discussed below in relation to the findings.

Sanderson (2015) describes how therapists may resort to intellectualization or protocol-driven techniques when their own sense of inadequacy and shame become triggered. Findings in the current study highlight variations on this theme. Two participants describe retreating behind a professional veneer when they feel uncomfortable or out of their depth with a client. For Christine, hiding behind her professional veneer was part of her 'survival mode' when she was going through a stressful period in her personal life. She describes how withdrawing from challenging a client led to a therapeutic impasse. Cathy also describes a tendency to default to a professional 'mask' when she experiences discomfort with a client. However, in her case, clients usually notice the change in tone and point out a sense of disconnect. Regardless whether her clients' observations are right or wrong, Cathy uses the opportunity to explore their experience and expand relational knowledge. This connects with findings in a study by Klinger, Ladany and Kulp (2012) who identified helpful reactions such as processing the therapeutic relationship, apologizing and humour as ways of restoring a positive sense of self-esteem and connection with a client.

Most participants described maladaptive ways of coping with stress that they link to their early years. In these accounts it seemed as if their patterns of coping were more deeply embedded. All spoke about ways in which a particular maladaptive coping strategy impacted on their client work leading to collusions, ruptures or a therapeutic impasse. One participant describes herself as having an *avoidant attachment* style and needing to 'cut herself-off a little' in order to protect herself from her work with traumatised patients. Clearly if a therapist is not emotionally available to experiencing *shame proper* (Wurmser, 1981), she misses the opportunity to reflect on her experience and change her behaviour as appropriate. Indeed one could argue that the therapist is missing an important therapeutic resource that is required for the therapeutic work to deepen and progress. As described previously, *shame proper*

helps us navigate optimal levels of closeness and distance (Steel et al, 2017). An inability to acknowledge shame can lead to fear and anxiety that further perpetuates shame (Wurmster, 1981). Sanderson (2015) suggests that therapists who are fearful of closeness and intimacy may feel shameful for avoiding psychological contact with their clients. Here we can appreciate how fear of showing vulnerability can also bind us to the past by obscuring and shielding us from deeper longings for connection (Bradshaw, 2006).

Three of the five participants describe either a 'self-sacrificing schema', or being 'stuck in caregiving mode'. According to Young and colleagues (2003) a self-sacrifice schema is very common among mental health professionals and a strong motivational factor in choosing their line of work. It often involves an excessive focus on meeting the needs of others at the expense of one's own needs. Self-Sacrifice may develop from a desire to avoid causing pain to others or experiencing guilt from feeling selfish about having needs of one's own (Young, Klosko & Weishaar, 2003).

While these patterns of relating implicate temperament, they also involve family of origin and cultural conditioning. A case in point is Christine's story describing an anxious childhood where her mother nearly died a few times. She recalls the sense of childhood 'omnipotence' she experienced; how she was convinced she could keep her mother alive. Here we see how the influence of a strict catholic upbringing shaped an over-developed sense of responsibility towards others. This is how she described it:

*Everybody else comes in front of you. And if, it wasn't just what you did, it was what you thought... so it was control over thoughts as well really.*

Maltsberger and Buie (1974) describe three narcissistic vulnerabilities common to all therapists: 'heal all, know all and love all' (p.138). These vulnerabilities reflect counsellors' unrealistic expectations of themselves with regard to caregiving. Arguably these qualities can only be sustained by a sense of omnipotence, which may be unconscious but nevertheless manifest in a driven quality. Sussman (2007) stresses the importance of understanding one's unconscious motivations to 'help' in order to understand their more destructive emotional undertow.

From an attachment perspective, Wallin describes what might lie at the root of a compulsion to help:

‘As protection from our trauma-based vulnerability to shame – shame that wears different colourings of badness, from destructiveness to selfishness to humiliating insufficiency and powerlessness – we may feel not just committed to healing, but *compelled* to heal, compelled to be good and effective’. (Wallin, 2014, p. 203. italics in original)

A significant factor obscuring participants’ ability to be more objective about their part in a therapeutic rupture is that maladaptive patterns of coping can *feel good* infusing one with the sense that one’s decision is serving the therapeutic work. Relational psychoanalyst Davies (1999) suggests that a therapist will often unconsciously make clinical choices ‘which are designed to heighten her sense of safety’ (p. 9). This pattern of behaviour is also reflected in the research on countertransference (Friedman & Gelso, 2000). According to Friedman and Gelso, whatever the manifestation of countertransference feelings (over-involvement or withdrawal) therapists are *avoiding client issues when their behaviour serves their own needs* (Friedman & Gelso, 2000, my italics).

#### **5.4 The implications of participants’ idiosyncratic patterns of relating in therapeutic ruptures with their clients.**

Despite the fact that most participants are aware of tendencies such as compulsive caregiving, self-sacrifice and compartmentalization, a significant blind spot when they experience a rupture with a client is a lack of explicit attention to the implications of their own attachment (developmental) history or idiosyncratic style of relating. This paradox becomes the ‘missing piece’ that is enacted with a client and leads to a therapeutic rupture. The journey involved in recovering and *taking responsibility* for this ‘missing piece’ becomes a transformative experience for participants in terms of their personal integration and attitude to their clinical work.

The significance of this is evident. According to McHenry (1994), when therapists lack awareness of their role in an enactment, they risk responding to the client in counter-therapeutic ways, as their attention turns towards alleviating their own discomfort. Accordingly, this is likely to impact on the client who is unlikely to feel understood or contained. The fact that most participants don't appear to reflect on the impact of their own history and patterns of relating when involved in a therapeutic rupture warrants further attention. Ritz (2005) argues that therapists have difficulties thinking about how their most vulnerable and subjective parts come to be sought out and explored by clients. This is despite the fact that there is now a significant body of attachment research showing that one's ability to generate a secure attachment relationship will be profoundly influenced by one's attachment history (Mikulincer, Shaver & Berant, 2013; Wallin, 2007). This 'knowledge' is not new; an old adage often quoted amongst therapists is that no client can achieve a greater level of healing than their therapist has achieved.

The inability of therapists to acknowledge how their own needs manifest in their clinical work obstructs therapy in a variety of ways. Firstly, what is not recognised or expressed will often be expressed nonverbally and indirectly through the therapist's interventions (Safran & Segal, 1996; Wallin, 2007). In the current study, all participants describe situations with their clients where their needs manifest in counter-therapeutic behaviours. Elena describes her difficulty managing the end of a session with a client she experiences as 'controlling' until she realises she also had a need to be needed by her client. Cathy recognises how her difficulty acknowledging her client at a bus stop was rooted in her fear of not managing the situation correctly. Christine realises how fear of rejection obstructs her ability to challenge a long-term client she experiences as demanding: *'Maybe it's that I don't want people to dislike me in any way for I would bend over backwards to accommodate'*. It is only when therapists are able to acknowledge their true feelings towards a client are they are able to reflect on the nature of the therapeutic relationship and the subsequent therapeutic task. Crucially, in terms of therapeutic process, until a therapist notices what's happening internally in her relationship with a patient, she is likely to be caught in an enactment or countertransference-transference transaction (Stern, 2003; Bromberg, 1998; Davies & Frawley, 1994; Wallin 2007).



Problematic here are situations where therapists feel guilty or ashamed about their feelings as they are also likely to have difficulty empathising and accepting these feelings in others (Safran & Segal, 1996). Wheeler elaborates:

'If a given feeling is so unacceptable or so unbearable as often to be denied, even to the self, then how are we to recognise it all? How do we know, personally or clinically, when anger, say, or depression is usefully thought of as in part reaction to or defence against shame, and when this is more our suggestion than the client's own reality?' (Wheeler, 1997, p. 225).

Winnicott (1947) broke new ground in psychoanalysis when he wrote his seminal paper describing the hateful feelings between therapist and patient. While Winnicott's discussion was mainly concerned with what he described as *psychotics*, it is important to bear in mind that members of the British School of Object Relations, often used the term flexibly to apply to what we might describe as borderline or severe personality disorders (Gabbard, 1994). Winnicott's contribution was pivotal in helping generations of therapists to face normal intense countertransference feelings with the strong conviction that tolerating such feelings would ultimately be useful for the patient. The important question here is how can a therapist know if her reactions are rooted in her personal wounds and blind spots or part of a response that most people would have when involved with a particular client presentation. Arguably, what might be decisive here is a therapist's ability to differentiate how the different modes of shame (Wurmser, 1981) manifest in the intersubjective space. An important element of this understanding is the therapist's ability to regulate her own bodily-based emotions and shame dynamics well enough to stay connected to her patient (Schore, 2015, p. 131).

This is easier said than done, but done it must be. However, findings in the current study indicate that even when participants are aware of their vulnerabilities and biases (e.g. self sacrificing script; avoidant or disorganised attachment style; tendency to compartmentalise), they are inclined to see the client as the problem when they experience intolerable feelings towards them. Here dysregulated shame

clouds one's ability to think (Lewis, 1971; Scheff, 1981). Brown (2006) describes how shame often produces overwhelming feelings of confusion, anger, judgement and the need to conceal these uncomfortable feelings. Furthermore, it's difficult to identify shame as the core issue when trying to manage such intense feelings (Brown, 2006).

Recent developments bringing together attachment research, relational psychoanalysis and affective neuroscience can help us understand participants' lack of explicit attention to the implications of their personal vulnerabilities when they become triggered by client material in clinical enactments (Schore, 2012). Schore describes how enactments are experienced at the edges of the regulatory boundaries of affect tolerance. According to Lyons-Ruth, these 'fault lines' of self-experience occur where 'interactive negotiations have failed, goals remain aborted, negative affects are unresolved, and conflict is experienced' (Lyons-Ruth, 2005, p. 21). In these situations *shame the master emotion* regulates these difficult feeling states (Scheff & Retzinger, 2000). For those with a history of insecure attachment, emotional dysregulation can impair one's mentalizing capacity. As Allen (2013) maintains, 'You most need to mentalize when you are least capable of doing it' (p. 241).

In terms of the current study, McLaughlin's (2005) concept of blind spots as knowledge that was once 'known' or 'lost' can be usefully employed to understand participants' loss of reflective function during therapeutic ruptures. In a review of the literature Mann comes to the following conclusion: 'The patient's struggles come into play with difficulties that the therapist is experiencing either temporarily or chronically in his or her own life' (Mann, 2009, p.8). The experience of being in the grip of experiences that cannot yet be formulated might also be explained by the presence of dissociative processes (Stern, 2003). Danielian and Giannotti illuminate:

'In a general sense dissociation can be seen as any behaviour that restricts, foreshortens or fragments experience as a result of feeling pressure of anxiety, guilt, shame, or the need to retain important relational ties' (Danielian & Gianotti, 2012, p. 8).

According to Danielian and Gianotti (2012), a common misconception is that dissociative splitting is a primitive defence, often associated with more severe character pathology and that repression occurs in less severely disturbed patients in order to block uncomfortable affect or memories and to maintain emotional equilibrium. Although Danielian and Gianotti accept that more extreme forms of dissociation are the result of extreme trauma, this is viewed as one pole at the end of the dissociative spectrum. Following Howell (2005), they argue that all points of the dissociative continuum involve splitting off aspects of behaviour (Danielian & Giannotti, 2012, p. 33).

Writers on relational trauma such as Davies and Frawley (1994), Bromberg (1998) and Donnel Stern (2003) convincingly relate enactments to dissociative process. Both Bromberg (2011) and Schore (2011, 2012) suggest that dissociation is a bottom line defence against trauma. More crucially, dissociation represents 'the major counterforce to the emotional – motivational aspects of the change process in psychotherapy' (Bromberg, 2011.p. xxv).

