What happens before we say "Hello"?
An exploration of psychotherapists' experiences of the emerging implicit during the assessment process

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Doctor of Counselling Psychology and Psychotherapy by Professional Studies

2016

Acknowledgements

Abstract

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This research explored psychotherapists' emergent implicit experiences during assessments. It was concerned with unconscious processes occurring during the assessment session and how therapists made sense of and used these experiences clinically, either implicitly or explicitly. The aims of the research were threefold: (1) to understand what and how therapists' experience the emerging implicit during assessment, (2) to explore how therapists understand their experiences of the emerging implicit, how they use these experiences in the therapeutic work (or don't) and (3) to explore how therapists put words and meaning to them.

Face-to-face semi-structured interviews were carried out with five senior psychotherapists. The interviews offered in-depth exploration of the psychotherapists' subjective experiences of the implicit emerging in their conscious awareness during assessment sessions. Verbatim transcripts of the interviews were then analysed using Interpretative Phenomenological Analysis (IPA).

Three main themes emerged: (1) *A dramatic and powerful experience that stands out,* (2) *What's going on?* and (3) *Difficulty in naming the experience*. This research found that therapists experienced the emerging implicit as dramatically standing out from other experiences at assessment. The emerging implicit was experienced as a rapid process that came without warning and could not be anticipated or created at will. The therapists' thinking and responses to the emerging implicit were complex and full of dilemmas. The therapists understood this as an intersubjective and dynamic experience. This research highlights the difficulty in studying common implicit experiences, and in trying to discuss these often profound experiences with verbal language, which is fraught with definitional and meaning issues. The hope was that this research would encourage dialogue concerning the importance of the implicit dimension in assessment sessions.

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1 Introduction

Overview

As an Integrative Psychotherapist and trainee Counselling Psychologist I see my primary goal as being critically curious both about my clients' and my own experiences during the therapeutic endeavour. A focus on what therapists experience in assessments, how their experiences are questioned, understood and used in the aid of promoting better outcomes for the client, I see as essential and ongoing. Counselling Psychology is an applied psychological science influenced by continual research into human behaviour, psychotherapeutic theories and developments, and by societal context and needs. This study draws on a broad base of psychology research and therapeutic theories to aid the investigation and understanding of a particular area of psychotherapists' emerging implicit experience during the assessment process.

There are phenomena occurring in assessment sessions that are difficult to capture, define and discuss. This study was concerned with exploring these phenomena. To do this I aimed to capture psychotherapists' subjective experiences of the emergent implicit during the assessment process. I am taking *emerging implicit experiences* to mean experiences emanating from unconscious processes that emerge into one's conscious awareness for consideration and reflection. Naming and conceptualising the emerging implicit experiences may differ from therapist to therapist, and between modalities. Literature explores similar phenomena but from varying and often contradictory perspectives. I used the phrase *emergent implicit experiences* as a means of offering a term that would incorporate the phenomena I was interested in studying but without defining it too tightly. By offering a loose definition initially, I hoped to encourage more open responses from therapists about their emerging implicit experiences. My intention was to explore therapists' subjective experience, conceptualisation, definition and name(s) they use for the implicit phenomena emerging into conscious awareness.

One of the main issues that became apparent as I began to consider this research question was the naming of implicit phenomena that emerge in assessments. I originally used the name *intuition* for the phenomenon I experienced in assessments. My use of the name *intuition* came from common everyday language and the language I used in my previous work as an artist. However, it quickly became apparent that there were difficulties in using the word *intuition*: definitional issues, assumptions regarding the nature of intuition, how others perceive and call their subjective experiences of the emerging implicit and theoretical perspectives. Recognising my initial assumptions, I put aside the word I used to name my subjective experiences of the emerging implicit. Doing this allowed me to open up this study to consider how therapists

experience, conceptualise and name these emerging implicit experiences. Becoming aware of the assumptions and definitions regarding the word *intuition* also highlighted the assumptions and definitional issues surrounding many other names and the language we use to discuss the implicit processes and experience.

My relationship to the study area

As an artist, my exploration of ideas and emerging implicit experience came hand in hand towards creating visual understandings of human experience. Previously I used the name *intuition* based on the context of the art world, my understanding at that time and common everyday language. At that time I conceptualised intuition as natural, accepted and part of my creative process. However in psychotherapy training I was faced with the problem of how to conceptualise my emerging implicit experiences in this new context. As a trainee psychotherapist and counselling psychologist I did not have an adequate theoretical framework to think about my emerging implicit experiences. Specific terminology in which to engage in a meaningful dialogue about my experiences, such as transference, counter-transference and projective identification did not fully or precisely describe my experiences. For experiences that seemed beyond words, I had previously used images and metaphors to create a visual parallel to my intuitive knowing, but in psychotherapy, the talking therapy, words and dialogue were now a central activity. As part of my journey as a psychotherapist and counselling psychologist I have been deeply engaged in what it means to experience the emerging of implicit data. I am curious to unpack what these experiences are for me and for others and how they impact (or not) psychotherapy. In doing so, I am interested to name and find an adequate language to develop meaningful dialogue with others concerning the emerging implicit.

As a trainee psychotherapist I had a number of memorable experiences when meeting new clients, but these experiences were not fully explained in the theoretical literature, by supervision or training. My training in Integrative Psychotherapy and Counselling Psychology did not refer to *intuition* or *clinical intuition* but rather talked of transference and counter-transference, attunement, intersubjectivity, implicit relating etc. Although all of these phenomena are important unconscious processes, they are each quite specific, discreet phenomena but they did not fully explain my emerging implicit experiences.

During my training I had two influential clinical placements; one in a NHS G.P. surgery working alongside the newly implemented Increasing Access to Psychological Treatment (IAPT) system, and the other in a local drug and alcohol recovery service. The NHS placement gave me the experience of meeting a huge variety of clients from across the socio-economic spectrum presenting ostensibly with 'mild to moderate depression' but in reality coming to address more

complex psychological problems. I became aware that the assessment often had a negative impact on patients. At that time the least experienced and qualified staff assessed patients, and were regularly unable to make complex clinical judgements about the appropriate level and type of intervention. For example, a patient with complex trauma, with a history of childhood abuse, presenting with depression and suicidal ideation may be sent for six sessions of counselling in the GP surgery. The experience of receiving inappropriate referrals that subsequently needed to be discussed in supervision and re-referred to the appropriate service made me aware of the crucial nature of the assessment and how poor assessments negatively impact a client's ability to trust services and engage productively with therapists working towards positive outcomes.

Working at a drug and alcohol recovery service as a psychotherapist impacted me greatly; giving me continual experience of working with people who had suffered early trauma with the consequence that often verbal communication was secondary to more somatic and implicit communication about their intra- and inter-psychic world. It was while working here that I began to engage with how I could think and work with emerging implicit experiences to enable better outcomes for the clients.

An example of emerging implicit experience

As a trainee psychotherapist in a drug and alcohol recovery service I saw clients who were abstinent and wanting to address the psychological aspects of their difficulties. Referrals for new clients were fairly brief: giving the client's name – Linda (a pseudonym for confidentiality purposes) and age (early 60s), the substance misused (alcohol), length of time of the misuse (over 20 years), length of abstinence (over 6 months), and participation in groups. The referral also gave an indication of areas the client wanted to address in psychotherapy. Linda indicated that she wanted to understand why she misused alcohol. When I met Linda in reception, I saw a lady who had clearly paid attention to her appearance; she dressed smartly, looked alert and attentive. As I saw Linda I immediately heard the word 'meagre' in my head and saw the word 'MEAGRE' in my mind's eye. This felt a powerful, emotionally full experience although I could not define the precise emotions in the moment. Meagre was not a word I particularly used, so I was baffled by why I was hearing and *seeing* the word. I introduced myself to Linda and showed her into the counselling room, but the word remained in my vision and sounded in my head continually as though on a recorded loop. I noted to myself this was an extraordinary experience to hear and see in my minds' eye the word MEAGRE over and over. At the time I felt certain this was important but I could not understand what it meant or what relevance it had, or what I could do with this experience, if anything at all. I consciously decided to hold the experience out of focus for the remaining assessment session and take it to supervision later. My supervisor was as curious as I was but we could not make any useful sense out of it at that

stage, but I was encouraged to just let it be held in open consideration without *doing* anything about it. Over many months of therapy, Linda told her story of *only just enough*; only just enough petrol to get to the counselling sessions, only just enough money to make ends meet and pay bills, only just enough attention from family and friends and as a child only just the bare minimum care from her parents. Although at the time of the assessment I did not know what to make of this experience, I did feel certain that it was important in understanding Linda. As a novice therapist I did not know how to frame this experience, the specific terminology or how to conceptualise it in the context of therapy, even though I had a very supportive supervisor. With hindsight and experience I now understand this experience as an implicit communication from the client's right-brain to the therapists' right-brain in order for perhaps previously un-named or consciously unknown experiences to be brought to conscious awareness for consideration and reflection.

The combination of both these placements (NHS and Substance Misuse Recovery Service) brought together the beginnings of my research question of how therapists experience, understand and then work with the emerging implicit during the assessment session. I believe developing knowledge and a universal language to discuss the emerging implicit can only aid our deeper understanding of the complex work of psychotherapy.

My interest in the social psychologist Nalini Ambady's work on first impressions (1993; 2001; 2008) opened up a way for me to consider the cognitive processes involved in the emerging implicit experiences occurring during therapy assessments. It also opened up further fields of psychology research giving me a broader base from which to consider emerging implicit experiences in my clinical work. Ambady's work centred on first impressions and responses to novel experiences such as meeting someone new, and therefore her research was important to my initial thinking about what happens when a therapist meets a new client in the assessment session.

Rationale for this study

It has been argued that we are able to communicate and understand feelings and attitudes implicitly without explicit, verbal communication (Mehrabian, 1968). Research highlights the importance of the presence of both non-verbal and verbal elements in accurate communication (Mehrabian, 1968). An essential aspect of psychotherapy is the integration of explicit and implicit experiences and learning, addressing the whole person and not just their presenting explicit difficulty. Psychotherapy is an intensely interpersonal and idiographic process where positive outcomes are dependent on journeys into uncharted territory (Addis et al., 2006; Maroda, 2010; Marks-Tarlow, 2012; Schore, 2012). The uncharted journey requires therapists

to attune to their clients' nonverbal, implicit communications. Some authors suggest that attention to the implicit brings about transformational change for clients (Schore & Schore, 2008; Schore, 2010, Maroda, 2010). However there has been sparse research on the implicit dimension at assessments. This research will tackle the gap in terms of studying what may happen implicitly during the therapy assessment.

Recent research argues for championing the idiographic nature of psychotherapy by cultivating and customising therapy towards the particular unique relationship between therapist and client based in the context where therapy takes place (Norcross, 2011). Specific research and attention to the implicit (as well as the explicit) dimension at assessments will enable therapists to cultivate and customise therapy adequately incorporating all aspects of communication within the therapeutic relationship. Attention to all available data regarding the client, both explicit and implicit, provides the therapist with a more complete picture from which to begin to formulate and plan treatment. This is particularly vital in commissioned services where there has been an increase in demand and uptake for psychological services. For example, the numbers of people entering the IAPT system double from 2010 to 2013, with 2.5 million people entering into the service since it began (Department of Health, 2014). With the increase in demand for psychological services also comes the increase in awareness of cost and efficacy of treatment. The quality of assessments becomes more crucial as psychological treatments rely more on the efficacy of short-term work.

My research questions

The purpose of this study was to explore therapists' experiences of the emergence of the implicit dimension during the assessment process. Rather than trying to ascertain whether implicit information emerges or not, my aim was to explore *how* it emerges for therapists. I focused on how the individual therapist attempts to understand and give meaning to their subjective experiences of the emerging implicit, within assessment. This included considerations of their theoretical framework, their philosophical stance and their belief systems regarding the nature of interpersonal communication.

My aim was to explore if and how therapists use these experiences as data for understanding the client and how therapists believe that impacts the therapeutic process or not. I aimed to explore how therapists name these experiences as a way of understanding them.

My research questions were:

1)   What and how do therapists experience the emerging implicit during assessment with a new client?

2)   How do therapists understand the emerging implicit experience during assessment and how do they use it (or not) in the therapy process?

3)   What names and theoretical frameworks do therapists use to discuss these implicit experiences?

2 Literature review

In this literature review I will firstly refer to the naming and language used in exploring implicit experiences, and identify some of the difficulties in the language of experience that require explicit acknowledgement. I will then consider the literature concerned with concepts of the unconscious in psychotherapy. The implicit processes of learning, memory, affect and communication are explored in terms of how these manifest as implicit processes in psychotherapy. I will give an overview of emergence as it relates to implicit experiences coming into conscious awareness within the psychotherapy setting. And finally, this review considers the emerging implicit with the assessment process.

Naming the experience

It is important to refer to the difficulties involved in using language when investigating experience, specifically implicit experience. An emerging question for this research was how language is used to communicate emerging implicit experiences when many of the words and names used have subjective meanings or may not fully capture the full sense of the experience. Psychotherapy and psychology literature make reference to difficulties in naming and language use. It has been suggested that more attention to naming and language is required when investigating implicit phenomena (Reik, 1948; Pally, 2007; Evans, 2008; Welling, 2005). However there has been little further attention to these questions, this may due to conceptual difficulties as illustrated with research on intuition (Welling, 2005; Boucouvalas, 1997; Sinclair, 2011).

A number of difficulties in naming have been identified. Firstly, names may be associated with subjective meanings or be theoretically laden. For instance, although the word *unconscious* is predominantly linked with Freud (1905) and psychoanalytic perspectives, consciousness (including the unconscious) is also a field of study in its own right. For example, the works of Damasio, (1994, 1996), Bargh and Morsella, (1992), Chalmers, (1995) and Kahneman (2011) have no direct link to analytic theory. In the broader psychology field the term *consciousness* now refers to all states of consciousness including unconscious states. Cognitive science makes the distinction between conscious and unconscious processes, where conscious processes are generally referred to as *explicit* and unconscious processes as *implicit*.