Inevitably therapeutic enactments are more likely to occur where there is a history of trauma. In the current study, two participants describe a history of developmental trauma and most participants work with patients with a history of relational trauma. During therapy with traumatised clients, the therapist becomes a witness and in transference-countertransference enactments sometimes even part of the past dramas of the client (Davies & Frawley, 1994). Crucial here is the therapists' capacity to reflect on their vulnerabilities and in particular, feelings that they find difficult to acknowledge in themselves. Within the trauma literature, Dalenberg (2007) describes how countertransference reactions can be shame inducing when therapists perceive their feelings as inappropriate. Here therapists' feelings of inadequacy may be accompanied by a sense of blame towards the patient as a way of avoiding their own shame, which feels too much to bear (Hahn, 2004). Dalenberg (2007) stresses the importance of supervision so trauma therapists can tolerate their shame and it doesn't derail the work. Accordingly, a useful sign of such a problem for on-going critical reflection is the sense that the client is 'making' the therapist feel something. According to Dalenberg:

‘Such a statement or conceptualisation (which might remind the reader of some versions of the projective identification concept) implies the disowning of the affect in the therapist, which in turn implies the therapist’s shame over the existence of the feeling. It is important in such instances not to ask or expect the client to take on the responsibility for the therapist’s unique responses to trauma’ (Dalenburg, 2007, p. 122).

Dalenberg’s observations can be brought to bear fruitfully on various categories of experience where participants describe a sense of ‘being done to’ by a client. Most participants describe an intense emotional interaction with a client where they felt ‘stuck’. Broadly speaking they describe situations where there is no room for manoeuvre in terms of interventions due to feeling bullied, manipulated or controlled. There is a sense of blame and shame.

Clearly the implications of dissociative processes and the foreshortening and restriction of experience that this implies can have serious implications for the therapeutic relationship. The seminal Vanderbilt studies show that therapeutic influence can manifest in subtle ways but with substantial effects where even low levels of disaffiliative process can be detrimental to treatment outcomes (Strupp, 1993). Feelings that go unrecognised are vulnerable to being expressed nonverbally and indirectly through therapists’ interventions. Again clinical supervision can be a vital source of support in helping therapists to reflect on the source of their feelings so that the therapeutic work can serve their clients’ best interests (Carroll, 2009). However, Wallin (2007) cautions therapists against the *defensive* need to feel benign. Indeed Celenza and Gabbard (2003) found that where sexual violations have occurred, they are the endpoint of a gradual shift in the therapeutic frame characterised by the therapist attempting to maintain a positive relationship with the patient by avoiding conflict or hostility. Often this process is managed through inappropriate self-disclosure. This may reflect the therapist’s desperate desire to be idealised, loved and sexually desired by the patient (Gabbard, 1997). Once again, we are reminded of the importance of uncovering one’s unconscious motivations to work

as a therapist so that their destructive potential can be held in check (Miller, 1997; Sussman, 2007).

It is clear that therapists' inability or unwillingness to reflect on how their vulnerabilities are implicated in therapeutic ruptures is a serious obstacle to therapeutic process. As described, it can even lead to unethical behaviour by the therapist. Thus a vital inner skill for therapists is learning to tolerate psychological discomfort. Rousmaniere (2016) highlights 'experiential avoidance' as a significant blind spot that impedes therapists' ability to stay attuned to their clients while the therapist experiences discomfort. Experiential avoidance or *avoidance reactions* are thoughts, emotions or physiological reactions that lead a person to avoid, distract, minimize or distant oneself from an experience in the moment (Scherr, Herbert & Forman, 2015, p. 22). As a counterpoint to this, clinical wisdom shows the importance of being able to experience a wide variety of feelings no matter how uncomfortable (Searles, 1979). Indeed empathy *requires* that therapists have the inner skill and capacity to tolerate psychological discomfort (Hatcher, 2015).

In terms of research, a recent qualitative study exploring therapists' subjective experience of countertransference in successful and unsuccessful cases showed how therapists with successful outcomes described experiencing *more* unpleasant feelings and problematic cognitive reactions than did therapists with unsuccessful outcomes (Hayes, Nelson & Fauth, 2015). While on the surface, these findings may appear counterintuitive: Hayes and colleagues speculate that therapists with successful outcomes were more aware of their countertransference reactions, and also willing to discuss their reactions with clients. Furthermore, therapists whose outcomes were successful also managed their covert reactions so that they were not acted out with their patients. This is consistent with previous research that awareness of countertransference reactions is associated with better psychotherapy outcomes (Gelso & Hayes, 2007).

### **5.5 Shame is a powerful mediating force that potentially blocks the way or with awareness, shows the way forward.**

Thus far, the discussion has focussed on the mediating power of shame to obscure and thus block the way forward through various processes of avoidance mobilised by the participants. In this section we see how awareness of shame can show the way forward and promote connection and integration (Brown, 2006). This process is evident in participants' accounts where they acknowledge their vulnerability and recognise the impact of a personal blind spot on their therapeutic work. A central theme in all accounts is that this recognition occurs within an interpersonal exchange. In all accounts new insight arrives through the process of rupture repair with a client or talking about the rupture in supervision or with the researcher. It is in *speaking about* their avoidance (implicit shame) that participants become aware of underlying motivations and feelings that impact on their ability to maintain a therapeutic stance. One participant describes it thus:

It's been fear that's driven so much of my practice actually...*I've felt it, but it's only in saying that now I realise what's driven my practice*, it's been fear.

Whatever I do in the room, the bottom line would be fear and that's not good.

Another participant describes how she made a connection when she was *emotionally touched* as she shared her experience of shock about a patient's traumatic history with other victims of trauma. She describes a sense of being '*blown out of the water*' when she realised the extent to which she sacrificed herself for her work: '*I'm still actually thinking about this, how much I can hold, um how much I defend against what I'm told every day and ... how much I can hold?*'

The process of recognising a personal blind spot seems to be marked by momentary experiences of surprise or shock as participants recognise the impact of their behaviour on their clinical work. The Boston Change Process Study Group (2010) refers to these moments as 'now moments'. This is a 'hot' present moment, a sort of 'moment of truth' (Stern, 2004). Accordingly the process of change involves meaningful emotional connections between two individuals in the form of 'now moments' and 'moments of meeting' which potentially resolve the crisis created by

the 'now moment' (Stern, 2004). During these moments, implicit relational knowledge rearranges 'implicit relational knowing' for both members of the therapeutic dyad. A significant finding in the current study is that a conscious intention to turn *towards* feelings of vulnerability rather than retreat behind defences promotes opportunities for 'now moments' to be transformed into 'moments of meeting'. Noteworthy in participants' accounts is how 'hot' moments of truth or 'now moments' and 'moments of meeting' take place in a relational context where conditions might be described as 'safe but not too safe', in other words sufficiently challenging (Bromberg, 2006; 2011). Here the challenge arises out of a deliberate intention to engage with uncomfortable or difficult emotions. As Schore maintains: 'You have to be *in* an emotion to learn how to regulate it in a new way- talking about it is not enough' (Schore, 2015, p. 132, italics in original).

Self-psychologist Martin Livingston's (2001) concept of a 'vulnerable moment' captures the fertile possibilities in these experiences. According to Livingston, the experience of vulnerability consists of two simultaneous aspects: 'the danger of shame or humiliation, or of fragmentation of the self, and the promise of new experience that greater openness allows' (Livingston, 2001, p. 48). The capacity to *be with* ones vulnerability is very different to the sense of vulnerability that emerges from a lack of potency or passive sense of helplessness that carries an undertow of shame. Instead it can be defined as a personal *quality of being* where a person is able to cultivate shame as an ally that can enhance one's awareness of pro-social behaviours (Deonna et al., 2011). It also involves the recognition that part of who I am escapes my control and depends on the other (Sartre, 2003).

Psychoanalyst, Jessica Benjamin's notion of the *third* as that to which we 'surrender' refers to a certain letting go of the self and the ability to take in the other's point of view of reality. Here Benjamin draws on Ghent's (1990) articulation of the distinction between surrender and submission by making the point that surrender does not mean '*giving in* or *giving over* to someone, an idealized person or thing', instead it involves 'letting go into *being with* them' (Benjamin, 2004, p.2, emphasis in original). Although Benjamin's work is on a level of high theoretical abstraction, her notion of *thirdness* can be usefully employed in this study to illuminate the process where

participants move out of a position of 'being done to' by a client to taking responsibility for the impact of their own needs and blind spots without needing to blame or idealise the other.

A second feature in participants' accounts is that when they consider the impact of their avoidant behaviour on a client, reflection brings forth knowledge that they already 'knew' but that was previously disavowed. Cathy describes the shock of recognition when her patient expresses distress about being avoided at the bus stop: *'It was like a bit of a shock, like a realisation that, I mattered to her even though I know that I matter to her'*.

The verb *recognise* comes from the Latin root words *re* (again) and *cognoscere* (to know) – literally 'to know again' or 'to identify'. Here concepts such as the 'unthought known' (Bollas, 1987), 'implicit relational knowledge' (Lyons-Ruth, 2005), and 'felt sense' (Gendlin, 1981) bear witness to the phenomenology of this lived experience. Relational psychoanalyst, Paul Wachtel's conceptualisation of dissociation also speaks to the sense of recognition that many participants describe:

'What is crucial in the work is most often not what we *don't know* about ourselves, but what we *both know and don't know*, the ways in which certain things we "know" do not really influence very much what we do or what we feel' (Wachtel, 2008, p.143, italics in original).

Noteworthy in participants' accounts is how affect makes things significant (Tomkins, 1962). Rather than intellectual insight, it is participants' capacity to be non-defensive and accepting of their vulnerabilities that promotes empathic connection. Safran and Segal (1996) argue that therapists must not only comprehend the *idea* of their patients' inner experiences, it is also vital that they can *sense* or *feel* subtle nuances of those experiences, which the patient may not have articulated for themselves. Thus empathy requires a process of affect attunement (Safran & Segal, 1996). Accordingly it involves a process of immersing oneself in the patient's inner world so as to articulate the implicit domain (Lyons-Ruth, 2005). Gendlin's (1981) concept of the 'felt-sense' is relevant here and speaks to the sense of *embodied* awareness that



participants describe as they use their vulnerability in service of their therapeutic work.

Self-acceptance is a significant sign of integration in participants' accounts. It is now widely recognised that acknowledging one's core vulnerabilities and common humanity with self-acceptance ameliorates shame and reduces the need to hide from self and others (Aponte & Kissil, 2012; Brown, 2006, 2012). Accordingly, this enables the therapist to gain freedom from their own self-limiting and 'self-blinding issues' so they can 'better see, hear, and feel their clients and their issues' (Aponte & Kissil, 2012, p.162). Within the countertransference literature, Gelso and Hayes (2007) maintain that when therapists accept their personal vulnerabilities and biases, they are less likely to attribute their struggles to their clients. Findings in the current study highlight how self-compassion helps one tolerate suffering with curiosity and acceptance. There is a growing body of research that shows the significant role of self-compassion in promoting shame resilience (Brown, 2006; Gilbert & Procter, 2006). Self-compassion brings an increased sensitivity to the feelings and needs of self and other which Gilbert argues can be distinguished from the experience of 'just being aware of vulnerability, fears or worries' (Gilbert, 2011, p.131). To clarify further, when we are embedded in experience, it's as if we *are* the experience as long as the experience lasts (Wallin, 2007, p.135, italics in original). While such a stance might be appropriate for experiences such as sport, music and making love that are further enhanced by being in a state of flow (Csíkszentmihályi, 1997), an embedded state of mind can be disruptive and cause immense suffering when we lose hold of our capacity for reflection. Wallin succinctly describes how loss of a reflective stance impairs psychological functioning:

'Within such an unreflective frame of mind, somatic sensations, feelings, and mental representations that might provide *information* about reality are felt instead to *be* reality. Here – and this is the crucial point – there is only a single perspective on experience, a single view, as if there were no interpretations but only perceptions, no beliefs that are not also facts' (Wallin, 2007, p. 135).