A second difficulty identified is the use of the same name for different phenomena (Langs, 1999). For example, using the term *unconscious* to describe both psychodynamic unconscious and also using *unconscious* to describe the non-psychodynamic non-conscious processes (some of which are mental and others brain activity). Gazzangia (1998), further argued that the use of language

may conflate mind and brain and thus reduce mind-related phenomena to brain processes. Therefore attention to how we name and conceptualise unconscious processes is fundamental to the exploration of emerging implicit phenomena.

A third difficulty can be seen as different names being used for the same or similar phenomena. Within psychotherapy literature a number of names are used to label unconsciously derived knowledge that comes into the psychotherapist's conscious awareness. Various terms are offered by the field of psychotherapy such as: *countertransference* (Freud, 1910), *projective identification* (Klein, 1946), *empathic attunement* (Mearns & Cooper, 2005), *implicit relational knowing* (Lyons-Ruth 1998), *embodied knowing* (Merleau-Ponty, 1945) and from common everyday language comes *intuition, hunch* or *gut feeling*. These terms each contribute a unique perspective to our understanding of the implicit domain, and yet seem to be largely exploring similar concepts, i.e. the non-linear, multi-dimensional complexity of implicit experience and knowing. Therefore more detailed comparisons of each of the named phenomena's unique characteristics would be a useful line of further research.

A further difficulty has been related to how different fields of study use different language to describe the same or very similar phenomenon. Pally (2005) has tried to bring together the knowledge and naming of similar phenomena (transference and *the predicting brain*) from the psychotherapy and cognitive psychology fields respectively. Although Grobstein (2005) agrees the need to bring differing stories and vocabulary together he notes there are underlying assumptions from both sides that need attending to. The activity of listening to the various stories (and names) for the same or similar unconscious processes (Pally, 2005; Grobstien, 2005), may enable an exchange of ideas and knowledge and may provide a more comprehensive framework from which to investigate and conceptualise unconscious processes.

The language and labelling of experience and unconscious phenomena appears problematic within and across fields of research (Langs, 1999; Pally, 2005; Sprenkle, 2005; Evans, 2008). Therefore, trying to name the emerging implicit phenomena experienced clinically and then to discuss and develop meaning about clinical experiences seems more complicated than may initially appear. Van Manen's (1999) approach of un-naming a phenomenon to identify and get beneath the possible biases, assumptions, theoretical, and subjective associations may enable a more open exploration of the implicit phenomena emerging at assessments.

Connected to the difficulties in naming this phenomenon because of the diversity of ways it can be labelled and understood is the difficulty of locating the appropriate body of theoretical and research literature upon which to base the study. This has meant taking into consideration a

relatively wide range of associated literature from fields as diverse as organisational, educational, developmental and evolutionary psychology, and cognitive/neuroscience, philosophy and psychotherapy theory. An additional challenge is that by definition implicit processes in psychotherapy are difficult to research (Casper, 1997). Consequently, much of the literature explored below relates to theoretical understandings of the phenomenon where there is an absence of robust research findings.

Qualitative research exploring the relationship between therapists' experiences at assessment and the accompanying language may give an insight into how experience and language inter-relate. This research holds a tension between different names and conceptualisations of consciousness to derive a more holistic understanding of emerging implicit experiences occurring at assessments from the therapists' own experiences.

The implicit in psychotherapy

Engaging with the unconscious or implicit knowledge has been and still is, the bedrock of psychoanalytic therapy. From Freud (1905) via Bowlby (1988) to contemporary psychotherapists such as Maroda (1998, 2010), Wallin (2007) and Tarlow-Marks (2012), there remains an underlying premise that clients have unconscious experiences and knowledge that greatly influences everyday life, decision-making, relationships, and play a crucial role in psychotherapy. Vast amounts of psychotherapy literature have been dedicated to understanding and conceptualising the unconscious in psychotherapy and yet there remains much that is still unknown and contentious in the wider field of consciousness (Crick & Koch, 1990; Chalmers, 1995). Current conceptualisations of the unconscious have changed considerably from an original focus on emphasising defensive repression and motivation (Freud, 1905, 1910) towards a relational, neurological and developmental concept (Bucci, 1997; Fosshage, 2005; Kihlstrom, 1984; Lyons-Ruth 1998; Siegal 2003). Despite this, Freud's notion of the unconscious as the primary guiding force over daily life persists in contemporary psychotherapy, (and psychology as a whole). Nahum's (2005: 697) comment that 'Most of the affectively meaningful life experiences that are relevant in psychotherapy are represented in the domain of the unconscious implicit knowledge' is central to psychotherapy and to this study of the implicit experiences emerging in assessments.

The theoretical mechanisms developed to explain aspects of the unconscious in the therapeutic encounter such as transference, countertransference (Freud 1905; 1910) and projective identification (Klein, 1946) have been continually adapted to incorporate developments in our understanding of the unconscious domain. Countertransference for instance, once considered

an interference to the therapeutic process (in terms of the analysts' unanalysed material) is now considered a normal and essential part of life and the analytic process (Winnicott, 1947; Heimann, 1950; Little, 1950; Bollas, 1987). In response to research and contemporary psychotherapy theory a person's unconscious is no longer exclusively thought of as separate, personal and developing from defensive repression, but as an expression of developmental and neurobiological processing of significant events in relation to self and others (Hinshelwood, 1991; Clarkson, 2003; Schore, 2010; Tarlow-Marks, 2012; Maroda, 2010; Erskine, 2008)**.** Clarkson's (2003) conceptualisation of countertransference and Hinshelwood's (1991) development of projective identification both exemplify the move towards a relational perspective and understanding the unconscious in terms of processes that are more complex and universal than earlier conceptualisations.

The development of concepts such as, transference, countertransference (Freud, 1905, 1910) and projective identification (Klein, 1946), not only parallel a move towards the relational in psychotherapy but also the shift from conceptualising *the* unconscious as a single state to an understanding of several unconscious processes. Westen (1999) argued using the term *the* unconscious is outdated, as cognitive and social psychology provide research findings to identify numerous different unconscious processes and not one state. Similarly, psychotherapy literature and developmental research now focus on unconscious processes (rather than a state of consciousness) that provide a more complex formulation of understanding the implicit domain (Schore, 2003, 2010; Siegal, 2003; Erskine, 2008; Cozolino, 2006).

Literature now identifies a number of unconscious processes, but definitions and names differ, across psychotherapy modalities and across psychology fields. Psychotherapists have identified unconscious processes that are relevant to the behaviours and experiences within the therapeutic encounter. For example Storolow and Atwood (1992) defined three forms of unconscious process: pre-reflective unconscious, the dynamic unconscious and the un-validated unconscious. Erskine (2008: 1) speaks of unconscious experience as being 'composed of pre-symbolic, sub-symbolic, implicit and procedural forms of memory as well as being the result of trauma'. It appears that Storolow and Atwood and Erskine are talking of the same or similar implicit processes but define and name them differently. The study of unconscious processes has boomed since the mid 1990s however our understanding of these processes is still limited and often made more difficult by the lack of consistency in definitions and language used. Pally (2005) among others has tried to identify the similarities between the fields of neuroscience and psychotherapy by her understanding of how transference associates with a cognitive science view of the predicting brain. The need for a wider inter-disciplinary approach to understanding

implicit processes has been increasingly discussed in the literature (Pally, 2005; McGilchrist, 2009; Dane & Pratt, 2009; Sinclair, 2011).

Intersubjectivity

As the notion of *the* unconscious developed over the twentieth century, so did psychotherapy, with a move from a one-person to a two-person psychology. Contemporary research identifies an innate human drive for connection with others, arguing individuals exist and thrive within interpersonal and intersubjective relationships (Wilkinson, 2010; McTaggart, 2011). Thus the relationship between the therapist and client became central to psychotherapy and the change process. Buber's (1958) work on the interpersonal nature of human experience has been instrumental in the philosophical literature supporting two-person psychology. *I-Thou* relating offers a view of the client's ontological reality that is generated between the client and the therapist via reciprocity and mutuality. The quality of the therapeutic relationship on both conscious and unconscious levels has become of great importance to psychotherapy literature and practice. The quality of the therapeutic relationship has been consistently seen to facilitate psychotherapeutic change as seen in the literature of Bordin (1975), Gelso and Carter (1985), Horvath and Symonds (1991) and Tallman and Bohart (2008). The relational qualities that appear so central to facilitating change are largely played out in unconscious interactions between client and therapist, (Maroda, 1999).

Understanding the unconscious in psychotherapy changes significantly when an intersubjectivity perspective is core to the psychotherapy process. Stolorow and Atwood (1992) and Mitchell and Aron (1999) suggest client and therapist each bring their own unique histories, interpersonal models and personal experiences to connect with each other intersubjectivity in a continual flow of reciprocal mutual influence and mutuality. The personal and relational qualities between therapist and client, (i.e. the quality of their intersubjectivity) offers moments in therapy to access the unconscious material in the form of implicit wisdom or knowledge (Milton & Corrie, 2002).

The Boston Change Process Study Group (BCPSG) focus on unconscious processes central to human relating and communication, and their work carries profound implications for psychotherapeutic change (BCPSG, 2002; 2008). They argue that change occurs through experience of the other and the co-created space, much of which may be implicit, rather than via explicit verbal interpretations. Their work builds on the work of previous psychotherapy and developmental theorists (e.g. Winnicott, 1947/1957; Bowlby, 1969; Bollas, 1987), infant observation studies (e.g. Ainsworth, Bell & Stayton, 1971; Tronick, 1989; Stern, 1985) and neuroscience findings (e.g. Damasio, 1994; Edelman, 1987). BCPSG demonstrate how

intersubjectivity and the implicit domain are essential in psychotherapy and the change process. This wider agreement concerning the centrality of intersubjective, non-verbal implicit experiences has been seen within psychotherapy as a whole but not explicitly investigated within the first meeting (or assessment).

Bollas (1987) described the process of the unconscious material emerging to conscious awareness as the client's need to consciously know and to put into words that which has been unconsciously known, and has not yet been thought or verbalised. Concepts such as the 'unthought known' (Bollas, 1987) and 'unformulated experience' (Stern, 1983) have been instrumental in acknowledging and developing the concepts involved with non-conscious experience and implicit knowledge. Bollas (1987) and Stern (1983) assert the importance of the unconscious processes of both the client and the therapist towards a co-created unconscious experience. The co-created unconscious or the 'analytic third' (Ogden, 1994), central to two-person relational psychology, now appears to dominate concepts of unconscious processes in contemporary psychotherapy. Fuchs and De Jaegher (2009: 476), from a phenomenological cognitive perspective, concur with this, stating; 'The 'in-between' becomes the source of the operative intentionality of both partners.' They further suggest that each person unconsciously enters an interactive process that gains its own centre of gravity, where meaning is co-created. Accessing the unconscious material in the form of implicit wisdom (Milton & Corrie, 2002) has been seen as a process that incorporates a meaningful change for the client, for the therapist and for the unique dyad they both create by BCPSG (2002; 2008) and Ogden (1994).

However Fuchs and De Jaegher (2009) make an essential distinction between an intersubjectivity of implicit relational knowing (where infants acquire interactive schemes of *being with* (Stern et al., 1998) and body micro-practices, and that of mind-reading and mentalisation. The former is holistic, connecting mind, brain and body, while the later ignores the bodily interactions and relies solely on mental activity. Fuchs and De Jaegher's distinction is opposed to theories of social cognition that focus on "theory of mind" (ToM) (Premack & Woodruff, 1978) and *simulation theory* (Carruthers, 1996). ToM and simulation theories suggest an individual brain observes another's behaviour and then attributes it to an inferential, simulative or projective process. However, theories of intersubjectivity that focus on social cognition in such a representational sense, have been criticised for ignoring the bodily interaction and only focusing on putting into operation a theory or mental model of how people act. Fuchs and De Jaegher (2009) have proposed a non-representational, enactive and embodied concept of intersubjectivity. Their argument states intersubjectivity relies on embodiment, the dynamic and embedded whole-body actions rather than just brain mechanisms. Psychotherapy literature supports the promotion of a holistic view of the

therapeutic process, incorporating body, mind and brain (Boadella, 1987; Rothschild, 2003; Ogden, Minton & Pain, 2006; Young, 2006).

Trauma, the body and the implicit

Research by Herman (1997) and Van der Kolk (1994) on the experience and impact of trauma has greatly informed unconscious processes in psychotherapy. Trauma literature focuses on the importance of body processes, the impact on the body (Rothschild, 2003) and the functioning of some brain areas involved in memory and speech (Van der Kolk, Pelcovitz, Roth, Mandel, McFarlane & Herman, 1996). According to these theories traumatised people respond through increased activation of the sympathetic neural system that releases adrenaline and increases oxygen, thus creating the energy to either run or fight. The response of brain chemistry to trauma, for instance causes the Broca area (associated with language) and the hippocampus (associated with encoding, retrieval and contextualising memories) to shut down according to Van der Kolk et al. (1996). They called trauma the 'speechless terror' (Van der Kolk et al., 1996: 517), whereby instinctive survival mechanisms are activated to keep the traumatised person safe. It has been argued that experiences of trauma disrupt the stress-hormone system and traumatic memories may stay stuck in the non-conscious, sub-cortical regions of the brain where they are not accessible to processing, thinking or understanding. Much of this trauma activation occurs at bodily, implicit, non-verbal and relational levels (Van der Kolk et al., 1996; Schore: 1994, 2010; Herman: 1997). If words cannot integrate the disorganised sensations involved in traumatic experiences then therapeutic treatment for trauma is required to attend to the implicit non-verbal, relational aspects including somatic memory and regulation of affective states (Van der Kolk, 1994; Van der Kolk et al., 1996; Herman, 1997; Rothschild, 2003; Schore, 2010).

Research focusing on the somatic symptoms and somatic countertransference found that patients suffering from borderline processes, psychosis and PTSD are more likely to project their embodied affective experiences onto the therapist (Warnecke, 2009; Stone, 2006: Van der Kolk et al., 1996), rather than explicitly verbalise their experience. Stone (2006: 109) proposes that somatic reactions are more likely to occur 'when there has been severe childhood trauma and where there is a fear of expressing strong emotions directly' as the client is unable to communicate their distressing experience. Trauma literature gives an understanding of how implicit experiences may be held in the body, and communicated via non-verbal, body-based, affective implicit interactions. This is of interest to this study investigating emerging implicit experiences at assessments as unconscious traumatic memories may manifest in somatic countertransference for the therapist during the psychotherapy process including the first meeting.

Current psychotherapy literature identifies a more holistic understanding of unconscious that involves intersubjectivity, body-based non-verbal implicit processes (Wallin, 2007; Schore, 2010; Marks-Tarlow, 2012). These implicit processes are involved in many important human experiences and can be categorized in terms of implicit learning and memory, implicit knowing and implicit communication.

Implicit processes involved in psychotherapy

A shift towards implicit affect

The paradigm shift in psychotherapy from the explicit cognitive to the implicit affect that Schore (2009) observes, parallels the shift from the notion of the unconscious as a singular state to that of numerous implicit processes. A shift of focus from the cognitive explicit to the implicit has implications for psychotherapy in terms of a move from interpretation to a focus on the relational experience as a therapeutic activity and intervention towards change. The move towards more relational and intersubjective therapy has required therapists to acknowledge their own part in the ongoing dynamic. Wachtel (2008) suggests that everything therapists observe in relation to their client is saturated with the therapist's own participation in the activity of observing. The *reciprocal mutual influence* of intersubjective theory (Storolow & Atwood, 1992; Aron 1996) requires the therapist to observe and attend to their own, as well as their client's material, to be aware of the co-created relationship and to acknowledge their own part in the ongoing dynamic with reflexive awareness (Bager-Charleston 2010).

Schore (2009) claims the paradigm shift legitimises research on the implicit and has positive implications for the study of implicit unconscious phenomena in psychotherapy. A move away from the dominance of the cognitive focuses on affect, feelings and the physical aspects of experience, which cognitive science has paid little attention to (Fuchs & De Jaegher, 2009). The move towards implicit processes highlights a need for a refocusing on how and what research investigates in terms of psychotherapeutic interventions and interactions. Rather than solely exploring explicit verbal interactions and interpretations, psychotherapy research needs to find ways of accessing the implicit processes and phenomena of the therapeutic dyad. A continual difficulty for researchers investigating unconscious processes is finding a method to investigate phenomena that is by its' very nature out of our awareness (Casper, 1997).

Understanding how we learn and develop memories (including implicit memories) is crucial to psychotherapy as psychotherapy can be considered a process of knowing and understanding the conscious and unconscious structures that direct our daily behaviours, thoughts and

feelings. I will look at implicit processes (implicit learning and memory, implicit affect and implicit communication) to map out the territory of what emerging implicit experience may involve and what implicit processes may emerge in the assessment process.

Implicit learning and memory

Siegal (1999) and Fosshage (2005) argue that understanding the process and structure of memory is crucial to psychotherapy as memory is the way past (learned) experiences impact current and future perceptions, decisions, and behaviours. Fosshage (1994) provides a useful explanation of the expectancies that reside in memory as attending selectively to cues, attribute meanings to cues and interact with cues in a way that confirms the original expectancies. In this way memory can be seen to hold the organising patterns that help negotiate life in relation to others (Watchel, 1980; Stolorow, Brandchaft & Atwood, 1989; Fosshage, 1994).

Cognitive science shows learning and memory are mutually dependent processes in the memory system; memory is essential to learning, allowing for storage and retrieval of learned information (Schacter & Tulvig, 1994). While learning also depends on memory, since the knowledge stored in memory provides the framework to link new knowledge, by association. Implicit learning is acquired passively without need for attention, via exposure to particular experiences or environments (Squire, 1994; Schacter & Tulvig, 1994).

Implicit memory or non-declarative memory within cognitive science (Cohen & Squires, 1980) refers to a memory that cannot be declared or spoken of. It is an experience that cannot be consciously recollected, as opposed to declarative (explicit) memory, which can be consciously recollected (Davis, 2001). Non-declarative memory or procedural memory comes from learning that incorporates both classic conditioning and skill and habit learning to process experience (Squire, 1994). Although the term 'procedural' had been used by Schacter and Tulvig (1994) to describe gradual incremental learning such as riding a bike, it has more recently been used to describe social learning or relational procedures such as 'how to be' (Stern, et al., 1998) within the psychotherapy domain.

Research on how infants develop using infant observations has identified crucial aspects of relational knowing or 'how to be' (Stern et al., 1998) via procedural learning. These understandings have been applicable to therapeutic understanding of the therapist and client interactions by many including Bowlby (1988), BCSPG (1998) and Schore (2003). Clinical work and infant observation research have identified concepts such as attachment, attunement and affect regulation (Bowlby, 1969; Beebe & Lachmann, 1988, 2002; Schore, 2003, 2004; Stern, 1985) that highlight the implicit learning and implicit memory mechanisms. Attachment theory

(Bowlby, 1969; Ainsworth, Blehar, Waters & Wall, 1978) based on implicit learning and memory mechanisms has been robustly examined and has consistently been supported by observational and longitudinal studies (Main, 1995; Main & Solomon, 1986, 1990) suggesting attachment patterns learnt in early infancy persist into adulthood and direct relational dynamics.

Attachment patterns, achieved through implicit learning by the infant about how their needs are responded to by their mother or primary care giver, act as a template for predicting future relational interactions (Ainsworth et al., 1978). A secure attachment is developed via the mother's 'reciprocal, attuned somatic and verbal communication with her infant' according to Ogden, Minton and Pain (2006). An important aspect of attachment behaviour that relates to the therapeutic dyad is the interactions between mother and infant (rhythm, co-ordinated sound and movement, facial expressions, gaze and touch) are sensed or apprehended directly rather than known reflectively. Lyons-Ruth (2000) argues that these micro-encounters between mother and infant, many of which are non-verbal provide a continual flow of experiences that developmentally construct the infant's ways of being with others in the future. From a neuroscience perspective Schore (2003: 48) argues that developing a secure attachment comes via the mother and infant being involved in a 'right-brain-to-right-brain emotion-transacting' process.

Stern (1985) argues that the mother co-regulates the infants developing central and automatic nervous systems during affective communications via mutual gaze episodes, and by attuned and sensitive responses to the infant's affective states. It has been suggested that through continual experiences of attunement, moments of misattunement and then re-attunement an infant implicitly learns the process of self-regulation (Stern, 1985; Trevarthen, 1998; Beebe & Lachman, 2002). Shore (2003) argues that this implicit interactive regulation experience is central to developing the framework that underlies essential survival functions of the human self-system. The nature of these functions become of particular interest in psychotherapy, as they tend to indicate the nature of particular relational dynamics and the possible relational difficulty underlying a client's presenting problem.

Although research findings suggest interpersonal patterns learned implicitly in the first year of life can be altered by subsequent events and experiences, they appear to be relatively stable (Behrens, Hesse & Main, 2007). It is argued that these internal working models created by attachment styles and emotional regulation, are encoded before language acquisition (Beebe et al., 2000; Jaffe et al., 2001; Schore, 2003). Therefore, attending to the implicit memory of the preverbal experience that constitutes the development of self is an essential activity in the therapeutic process.

An important issue for psychotherapy is concerned with how relational procedural memory is connected and interacts with declarative memory and how these two memory systems operate to effect change in the therapy setting. BCPSG (1998, 2002, 2008) have argued that the two systems, declarative and procedural knowing are separate and parallel systems thereby suggesting that procedural knowledge is often not accessible to or altered by declarative processing. They argue that explicit verbal interventions in psychotherapy cannot wholly impact and deliver transformational change of implicit procedural structures (or memories) but need new implicit experiences that develop new procedural knowing.

However, Bucci (1997) asserts that the two systems must be connected and it is the interaction between the two systems that leads to integration, communication and development. Bucci (1997: 160) argues that although the declarative system in the form of language can only partially capture sensory and emotional aspects of experience, 'the non-verbal representations, in subsymbolic and symbolic formats, must be connected to one another and to language.' She suggests this connection occurs via a referential process that has 'the power to add new connections and new meanings, not previously seen' (Bucci, 1997: 161). How implicit and explicit learning and memory systems are connected is of crucial importance to psychotherapy as it will suggest how psychotherapy change occurs and which interventions are most effective and in which circumstances. However, neither the BCSPG nor Bucci have been able to convincingly demonstrate the precise nature of the interaction between the implicit and explicit experience yet. This question of how the two processes interact has proved problematic in other fields of psychology, particularly in cognitive science.

Cognitive science has identified the mechanics of some implicit processes that are pertinent to implicit experiences occurring in psychotherapy. Dual processing models offer an understanding of the distinction between conscious and unconscious processes, and between different ways of thinking and knowing (Stanovich, 1999, Kahneman & Frederick, 2002). Evans' (2008) review of the many varieties of dual processing models suggests they are similar in many respects, although there are some differences, not least in the language and names used to describe the two systems. These models define two distinct operating systems, System one: fast, implicit and automatic, and System two: slower, controlled and explicit (Stanovich & West, 2000). Although the distinction between ways of processing is well established (Evans, 2008), continued research by Kruglanski and Gigerenzer, (2011) and Evans and Stanovich (2013) indicates a more complex process of thinking and knowing which highlights the possibility of 'multiple kinds of type [system] one processes' (Evans 2008: 35). Although the concepts and understandings of dual processing models have great support, there is less commonality

surrounding the issue of how in detail these two systems work together. McGilchrist (2009) advocates the continued attention to distinguishing the two systems of processing while being mindful of the need to remember these two systems work in tandem and are mutually dependent. While the neuroscience findings used for McGilchrist's argument has enabled the identification of the brain architecture of particular processes, it has not been able to provide a sufficient explanation of the nature of how those processes work and interact.

Psychotherapy can involve working with both systems, relating system two to the verbal interactions, reflections, considered reasoning and narratives of the therapy process and system one to the body based, moment-by-moment, relational implicit interactions. If we accept the premise that there are two such systems, then attention to how in practice therapists' experience the interaction between these two systems of knowing and how they integrate these processes is pertinent to this research. However research is only able to observe the outcome of the implicit process, which may not fully explain the processes involved.

Implicit affect

There have been a number of theories of emotion (e.g. James-Lange, 1884; Cannon-Bard, 1927; Schachter & Singer, 1962; Lazarus, 1991) however the idea and theory of implicit emotion has been controversial until the 1990's. Cognitive science as a whole had been criticised for its' lack of attention to affect, emotions and physical elements of cognition. Clore (1994) had argued that emotions could not be unconscious because the essence of emotion is feeling, and if emotions are felt then they cannot be unconscious, by definition. However, the impact of neuroscience and the work of Damasio and LeDoux in particular have greatly developed the theory of emotion and implicit emotion. Damasio (2003) argues that emotion and feelings must be considered separate, viewing emotions as unconscious and feelings as conscious, although they operate in close interaction with each other. From an evolutionary perspective Damasio (2003) considers consciousness, and conscious feeling systems to have developed after unconscious emotional systems within the brain. Therefore, although emotions and feelings are interrelated they are separate and distinct from each other. Similarly, LeDoux (1996) asserts emotions are survival mechanisms that occur quickly at unconscious levels before conscious processes can be activated, for example the fear response being activated rapidly in danger situations independent of conscious processes.

Edelman (1992), Damasio (1994), LeDoux (1996), and Panksepp (2006), all stress the important relationship between emotions and bodily functions, such as emotions engaging the physical responses of the face, posture, voice, heart rates, blood pressure, skin conductance, and endocrine responses. Ekman's (1990, 1992, 2002) work on emotions has focused in recent

years on facial expressions related to emotions. His Facial Action Coding System (1978, 2002) identifies the individual facial muscles that work together to express particular emotions rapidly and often outside of conscious awareness. He argues micro expressions are small rapid facial movements that leak out and are difficult to consciously suppress. These micro-expressions are also often difficult to interpret consciously as they are so rapid, but may register unconsciously as implicit affective communication.

Damasio's (2003) argument that implicit emotional states come first and conscious feelings follow suggests people are unaware of most of their emotional processes. Although current psychotherapy literature has supported these understandings of implicit emotional processes being primary, explicit narrative or interpretative interventions within actual therapy practice may still dominate. This may be particularly relevant within commissioned services where explicit data is required for monitoring effectiveness of outcomes and funding.

The literature on implicit affect from Schore (2003, 2010), Damasio (1994, 2003), LeDoux (1996) and others, has encouraged psychotherapists to focus their attention to emotions, feelings and the physical body in the psychotherapy process. They emphasise the therapist's attention to the client's affective states occurring at both conscious and unconscious levels. Schore (2003) argues that affective processes, which are mainly out of awareness are part of the affective regulatory mechanism of the attachment dynamic. Schore (2003) further suggests that affect dysregulation is a fundamental mechanism of psychiatric disorders. Ogden, Pain, Minton and Fisher (2005) champion the importance of the therapist's particular attention to the implicit affective aspect of therapeutic process. They suggest that attuned interactive affective regulation lies at the core of the psychotherapy change mechanism.