An important element of therapeutic presence is a therapist's ability to be fully in the moment on a multitude of levels, physically, emotionally, cognitively, spiritually and relationally (Geller & Greenberg, 2002; Geller & Greenberg, 2012). Many participants describe a greater awareness of their bodily sensations when they bring a sense of curiosity and acceptance to their experiences of vulnerability. A case in point is that of Jane during our second interview. There is a moment of emergence as she notices how her bodily sensations provide her with clues about her patient's experience:

*I can now pick up the difference of how I respond to different presentations. So people in pain, people who are depressed, people who have awful things happened to them, I am leaning forward in my chair. People who are presenting hysterically, whatever is going on, I lean back... I haven't thought of that before... so it's completely different, yeah how my body responds.*

Orbach and Carroll describe *somatic transference* as 'the therapist's awareness of their own body, of sensations, images, impulses, feelings and fantasies that offer a link to the client's process and the intersubjective field' (Orbach & Carroll, 2006, p. 64). Accordingly, embodied awareness promotes empathy (Orbach & Carroll, 2006). In the current study participants' accounts indicate that developing a more curious self-compassionate attitude to subjective feelings of discomfort enables them to become more reflective and present both to themselves and their clients' concerns. Arguably these attitudes form the bedrock of empathy and affective attunement. Affective attunement requires that therapists attend not only to the emotion itself but also to the message being sent by the display of emotion (Erskine, 2015, p.30). Erskine (2015) elaborates describing how emotional resonance and attunement enable the therapist to distinguish between patients' tears that plead 'Please take care of me and make things better', and tears that say 'I'm ashamed to be so upset about this', and to respond appropriately (Erskine, 2015, p. 31). Arguably therapists' ability to notice these distinctions will be influenced by their ability to attend to the variety of ways that shame processes manifest in the therapeutic relationship (Lewis, 1971; Wurmster, 1981; Nathanson, 1987). The importance of attending to process is emphasised by Mills: 'Process is everything and attunement to process will

*determine* if you can take the patient where he or she needs to go' (Mills, 2012, p. 123, my italics).

To some extent one could speculate that the way therapists treat themselves as *persons* seems to influence their ability to be present to their own experiences of vulnerability *and* those of their clients. This observation is evident in the wider literature where there is a greater focus on encouraging therapists to embrace ambiguity and develop the ability to contain their shortcomings and limitations 'without fear of losing face or authority' (Nissen-Lie et al, 2015, p. 57). Above all, this requires courage and integrity and the capacity to walk with shame and imperfection with the promise of new experience that greater openness allows.

Zen saying – 'When the realisation is deep, your whole being is dancing'.  
(Cited, Steele, Boon & Van Der Hart, 2017, p. 3).

### **5.6 The strengths and limitations of the current study.**

In this section I seek to evaluate this study in terms of the method and methodology chosen. IPA is examined in terms of its efficacy in bringing to light participants' blind spots; i.e. personal beliefs and assumption that are not readily available to the person who holds them. Here the challenge for the method was not just to reveal the participants thinking, a problem in itself as people are not always able or indeed willing to reveal their world view to order, the researcher also needed to be in a position to make interpretations about processes that in a sense lie beyond articulation, and yet are reliant on language to reveal them (Carpenter, 2009).

Reflexivity as hermeneutic reflection, with its grounding in hermeneutics and phenomenology (Shaw, 2010) was a vital construct for guiding my engagement throughout this study. This is evident throughout the hermeneutic process (see section 3.14 p. 84). Given the challenge involved in uncovering both participants blind spots as well as my own, a secondary level of self- awareness about the

process of reflexivity itself was required. Finlay (2002) suggests this is sometimes necessary in order to critically evaluate the reflexive process itself so as to avoid falling into the “swamp of interminable deconstructions” (Finlay, 2002, p. 209). The implications of my subjectivity on the findings became manifest in a hermeneutic journey that enabled me to recognise how shame can block the way or with awareness, show the way forward. Arguably it is my recognition of this paradox that allowed me to see the phenomenology of shame processes and the purpose shame serves more clearly.

IPA encourages researchers to be imaginative and flexible in the design and execution of a research study within the parameters of clearly accessible guidelines (Eatough & Smith, 2017). The question here is to what extent IPA was able to generate data that provided access to both the researcher’s blind spots and those of the participants. It is argued that my experiences of interviewing the five participants along with the *intersubjective reflections* that emerged during the interview (Finlay, 2002), and in later analysis demonstrated the transformative quality of the reflexive material and provided the experiential context from which meaningful findings emerged. Without this systematic approach, the surface of the data may have only been touched without a full understanding of the obvious and hidden gems buried within it (Goldspink & Engward, 2019).

### ***The significance of the second interview.***

IPA presupposes that participants’ verbal accounts will provide sufficient data to enable the researcher to make interpretations about the participants’ implicit theories (blind spots). The second interview was significant in providing a context where the researcher developed a deeper understanding of the impact of self-disclosure and personal exposure on the participants. Carpenter (2009, p.24) highlights how the participant’s perception of the research situation influences what they feel able to reveal. Inevitably, this impacts on the data. Two points are worth considering here. Firstly although all participants seemed to experience the interviews as therapeutic, the lack of explicit attention to shame processes by participants during the interviews was a surprising finding. Only one participant disclosed how the process of describing her vulnerabilities had evoked shame. Noteworthy here is how this was

also a surprise to her. A further reflection is that her disclosure of shame in the interview provoked shame in me and made me more hesitant in my process of inquiry. Two further points are relevant here. Firstly the process of self- disclosure can be shame inducing because it requires facing one's vulnerabilities again. Secondly, shame is a recursive emotion and speaking about shame can evoke shame in the intersubjective space. However, by sharing her experience of shame I was alerted to the possibility that other participants might also have experienced shame but were unable or unwilling to disclose it. My reflexive process here supported the emergence of findings that more usefully captured the dyadic nature of the interpersonal tensions that develop when therapists are triggered by client work.

IPA's idiographic approach was essential for revealing the idiosyncratic ways in which participants' experience of vulnerability and shame manifested through a variety of avoidant processes. In this vein, an interesting finding was that one of the participants could not recall a recent experience of recognising a blind spot in over twenty years! My feelings of confusion, disbelief and disappointment dissipated at the end of the first interview as we shared a 'laugh' at a funny video clip that poked fun at therapy! It is possible that this experience created a new context from which we were able to develop a sense of connection and trust. Whatever the case, during the second interview she shared a recent transformative experience where she was able to acknowledge the extent to which she sacrificed her own needs to her work. Reflecting back on her first interview, I am reminded here how Master therapists describe unresolved pain and shame as they reflect back on their 'worst mistakes,' some of which took place decades earlier (Kottler & Carlson, 2002). It is interesting now to reflect on the 'pilot interview' and my perception of the lack of analysable data in the text. Although this potential participant did not describe a 'lived experience' of recognising a blind spot, his avoidant demeanour as he shared experience distant accounts of blind spots that he *used* to have might be interpreted as a blind spot to the extent that it could be understood as an avoidance of vulnerability and potential shame in the here-and-now.

### **Limitations of the current study**

Reflexivity in IPA strengthens the rigour of the research process and enables the researcher to gain deeper interpretative access to the data. In the current study the researcher's own experiences and observations of the data, combined with the phenomenological philosophy of IPA provided a multidimensional approach to interpretative work (Goldspink & Engward, 2019, p. 12). However a significant limitation in the method is the extent to which the researcher's *personal equation* is implicated in the findings. According to Samuels:

'The 'personal equation' is the bias that the observer brings to his or her observation, and to subsequent thinking and theorising. As Jung put it, 'One sees what one can best see oneself' (Samuels, 2014, p. 224).

In summary, the findings in the current study reflect what I *made* of what I found (Richardson, Flowers & Guignon, 1999, p. 212). The extent to which my interpretations of the data are rooted in my projections and theories is a significant bias influencing the findings. It is significant that only one of the participants acknowledged the experience of shame and that this was in relation to her experience of disclosing her blind spot through the interview process. On the other hand as the study reveals, the complex and nuanced nature of shame means that it often goes unnoticed and therefore is not recognised or spoken about. This is reflected in the dearth of research exploring therapists' experience of shame in relation to their therapeutic work (Dearing & Tangney, 2011; Ladany et al, 2011). Also significant is how my *personal theory* of shame became a source of countertransference that impeded my ability to recognise shame as an affect that could contain an important message (Kelly, 2012). Both my experience and theoretical understanding of shame as a chronic and acutely painful emotion blinded me to the generative potential of shame when viewed through the theoretical lens of affect theory (Tomkins, 1962; Nathanson, 1994; Kelly, 2012).

Fauth (2006) argues that more research needs to be done to capture the full richness of countertransference phenomena. Arguably another researcher with different blind spots might have 'seen' other 'gems' in the data. It is possible that both the subject

matter of the research and the phenomenological hermeneutic approach biased the researcher towards finding her dissociated experience in the data. In order to address this bias, I have endeavoured to provide a transparent account of my reflexive journey while paying attention to Yardley's guidelines for assessing quality and validity in terms of how the study was carried out (Yardley, 2008).

Another limitation is that this research is based on a small, self-selected and somewhat homogenous sample. Despite the fact that I advertised my research with the main governing bodies for Counselling and Psychotherapy, only seven potential participants came forward, two male and five female. One of the males was a Clinical Psychologist who did not meet the criteria for the research. The second male provided the 'pilot' interview however, this interview was deemed unsuitable. This participant had no recent experiences of blind spots in his clinical work. All the other participants were middle class, middle- age women. One of the female participants identified as mixed race. To counter questions arising from this homogeneity of participants, future research should perhaps address a wider range of participants and hear the voices of male therapists and therapists from different ethnic groups. Research suggests the presence of gender- specific patterns in emotional responding with women generally reporting more sadness, fear, shame and guilt, whereas men report experiencing more anger and other hostile emotions (Fischer et al., 2004, p. 87). Notwithstanding these differences, shame is often accompanied by anger (Scheff, 2003). For example, shame may manifest as anger towards oneself or against another person or a situation. Indeed shame is often described as 'the master emotion of everyday life' (Scheff, 2003). The task now is to *reveal* how it manifests in various socio-cultural and psychological contexts.

There may also be a self-selection bias within this study, given that all the participants were volunteers who self-selected. This raises questions about the participants' attitudes to the experience of exposing their blind spots for the research. The fact that they made themselves emotionally available presupposes a certain amount of shame resilience and courage. Indeed it makes the findings even more surprising and one is left wondering how therapists in general manage shame and its vicissitudes. On the other hand the study indicates that participants were unaware of

the role of shame in their therapeutic ruptures or were aware but choose *not* to discuss it with me during the interviews. As Kaufman (1989) asserts, the 'taboo' nature of shame leads us behave as if it doesn't exist.

As an IPA study, the current research was necessarily non-randomised and did not have a control group for comparison and verifications. Its findings are based on the researcher's personal interpretations of the interviews with five respondents and are not transferable across the entire population of psychotherapists. However, given that the purpose of the study was to explore the lived experience of a specific category of therapists (qualified practicing integrative psychotherapists (UKCP registered) or counselling psychologists (HCPC registered) and currently practicing relational psychotherapy), the focus was not on the transferability and generalizability of its findings. Rather, its scope was to understand the lived experience of a homogenous group of therapists who subscribe to ideas within contemporary relational psychotherapy that emphasise intersubjectivity, and the concept of 'reciprocal mutual influence' (Stolorow & Atwood, 1996, p. 18).

### **5.7 Possible Future directions**

This study shows the pervasive influence of unprocessed shame on therapeutic process; how 'hidden' shame manifests in avoidance and leads to ruptures that often go unrecognised. The task for practitioners and researchers now is to find ways of bringing shame to light so that it can be addressed consciously and understood rather than remain hidden. Given the importance of identifying *hidden shame* in therapists, a salient line of inquiry might be exploring how training and working as a psychotherapist impact on therapists' personal relationships, e.g., friendships, partners, parents and children. This could illuminate therapists' inner world; their motivations and creative solutions when faced with challenges in their intimate relationships. The current study suggests a potential interplay between some aspects of psychotherapists professional and personal functioning (Nissen- Lie et al., 2015). The powerful mediating influence of therapist shame on therapeutic process also highlights the need for further research that contributes to our understanding of both therapist self-care and the defensive coping strategies of caregivers (McCluskey & Gunn, 2015).



## **5.8 The value of this study and the implications for the training and supervision of therapists.**

It is a salutary observation that neither years of professional training, discipline or years of experience can consistently predict psychotherapy process and outcome (Beutler et al., 2004; Goldberg, Rousmaniere et al., 2016). Much more important are therapists' personal and interpersonal qualities alongside facilitative interpersonal skills (Anderson et al., 2009). Indeed, research suggests that therapists' capacity to be emotionally responsive and empathic has ten times more impact on the outcome of therapy than their choice of a model or adherence to a model (Wampold & Imel, 2015). An important focus for research, training and supervision therefore, is developing an understanding about how therapists' relational skills are limited by their intrapersonal (inner) skills and psychological capacity to stay attuned to clients while the therapist experiences discomfort (Rousmaniere, 2019).

In this study I make the argument that therapists' lack of awareness of the presence of shame processes is a significant clinical blind spot that influences how they relate to themselves and their clients when they feel outside their comfort zone. The current study adds to the literature describing how shame can be profoundly unsettling and at the same time a disguised or hidden phenomenon (Dearing & Tangney, 2011, p. 397). The identification of therapists' reactions to self-exposure when they experience feelings of incompetence or a loss of self-efficacy is especially useful for our understanding of countertransference (Gelso and Hayes, 2007). Participants' reactions to feelings of vulnerability and personal exposure illuminate the various ways in which countertransference *avoidance* manifests and its negative effects which lead to a therapeutic rupture with their clients.

Throughout the study, I draw on Gelso and Hayes's integrative conceptualisation labelled the 'countertransference interaction hypothesis' in which countertransference is defined as 'the therapist's internal or external reactions that are shaped by their past or present emotional conflicts and vulnerabilities' (Gelso & Hayes, 2007, p. 25). The work of affect theorists Sylvan Tomkins (1962) and Donald

Nathanson (1994) is generative for grasping how shame as a powerful modulating force can obstruct the therapy or with awareness, show the way forward to promote pro-social behaviours such as rupture repair that further harmonious social relations. Nathanson's 'compass of shame' is of particular value for informing how to understand the various ways in which shame manifests in behaviour and the non-verbal realm (Nathanson, 1987).

The pervasive influence of 'hidden shame' in participants' accounts and its negative effect on therapeutic process highlights the need for more psycho-educational group work in building resilience against shame on psychotherapy training courses. Brown and colleagues argue that it is essential to develop a language about shame before we can process our experiences in a meaningful way (Brown et al., 2011).

Developing a language for shame and a thorough understanding of the different theories, concepts and modes of shame is only the first step in raising therapist awareness. Also important is *speaking* about shame in order to develop awareness about the socio-cultural and psychological sources of shame and to develop strategies that promote shame resilience (Brown, 2006, p. 50).

Jungian analyst, Henderson (2003) argues that one of the challenges in the education of a therapist is the development of a secure psychotherapeutic identity, which integrates the inherent shame of being a therapist so that therapists do not feel compelled to hide behind a professional veneer when they experience shame. In these situations therapists are a danger to both themselves and their clients (Henderson, 2003). To clarify further, it is vital that a therapist is able tolerate feelings of shame when she feels useless, embarrassing, powerless and disgusting (Henderson, 2003, p. 327). If a therapist is emotionally available to be touched by her client's distress, these feelings are likely to be part of the work (Davies & Frawley, 1994). Indeed empathy *requires* that therapists have the inner capacity to tolerate psychological discomfort (Hatcher, 2015: my emphasis).

Given the role of shame in a wide range of mental health issues including self-esteem issues, depression, anxiety, addiction and eating disorders (Dearing, Stuewig, & Tangney; Nathanson, 1997; Tangney & Dearing, 2002), shame's

presence is likely to be felt when uncomfortable topics are broached or when working with the effects of trauma (Dalenberg, 2007). To complicate the situation further, the recursive nature of shame means that fear of shame tends to promote the experience of shame itself (Scheff, 1997). Therefore it is vital that therapists are grounded in a thorough understanding of their personal responses to shame and potential triggers so that they can differentiate themselves from their clients and their clients' issues. Brown (2006, p. 51) stresses the importance of understanding one's main concerns and struggles when experiencing shame so that persons can identify strategies and processes that promote resilience. Arguably what might be decisive here is the extent to which a therapist understands the difference between 'shame proper' which is arguably a developmental achievement and the more debilitating modes of shame such as 'shame anxiety' and 'shame as potential' which lead to development of a character style meant to ward off shame (Wurmser, 1981).

In terms of managing difficult feelings, Shapiro and Powers (2011) strongly advocate professional or peer supervision not only in instances when shame issues arise but also to support therapists when they find themselves feeling stuck, incompetent or ineffective. As the current study suggests, these experiences are often triggered by shame. Noteworthy in Brown's research is how 'being with others who have had similar experiences' is identified as one of the most effective strategies in building resilience (Brown, 2006, p. 51). Indeed Brown suggests that this might be even more effective than personal therapy. According to Tangney and Dearing, 'The context of psychotherapy is by its nature a shame-inducing relationship aimed at exploring shameful issues' (Tangney & Dearing, 2001, p. 173). Tangney and Dearing's observation emphasises the need for specific training that helps therapists recognise their personal and professional shame triggers so that they can be managed and not impede their therapeutic work. More focussed education and skills training in identifying and managing shame processes is likely to empower therapists to access choice in how they respond to their clients rather than default to *avoidant* coping strategies to manage personal feelings of discomfort (Nathanson, 1994).

Attachment research demonstrates that one's ability to generate a secure attachment relationship will be profoundly influenced by one's attachment history (Mikulincer et

al., 2013). Evidence suggests that rates of insecure attachment are similar among cohorts of trainee therapists and the general population (Rizq, 2011). For those with a history of insecure attachment, emotional dysregulation can impair one's mentalizing capacity (Fonagy et al., 2004). A second significant finding in this study is that even when participants are aware of personal blind spots and triggers (e.g. self-sacrificing script; compulsive caregiving relational style; avoidant attachment style), during stressful interactions with their clients, they seem to lose their capacity for reflective function (Allen, 2013). This is despite the fact that all the participants experienced personal therapy while in training and also attended regular supervision. Furthermore most of the participants had at least ten years experience (post-qualification) of working as a psychotherapist. Although this was a surprising finding, it is understandable when one considers that it's most difficult to mentalize when one needs to do it (Allen, 2013). On the other hand, the element of *surprise* is a sensitive indication of one's assumptions about the world (Kahneman, 2012). In the current study it highlights expectations I held about therapists' competencies when they become experienced practitioners. Arguably these findings can help us understand, at least in part, why neither years of professional training, discipline or years of experience consistently predict therapeutic process and outcomes (Beutler et al., 2004; Goldberg, Rousmaniere et al., 2016). The findings raise important questions about the role of both personal therapy and supervision in promoting reflective function. Although personal therapy during training is conceptualised as providing opportunities for students to learn to manage their experiences in interactions with a client through engaging reflective function (Ensink, et al., 2013), Rousmaniere (2016) highlights how therapy only works if the client is highly motivated for personal introspection. This is one of the problems with mandatory personal therapy during training. Furthermore, even when therapists report that personal therapy benefits clinical practice, the literature has so far failed to provide a comprehensive model that is able to explain how therapy might impact on clinical and reflective practice (Wigg, Cushway & Neal, 2011).

Research, training and supervision needs to focus on helping therapists develop their capacity for *reflective function* during training and throughout their careers. Given the difficulties that participants experienced in managing feelings of discomfort around

personal exposure, training needs to focus on a variety of processes that might promote reflective function. As discussed, Brown's (2006) work on shame resilience has much to contribute to the training of psychotherapists by helping them to embrace their vulnerabilities. However it has yet to be empirically validated. The process of a training group is also important to develop a context that can maximise the development of trainee therapists' inner resources. Trainees should be encouraged to write about their core vulnerabilities with the use of reflective frameworks to help promote reflective capacity (e.g. Carroll, 2009-2010). Also important is supporting trainees to *talk* about their core vulnerabilities at a level that feels comfortable for them while also supporting them to expand their comfort zone through feedback and dialogue. The emphasis needs to focus on their reflective stance towards their life experiences rather than the details of these experiences so that they can be supported to integrate their vulnerabilities in a way that adds depth to their therapeutic work (Aponte & Kissil, 2012, p. 7).

The training group can provide a wide variety of intersubjective contexts other than individual therapy where trainees can learn about their relational style and the impact of their behaviour on others. Given the emotionally challenging nature of this personal work, trainers need to work continuously on creating a safe-holding environment (Aponte, 1994). It is suggested that both trainers and supervisors share and discuss some of their own struggles in their clinical work, normalising feelings of vulnerability and modelling how self-acceptance works for them (Aponte & Kissil, 2012). This might be conceptualised as 'courageous imperfection', a sensibility that lies at the heart of shame resilience (Brown, 2012).

Research suggests that therapist 'in-session anxiety', i.e. feelings of being overwhelmed, anxious and pressured, has a negative effect on the alliance as rated by patients but not the therapist's perception of the alliance (Nissen-Lie et al, 2015). Although the current study did not specifically explore either the participants' or their patients' perception of the alliance, a significant finding is that even though participants described feeling anxious and incompetent, they were unaware of the impact of shame processes on the relationship. Noteworthy is how unacknowledged shame causes ruptures which *often* go unrecognised (Kelly, 2012, my italics). The

concept of 'premature closure' has been postulated for the unconscious or preconscious defensive processes that therapists engage in when they are challenged by feelings of incompetence in their work (Skovholt & Rønnestad, 1992). As a countermeasure, client feedback could make a significant difference to therapeutic practice. Macdonald and Mellor-Clark (2014) suggest that formal feedback from clients is likely to help therapists correct naturally occurring biases in their assessments of their work. In addition, systematic feedback may also facilitate deeper client engagement in therapy (Duncan, 2010).

Alan Schore (2015) maintains that a therapist's ability to regulate her own bodily-based emotions and shame dynamics, while staying connected to the patient who may also be in a dysregulated state is central to the art of psychotherapy. Critically, according to Schore 'all other techniques and skills sit atop this essential substratum' (Schore & Schore, 2014, p. 189). The current study reveals the complex and nuanced nature of shame processes in therapists. A significant finding is that the coping strategies mobilised by participants to defend against feelings of shame, often reinforce and obscure the phenomenon and lead to a rupture or impasse. To clarify further, a person's defences against shame might be so strong, they may not even realise that they are locked in the grip of shame processes. This is a significant obstacle for therapists when their defensive coping strategies feel good and become conflated with their role as therapists. For example, in the current study, most of the participants described an unhelpful relational pattern such as compulsive caregiving or self-sacrifice that originated in their developmental years. Not only is this behaviour unhelpful for the client, it can also lead to emotional exhaustion or professional burnout and compassion fatigue in the therapist (Simionato & Simpson, 2018). To some extent one could stipulate that the way participants treat themselves when they feel under pressure influences how they respond to their clients. In terms of understanding what can be done to support therapist resilience and reflective function, Rousmaniere (2014) reminds us that it can be hard to tolerate discomfort and uncertainty - not only in others- but also in ourselves. This is no easy task and takes deliberate practice and discipline. Rousmaniere argues thus:

We are the only field that has to sit eye to eye with someone else's pain and be emotionally open as we try to help while simultaneously withholding the instinctual urge to immediately do whatever we can to make it stop (Rousmaniere, 2014, p. 105).