Clinical decision-making

Lerner, Li, Valdesolo and Kassam (2014) note that the recent upsurge in research on emotion supports emotion being a potent and pervasive driver for decision-making compared to previous negative views of emotion's role in reasoning and decision-making. Recent literature suggests that emotion may serve several functions in interpersonal decision-making (Dane & Pratt, 2007; Lerner, et al., 2014; Lieberman, 2007). Most relevant to this research is how emotion helps individuals understand one another's emotions, beliefs, and intentions, and that it can evoke complementary, reciprocal, or shared emotions in others (Keltner & Haidt 1999).

According to Hodgkinson, Langan-Fox and Sadler-Smith (2008) implicit learning and implicit knowledge create knowledge structures that are used when making nonconscious judgements. It has been suggested that autonomic responses based upon unconscious affective states and

previous experiences guide decision-making processes and outcomes in advance of conscious awareness (Ekman, 1992; Lazarus, 1991; LeDoux, 1996). Based on their research with patients suffering ventromedial prefrontal cortex damage, Damasio, Tranel, and Damasio, (1990) found that the participants' inability to generate emotions, or somatic markers, which encode an appraisal of a situation or person, resulted in deficits in decision-making.

Although implicit affect is widely considered an important aspect of the decision-making process, much of the research still focuses on accuracy according to Lane and Corrie (2012). Literature suggests that clinical practitioners have poor awareness of the factors that influence their decision-making (O'Donohue & Henderson, 1999). This is particularly relevant to this study when considering therapists' emerging implicit experience at assessments. Therapists may not be aware of their implicit biases and judgements that influence their individual decision-making process. Arkes (1981) argues that bias and overconfidence in clinical judgements impede accurate decision-making. Therapists may also wrongly judge the accuracy of their emerging implicit experience or hunch when assessing a new client. Kahneman (2011: 114) suggests 'Sustaining doubt is harder than sliding into certainty' as one explanation for clinicians' misplaced confidence in the accuracy of their intuitive decision-making. A meta-analysis of practitioner confidence and accurate decision-making by Miller, Spengler and Spengler (2015) suggests that overconfidence bias can have a negative impact on accurate clinical judgements. They conclude by urging counselling psychologists to be cautious and to take a "don't be so sure" attitude towards their clinical decision-making. Miller et al., (2015) suggest clinical practitioners be open to disconfirming evidence, consistently acknowledging alternative possibilities, and thus remaining prepared to adjust decisions, and decision-making processes.

Although decision-making research has been seen to focus on accuracy, Lane and Corrie (2012) suggest we do not become so focused on accuracy that we overlook the wider types of decision-making and thinking skills involved within real world clinical judgements. They suggest that therapists' decision-making process is not only concerned with accuracy, reliability and outcome, but also may involve innovative and creative opportunities to extend knowledge (Lane & Corrie, 2012).

Part of the pre-occupation with accuracy may be concerned with the difficulty in investigating implicit phenomena within naturalistic environments. The question for many researchers is how do you capture implicit processes (Casper, 1997; Rea, 2001). Dane and Pratt (2007) make a useful contribution to this debate by emphasising the distinction between implicit process and implicit outcome. Implicit processes are unavailable for observation, while implicit outcomes are

the judgements, decisions, feelings and thoughts that can emerge to conscious awareness and therefore can be observed and investigated.

Implicit communication

Communication is defined as: 'a process by which information is exchanged between individuals through a common system of symbols, signs, or behaviour and as an act or instance of transmitting' (Merriam-Webster). We transfer or transmit information from one person to another in a two-way process of expression and perception. All communication has a sender, a message and a receiver. According to Mehrabian (1971) there are three aspects to communication; words, tone of voice and nonverbal behaviour. This study is concerned with the nonverbal aspects of communication and in particular those that are implicit. (Note that not all nonverbal communication (NVC) is implicit.)

Darwin (1872) suggests in *The expression of the emotions in man and animals* that nonverbal communication stems from early evolutionary history, whereby nonverbal behaviours and communication had specific and direct functions for survival. It has been argued that nonverbal communications continue to be used as they hold communicative value (Hinde, 1972; Ekman 1972). An evolutionary perspective of understanding nonverbal communication persists with the work of LeDoux (2002), Damasio (1994), and Panksepp (1998).

Communicating implicitly via nonverbal behaviour is considered a primary process and according to Ambady and Weisebuch (2010) it is the core of social intellect. To communicate implicitly is to infer others' motives, intensions, character traits and emotions, and to communicate one's own. NVC involves encoding (the production and communication) and decoding (recognition and interpretation) of nonverbal behaviours and messages. Nonverbal behaviours include gaze, facial expressions, posture, touch, tone of voice, gestures etc.

Mehrabian's work on NVC has had a lasting impact on how we understand implicit communication. However, some of his findings have been exaggerated or taken out of context, for instance the 7%-38%-55% equation from Mehrabian and Ferris's (1967) study has been used to generalise all communications rather than only those where feelings and attitudes are being communicated. This has led to the misconception that NVC is solely concerned with communicating emotions and that verbal communication is solely concerned with communicating ideas. An account of implicit and explicit communication being so polarised does not stand up to scrutiny, for instance NcNeill (2000) argues that people use nonverbal communication in terms of hand gestures to convey ideas as well as feelings (think of someone

directing traffic with just hand gestures to move forward or to halt). Explicit verbal language can also communicate affective and attitudinal messages, for example when one person tells the other 'I love you'.

Another misconception regarding NVC is that it is primarily unintentional and uncontrollable. Some NVC are uncontrollable such as blushing that conveys embarrassment (Castelfanchi & Poggi, 1990) and the *Duchenne* smile that conveys genuine joy (Ekman, Davidson & Friesen, 1990), while other NVC such as showing disgust may be controlled. Although it could be argued that micro-expressions that are imperceptible to conscious awareness may still be perceived unconsciously.

Understanding the process of implicit communication within psychotherapy has focused on affective states that are connected with brain activity. Schore (2003) argues that implicit communication is concerned mainly with affective content due to its' association with right brain processing. Similarly, Marcus (1997: 238) suggests 'The analyst, by means of reverie and intuition, listens with the right brain directly to the analysand's right brain.' However to fully understand the processes involved in implicit communication, we need to consider the mechanisms at work rather than relying on references to the brain areas or structures involved. Dorpat (2001: 451) offers an understanding of implicit communication as a primary process and involves the therapist and client both attending to their own and the other's 'body movements (kinesics), posture, gesture, facial expression, voice inflection, and the sequence, rhythm, and pitch of the spoken words.' This view is similar to Ambady's (1998), who describes *channels* of communication in social psychology, which include activity in the face, the body, gestures and the voice. Attending in this way suggests a focus on the outcome rather than the process of implicit phenomena as highlighted by Dane and Pratt's (2007).

Ginot (2007) suggests that neuroscience and mirror neurons may explain implicit communication via our neural ability to sense and understand another's' affective experience. Research explains that the mirror neuron system enables us to recognise other peoples' emotional states by 'internally generating somatosensory representations that stimulate how the individual would feel' (Galleses, Eagle & Migone, 2007: 143). They suggest this is an embodied simulation that has implications for 'attunement, empathy, therapeutic action, and transference-countertransference interactions' (Galleses, et al., 2007: 131). Galleses, et al.'s (2007) research corresponds to an understanding of infants' ability to engage in intersubjective activity with their primary caregiver from birth, rather than due to cognitive development over time. An infant's pre-verbal period consists of emotional communication between mother and infant via crying, vocalisation, facial expressions, gaze interaction and body movement. This enables

infant and mother to maintain and direct the others attention and build patterns of dyadic interaction and communication (Bornstein, Suwalsky & Breakstone, 2012).

Understanding implicit communication via an integrated framework consisting of infant development research, neuroscience, cognitive and social science perspectives gives a consistent and robust view of affective, implicit communication steeped in an embodied process. Within psychotherapy literature implicit communication has been associated with enactments (Maroda, 2005) and with working intuitively (Marks-Tarlow, 2012). It has been argued that implicit communication in psychotherapy occurs at an implicit level, is too rapid to be simultaneous with verbal transaction or conscious reflection but contains information pertinent to unconscious concerns of both client and therapist (Maroda, 2005; Lyons-Ruth, 2000; Chused, 2007).

Emergence

Understanding some of the implicit processes associated with implicit experiences that may emerge in therapy, highlights the question of how the explicit and implicit inter-react with each other. A central purpose of psychotherapy and psychoanalysis is to make the unconscious conscious. The point of inter-reaction between conscious and unconscious material may be considered the border between the known and the unknown, or *the edge* of awareness. The metaphor of *the edge* has been evocatively used by several psychotherapists. Gendlin (1984) uses the term *edge of awareness*, while Ogden (1992) calls it the *primitive edge* and Ehrenberg (1974,1992) names it the *intimate edge*. For Gendlin (1984) the unclear edge of experience signifies an intriguing confusion that accompanies the point of emergence of the implicit material. Others talk of the *getting lost* (Bollas, 1987), *surrender* (Maroda, 1998) and the moment-to-moment *vagueness and possibility* Donnel Stern (1997) where the something more at the edge of experience has the potential to become consciously felt or known (Wallin, 2007).

For others, the emergence of the unconscious material is evoked in terms of an intuition (Reik, 1948; Tarlow-Marks, 2012), a now moment (Stern et a., 1998) or an enactment (Ginot, 2007). In his book Listening with the Third Ear, Reik (1948) outlines intuition as the therapist's ability to listen to both the client's and their own unconscious mind, to decipher the client's deeper emotional experiences and meanings without explicit communication. While Tarlow-Marks (2012) understands intuition as a right-brain to right-brain process, that enables therapist and client to access a deeper unconscious connection that parallels the attunement and affective regulation of mother–infant dyads. For Tarlow-Marks intuition emerges as flashes, hunches or gut reactions, in bodily feelings, images or metaphors. Although intuition has been investigated by Petitmengin-Peugeot (1999), Charles (2004), Welling (2005) and Swanepoel (2008) it appears to be on the

fringes of the psychotherapy debate regarding implicit processes. It has been suggested that this is due to a lack of a clear definition and conceptualisation of the phenomena of intuition (Boucouvalas, 1997; Rea, 2001; Rowan, 2002; Charles, 2004). Intuition in the first meeting or at assessment has not been researched or investigated within psychotherapy literature.

Stern et al. (1998: 911) characterised *a now moment* as a move away from the habitual to a moment of intensified, affective attention that offers 'a unique opportunity'. The resolution of the now moment of interpersonal crisis may then occur in what Stern et al. (1998: 906) calls a 'moment of meeting'. A moment of meeting results in psychological change in both the therapist and the client's implicit knowing about how life may be experienced.

An enactment has been described by Maroda (1998: 530) as; a dynamic 'manifestation of the transference and countertransference emerging into a living entity, making the past alive in the present.' Enactments have three elements, the past unconscious material emerging into the present, the interaction between therapist's and client's unconscious and a strong or overwhelming affect (Wallin, 2007; Stern, 1994; Maroda, 1998). Enactments have been seen as repeated behaviours or actions that occur in the dyad to bring to conscious awareness (of both the client and therapist) the unconscious dissociations of past events or patterns (Stern 2008). Ginot (2007: 317) further suggests that enactments come into conscious awareness and 'consequently alter implicit memories and attachment styles'. Enactments represent emergence of unconscious material to conscious awareness via affectively charged action within a dyad. Understandings of enactments have moved away from defences and obstacles to treatment and towards offering a form of communication about dissociated memory (Schore, 2010; Wallin 2007; Stern 2008).

Intuition, now moments and enactments appear to be describing very similar phenomena, the emergence of implicit experiences to conscious awareness. They are each concerned with the implicit, affective knowing of both therapist and client meeting in a unique way to create an opportunity for a new relatedness. However as yet there does not appear to be sufficient understanding of the mechanisms involved in emergence of the connection between unconscious and conscious processes.

Implicit processes in assessments

The implicit processes discussed above are pertinent to the activity and interactions taking place between therapist and client within psychotherapy. Psychotherapy literature emphasises the importance of the implicit domain once the therapeutic relationship has been established, but appears to overlook the implicit domain at the first moments of the encounter. However social

psychology suggests implicit processes occur all the time, as Bargh and Morsella (2008: 8) indicate at the end their article; 'In nature, the "unconscious mind" is the rule, not the exception.' If we agree with this premise, then literature on the implicit domain at assessments has been severely neglected.

Literature identifies the assessment as an important and essential aspect of therapy, as exemplified by Shoai (2014: 6) referring to the assessment as: 'the foundation of all mental health treatment and as arguably the most valuable skill among psychologists'. Although on closer inspection the valuable skills referred to are those of explicit interactions and formulated protocols rather than the development of expert knowledge including the understanding of implicit and explicit processes. Assessment literature gives very little insight into the implicit domain and often focuses on the explicit.

Clinical assessment literature is mainly concerned with the explicit aspects of the process such as: the role of the assessor, diagnosis, risk assessment, ethical considerations and accounting for difference, the necessary skills and techniques as exemplified by Bager-Charleson and van Rijn's (2011). Although the relational aspects, unconscious patterns and embodied experiences of the psychotherapeutic assessment are named as significant (Bager-Charleson & van Rijn, 2011; van Rijn, 2015), there is very little detail or exploration of these elements compared with explicit data.

In recent years, an increasing demand for quantifiable results and payment on results for therapeutic services has resulted in explicit data of therapeutic instruments being prioritized. Quantitative instruments such as the Clinical Outcome in Routine Evaluation- Outcome Measures (CORE-OM) (Barkham et al., 1998), the Patient Health Questionnaire (PHQ-9) (Kroenke, Spitzer & Williams, 2001) and the Generalized Anxiety Disorder (GAD-7) (Spitzer et al., 2006) are used routinely for recording clients' symptoms, for diagnosis, for treatment suitability and as aids to monitoring change. These instruments also provide data for service planning and funding especially in the NHS and other commissioned services. History taking, (family, psychiatric, medical etc.) are important in setting the context of the client's past and present difficulties and giving an indication of their frames of reference. Yet Ogden, (1992: 243) warned against too heavily relying on explicit measures, suggesting they are likely to miss vital understandings of the client's 'conscious and unconscious versions of his history (presented) in his own way'.

Assessment literature has focused on the relational within the assessment in terms of developing a working alliance rather than as a means of understanding unconscious material and implicit

relational patterns. Bordin (1975) for instance, differentiates goals, tasks and bonds as aspects to attend to in the assessment, where the bond is the personal relationship between therapist and client necessary for establishing a working alliance. The crucial goal of developing a working alliance during the first meeting has been supported by Horvath, 1994 and Constantino, Castonguay and Schut, 2002. The importance of the therapeutic relationship to clinical outcomes has been outlined by the research on common factors (Lambert & Bergin, 1994; Wampold, 2001). Research suggests early establishment of therapeutic alliance is a moderate but reliable predictor of outcome (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000). Although the relational aspects involved in assessments have been widely researched and supported there is a dominant focus on the explicit aspects.

Several authors have highlighted the significance of attending to the implicit during the assessment process. Bruch (1974) considered the assessment as a means of determining the course of therapy and Clarkson (2003: 47) writes that it is 'an overture for the whole therapeutic journey' encapsulating the crux of the client's deeply seated issues, but neither explore the assessment in depth. Cooper and Alfille (1998) explored the assessment in psychotherapy in depth combining both the explicit and implicit aspects of the assessment process. They include the purposes of assessments in different contexts, the qualities and motivations of clients, the patient-analyst match, the significance of opening stories and importantly the unconscious dimension of the first meeting. Stumpfl's chapter (in Cooper and Alfille, 1998) draws attention to the implicit in terms of transference and countertransference issues saying; 'One's awareness of the patient's transference and of one's own countertransference should be seen as signposts along the road to understanding the patient's unconscious, and the importance of this should not be underestimated' (Stumpfl, 1998: 107). However the implicit phenomena emerging at assessments has not been explored further despite its' acknowledged occurrence and possible impact the ongoing therapy (Greenson, 1992; Clarkson, 2003; Maroda, 2010). Feasey (2005: 27) comments on countertransference saying; 'it never ceases to amaze me how feelings of the first encounter continue to manifest throughout the course of therapy'. These understandings that implicit experiences occur in assessments have not been followed up by clinical research (Armstrong, 2000).

Schore in the foreword to Marks-Tarlow (2012: xvi) says; 'the ruptures of the therapeutic relationship, often associated with relational trauma, are characterised by a density of negative affect and a high degree of uncertainty on both sides.' (The ruptures of the therapeutic relationship, associated with relational trauma, manifest in implicit experiences and implicit communications as discussed earlier). Although Schore was not directly discussing ruptures during assessments, his understanding of the conditions for ruptures to occur is worth noting. A

first meeting is full of uncertainty for both therapist and client. The client's need to seek psychological help suggests the likely presence of negative affect therefore the assessment presents an opportunity where the conditions for ruptures or enactments to occur would be likely.

The assessment can be viewed as a time of complex and tentative relational uncertainty (Schore, 2010) that delves into the intersubjective process at the heart of establishing the working alliance between client and therapist. It has been suggested this is where ego boundaries are unreliable and primary processing may dominate (Searles, 1973) to process object relational novelty (Schore, 2010). Finn and Tonsager (1997: 383) suggest it 'requires a high degree of clinical skill' and understanding to manage both the explicit data collection while being open and available to receive the implicit data. The client may be unable to communicate explicitly and therefore the implicit messages become crucial data for the therapists to notice and attend to.

An intersubjective process allowing both therapist and client to consider how they fit is an important aspect of the first encounter. This is a primitive process of sniffing each other out and finding out how they may fit and work together (Stern, 2004). The central task of the assessment for therapists working intersubjectively is to gauge relational possibilities and intimacy, the foundations of a working alliance and positive outcomes (Gabbard, 1990; Meltzer, 1986). The relational aspects of any dyad will be centred within the implicit domain (Schore, 2004, 2010).

Not only is the assessment a time when a vast amount of explicit information is exchanged, but it is also suggested that it is a time of heightened implicit communication (Jung, 1928). Finn (2007) argued the assessment marks the beginning of a process where the client's desire to be known, understood and accepted is being attentively addressed by the therapist. Maroda (2010) highlights the possible opportunities for first meetings when she says; 'Clients usually tell you something essentially important about themselves in the first session, just as people do in all relationships' (Maroda, 2010: 14). First meetings offer both therapist and client the possibility to be known and to know the other in a fresh and important way. Much of what we know about others is not gained solely through explicit verbal exchanges but is acquired via unmediated implicit affective information (Ginot, 2001; 2007). During assessments, for example, the therapist is not only gaining the explicit knowledge about the client from verbal exchanges, written data from measures and history taking, but more importantly is unconsciously acquiring vast amounts of *knowing* about the client, *how* the client is with others and *how* it is to be with the client (Ginot, 2007; Schore, 2010; Siegal, 2006). Therefore, it is surprising that little has been written concerning implicit processes at this stage of psychotherapy. Armstrong (2000) acknowledges

that literature on the first session of psychotherapy is minimal and argues that the implicit in the form of transference is a key element at the first session.

Explicit experience and knowledge has been given priority in psychotherapy assessments reflecting western society's more general view of the preference for explicit over implicit domains of knowing (McGilchrist, 2009). Denman (2005) argues that the polarisation of data collection is limiting and therefore a combination of the explicit and implicit is vital if assessors are to capture the essence of the client. The implicit can give meaning and context to the explicit therefore it is important to understand how therapists take note of that implicit data during assessments and how implicit data adds to, or detracts from, the explicit. Exploring therapists' reflective process at assessment enables a deeper understanding of the meaning therapists attach to particular data (both explicit and implicit) and their decision-making in the therapeutic processes. In turn it is hoped this will impact their learning and understanding of clients and improve outcomes and professional practice (Bager-Charleson, 2010).

Throughout the literature on implicit experiences in psychotherapy there has been an assumption that therapists actively engage with the emerging implicit experience as an intersubjective process. Intersubjectivity requires therapists not only to acknowledge their own part in the ongoing dynamic but also to be engaged in reflexive awareness (Bager-Charleson 2010). Reflexive awareness or reflexivity is an essential aspect of therapists' practice aimed at increasing personal self-knowledge and developing professional practice. Sandelowski and Barroso (2002) define the complexity of reflexivity well:

> *Reflexivity implies the ability to reflect inward toward oneself as an inquirer; outward to the cultural, historical, linguistic, political, and other forces that shape everything about inquiry; and, in between researcher and participant to the social interaction they share* (Sandelowski & Barroso, 2002: 222).

Reflexivity enables new, deeper levels of knowing and learning for therapists about themselves, their client and the particular dynamic that the two create together. Discovering and challenging one's own and other's assumptions are crucial steps in establishing new meanings and new perspectives. This can lead to qualitatively more complex ways of understanding and knowing (Kegan, 2000) for both clients and therapists and are important processes for decision-making. Transformational knowing and learning, essential to therapy depends on meaning-making evolving from discourse and critical reflection. Reflective practice is important at assessment where reflexivity supports critical introspection leading to growth, change and improvement in practice.

Conclusion

Naming and conceptualising the implicit experiences that emerge in psychotherapy is problematic. Therefore attention to and exploration of the differing names and labels used within and across modalities of psychotherapy and psychology is crucial when developing an understanding of the emerging unconscious within psychotherapy. Making the unconscious conscious remains the foundational process of psychotherapy even though concepts of consciousness have continually developed over the last century. Theoretical literature has consistently emphasised the importance of an intersubjective perspective, and attention to the body, implicit affect and nonverbal communication as essential aspects of change in psychotherapy. A move away from interpretation towards the implicit relational aspects of interaction in the therapy process parallels the move towards understanding consciousness as processes rather than single states. The unconscious processes relevant to emerging implicit experiences at assessments are implicit learning and memory, implicit affect and implicit communication. Although unconscious processes appear to be accepted as fundamental to the therapeutic process, there has been scant research on the implicit domain during the first meeting or the assessment process. Literature identifies some of the difficulties that arise when investigating implicit processes: firstly how to define and conceptualise non-consciousness, how to research phenomena that is out of awareness and how conscious processes and unconscious processes interact. Psychotherapy literature has tried to address the last difficulty via theory on emergence (Gendlin, 1984) while decision-making literature (Dane & Pratt, 2007) outline the distinction between implicit process and implicit outcome. This research addresses implicit experiences at assessments via exploring psychotherapist's experience of the implicit as it emerges to their conscious awareness during the assessment.

3 Methodology

This section aims to give a full account of the philosophical and methodological aspects of this study. I highlight the choices made, the tensions and difficulties that I encountered during the process of this study.

Philosophical perspective

This study reflects the values, philosophy, skills and concerns that I hold as an integrative relational psychotherapist (McLeod, 1999). An integrative relational perspective is also central to how I position myself as a Counselling Psychologist in training and within this research study. Therefore I will give a brief outline of my philosophical and theoretical framework for clinical work.

My theoretical framework is integrative and relational, anchored in a multi-dimensional developmental-relational model akin to Evans and Gilbert (2005). They suggest early experience and relationship is central to physiological, emotional, cognitive and behavioural development and future patterns of connecting. My framework encompasses a complex and ongoing process, which occurs at both explicit and implicit levels, to understand human being and develop meaning, coherence and integration of the self and experience.

An important aspect of how I see others and myself is via both explicit and implicit experience within relationships. Humans are primed for relationship to: the self, the body, the other, the world and the spiritual aspect of life (Stern, 1983; Gendlin, 1993; Rowan, 1993). I see an emphasis on the importance of the *lived body* (Merleau-Ponty, 1945) as a basis for experience and the *felt-sense* (Gendlin, 1993) as a way of bringing the experience of the lived body into psychotherapy practice. It is crucial to acknowledge the complexity of historical and socio-political context to how humans experience the world and how meaning is made. From an integrative perspective I see humans as essentially relational beings, where meaning making is a core activity and process.

The assumptions I hold in this research study concerning the nature of reality and knowledge are consistent with my theoretical and philosophical stance as an integrative psychotherapist. I hold a collaborative stance where reality, learning and meaning-making are centred in a relational context. I understand there will be multiple perspectives of reality and knowing which may sit side by side, and my aim is to be curious about others experiences and how they make meaning from those experiences. Holding a perspective of the participants as co-researchers, encourage

multiple realities to co-exist, and for new realities to develop from the particular dynamic relational context within the research process. So my aim in this study was to explore and examine the experience of other psychotherapists', their perceptions and their process of understanding implicit data emerging to their conscious awareness during assessments. This study aimed to get as close as possible to therapists experience of the emerging implicit data and the meanings that are attached to their subjective experiences (Smith, Flowers & Larkin, 2009).

This qualitative inquiry was concerned with subjective meanings; the *how* and *what* of the emerging implicit experience, therefore it was inductive and exploratory. I held the position that I was investigating and trying to capture the phenomenon of emerging implicit experience as closely as it was subjectively experienced by the therapist (participant). I accepted that I could not directly access another's 'lifeworld' (Husserl, 1936/1970) as it was wholly experienced but I hoped to get as close as possible to that subjective experience via the therapists' vivid descriptions, interpretations and meaning-making and by my interpretations and meaning making of their process (Eatough & Smith, 2008).

Willig (2001) argues that researcher may be the witness or the author, however, I see myself as a relationally centred researcher (Finlay & Evans, 2009), holding a position of both witness and author that is akin to my stance as a relational psychotherapist. The data emerges out of the intersubjective space between the researcher and the participant (co-researcher) and therefore is a unique product of the particular dynamic relationship and process of each research interview. Interpretative Phenomenological Analysis (IPA) is a research methodology whereby experience is understood via the relational context, as Smith argues (1996: 263) IPA 'considers that meanings occur (and are made sense of) in, and as a result of social interaction'.

Phenomenology

The use of a phenomenological approach for this study was compatible both with my philosophical stance and with the subject matter being investigated: exploring particular lived experiences of therapists during assessments. Phenomenology as founded by Husserl (1936/1970) brings the philosophical stance of *Being* back from abstract metaphysics to the more concrete lived experience (Moran, 2000) that is more in line with the exploration of *being* that takes place in psychotherapy and this research. Trying to get to the essence of phenomena (Husserl, 1936/1970) as it presents itself to consciousness is the crux of this research; capturing the *what* and *how* of the experience of implicit data coming to a therapist's consciousness. Husserl was concerned with the phenomena as it appears, believing that assumptions could be bracketed off to arrive at the *essence* of the experience. However, I take Heidegger's position (Heidegger, 1927/1962) that we cannot suspend our assumptions and our position in the world is

critical to how we experience it. Our observations are always informed by our position and involvement in the world and in relationship to and with others.

Phenomenological concepts of *Dasein* (Heidegger, 1927/1962) are relational in terms of the self being both situated in a time and place in the world and in relationship to others in that world. These phenomenological concepts marry both therapeutic and research activity in listening and exploring first-person accounts and accepting subjectivity in the construction of knowledge.

My clinical experience has emphasised the importance of the felt sense and the embodied experience of our being in the world. Merleau-Ponty's (1945) emphasis on the embodied nature of our being is central to the phenomenological method of enquiry. It is when embodied experiences are captured and engaged within relationship that understanding and meaning come to fruition.

Engagement in relationship allows us to understand a person's experience and perspective in their world and how we, with our own perspective, see and understand their experience. Finlay (2009: 11) emphasises Heidegger's point that 'the meaning of phenomenological description as a method lies in interpretation' (Heidegger, 1927/1962: 37) by saying that 'interpretation is not an additional procedure: it constitutes an inevitable and basic structure of our being-in-the-world.' This hermeneutic phenomenological approach is the basis of Interpretative Phenomenological Analysis (IPA), which I chose for this study.