Mindfulness is a form of deliberate practice with the goal of building '*awareness of present experience with acceptance*' (Germer, 2013, p. 7, emphasis in original). In terms of clinical practice, Wallin suggests that mindfulness practice can support therapists' capacity for *reflective function* by enabling them to be more fully and calmly present (Wallin, 2007, p. 310). Not only does this benefit the therapist (Davis & Hayes, 2011), a therapist's capacity for reflective function within the context of an increasingly secure attachment relationship, strengthens the client's own capacity for mindfulness and mentalisation (Wallin, 2007, p. 312).

There is a growing body of research showing that mindfulness training promotes therapists' capacity for empathy (Walsh & Shapiro, 2006) and ability to respond less defensively to clients with negative affect (Davis & Hayes, 2011). Based on the findings of this current study, it is proposed that mindfulness training should be incorporated as a core component of psychotherapy training. Alongside this, compassionate mind training is likely to be a complementary addition that can promote resilience against shame (Gilbert & Irons, 2005; Gilbert & Procter, 2006), and thwart compassion fatigue (Figley, 2002)

Rousmaniere (2016) highlights 'experiential avoidance' as a significant blind spot that impedes therapists' ability to stay attuned to their clients while the therapist experiences discomfort. Alongside mindfulness training, Rousmaniere emphasises the importance of devoting time to 'deliberate practice' where therapists watch video recordings of their client work with the purpose of tracking their psychological reactions and learning to regulate them through mindful- awareness rather than resort to experiential avoidance (Rousmaniere, 2016). While the feasibility of video taping client sessions is not a common practice for qualified practitioners in the UK, it could be very helpful for trainees when practicing counselling skills with their cohort during training. More research needs to be carried out into this interesting area of

inquiry. Another option is listening to tape recordings of one's clinical work both privately and during supervision and observing one's responses. Although much of the non-verbal communication is absent, from my personal experience, there is much to be learnt. Reflective function and practice can also be promoted with the use of Interpersonal Process Recall (Kagan, 1980). Supervisors can draw on the framework to enhance supervisees' awareness of their blind spots at their own level of readiness and capability (Borders & Leddick, 1987). Important here is that trainers and supervisors try to promote an atmosphere that is characterised by tolerance for not knowing and ambiguity while encouraging therapists to embrace their shortcomings and limitations with humility and self-compassion, without fear of 'losing face' or authority (Nissen-Lie et al., 2015, p. 57).

A central premise of this study is that therapists' capacity to acknowledge their vulnerability and shame and yet not be overwhelmed by it is a developmental achievement and work in progress throughout one's life. The study highlights how the capacity to tolerate shame and its vicissitudes is a therapist's most sensitive instrument (Ehrenberg, 1996). Furthermore, *hidden* shame is a significant obstacle to therapist personal and professional development and leads to ruptures in the therapeutic relationship. More attention needs to be given to promoting shame resilience in therapists during training and supervision throughout their careers. Given that a therapist's ability to tolerate uncomfortable feelings is a key precursor to providing empathy for their clients (Hatcher, 2015), training and supervision is vital so that we can prepare and protect therapists against the normative force of subjective negative self-appraisal when they experience a sense of inadequacy/incompetence in their therapeutic work (Thiériault & Gazzola, 2006).

Currently the British Association of Counsellors and Psychotherapists (BACP), the British Psychoanalytic Council (BPC) and the UK Council for Psychotherapy (UKCP) are undertaking a collaborative project to systematically map existing competencies, standards, training and practice requirements within counselling and psychotherapy (British Association of Counselling and Psychotherapy, 2019). An important task for the expert reference group is identifying gaps in training to produce a final, evidence-based competence framework. It is argued that *therapist shame* has been



overlooked and that researchers, trainers and practitioners need to become more invested in understanding shame and contributing to the growing body of research in this important area.

### **5.9 Personal Reflections**

The process of doing this study has been a hermeneutic journey of endurance and discovery where I have learnt to understand and acknowledge my vulnerabilities with self-compassion and courage. Before I carried out this study, I saw my vulnerability as a means of empathising and connecting with people. I didn't realise the extent to which it also pulled me too much into confluence with their suffering. This was a significant blind spot for me. I now see how my vulnerabilities can bias me towards *misunderstanding* others. This is a gift and in the spirit of Hermes I can now appreciate the message shame brings. The pioneering work of Sylvan Tomkins and Donald Nathanson has enabled me to reflect on the generative possibilities of experiencing shame and I am now less thrown by shame's toxic waste! I have also been inspired by the work of Brené Brown (2012) who postulates vulnerability as courageous imperfection. I am grateful for a framing that helps me understand how shame need not be incapacitating but also an affect that when accompanied by empathy and compassion, keeps me grounded, present and curious.

*We shall not cease from exploration*

*And the end of all our exploring*

*Will be to arrive where we started*

*And know the place for the first time*

(T.S. Eliot, Little Gidding, 1971, p. 79).

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## **Appendices**

Appendix 1 Participant recruitment letter.

Appendix 2. Participation Information Sheet.

Appendix 3. Participation recruitment advertisement.

Appendix 4. Participants' Characteristics.

Appendix 5. Participant Consent Form

Appendix 6. Participant Interview Schedule

Appendix 7. Descriptive Themes.

Appendix 8. Emergent Themes: Cathy

Appendix 9. Final Themes: All Participants

Appendix 10 Metanoia Ethical Approval Form

## Appendix 1

Dear xxx

As an accredited psychotherapist or registered counselling psychologist you may be willing to participate in my research project. I am currently completing Professional Doctorate in Counselling Psychology and Psychotherapy at Metanoia Institute, London. I am researching therapists' experiences of recognizing personal blind spots through relational therapeutic work.

My aim is to interview six qualified psychotherapists or counselling psychologists each of whom I will interview separately using semi-structured interviews. I will need to interview you twice, one month apart. The first interview will require 60-90 minutes of your time and the second interview would constitute up to an hour of your time. You will find a Schedule of possible questions attached. A Participant Information Sheet is also attached which explains the purpose of the research, why you have been chosen and the undertakings regarding confidentiality that apply to your participation. This project has received ethical approval from Metanoia Research Ethics Committee.

If you are interested in learning more about the study or in participating, please contact me within two weeks of receiving this letter. You will need to read carefully and sign one copy of the Consent Form and return it to me: please retain the other copy. If you are not interested in participating, please do not worry to reply if you do not wish to.

Yours sincerely

Paula MacMahon

Version 1 April 2015

## **Appendix 2**

### **Participant Information Sheet**

#### **1. Study title**

Therapist Blind spots: A phenomenological enquiry into the experience of recognising personal blind spots through relational therapeutic work.

#### **2. Invitation**

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish! Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

**Thank you for taking the time to read this.**

#### **3. What is the purpose of the study?**

There is increasing recognition in the counselling and psychotherapy literature that therapists' ability to reflect on how their own wounds, vulnerabilities or blind spots shape the therapeutic relationship offers opportunities for transformation for both therapist and client. As each therapeutic relationship is unique, there are aspects of the person of the therapist that are specifically and often only revealed to the clinician through the unique experience of conducting treatment.

The purpose of this study is to explore how therapists experience recognising a personal blind spot through their relational therapeutic work. More specifically, it will investigate how therapists understand a personal blind spot and the impact it has on their clinical work. My aim is to understand participants' phenomenological experience of this as well as how they make sense of this experience and its personal and professional impact.

#### **4. Why have I been chosen?**

The choice to take part in the study is through participant self-selection and is open to qualified psychotherapist or counselling psychologists who meet the following criteria.

#### **Research Study Criteria Checklist.**

- I am a qualified psychotherapist, HCPC registered.
- I practice relational psychotherapy from a modality that engages with subjectivity, intersubjectivity, values and beliefs.
- I am currently seeing individual clients and in clinical supervision
- I have access to personal therapy if necessary.

There will be six participants in total.

#### **5. Do I have to take part?**

It is up to you to decide whether or not to take part. If you do decide to participate you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

#### **6. What will happen to me if I take part?**

This research is a qualitative study exploring through the use of semi-structured interviews, your experience of recognising a personal blind spot through your therapeutic work. It will require you to participate in two interviews, a month apart at a mutually agreed time and place. Before you attend the first interview, you will be sent a list of possible questions that you may be asked about. These questions may help you to think more deeply about your experience of recognising a personal blind spot. They are not compulsory and you are free to talk about your experience in a way that is meaningful for you. After the interview, you will have the opportunity to ask any

questions or delete parts of the interview without explanation if you decide to do so. Both interviews will be taped and transcribed by the researcher.

Please note that in order to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However if this is the case, your signed consent form will only be accessed by the designated auditor or a member of the audit team.

## **7. What do I have to do?**

**There are three steps to the research process:**

1. An individual interview (face to face) to discuss your experience of recognising a blind spot in your therapeutic work. This will last approximately an hour.
2. A second interview (face to face) approximately one month later in order to discuss any reflections or insights that have arisen since the first interview (30-60) minutes.
3. You will be invited to write down any thoughts or further insights that you experience after the first interview in a journal and to bring this material to the second interview for discussion.

## **8. What are the side effects of any intervention when taking part?**

It is possible that talking about personal blind spots may evoke feelings of personal exposure or shame or put you in touch with unresolved personal issues. It is a requirement that all participants have access to personal therapy and supervision in order to receive further support should this be necessary. I am also available throughout the research process should you need to discuss any issues that arise for you.

Paula MacMahon 0777 xxx xxx [pmacmahon@gmail.com](mailto:pmacmahon@gmail.com)

## **9. What are the possible disadvantages and risks of taking part?**

While your account of a personal blind spot has the potential to elicit potentially unethical conduct (such as sexual misconduct, inappropriate personal disclosure or extra-therapeutic relationships), **we are not interested in grossly unethical practice which you may chose therefore not to disclose.** If such violations are disclosed to me, I will inform my supervisor and if necessary contact appropriate safeguarding bodies. I will discuss this with you before you sign the consent form to participate in the study.

## **10. What are the possible benefits of taking part?**

All information that is collected about you during the course of the research will be kept strictly confidential. Any information about you, which is used, will have your name and address removed so that you cannot be recognised from it. All data will be stored, analysed and reported in compliance with the Data Protection legislation of the UK.

## **12. What will happen to the results of the research study?**

The results of the research will be published as part of a post-graduate dissertation around December 2016. An electronic version of the research will be provided to participants on request. The research may also be published in relevant academic journals or used in conferences/seminars. Participants will not be identified in any report/ publication.

## **13. Who has reviewed this study?**

The Metanoia Research Ethics Committee has reviewed this research proposal.

## **14. Contact for further information.**

**Researcher:** Paula MacMahon 07775 xxx xxx xxx [pmacmahon@gmail.com](mailto:pmacmahon@gmail.com)

**Supervisor:** Dr Saira Gracie Razzaq. 07xxx xxx xxx [saira.razzaq@sky.com](mailto:saira.razzaq@sky.com)

Both c/o: Metanoia Institute, 13, North Common Way, London W5 2QB

## Appendix 3

### Participant Recruitment Advertisement

#### **Seeking qualified integrative or relational psychotherapists and counselling psychologists.**

Participants sought for doctoral research into therapists' experiences of recognising blind spots through their clinical work. I will be inviting you to discuss how your clinical work helped you to become aware of your vulnerabilities. The focus will be on your lived experience. I will need to interview you twice with an interval of one month. The time and place will be at your convenience. If you are interested in learning more about the study or participating please contact Paula MacMahon at [pmacmahon@gmail.com](mailto:pmacmahon@gmail.com). Mobile: 0777 xxx xxx. Your details will be kept in confidence and you are under no obligation to take part.

## Appendix 4

### Participants' Characteristics

<b>Pseudonym and qualification</b>	<b>Age range</b>	<b>Years qualified</b>	<b>Type of Practice</b>	<b>Therapeutic Modality</b>
<b>Christine</b> Counselling Psychologist	<b>60-65</b>	<b>15-20</b>	Mental Health Services.  Private Practice	Integrative: Humanistic, CBT and Psychodynamic therapy
<b>Elena</b> Counselling Psychologist	<b>45-50</b>	<b>2-5</b>	Private Practice	Integrative: Humanistic, CBT and Mindfulness based therapy
<b>Jane</b> Counselling Psychologist	<b>50-60</b>	<b>15-20</b>	Mental Health Services.  Private Practice	Integrative: Schema Therapy, Dialectical Behaviour Therapy
<b>Cathy</b> Counselling Psychologist	<b>55-60</b>	<b>15-20</b>	Mental Health Services. NHS  Private Practice	Integrative: Psychoanalytic and Humanistic Psychotherapy
<b>Zoe</b> Psychotherapist.	<b>55-60</b>	<b>10-15</b>	Private Practice	Integrative: psychotherapy Psychodynamic therapy. Body focussed trauma therapy



## Appendix 5

### Participant Interview Schedule

#### Semi-structured Individual Interviews.

April 2015

#### 1. Introduction (5 mins)

- introductions
- Rapport building
- Reiterate anonymity/right to withdraw
- A reminder that I am not interested in hearing about grossly unethical conduct and of the measures I will need to take should they choose to disclose such violations (sexual misconduct, inappropriate personal disclosure or extra-therapeutic relationships)
- Introduce questions- reinforce- 'your experience that's important, any examples....'

#### 2. Interview questions (45-60 mins)

3 Thank you/de-brief / permission to contact for clarification. Arrange second interview at a mutually agreed time for a month later/close interview. (5mins)

#### **Interview Schedule:**

All of the questions below may be followed-up by more supplementary questions in order to amplify the participant's reported experience.

#### General experience of relational therapeutic work

1) I'm going to start by asking you what you understand by working with the therapeutic relationship? Perhaps as we talk, you might share any examples that come to mind

2) I'd now like find out you how central the relational piece is to your way of working? Perhaps as we talk you might describe what it means to you?

3) I'm interested in finding out what aspects of your training and supervision support you to work with the therapeutic relationship? Perhaps as we talk you might describe what supports you?

### **Bringing the research theme into focus; recognising a Blind Spot.**

I'm interested in finding out how your personal involvement in your therapeutic work puts you in touch with your own material, and I would now like to begin talking to you about some of those experiences.

4) Looking across your clinical experience, perhaps as we talk, you might share an experience when your clinical work put you in touch with your personal issues, what I am calling 'Blind Spots,' that until that time were outside your awareness?

#### **Focussing on the experience(s)**

5) I'm interested in finding out about when you started to notice the emergence of your personal material, if you like, the moment when your 'blind spot' became apparent to you? (During the therapeutic session or afterwards?)

6) I'm interested in understanding how you become aware of it? Perhaps as we talk you could describe your experience.

7) I'm interested in finding out what happened when you became aware of your blind spot?

8) I'm interested in finding out what you noticed in yourself during this experience? Perhaps as we talk you could describe what your experience (Physically / Emotionally / Cognitively)

9) I'm interested in finding out what you notice in yourself as you recall the experience here with me? Perhaps as we talk, you could share what's happening for you here and now?

#### **The meaning and consequences of the experience(s)**

10) I'm interested in finding out how you made sense of the experience? Perhaps as we talk you might describe what the experience meant to you personally?

11) I'm interested in finding out how the experience impacted on you as a professional? Perhaps as we talk you might describe how or if indeed, the experience impacted on your therapeutic work at that time.

12) I'm interested in finding out if the experience shaped your subsequent clinical work? Perhaps as we talk, you might describe the change it brought about.

13) I'm interested in finding out what supported you through this experience? Perhaps as we talk, you might describe examples that come to mind.

14) I'm interested in finding out how this experience of self-discovery differs from experiences of self-discovery in your own therapy or supervision? Perhaps as we talk you might describe your experience.

15) We are coming toward the end of the interview so I want to give you the opportunity to talk about any aspect of your experience in relation to the theme of recognising blind spots that we have not covered? To finish please would you take a minute or two to summarise what aspects of the experience of getting in touch with a personal blind spot has stood out most for you

### **Semi-Structured Individual Interview (Second Interview)**

The second interview will be arranged to take place approximately one month after the first interview.

#### **1. Agenda:**

1) Introduction (5 mins)

- Rapport building
- Reiterate anonymity/ right to withdraw
- A reminder that I am not interested in hearing about grossly unethical conduct and of the measures I will need to take should they choose to disclose such violations (Sexual misconduct, inappropriate personal disclosure or extra-therapeutic relationships).
- Introduce questions- reinforce – 'your experience that's important, any examples...'

2) Interview questions.

3) Thank you/ debrief/ permission to contact for clarification/ close.

#### **2. Interview Schedule: (30-45 mins)**

1) I'm interested in finding out if you have had any further thoughts about your experience of getting in touch with personal blind spots. Perhaps as we talk you might share anything that has come to mind?

2) I'm interested in finding out about your experience of talking about your personal blind spot(s) for this study with me. Perhaps as we talk you might take a minute or two to summarise what aspect of talking about your personal blind spot has stood out most for you.

## Appendix 6.

### Participant Consent Form

Participant Identification Number:

**Title of Project: Therapist Blind spots: A phenomenological enquiry into the experience of recognizing personal blind spots through relational therapeutic work.**

**Name of Researcher: Paula MacMahon**  
**please initial box**

1. I confirm that I have read and understand the information sheet dated.....for the above study and have had the opportunity to ask questions.
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason. If I choose to withdraw, I can decide what happens to any data I have provided.
3. I meet the participant criteria detailed in the Participant Information Sheet.
4. I understand that my interview will be taped and subsequently transcribed.
5. I agree to take part in the above study.
6. I agree that this form bears my name and signature and may be seen by a designated auditor.

\_\_\_\_\_  
Name of participant                      Date                      Signature

\_\_\_\_\_  
Name of person taking consent      Date                      Signature  
(if different from researcher)

\_\_\_\_\_  
Name.                      Date                      Signature

**Appendix 7**  
**Descriptive Themes**

**Table excerpt from anonymised transcript (Elena)**

<b>Concepts and exploratory comments</b>	<b>Quotes</b>	<b>Page numbers and lines</b>
<p><b>The troubled self</b> <i>The sense of feeling stirred up- sense of self-doubt</i></p>	<p>I could think of a few things, some of them coming to light more during a supervision that followed a planned session that troubled me in some way.</p>	<p><b>p. 2. Lines 34-35</b></p>
<p><b>Overwhelming client needs</b> <i>Difficulty containing client's needs. Sense of helplessness, powerlessness</i></p>	<p>It's very difficult to end the sessions with her because she talks a lot. And she hijacks it a little bit. She needs more.</p>	<p><b>p. 2/3 lines 37-38</b></p>
<p><b>Self as being done to</b> <i>Feeling of pressure -sense of time as space, time running out; also no space for therapist to get in; therapist as victim when she describes being manipulated by 'usual techniques.'</i></p>	<p>I've always felt I was struggling a bit to end the sessions on time. It was always something I thought I wish I could do that. But she would never let me. She always spoke. She always opened up a new topic. She used the usual techniques</p>	<p><b>p. 3 Lines 40-42</b></p>
<p><b>The stressed self</b> <i>Confusion- sense of an impasse</i>  <i>Out of her depth- i.e. no boundary to contain the pressure but also a sense that Elena has reached</i></p>	<p>And I didn't like that. It felt unboundaried and I was quite unhappy with that, but I felt it was- I was doing my best</p>	<p><b>p. 3. Lines 42-44</b></p>

<i>her internal limit 'doing my best'</i>		
<b>Sense of surprise for therapist.</b> <i>Change in client behaviour marks client progress</i>	So for the first time in all the months that we've been working together, which was quite a breakthrough in a way, she took my cue and waited for me to end.	<b>p. 3 Lines 48-49</b>
<b>Behaving on impulse</b> <i>'threw' - folk wisdom- 'actions speak louder than words. Self-knowledge that comes from a surprising behaviour. Sense of inner turmoil as she ask client question. Observing self needing to understand the intention behind the behaviour (consider 'surprise as a neutral word as opposed to shock which feels more acute and possibly traumatizing)</i>	I threw a question at her. And I was very surprised by that. As I was doing it, there was a part of me saying, what are you doing? What is that about?	<b>p. 3 Lines 50-52</b>
<b>Recognition of mutual needs</b>  <i>Pressure of therapist's emotional need for recognition</i>	as much as she needed me to receive, I perhaps needed to take. That was something I hadn't realized in that way. Um so I suppose for me it was an example of something that was a blind spot	<b>p.3 Lines 54-55</b>
<b>Therapist's need to be needed</b> <i>as able to provide something for client Mutual vulnerability of therapist and client</i>	I wanted her to need me or want something from me. I wanted to draw her in perhaps as much as she did need me	<b>p.4. Lines 56-57</b>

<p><b>Recognition of a blind spot as a metaphor for developing awareness leading to a more reflexive self. Insight leads to empathy for client</b></p> <p><i>Threshold of change and restoration of equilibrium</i></p>	<p>once I'd got an insight into that I've decided to be quite mindful at the next session. And we now finish on time which is very nice.</p>	<p><b>p. 4 Lines 58-59</b></p>
<p><b>The Surprised Self</b></p> <p><i>surprise as a kind of self recognition, parallel processes between self and client?</i></p>	<p>But I think I was quite surprised by the sort of duplication that occurred when I heard myself say this.</p>	<p><b>p.4 Lines 60-61</b></p>
<p><b>Internal conflict</b></p> <p><i>Internal focus on self. Inner supervisor versus vulnerable self</i></p> <p><i>who is the vulnerable 'needy' self that is being questioned by internal supervisor?</i></p>	<p>And then there was this little inner supervisor sitting on my shoulder saying, What are you doing? What's that about?</p>	<p><b>P. 4. Lines 61-62</b></p>
<p><b>Self as being done to/ victim/ passive</b></p> <p><i>(feeling of pressure by client resulting in feelings of blame towards her)</i></p> <p><i>Dysregulation around power struggle</i></p>	<p>And I'd often felt annoyed with her for dragging the session on or for making me feel, gosh someone else is going to arrive, the bell was going to be rung, and then we're going to go through the hall, then I'm going to have to stop her.</p>	<p><b>p. 5. Lines 67-69</b></p>
<p><b>Irritation -Shift of blame from client to self</b></p>	<p>And I was annoyed with her. But this time I was really annoyed but with myself</p>	<p><b>p. 4 . Lines 69-79</b></p>
<p><b>Curiosity about involuntary behaviour. Self reflection</b></p>	<p>What's going on with me that I do that?</p>	<p><b>p. 4 line 71</b></p>
<p><b>Reconciliation</b></p> <p><i>Insight leading to</i></p>	<p>How are we going to wrap this up in a way that</p>	<p><b>p. 4. Line 72</b></p>



<i>empathy for self and other.</i> <i>New vitality</i>	doesn't feel abrupt and harsh and that's thoughtful?	
<b>Frustration-</b> needs time to process  <i>(head space and time space- distance – perspective)</i>  <i>Confusion</i>	I hadn't had time to process it. So part of me got tense and thinking, gosh what's going on here?	<b>p. 5</b> <b>Lines 61-62</b>
<b>Need for space-</b> <i>Curiosity providing opening to new possibilities</i>	And then part of me was really wondering. And it was like there's a little bit of a space that opened. I needed time to think.	<b>p. 5</b> <b>Lines 76-77</b>
<b>Frustration of needs.</b> <i>Feeling of pressure.</i> <i>Responsibility</i>	I needed time to think. And of course I didn't have it just then because I needed to finish the session	<b>p. 5</b> <b>Lines 77-78</b>
<b>Taking responsibility</b> for behaviour. <i>Bewildered.</i>	Perhaps this time I was the culprit.	<b>p.5 Line 80</b>
<b>Developing insight through the work</b>  <i>Nugget of knowledge leading to self development and sense of awe</i>	So it was confusing and it was a little bit annoying, but also it was one of those little nuggets that you get sometimes in the work about yourself, and you think, wow where does that come from?	<b>p. 5 Lines 86-88</b>
<b>Self support</b> <i>intellectual curiosity and feelings of satisfaction</i>	So there was a little bit of –some curiosity, perhaps some mild little pleasure. That was support.	<b>p. 5</b> <b>Line 89</b>
<b>Change;</b> now emotional containment  <i>Boundaries enabling presence and implicitly taking the pressure off</i> <i>Change as room for two;</i> <i>David Wallin</i>	There's been an ability to be more boundaried, but also for me to be more present in the relationship	<b>p. 6</b> <b>Lines 97-98</b>