My research question was centred on the lived experience and therefore my choice of methodology was based on the subjective experience being seen as figural, where the *qualia* of the experience was able to be captured. IPA captures the quality of experience by being 'concerned with the detailed examination of human lived experience' (Smith, Flowers & Larkin, 2009: 32). Although IPA focuses on the exploration of the participants' lived experience, it goes further than just giving rich and vivid descriptions. IPA acknowledges the interpretative roles of both participant and researcher to make meaningful understandings of experience. IPA gives voice to the participant's subjective experiences, where those experiences are meaningful and matter to the participant. This method allows the person to describe their experiences and their understandings of those experiences, followed by systematic analysis by the researcher who is reflective and reflexive concerning their own position in trying to understand the participant's experience.

I am particularly drawn to IPA as it is committed to first person accounts rather than focusing on theory first; in this way IPA has the potential to dismantle often rigid power dynamics especially in

the mental health arena. Having worked in the mental health system for many years I have become very aware how the hierarchy of the system can often seem and be disempowering for those most in need of therapeutic support, and for some of those working in the system. Prioritising the first person accounts locates research at the personal level; hearing individual voices and stories may have resonance for others. This is compatible with my therapeutic work whereby individual stories and experiences inform me and my theoretical position rather than the other way round.

From a philosophical and political stance I wanted to be involved in research that is data driven, rather than theory driven, so that understandings are centred on actual experiences of therapists rather than models of how therapists say they work or *should* work. This is akin to Argyis & Schon's (1974) conception of theory-in-use verses espoused theory. It is important to counselling psychology and psychotherapy practice that therapists voice their understanding of their experiences in practice (and in this instance in assessment) not only to develop practice, to engage in debate regarding the complexity of the therapeutic process but also as a counterbalance to the dominance of manualized therapies being championed in the present climate.

In the process of choosing a methodology to investigate my question I considered other qualitative methodologies such as Grounded Theory, Discourse analysis and Narrative analysis. Grounded Theory develops inductive theory and hypotheses, with attention to macro analysis of often large scale sample groups. My inquiry is aimed at more detailed and nuanced analysis of lived experience, prioritising a focus on idiographic accounts rather than a generalisation of a large number of accounts. Grounded Theory is aimed at generating theory; this is not my aim within this particular research question. The Grounded Theory researcher systematically and sequentially analyses the data, while the IPA researcher tries (also in a systematic way) to make sense of the participant's world while the participant tries to make sense of their own world and experience. This double hermeneutic embraces the dynamic tension between researcher and participant (interpreter and data) encouraging an ongoing process of interpretation, which it is hoped will continue with the reader and this study report, increasing thought, questions and dialogue.

I considered Discourse Analysis and Narrative Analysis initially but as the emphasis with both is more concerned with how the story of an experience is told, rather than an inquiry of the experiential aspect of the subject, I chose to use IPA. The focus of interest in this study is on the felt-sense and embodied experience firstly and then how this phenomena is expressed. Discourse and Narrative analysis both emphasise language and what the story tells the reader

rather than finding out what the essence of the experience is and the meaning attached. IPA seeks to capture the participant's individual felt experience and interpretation, the communication of which is vital but secondary to the embodied experience.

Pilot self-interview

As researcher, I aimed to be reflexive and reflective as I am in my clinical work as a relational psychotherapist. Early in this research process I was interviewed about my own experiences of the emerging implicit during assessments by a counselling psychologist and psychotherapist. This enabled me to explore more fully my own experience and to use that in comparison with other participants' experiences, therefore using myself as test participant. The pilot interview in a small way parallels the personal therapy psychotherapists undertake during training. As Denzin (1997) suggests: we must first look inward on the self. There were a number of aims of being interviewed: it allowed me to further define my research question, and it enabled me to highlight my own biases, desires and stereotypes in relation to the research question. During the interview I was able to discuss and reflect on my assumption that emerging implicit experiences were always useful. This opened up my awareness and inquiry regarding when and how emerging implicit experiences may be unhelpful or wrong. In doing this I was more mindful of these assumptions when I began the participant interviews. The pilot interview also gave me a good indication of how to structure participant interviews and how I may actively speak out what I see and notice of non-verbal communication during the interviews. In the pilot interview the interviewer had commented verbally (therefore was recorded) on how I used my hands to describe what I was saying. This vital piece of communication would have most likely have been lost without the interviewer's explicit witnessing.

Participants and sampling

This study was designed to interview a small, purposively chosen sample of therapists for whom the research question would be meaningful (Smith et al., 2009). My rationale for choice of participants was that they should be working within a theoretical framework that draws on the use of unconscious process as part of the therapeutic engagement, and as part of their clinical thinking. Casper (1997) found that theoretical orientation had little impact on the level of engagement with emerging implicit activity, and I felt it was more important to consider the nature of the experience rather than any comparison of orientations at this stage -this may be material for further research.

In trying to find a fairly homogeneous sample, I focused the criteria on psychotherapists and counselling psychologists who had their own personal therapy as part of their training and

therefore have a deep insight into their own process. Participants were psychotherapists and/or counselling psychologists who had been consistently working for 10 years or more after qualification. Interviewing therapists with at least 10 years' experience meant they were more likely to have many experiences of the emerging implicit. Also they were more likely to have developed a mature reflective practice from which to articulate their experiences. As this research was aimed at discovering the therapist's reflections and understandings of implicit experience it was vital that participant's reflective and reflexive skills had become honed over time.

I used local directories and known therapeutic services (National Health Services, universities and Employee Assistant Programme services) to approach psychotherapists and counselling psychologists to take part in this study. I advertised (Appendix 1) on a number of psychotherapy organisation websites. I also direct mailed therapists using the British Psychological Society (BPS) and United Kingdom Council for Psychotherapists (UKCP) listings, and by using the counselling-directory website (Appendix 2). This resulted in eight participants offering to be interviewed. I spoke to each participant over the telephone to verify qualifications, explain what I was doing and to arrange a suitable appointment for a face-to-face interview. Three therapists were not included in the study as they were not currently BPS or UKCP registered or else lacked relevant experience. As IPA is essentially a methodology looking at idiographic accounts (Smith, 1996) I felt that the data from five participants was sufficient and both valid and rich in detail and knowledge.

Descriptions of participants

'Rachel' has been a Psychoanalytic Psychotherapist (UKCP) for more than 10 years. She is a white British, female, working as a therapist and supervisor, both privately and in a university counselling service.

'Lorna' has been an Integrative/psychodynamic Psychotherapist (UKCP) for more than 15 years. She is a white British, female, working privately as a therapist and supervisor and is engaged in teaching.

'Ian' has been an Integrative/Relational/Transactional Analysis Psychotherapist (UKCP) for more than 15 years. He is a white British, male, working privately as a therapist and supervisor.

'Tracy' has been a Transactional Analysis Psychotherapist (UKCP) for more than 15 years. She is a white British, female, working as a therapist and supervisor privately and is engaged in teaching.

'Janis' has been an Integrative Psychotherapist (UKCP) for more than 20 years. She is a white British, female, working privately as a therapist and supervisor.

Data collection and method

The data was collected by use of semi-structured interviews lasting between 60 and 80 minutes. Face-to-face individual interviews were essential as this enabled the collection of both verbal and non-verbal data such as body language, and facial expressions, which create rich detailed data. Interviews were carried out over a four month period and were digitally recorded.

Semi-structured questions were asked using the following three main questions, with prompts and clarifying questions:

1) **Would you tell me something of your experiences of implicit data emerging to your conscious awareness when you first meet a new client?**
(Thoughts, feelings, images, bodily reactions, and other sensations)

2) **How do you use the emerging implicit data from these experiences within the therapy?**
(How did it relate to explicit information? Does it confirm or contradict it?)

3) **Do you discuss these experiences in supervision, your own therapy, with peers and /or with the client?**
(Name used to label experience? Meaning and theoretical concepts used in connection with experiences?)

4) **How do (or don't) you see these experiences impacting the assessment and the course of therapy**?
(Does the meaning and use of these experiences change over time or are they static?)

Informed consent was addressed over a number of stages; at the recruitment stage, over the telephone while explaining the project to possible participants, then each participant was emailed an information sheet (Appendix 3) so that they could read the project aims, about procedure, consent and contact details of supervisor and accrediting institution before the actual

interview. Informed consent (Appendix 4) was signed on the day of the interview. All participants were told that they could withdraw at any stage of the study.

Data analysis

Analysis of the data was undertaken based on Smith et al.'s (2009) analytic stages as follows:

Initial reflective journal after the interview

Immediately after the interview I wrote a reflective piece about my experience of the interview and my initial thoughts and impressions of my experience of the interview. This was both exciting, as the interviews were very rich with detail, but slightly overwhelming in terms of the amount of data generated, and the possible divergence into new and unexpected areas- e.g. in Interview 1 with Rachel a new concept came up regarding how previous training and careers impact therapist's perspective of what *knowing* means and how that impacts the perception of emerging implicit data. As this was an unexpected theme I noted it down and asked about this in the subsequent interviews.

Transcribing the digital recording and immersion in the data

As the digital recordings were being transcribed I listened to the interviews over and over again, noting initial impressions and thoughts in a reflective journal. Re-reading and re-listening to the recording immersed me in the data, so much so that I felt very close to the stories and experiences of the therapists.

Capturing descriptive themes

Although the transcript was then entered into an excel spreadsheet, I found making notes on a paper hardcopy more immediate and more personal to how I think and work. I made initial notes and thoughts and proceeded to analyse the descriptive themes line by line (Appendix 5).

Developing emerging themes

Emerging themes were noted in a column on a spreadsheet**.** At the end of this stage I listed all the emerging themes on a separate piece of paper (Appendix 6). I printed the list of emerging themes and cut up each theme to try to manually organise and collapse the themes. As I was doing this I listened to the recording again to make sure that my interpretation was in line with the essence of the therapist's narrative. This was a very time-consuming process of going back and forth from the recording, to the text, to my notes, to descriptive and emerging themes, and back again. This process enabled me to reduce the amount of data while maintaining and developing the complexity of interconnections and relationships from my notes, thoughts and

interpretations. Following from this process I was left with 10 themes from the first interview (Appendix 7).

I highlighted phrases or passages on the hard copy that I thought illustrated a theme and may be used as a quote later in the process (Appendix 8). Before transcribing the next interview I typed all the information onto the excel spreadsheet for the first interview. This offered another layer of reflection and continual analysis to make sure that my understandings and interpretations were grounded in the therapist's narrative. This developed a closer collaborative analysis between my interpretations and the therapists' reported experiences. I continued to add to the spreadsheet as the themes developed across the cases (Appendix 9).

Connecting the themes across the cases

With each case I followed the same pattern of the process described above. Once all the cases had been analysed I printed off the themes for each case and cut up the themes to try to create a map of where the themes connected and where themes were very separate.

Developing super-ordinate and sub-ordinate themes

Through many cycles of back-and-forth between and within each case, themes began to emerge over a number of months until five main themes stood out. I used processes of subsumption, abstraction, polarization and frequency to gradually reduce the themes to develop those themes that had a strong connection within and between each of the participants' narratives (Smith, 1996). For example 'Response to implicit experience' and 'Trying to understand the experience' were initially two separate but similar themes that were brought together via abstraction under the new theme called 'What's going on here?' The phrase "What's going on here?" had been used by a number of the participants and it had been a continual question I had been asking throughout the research. The pithy phrase encapsulated the reflexivity and complexity of questioning both from therapists, and for me as researcher.

Through this process the number of themes was reduced. Some themes were collapsed into other themes, but some were let go, even when they were of great interest. The theme 'Optimum conditions to experience implicit experience' for example, was discarded at this stage. This theme had been a rich and very interesting theme discussed by two of the therapists. I considered this theme to stray away from the core research question of the experience and understanding of emerging implicit experience to another question of how we foster the conditions for these experiences to occur. As there was so much rich and vivid data available

from the interviews, I continually went back to my research question as a means of focusing the analysis.

I continued the process until there were three main themes with sub-themes (Appendix 10). These choices were difficult to make but continuing to focus on the research question and having it written in front of me as a reminder allowed me not to become side-tracked. Labelling the themes was an important stage, as this was a continual process of further defining each theme and finding a label (often using a direct quote) to capture the particular nature of the concept, e.g. the sub-theme from Theme 1- 'Resonance' and the sub-theme 'Wait and see'.

Quotes and extracts

Using the direct quotes from the transcript helped to keep the focus on the participant's voice in the labelling of themes. From the first read through of the transcript I had highlighted quotes or parts of the transcript that I felt encapsulated a particular concept or theme. I collected all the possible relevant quotes together for each participant and for each theme, exemplified in Appendix 11.

Although these stages of analysis are described sequentially to explain clearly the process of analysis, there was a much more complex back-and-forth, and recycling of the stages to identify themes; listening again to the recording, pulling out quotes, re-thinking the concepts and themes and cross-matching within and between participants.

It was critical at this stage to have input from peers, my supervisor and online groups who were also working on research as this enhanced my reflections on the analysis and ability to think more deeply about the research process.

Assessing trustworthiness and quality

I considered criteria from Yardley (2000) and Finlay and Evans (2009) as means of assessing the quality of the research. Finlay and Evans (2009) talk of the four R's; rigour, relevance, resonance and reflexivity, while Yardley (2000) talks of four principles; sensitivity, commitment and rigour, transparency and coherence and impact and importance. I see both these sets of criteria mapping on to each other as a means of monitoring the quality of the qualitative research that I undertook.