<p><b>Self as being done to</b> <i>Lack of emotional connection</i> <i>Failure of intersubjectivity?</i></p>	<p>I found it difficult to engage her on a purely personal level. Uh she's, well I experienced her as very controlling</p>	<p><b>p. 6. Line 101</b></p>
<p><b>Recognition</b> <i>Client and therapist influenced by each other-change</i></p>	<p>I suppose since I've had a better sense of my contribution to the whole dynamic, maybe I've changed the way I am a little bit with her.</p>	<p><b>p. 5. Lines 105-108</b></p>
<p><b>Making room for two subjectivities</b>  <i>Change through acceptance.</i> <i>emotionally available to be present to client needs now that she recognizes similar needs in herself: insight and empathy</i></p>	<p>I feel perhaps more accepting of her and more willing to cut her some slack I suppose for-I don't know. It's interesting... It feels less of a tug of war. I mean a little bit, less of a fight for control in the session which is, we're just –we're both there and that's easier. That's perhaps more- there's a kinder feel to it</p>	<p><b>p. 6. Lines 105-108</b></p>
<p><b>Recognition of blind spot</b> <i>as something familiar from the past</i></p>	<p>I think it's one of a number of others that have been unearthed. But yes, I think it's been, it's been helpful. Because to be fair, it wasn't the first time I, I was finding it hard to finish with a client.</p>	<p><b>p. 7. Lines 110-111</b></p>
<p><b>Recognition of therapist needs</b>  <i>Moving from victim state of mind occupied by victim –persecutor to recognition of personal needs- vulnerability</i> <i>(Binary positions</i></p>	<p><i>But a few clients I've had problems with. And in my mind it was always them who would not finish. It was always- and I was berating myself for not being stronger and firmer.</i> But actually recognizing I had a need to be in that interaction as well, that it</p>	<p><b>p. 7. Lines 114-117</b></p>

<p><i>responsibility- encompasses an ability to own one's reactions in an accepting way</i></p>	<p>was doing something for me, was quite useful</p>	
<p><b>Growing understanding of personal vulnerabilities leading to greater acceptance of client's needs. Humility</b></p>	<p>I have yet to tease out all the meanings that may be attached to that, that way I am sometimes, which sometimes- I think certainly it's given me food for thought and perhaps a slightly less adversarial approach to endings with clients who find it difficult</p>	<p><b>p. 7 Lines 118-121</b></p>
<p><b>Surprising behaviour by therapist as a manifestation of a potential blind spot</b></p> <p><i>Exploring surprises as a threshold to moments of intersubjectivity</i></p>	<p>There have been times when I have had behaviours in sessions or reactions to a session that seemed inappropriate. And then it's about trying to understand where that came from. Because it doesn't seem to be coming from my client only. There has to be something of me in there, but I can't really make sense of it. Seems strange</p>	<p><b>p. 8 Lines 130-131</b></p>
<p><b>Mutual affect dysregulation leading to rupture crisis</b></p>	<p>But I hadn't warned her early enough and then the bell rang. And she panicked a little bit. And we concluded in a bit of a state</p>	<p><b>p. 8 Lines 141-142</b></p>
<p><b>Internal dissonance</b> <i>Rupture in relationship. Anger at self</i></p>	<p>It felt like something had been interrupted. I went to the loo and I slapped myself</p>	<p><b>p. 9 Lines 149-150</b></p>
<p><b>Self critical self versus internal observer</b> <i>In the grip. Out of control</i></p>	<p>I was really, really angry with myself for making a mess of this ending of the</p>	<p><b>p. 9 Lines 151-152</b></p>

<p><i>self versus reflective self.</i></p>	<p>session. I thought, this is really bad, this is dreadful. Then I calmed down, I walked home. And em. Then I reflected that this was a pretty extreme reaction to a rushed ending and that that was something I would take to my supervisor next time</p>	
<p><b>Vague Recognition of something that can't yet be expressed in words</b> <i>unformulated experience but something is emergent</i></p>	<p>Because I couldn't really quite see- I could see there was something there.</p>	<p><b>p. 9   Lines 152-155</b></p>
<p><b>Trying to find meaning</b> <i>Support from psychological concepts to make sense</i></p>	<p>So was that because perhaps I felt I was letting my client down and that she needed me? Or was I punishing myself like she would sometimes? Because she was someone with a history of self-harm. And so I tried to make sense of it in terms of transference and countertransference.</p>	<p><b>p. 9 Lines 153-156</b></p>
<p><b>The Surprised Self/ the body knows</b> <i>parallel processes between client and therapist</i></p>	<p>So she listened. She said, 'Oh'. Then she said, "How's your therapy going? Then I burst into tears because my therapist was going on maternity leave which of course from my end was a very rushed ending.</p>	<p><b>p. 9 lines 158-160</b></p>
<p><b>Experiential avoidance</b> <i>Disavowal of therapist needs Denial</i></p>	<p>Um and I realized I hadn't mentioned my therapist to my supervisor in a very long time. I had completely put the whole conundrum of having to deal with this interruption to the side. I</p>	<p><b>p. 9 lines 160-162</b></p>

	just didn't want to think about it.	
<b>Experiential avoidance</b> <i>Suppressing loss</i>	It had become the real blind spot. I was obviously trying to process the loss of my therapist for a number of months on some level without letting that come to my awareness and certainly without considering how it might effectively impact my work.	<b>p. 10</b> <b>Lines 163-164</b>
<b>Disavowal of personal needs</b>	I thought I was dealing with it just fine and I was a therapist and we- she had told me several months before going and it was fine and I didn't need to think about this	<b>p. 10</b> <b>Lines 165-166</b>
<b>Change in emotional intensity</b> <i>reveals unthought known</i>	The very strength of my emotional reaction in supervision suggested that she'd hit the nail on the head basically and that there was something there about my anger towards my therapist	<b>p. 10. Lines 167-168</b>
<b>The surprised self</b> <i>linking of experiences promotes recognition which registers in a moment of surprise</i>  <i>Support to facilitate insight through 'linking'</i>	Again that was something I hadn't seen coming at all. I don't think I would have made the link if it hadn't been for her. I certainly hadn't made it until then.	<b>p. 10</b> <b>Lines 170-171</b>

## Appendix 8

### Table of Emergent Themes- Cathy

#### **In the Grip**

**Cathy describes getting a strong physical reaction “if a patient is a bit of a bully.” Note, emotional intensity and strong-reactions.**

*So if I start to feel bullied, I get a very strong physical reaction. And um I didn't understand it at first but I did take it to my therapy and um I made a connection in my mind with my stepfather who could be quite controlling. Um and that was quite, I still get that physical reaction although I don't actually, I haven't seen patient who've been quite like that. I don't think I helped that patient.*

*In the end we had to end it and I don't think - I felt I couldn't help this patient. I felt we were going round in circles all the time. I was going round in circles with her. There was something in me, which was just not helping her. So I don't think I work quite so well with, with that type of patient.*

#### **Managing stressful situations: using avoidance and hiding behind a professional person when under stress**

*Most of my patients are really sensitive if I'm professional, they notice it straight away. This patient who I saw for a long time used to say to me, they say that that 'you're being professional.' If I think about it, it's probably at times when I was feeling a bit more uncomfortable about things and you know what was happening and stuff, slightly retreating, so the mask.*

#### **She also uses avoidance when she gets on the same bus as her patient:**

*I didn't actually look for her again once I got on the bus so you know my shutting down was complete you might say in thinking of the blind spot in a way. And the anxiety which was evoked around that in terms of how to handle it so that the boundaries are kept and you know- but then I think I sort of over- was over firm in a way in my determination to avoid the contact with her. And I think that's where- and it wasn't until- actually I didn't think of that at the time em except for I felt uncomfortable and relieved that we hadn't –that she hadn't seen me but them of course she had seem me but I thought she hadn't. And then it was only when she came back after the break that I realized that I suppose that I had been- um you know that part of me had not been in touch with her experience of rejection.*

**Coming face to face with one's blind spot.**

**This theme describes the internal struggle Cathy experiences facing her blind spot. Here Cathy describes her sense of disorientation as she faces how she has hurt her patient when her patient confronts her about not acknowledging her at the bus stop:**

*And I, must say I hadn't realised how wounding that had appeared to her at all, that had been, I suppose, a blind spot for me in a way. But when she told me that um and that she felt that I- It was something which was alien to me. And I, not alien to me, but didn't feel quite right. For she had interpreted it in a much harsher way than I had meant it to be. I had actually meant it to be- in my mind I justified it by thinking this is a boundary issue. It's clearer and better and less turmoil for her. I won't be unsettling her if she doesn't see me. That was my thought*

**Cathy faces up to how her approach was over rigid and becomes curious about her motives:**

*'would it have been so bad just to have acknowledged her and smiled and got on? What was it about me that's not wanting you know, was having such boundaries which weren't helpful?*

**Changing perspective**

**Various events involving surprise or shock facilitate shifts in perspective: creating distance; notice physical metaphors 'step outside of my own experience' also 'she made a leap forward' Taking her clients perspective enables Cathy to see her blind spot. Capacity for mentalisation.**

*And her experience when I think of it now that - how that um repeats something really quite painful. For instance if I think of her hearing that little bit that I've just said, I really wouldn't want her to hear that. So that's the sort of you know- her - when I - so I step outside of my own experience and think and - think a bit more about her experience and you know - so where does that blind spot - so the blind spot really is just - is not - is being too much in myself really and not tuned in to her I suppose is one way I would maybe think about it. Um is that alright?  
(whispered)*

**Integrating the blind spot**

**This theme describes the difference between knowing *about* something and knowing something at a deeper level where it becomes embodied or habituated- deeper understanding.**

**Embodied understanding**

*I suppose in a way it's a bit like you practice say psychoanalytic psychotherapy, for example, but it's um the movement between practising it and embodying it so that*

*you actually just naturally - it becomes a part of you, I suppose and it's the way you are in the room with the person*

*when I feel the connection in that way emotionally, a human connection or and it often comes with the physical - definitely comes with a physical resonance as well. It's something in me quite physical, um but it helps me to then work with a patient or understand a patient a bit*

**Surprise/ Shock pre- empts shift in perspective (different levels of knowing)**

*And if we were to think of the physical - so just think of the physical sort of experience I was having when she was telling me about it, it was like a bit of a shock, like a realisation that - I mattered to her even though I know that I matter to her*

**Touchstone**

**This theme describes learning that's taken forward from experience leading to purposeful intent. Authenticity and congruence**

**Authenticity-**

*So I think those are examples um of where I've had to challenge my assumptions on what I should be doing and why am I doing it in that way you know. I think what's really helpful is that I suppose I must feel um able to admit I'm sorry you know to her and try and obviously not to reassure her, but just to you know admit, admit when I've made a mistake. I think that was very helpful to her because that was really affirming you know, that I was able to think God, that must have been really horrible for someone who she feels really close to not to have made that simple eye contact, that human contact in a way*