Rigour and commitment

Rigour, Finlay and Evans (2009: 61) argue, is centred on asking critical questions; 'Has the research been competently managed and systematically worked through? Have the knowledge claims been tested, validated and argued in dialogue with others (including co-researchers, supervisors or colleagues)?' I have demonstrated a thorough and systematic process to the research undertaken here; this began with a thoughtful process regarding the precise question I was studying, a pilot interview to further define my question and to reflect on my own biases and position. The sampling was carried out with openness and attention to finding participants who met the criteria and excluding those who did not. The sampling was thoroughly and carefully thought through; focusing on the need for a homogenous group and the quality and richness of the data provided rather than the quantity of participants. Yardley (2000) talks of rigour and commitment in terms of the thoroughness of the study and the completeness of the analysis, as well as the degree of attentiveness and care towards the participants and the process. My explanation of the process of the research above indicates the lengthy process of analysis that I undertook to result in an in-depth analysis of the data. (Smith et. al, 2009)

Sensitivity and reflexivity

Reflexivity refers to the researcher's own self-awareness and openness about the research process. In similar ways to therapists' understanding of their own subjectivity and position in relation to a client, reflexivity here (Finlay and Evans, 2009) means the extent to which I as the researcher am able to own my position in relation to the participants, the data and the interpretation. By giving a clear outline of my philosophical stance and my position as an integrative psychotherapist and my understanding of that similar position as a researcher, I aim to be as transparent as possible. Part of the process of reflexivity is seen in the pilot study where I state my own experience of the emerging implicit experience with a new client. I name my experience as intuition while holding the tension of how naming the experience may alter it and create possible barriers for dialogue. Keeping track of my developing ideas throughout the research has been invaluable; journalling has allowed me to gain a deeper understanding of the subject area, to develop myself as a researcher and also to have a place for ideas, biases and prejudices to be acknowledged and worked through with time. The constant questioning of "What are my blind-spots?" and "What am I missing?" not only kept me curious about the research data but also highlighted choice points and possible avenues of inquiry that I had to put aside in this study, however interesting. Attending to my reflexivity also concerned me staying with the difficulty of not knowing, which happened to be pertinent to the experiences of the participants. For me, not knowing was concerned with not knowing how to do the research

initially, not knowing whether participants would deliver rich and interesting data on the research subject and ultimately not knowing how this piece of research would develop and be received.

Yardley's (2000) sensitivity is closely aligned to reflexivity, where the researcher is mindful to the context of the research process in terms of the socio-cultural elements, existing literature, and the actual data produced. Yardley sees this sensitivity as beginning early in the research and being an ongoing process. I remained mindful of the need to keep the actual data and the participants' voices focal to my developing study. By continually going back to listen to the recordings and re-reading my initial impressions I was able to maintain faithfulness to the data (Crotty, 1996) throughout the process of interpretation and analysis. Grounding the analysis in examples has been an essential aspect of sensitive analysis (e.g. Elliot et al., 1990).

Relevance and importance

Relevance (Finlay and Evans, 2009) and importance (Yardley, 2000) are concerned with establishing whether the research is actually adding to the body of knowledge on the subject. Does it enrich our understanding? And will it be relevant for others in the field? Developing a greater understanding of what actually happens in assessments, rather than what we assume happens or what protocol is supposed to be followed during assessments is essential to the continual developing of better outcomes for clients. This is even more important at the moment when commissioning in the public sector is so focused on recordable results. The funding and commissioning of therapeutic services is under greater pressure as demand is increasing for therapeutic services, and if we are not to limit services to manualised or heavily protocol therapeutic methods, we must look in more detail to the nuances of psychotherapy. The emerging implicit data is a nuanced aspect of the therapeutic activity and is occurring during assessments, and as such is worthy of study. The emerging implicit data is an important aspect of the psychotherapeutic activity that appears to lead to deeper levels of knowing, and possible change for the client. Acknowledging this experience during the assessment process will open up dialogue about how therapists' work and the types of data that they are taking note of to develop their formulation of the clients' issues and most appropriate treatment direction.

Resonance and impact

Resonance (Finlay and Evans, 2009) and impact (Yardley, 2000) are concerned with whether the work has an impact on the reader and whether the reader can engage with the findings emotionally. By presenting this study steeped in examples that are rich and vivid I aim to give the reader a sense of the depth of the feeling and at times extraordinary experiences that therapists encounter during their assessments with clients. By using few participants I have

been able to offer a deeper insight into the experiences and thought processes of the therapists taking part. My aim is for the reader to be impacted in a similar way to how I was impacted by the initial interviews with these therapists, and my hope is that this will have resonance with their experiences.

Ethical considerations

Ethical considerations are an essential aspect of valid research and are integral to the clinical work of psychotherapists and counselling psychologists. Furthermore it was imperative my own core values were in line with ethical considerations, and therefore it was essential that I behave in the same honest, trustworthy and respectful way towards my participants as I do with my clients and to everyone I encounter. Throughout the research process I followed the ethical framework for research from British Psychological Society research guidelines (BPS, 2010).

On contacting possible participants I gave full details of the nature of the study, how and where the results would be presented. I sent the information sheet for participants (Appendix 3) to everyone who replied to my requests for participation. I fully disclosed the purpose, nature and implications of taking part in the study. Issues of consent, confidentiality, use of data, and contact details for me and my supervisor were detailed so that participants would be fully informed before agreeing to participate.

While arranging the interview by telephone I again reminded participants they were able to withdraw at any stage if they so wished. I informed participants of how I would anonymise their data and would let them see and agree to any direct quotes I wanted to use in the write up of the research. I was particularly mindful of the ethical implications concerning confidentiality. Confidentiality was a particular ethical issue as participants were telling me about their personal subjective experiences in relationship to their clients, therefore I actively protected personally sensitive information through the use of pseudonyms for therapist and client names, places of work or other identifying features so that participants and their clients were not identified or recognised in any way (Bond, 2004).

At the interview I reminded each participant of the confidentiality and anonymity steps to protect their identity and the identity of the clients they talk about. Two participants asked me directly to delete potential identifying information regarding clients they had mentioned. We agreed at the interview what and how I would do that. When each transcript was completed I emailed it to the participant for them to check and again reminded them that any or all information could be withdrawn from the study. All participants agreed for the data to be used.

All confidential material, paper, digital documents and audio recordings were securing kept. Digital information (documents and digital recordings) were kept in files on a password protected computer, and paper documents were locked in a secure filing cabinet. Personal information and data were held separately from the main body of the anonymised transcripts.

At the write up stage the direct quotes from each participant were sent for further consent. I asked permission for use and informed participants that they may still withdraw their data at this stage. All participants agreed permission to use their data.

Although I did not anticipate an adverse psychological impact of participating in the research, I felt mindful of the sensitivity and personal nature of the information being expressed by the participants. In one interview a particularly distressing story was told which clearly impacted both the participant and me in the moment. The participant acknowledged the distress and spoke of good support (supervision, personal therapy, friends and family). We agreed to continue and later at debrief I checked how she was again. I had considered that distress may inadvertently occur and therefore debrief was an important check after the interview. I was also prepared to direct or refer participants towards their own established means of support e.g. personal therapists and supervisors, if necessary or provide names of other professionals. Debriefing gave the participants the opportunity to say how the interview process had impacted them and their thinking on their clinical work. Four participants commented on the experience of the interview being similar to supervision and finding it a useful reflective process.

Debriefing also allowed the participants to ask me about my research question and discuss briefly the motivation for this particular question. In doing so, the asymmetrical power dynamic (researcher having more power during the research process) was shifted a little by my transparency and willingness to share my thoughts about the research question. This created a more collaborative feel to the research process.

4 Findings

Examples of participants' stories

All five participants gave numerous examples of their experiences of emerging implicit data occurring in assessments. As a brief introduction to the findings and to contextualise them, I give an example of an emerging implicit experience from each of the five therapists.

Rachel

A male client concerned about his academic studies came to an assessment with Rachel. Before speaking to each other, Rachel had a "concrete and intrusive thought" that her client's parents had divorced and this was the primary reason for coming to therapy. Rachel described her feelings as "almost a schizophrenic experience; it was almost like hearing a voice in my head. It was so weird." Without directly asking the client Rachel's intrusive thought was confirmed by the client and the impact of his parent's divorce was the main reason for coming to therapy and not his academic concerns as initially stated.

Lorna

When Lorna answered the door to her new male client she found him waiting outside with one knee up against the tree posing. Before even saying 'Hello' Lorna said "my gut reaction to him was vain, narcissist, James Dean, fancies himself a bit." Lorna talked of how initially she was seduced into giving a reduced fee for this client even though he was clearly wealthy. Lorna was struck by the posing and the narcissistic nature of the first image of her client and how this had been an alert to the possible boundary issues that later followed.

Ian

An email enquiry from a potential female client appeared "disjointed and strange". Ian said it "set his antennae off." When the client arrived for the first session Ian "felt an urge to want to get them into the room and shut the door" and to "structure things quite strongly". It transpired this lady had been traumatised, raped as a teenager and displayed strong borderline features.

Tracy

A telephone call with a new male client caused Tracy to have "an overwhelming sense of needing to be careful with this man" and that there was a sexually driven aspect to the danger. She described a bodily experience in her solar plexus attached to disturbance in her breathing with the knowledge or warning of danger.

Janis

On meeting her new "ordinary-looking" male client in the waiting room, she directed him into the therapy room where upon she felt "totally alarmed" and felt "frightened for the client" (not for herself). Janis said "something happened before he started speaking" to alert her to danger. Janis instantly felt this was a dramatic and very powerful situation. She acted upon her feelings immediately by contacting the GP. Unfortunately this client committed suicide a week later even though psychiatric help was put in place.

The findings are organised into three themes, each with sub-themes. The table below displays these main and sub themes.

Overview of Themes

Table 1. Main and Sub- themes

Main Themes	Sub-themes
1. A powerful and dramatic experience (that stands out)	1.1 Dramatic and powerful 1.2 An Alert 1.3 Physical 1.4 Speed 1.5 Imagery 1.6 Resonance 1.7 Anomaly
2. What's going on here?	2.1 Where did that come from? 2.2 What am I bringing to the experience? 2.3 Noticing things I don't really understand yet 2.4 Wait and See 2.5 Accepting the unknown/unknowable
3. The difficulty in naming the experience	3.1 Playing with words to name a precise experience 3.2 The wholeness of the experience is beyond verbal language 3.3 Gestures aid understanding

Theme 1 - A powerful and dramatic experience (that stands out)

The theme *A powerful and dramatic experience*, presents a vivid account of an implicit experience at the moment it emerges into the therapist's conscious awareness. All the participants reported the presence of powerful emerging implicit data at assessments. They uniformly suggested it was the power and dramatic element that alerted their attention to the extent it was impossible to avoid noticing and remembering the experience. There was so much data for this theme that it was essential to show seven sub-themes, they are: *'dramatic and powerful', 'an alert', 'physical', 'speed', 'imagery', 'resonance',* and *'an anomaly'*.

Dramatic and powerful

All the therapists described their emerging implicit experiences in powerful and dramatic terms. The use of language and the way they described their emerging experiences emphasised the power of the impact. The language used to describe the emerging implicit material was vivid, strong and dramatic such as; "weird", "startling", "charged", "shocked", "a very powerful exchange", "on the edge" and "a schizophrenic experience". The delivery of therapists' descriptions was equally animated and dramatic, energy levels increased, presentations were particularly excited with voices raised and expressiveness acute; exemplified by exclamations such as: "WHAT!" "BANG!" "WOW!" There was almost comic action-book intensity in the narration of the therapists' stories of the emerging element of the implicit experiences. These dramatic and powerful experiences were fully charged with emotional content that brought to life the therapists' remembered experiences of meeting new clients in assessments.

The therapists all acknowledged the powerful, almost violent impact of the implicit experience coming into conscious awareness.

> *Something happened to me, and it is dramatic and it was very powerful.* (Janis)

It was the strength and force of the felt sense that stood out for many of the therapists, such as:

> *It was so weird because it was so concrete.* (Rachel)

> *It felt like one of those startling thoughts. It was like "WHAT!"* (Rachel)

Lorna acknowledged the shock she experienced at the strength of the impact of the implicit feeling emerging:

> *I think I was shocked.*

There were very strong reactions to the implicit data emerging during the assessment that were difficult to miss or ignore. Ian described the feeling as "BANG!" While Janis identified the physically violent aspect impacting her as:

> *That definitely hit me.*

The participants accentuated their experiences by the use of dramatic expression and punctuation, Ian said "Bang!" with such force and loudness that I, as the interviewer, felt the shock and impact of his experience. Rachel commented "it felt like one of these startling thoughts, it was like; WHAT!" Again the exclamation of shock and almost disbelief was forceful in the therapists' narration. Janis goes further when she explains her sense of shock and accompanying wonder at the experience of a client in the assessment:

> (It was a) *Wow! What have I got here? Sort of feeling.*

A number of the participants highlighted the sense that the implicit feeling came to their awareness in such a way to feel out of their control, or as if something was being done to them without their consent. Rachel talked about the feeling being "intrusive" as if a thought had been put inside her head against her will:

> *It came again like an intrusive thought that somebody had just put into my head.*

This sounded as though the implicit experience felt like an invasion by another, unlike a co-created occurrence but a dominant projection from the other. Furthermore, Rachel recognised the disturbing aspect of her experience as akin to serious mental ill health, as though her experience is beyond her rational control and had become overtaken by something that did not make logical sense:

> *It was almost a schizophrenic experience; it was almost like hearing a voice in my head. It was so weird.*

Lorna talked about her experience as another having control over her, rather than her having rational, or logical thought to direct her own experience. She said "it was like something got pulled up" not of her doing but by some other means. Although Lorna did not indicate this had felt like a threat, Ian did experience a "threatening" feeling that had him "right on the edge". The

power, shock and possible fear of the emerging implicit experience hints at a feeling of threat or danger the therapists were able to register and begin to access in the moment.