**Presence: Attunement**

*Um listening out, I suppose it's listening closely, um tracking the patient's responses to me and then not becoming, I suppose, too defensive, isn't it really, you being open to- without, but also obviously having a clear sense of what's appropriate, but you know being open to um their experience.*

*Understanding limitations: it just makes you more aware of um your own practice and the limitations of it also, I suppose and of being - that's now not such a blind area, I suppose. I'm a bit more sensitive to that you know I suppose with other patients as well. And then the realisation when she comes back to see me that - the way that she had experienced it had been quite wounding and then me, you know being - thinking in future I need to be more aware of these sorts of things with patients in general and with her and not be so anxious about um these moments and that they can be handled in a way which is less rejecting.*



## Appendix 9

### Table of Superordinate and Subordinate Themes.

#### All Participants.

Themes and original text
<b>Superordinate theme 1: Feeling under pressure.</b>
<b>1.1 Feeling Vulnerable</b>
<p><b>Christine:</b> I can feel, talking about blind spots, I just didn't know what could be triggered and I was fearful of what could be triggered. I was fearful of material that would come up, especially if it was relevant to what I was going through in my own life.</p>
<p><b>Elena:</b> But I still felt a little bit wobbly afterwards and a little bit doubting myself and whether I was actually in control in that relationship, who had control, who was actually keeping the boundaries for everyone, could I do that?</p>
<p><b>Jane:</b> I've not taken things forward a couple of times this year with people that I thought are just to suck all the life out of me and so I've been able to say no and pass them on. I don't do well with hysteria</p>
<p><b>Zoe:</b> And for me, my vulnerabilities are around invalidation and that actually triggers anger and it's all around boundaries and you know when boundaries are crossed.</p>
<p><b>Cathy:</b> I remember I felt quite uncomfortable. I thought oh dear, I don't really want her seeing me, but I needed to get into town. I remember feeling uncomfortable, a little bit unsure about how to handle it, um you know</p>
<b>Subordinate theme 1.2, In the Grip.</b>
<p><b>Elena:</b> I was on time, but it felt like something had been interrupted. I went to the loo and I slapped myself!</p>

**Christine:** It's such a strong urge not to disappoint her that I battle. One of the things I feel like I need to do with her is to disappoint her.

**Jane:** Go away, just leave me alone. I don't want to talk to you. It's just 'go away', which is completely counterproductive to therapy. I just shut off completely. I can't. I just shut down and I really do shut down

**Zoe:** I just think that's because it was such an early thing it's almost like in my DNA. It's almost like my- and of course therefore my attachment is disorganised. Um it would have been even if I didn't have that experience but I know that because there's this stop start in me. I want to go towards the object but then of course I have to repel it as well in case it's dangerous or toxic

**Cathy:** In the end we had to end it and I don't think - I felt I couldn't help this patient. I felt we were going round in circles all the time; I was going round in circles with her. There was something in me, which was just not helping her. So I don't think I work quite so well with, with that type of patient.

### **Subordinate theme 1.3. Trying to cope.**

**Elena:** So I- and listing all those people and all those theoretical tools I created some sort of wall between us. Then surely my own lack of experience or need for more therapy was in evidence I felt. So something was lost.

**Christine:** when I get a sniff of her feeling threatened in some way, I'm very aware that my own process is to back off and actually em when I say back off I mean not challenge her anymore.

**Jane:** I think it's fair to say that my attachment style can be quite avoidant quite a lot of the time in order to protect myself from what I'm hearing.

**Zoe:** my capacity to be more flexible around anger or my capacity to be flexible

around good things and expecting good things in my life, is probably more clunky than say somebody who's never experienced those things and um the clunkiness is this thickened sort of skin scar tissue that's underneath there with an old scab- with an old scar on top.

**Cathy:** I didn't actually look for her again once I got on the bus so you know my shutting down was complete you might say in thinking of the blind spot in a way.

## **Superordinate theme 2. Facing a blind spot and finding the missing piece.**

### **Subordinate theme 2.1. Becoming a problem to myself.**

**Jane:** But it's holding somebody's trauma like that, it made me realise all these other smaller little traumas, smaller trauma are just equally as powerful and I'm not feeling them or picking them, picking them up. I'm still actually thinking about this, how much I can hold, um how much I defend against what I'm told every day and that the- yeah, how much I can hold?

**Zoe:** my vulnerabilities are around invalidation and that actually triggers anger and it's all around boundaries and you know when boundaries are crossed. So I know and I've worked with this a long time in my own therapy so I've always known about the anger. In fact that's one of the reasons why I went into therapy because I was experiencing a lot of anger that I felt quite inappropriate and you know, over the top sort of stuff...

It's come from which is actually really, really early stuff where my- I think my mother was a very anxious person.

**Cathy:** And I, I must say I hadn't realised how wounding that had appeared to her at all. That had been, I suppose a blind spot for me in a way. But when she told me that um and that she felt that I, it was something which was alien to me. And I, not alien to me, but didn't feel quite right. For she had interpreted it in a much harsher way than I had meant it to be. I had actually meant it to be, in my mind I justified it by

thinking this is a boundary issue. It's clearer and better and less turmoil for her. I won't be unsettling her if she doesn't see me. That was my thought.

**Christine:** So- at the base of it really, it's fear that's driven so much of my practice actually which is a difficult thing to really acknowledge but it has. It's been fear and that's a blind spot in itself because it's only in speaking it- I've felt it but it's only in saying that now I realise that's what's driven my practice, it's been fear. Whatever I do in the room, the bottom line would be fear and that's not good.

**Elena:** ...as much as she needed me to receive, I perhaps needed to take. That was something I hadn't realized in that way. Um so I suppose for me it was an example of something that was a blind spot.

### **Finding Perspective**

**Cathy:** Perhaps others are more able to point out our blind spots than we are ourselves. Patients, if you've got a close enough relationship with a patient and you are open enough, they obviously can point them out to you as well as hopefully supervisors can, in a safe way

**Christine:** I mean I think my supervisor would know yes, you know, but no, I've never said that to her in that way for her to be able to work with it

**Zoe:** I suppose when you're in your own stuff you don't really- you don't have that analytical capacity as you do when you actually have access to somebody else's um prefrontal cortex if you like, because then they can make the links for you... So that was really very helpful to think about it and to have the space to think about it with you (p. 40 lines 602-606)

**Jane:** Um so I was able to sort of phew- put it out there for a small group of people, which was great but still not quite enough because I'm still processing this.

**Elena:** I feel it was more of an inner process. So it was more that little part of me that was a little bit critical, that said 'what are you doing?' But also- again it's probably something I think about with hindsight and – there was also some interest and curiosity, and then- think, wow that's interesting. I'll need to think about- so it was confusing and it was a little bit annoying but also it was one of those little nuggets that you get sometimes in the work about yourself, and you think, wow, where does that come from? So there was a little bit of –some curiosity, perhaps some mild little pleasure. That was support.

### **Superordinate theme 2.2. Finding Perspective**

**Cathy:** Perhaps others are more able to point out our blind spots than we are ourselves. Patients, if you've got a close enough relationship with a patient and you are open enough, they obviously can point them out to you as well as hopefully supervisors can, in a safe way

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that you get sometimes in the work about yourself, and you think, wow, where does that come from? So there was a little bit of –some curiosity, perhaps some mild little pleasure. That was support.

### **Superordinate theme 3. Holding my own.**

#### **Subordinate them 3.1. Gathering together-**

**Christine:** Because you can know the theory of something, you can know- you can think it and think it and think it but until it integrates into the emotional level, there's a certain amount of meaning to it but it isn't truly meaningful in the way that you can experience it.

**Cathy:** There's just something sometimes that they say which really moves me. And I can feel myself welling up and I'm able to manage it, but at that moment I feel much more hopeful about our work because before with that patient, with that chap you know, I was feeling quite irritated with him and he was repeating a lot of what I was saying... he made this connection with me and I felt much softer and more gentle and able to be more hopeful about the work

**Zoe:** And so, my healing was you know about thinking about that. Although I knew about the hot milk and I've known about it in my therapy and we've talked about that. One of the things about being able to share it with you when we talked about it, I hadn't quite thought about it in the way that I actually articulated it to you, even though it as a story I knew

**Jane:** So people in pain, people who are depressed, people who have awful things happened to them, I am leaning forward in my chair. People who are presenting hysterically, whatever is going on, I lean back.

**Elena:** Well first of all I went back to therapy and had a fair bit of things to work on there. Um but yes, I think it's made me more alert to- well I hope it has. I'm sure zillions of other blind spots will come up in that respect, but more alert to the fact that

you can't really compartmentalise. I mean I'm now very wary of any assumption that there's your life or there's your inner world and then there's the work, there's the relationship. Um I suppose I was a bit naïve there.

### **Subordinate theme 3.2. Taking Responsibility**

**Christine:** But there's something about me acknowledging that I have to start being more challenging whilst still respecting the client.

**Cathy:** I think what's really helpful is that I suppose I must feel um able to admit I'm sorry you know to her and try and obviously not to reassure her, but just to you know admit, admit when I've made a mistake. I think that was very helpful to her because that was really affirming you know, that I was able to think God, that must have been really horrible for someone who she feels really close to not to have made that simple eye contact, that human contact in a way.

**Zoe:** We'll be done, our work will be done when you realise actually that you know it's more than just care giving. It's about being able to- and it's not just the care receiving because to me there is a step before the receiving which is actually recognizing you need care and being able to ask for it, which means that you've got to be in a position perhaps of power or vulnerability whatever.

**Jane:** That I'm going to be good to myself, yeah, I'm not going to take it all because there's- I've got a really strong self-sacrifice schema um which is- most therapists do. I'm sure you do, which is doing for others and it's all right, it's not problem, I'm okay and all this, which isn't right.

**Elena:** I've noticed that in subsequent supervision sessions I've been perhaps a bit more open, which is, could be related a little bit, which is interesting. A bit more open and self-disclosing. I probably would say my supervisor knows more about me as a person as a result of that. And so perhaps there was a sense in me that I did need help with my blind spots, perhaps more help than I realised, um and that it would be helpful to have someone who knew enough about me personally to help me spot them even better

30 June 2014

Paula MacMahon

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Dear Paula,

Below is the confirmed outcome of your Programme Approval Panel presentation on 20<sup>th</sup> June 2014:

**Paula MacMahon: Candidate No. 19939 / M00251348**

**Project Title:**

*Beyond the Comfort Zone: How therapists experience a vulnerable moment in their clinical work*

Panel Decision: Approved with six conditions and three recommendations.

Strengths of the project: This is potentially a very interesting project in an under researched area.

**Conditions:**

1. Adopt a tighter focus for the project that avoids the use of emotive language, e.g. 'an exploration of 'blind spots' in relational therapeutic work';
2. Amend your title in relation to the above point;
3. Rethink the design of the project to incorporate a second interview, plus any further creative ways in which you might explore the phenomenon under analysis;
4. Incorporate a self-interview into the design;
5. Clarify your own deeper involvement in this area of exploration;
6. Clarify more clearly the wider contribution that this project could make to a broader range of practice fields.

**Recommendations:**

1. Please attend carefully to the word count when making revisions – at times, your writing rambles a bit and would benefit from a more succinct approach, coupled with clearer presentation (e.g. 1 ½ line spacing);
2. You need to attend more carefully to your referencing in the text (e.g. only quotes require page numbers); perhaps revisit the Harvard Guidelines;
3. You could reflect further on your style when presenting so that you come across as more succinct and authoritative.

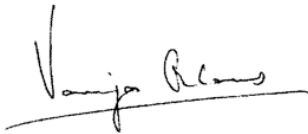


Note: You are not required to implement recommendations but we do suggest that you give them some very careful thought.

The panel suggests that the above conditions should be implemented and submitted *within six months* to the DCPsych Programme Leader, the Research Coordinator and the Research Supervisor.

*Please note that you need to highlight all amendments in your revised submission.*

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Vanja Orlans', with a horizontal line drawn underneath it.

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