The affective content of these powerful experiences not only impacted the therapists greatly at the time, but also remained powerful in their memory and in their recounting of the experiences in the research interview. As the therapists told their stories, the strong affect associated with the emerging implicit experience had the ability to fully engage me, the researcher with the therapists' felt sense of incidents being described.

An alert

The power and dramatic feel of the experience not only forced the therapists to notice the emerging data but also register it as an alert to pay attention to. The emerging experience of alert was unusual and dramatic, so could not be missed or overlooked by the therapist during an assessment session. This alert differentiates between the data or people who either stand out for some reason and the data or people who do not stand out from the usual experience during assessments.

> *Some people stand out; the rest don't so much*. (Ian)

Lorna recognised that she "picked something up" and had thoughts of surprise and curiosity; saying to herself "What just happened?" as though alerted to something to pay special attention to. Many of the therapists reported an alarm signal going off within them. Lorna felt "alarm bells started to go off" and Ian hints at a more primitive, perhaps mammalian alarm system when he comments that the emerging experience "sets my antennae off". Similarly Tracy and Janis had alarm signals that seem to be activated in the older part of the brain system relating to instincts of survival in the face of danger.

> *And so I think, even as a little one, that instinct had been honed. It was like, 'Beep! Beep! Danger here!* (Tracy)

> *I did have, instinctively, a concern – my concern was for his safety*. (Janis)

There often seemed an overwhelming aspect to the emerging data that consumed the therapist for a moment, as if this was an essential piece of information or communication that was vital for the therapist to know. Janis described the alert as being alarmed by her new client, as if the emerging experience of being with the client was centred on urgently drawing her attention to a possible danger:

He totally alarmed me.

All of these descriptors suggest the therapists were attuned to noticing and reacting to signs of danger of some sort. Ian had been able to detect very quickly that his emerging experience was a warning for threat and danger.

I had already picked up that there was something quite threatening. (Ian)

Other therapists were able to recognise the danger in the emerging data and were able to distinguish very quickly to whom the danger was directed. Tracy talked of experiencing a "warning" and a direction of action for her to take: to be careful with a new client at assessment:

And I also had this overwhelming sense of; "Tracy, you need to be really careful with this man."

The therapists talked of a precision in knowing the nature or direction of the alert presented; knowing to who the alert was directed, e.g. a danger for the client, for the therapist or others. The precision was also in terms of the direction taken by the therapist, either by an action, a process of thinking and planning for the client or themselves to reduce the suspected danger. As Tracy "opened the door and looked at him" she was able to register the specific danger (a sexual danger) with this new client. Tracy also had a knowing that the danger was directed at her primarily as she says: "it was dangerous for me" and not immediately a danger for the client in this instance.

Janis also gave an example where she was alerted to danger in the first moments of an assessment session and her fear was precise in terms of who was in danger:

I wasn't frightened of him – I was frightened for him.

Within moments of meeting a new client the therapists had experienced alerts of warning, either of danger for themselves or for the client. Tracy went further, she immediately felt a knowing that there was danger for her with a new male client and felt sure that danger would be of a sexual nature and of therapeutic boundary invasion. She said:

As I opened the door and looked at him, I knew that whatever he was bringing, it was sexual, and it was dangerous … for me.

Physical

The physical aspect of all the therapists' experiences was very clear. It seemed the emerging implicit data was most easily and commonly experienced as a physical, bodily experience; described as a "feeling", "a physical sensation", a "sense", "a somatic response" or "a gut reaction". All therapists interviewed talked of initially "feeling" rather than thinking of the implicit data emerging when meeting with a new client at assessment.

I would definitely say it was more in my body than in my thinking process. (Lorna)

But I won't consciously think 'Did that happen?' It is all part of the picture of getting a feel for this person and yeah I think of it as that, a feel for this person. (Rachel)

The therapists recognised the implicit data emerging as a feeling not a thought that was attached to a bodily experience. The emerging implicit knowing had a more holistic presentation, which often began with the body followed by emotions and cognitive thoughts as it emerged into fuller conscious awareness.

*it's a sense that I get inside of me… which is not being told to me, it's what I feel…(*Janis)

Janis identified the type of implicit data emerging as "concern" but she did not think about being concerned, she "felt" concern for the client. Feeling seemed a more readily available means of experiencing the implicit as it first entered awareness for the therapists.

I certainly got a feeling of concern for him. (Janis)

The feeling was linked to an emotional sense for Rachel; when I asked her if her "feel for this person" was a bodily sense or a thinking sense, she said:

Really interesting question! No, it's an emotional sense that I translate into a thought. So I will feel comfortable or uncomfortable or a little bit threatened, or in charge or something like that. I will have that sense, an emotional sense.

Although Rachel includes the emotional sense she is also talking about her physical experience, of being or feeling uncomfortable via somatic experiences. A little later in the interview she said:

> *I have a very uncomfortable feeling.*

The bodily physical aspect of the experience was referred to by all therapists describing their emerging implicit experiences. Levels of awareness of one's own physical state in the moment differed between the therapists; some were more obviously connected to knowing how their bodies felt in the moment while others were less in tune with their somatic states. Janis described it as feeling very strange but not quite able to expand on the feeling as if it was not precise or strong enough to put her finger on. She said:

> *I felt very strange. I felt really quite strange.*

We will see more of this later, in Theme 2, when Rachel talks of not recognising her physical experience as much as she would wish. However Ian had a more clear sense of his physical reaction as the implicit emerged to his awareness:

> *It's a kind of tightening… what else is there?*

> *Internally, that's what it feels like. It's like "Oh!" I sort of stiffen up, as if a bit of me's got ready for something here.*

There was often a strong physical feeling that could not be ignored, so even if therapists were less in tune with their bodily responses, the emerging experience seemed too powerful or strong to be avoided.

> *But that had come up as a blind feeling in me and I trusted and took a risk to say because partly I could barely keep it down because it was such a, it was so powerful a feeling coming up.* (Lorna)

As the therapists talked of their physical experience they all demonstrated with actions, pointing to where the physical response was felt, showing the intensity. (I consider this in more detail later in Theme 3.) Janis was particularly expressive when talking about her physical response to the emerging implicit:

> *It was a* [Janis gasped] *a feeling right up here* [she pointed and touched the centre of her chest] *of concern.*

All the therapists demonstrated the same action of touching their stomach and in Tracy's case making circle movements when talking about their physical reaction as "a gut reaction".

The "gut" was universally named as an important physical part of the body impacted by the emerging implicit.

> *That's my gut feeling.* (Rachel)

> *It was more of a gut or intuitive sense.* (Lorna)

> *I suppose what I mean by intuitive is well it's partly gut reaction.* (Ian)

> *It would be a gut response. Yes, again, it's in that gut!* (Tracy)

The somatic aspect of the emerging implicit experience was evident for all therapists, suggesting that somatic activity is important in grasping the nature of the implicit experience as it emerges into awareness. It seems the body or somatic activity was the point from which the therapists were first able access and explore the implicit experience as it emerged to a conscious level.

Speed

It was noticeable that all participants talked about the speed at which the implicit data emerged to their awareness, both in terms of the immediacy from meeting the new client and in terms of it being a fast process. The therapists recognised that the process of the implicit data coming into their conscious awareness was rapid, and the speed of sudden awareness was often shocking and surprising.

> *It feels like an intrusive thought and I think it comes suddenly.* (Rachel)

> *It registers quite quickly.* (Rachel)

> *I do get an instant feeling about people.* (Janis)

The therapists talked of experiencing implicit data emerging very rapidly on first meeting the new client. This very quick knowing that occurred in seconds of meeting a new client was called an intuitive process for Lorna and Ian.

So quite quickly I was putting some of those things together… but again it was more of a gut or intuitive sense. (Lorna)

The second I opened the door, yeah. I didn't know that it was threatening, but my body knew that it was threatening intuitively…physically intuitively I was there before thinking had caught up with it. (Ian)

I just knew immediately that this had nothing to do with his patients; that it was to do with him. (Tracy)

Ian recognised the emerging implicit process happened before he could think about the client or the situation he was encountering. He like others felt that the emerging implicit data came to his awareness within seconds rather than minutes of meeting the new client at assessment. Tracy and Janis both recognised their emerging implicit experience occurred before the client said anything, even before anyone said "Hello".

It was immediate. It was as soon as I picked up the phone. (Tracy)

I think something had happened before he started speaking. (Janis)

Tracy explained the experience as a transmission from client to therapist (or vice versa) that happens at an unconscious level and that takes a fraction of a second.

It's a sort of a transmission, almost. It's nanoseconds… (Tracy)

All the therapists acknowledged speed being an unmistakable aspect of the emerging implicit data emerging at assessment.

Imagery
Common to all therapists were imagery and a visual component to the emerging implicit experience occurring at assessment. The visual aspect of the therapists' emerging implicit experience of a new client had a number of features; a vivid and evocative image, the significance and power of the first "glimpse" of a new client, the difference between seeing the client in person and creating an image of the client before meeting in person and individual propensity to use images over other senses as a means of accessing implicit data into conscious awareness. Images, visual language and images as metaphors were used as a means of understanding and expressing the emerging experiences and their complex meaning.

The images and visions that occurred on meeting new clients were vivid, dramatic and evocative. There was a qualitative difference between the images that stood out to the therapists and those that did not. The images that stood out (either in response to seeing the new client in person or creating an image due to contact via email, letter or telephone call) were not only dramatic and powerful in the moment but held their intensity over the assessment session, throughout the therapy and in some cases for many years. This was illustrated by Janis whose response to seeing her new adult female client in the waiting room was via a dramatic and evocative image.

> *Janis: I think, you know, behind all the ability to project herself …I could… I always saw this absolutely destroyed child.*
> *Carole: Is that what you saw when you went into the waiting room? You saw that?*
> *Janis: Oh yes, a very frightened, very despondent child.*

The initial image of the client remained with Janis and was still evidently powerful as she spoke in the research interview many years later. The power and significance of the first "glimpse" of a new client was often remarked upon by the therapists. Janis talked of the importance of the first moment of seeing the new client and the strong impact it had on her. There was recognition or knowing that happened within the first moments of seeing a new client that seemed powerful and difficult to explain in the moment and yet held significance for the therapists' understanding of their new client.

> *I saw her, I glimpsed her as I was going into the thing* [the waiting room], *and I didn't know if it was my client, because we were about six or seven therapists. But I just had this absolute certainty that this was my client.* (Janis)

Janis comments that her visual sense was not predominant over her other senses, but "the look" was important to how she worked, how she gained an understanding of the client in the moment of meeting and how she continued to think about the client later in supervision:

> *I like to… I do get an instant feeling about people. About the way that they look...And I like presenting* [in supervision] *in that way that you describe what the person looked like.*

Tracy also indicated how the first glimpse of new clients had a profound impact of knowing something that was important for the client, the therapist and the therapeutic work ahead. This first glimpse of the new client somehow offered the therapist a golden moment of seeing and

understanding the relational dynamic clearly and precisely without being encumbered by the clients narrative, the therapists' biases, both parties' defences and any other distraction. She said:

> *As I opened the door and looked at him, I knew that whatever he was bringing, it was sexual, and it was dangerous… for me. Um, he was a charming man. I wasn't, you know, I wasn't scared that he was going to be hitting me or persecute me in any way. Somehow I knew that what he was bringing could be dangerous for me.*

There seemed to be differences in individuals' propensity to use images over other senses in accessing emerging implicit data, although all therapists remarked on the importance of the visual aspect of their experience of emerging implicit data. Lorna remarked on imagery and visual sense being dominant in her work as a therapist and consequently a dominant sense in implicit data emerging to her awareness.

> *I would say it's dominantly visual, I would say pictures and vignettes are passing through my inner screen all the time.* (Lorna)

Imagery and metaphors were prominent in Lorna's narrative as well as her experiences of the emergence of implicit data to her awareness. Lorna was explicit about the importance of imagery in her work and particularly in how the implicit data comes into her conscious awareness at assessments. She said:

> *It was an image. I would say it was an image. I do work with a lot, I… when I say I use imagery I speak in quite a metaphorical way and pictures are coming to me all the time.*

Imagery was an important mode by which the therapists experienced the implicit data coming to their attention. Although Ian expresses himself as "I'm quite auditory" (Ian), he also found himself creating pictures in his head as a response to the new client:

> *It's partly, erm, it's a kind of blend, actually, of a sort of visual/auditory picture of what I might be seeing and hearing from someone.*

While being interviewed it was clear that the images that had previously occurred in assessments remained vivid over time, not just through the assessment session but throughout the therapy and sometimes for many years afterwards. Janis exemplifies the persistence of the

vivid images when she reported still seeing in their mind's eye again the images that had been so arresting at the time of the assessments many years previous:

I can see him.

A number of times throughout the interview Janis spoke in the present tense when giving examples of emerging implicit data that happened many years ago as if she was experiencing the past event happening in that moment of being interviewed:

I can see her shoes!

Imagery as a metaphor seems to encapsulate a more complex understanding about a client and the issues they bring to therapy than words can capture, especially in moments of relational intensity and possible uncertainty, such as an assessment session. Imagery as a metaphor was prevalent within all therapists' accounts of the implicit data becoming available to conscious awareness.

The image that I had in my mind...was like imagining a set of scales, and I'm hearing the version of what's in one end of the scale…It's like there's part of the story that is missing, and it's out of balance somehow. (Ian)

An aspect of the visual data can stand out and represent an issue that the client may be unaware of or unable to articulate easily to the therapist in the moment of meeting, but may be crucial to the relational dynamic that is about to begin between the two in therapy. Here Janis gives an example where on first meeting a new client the vision of her hair became a significant metaphor for the client's dilemma: to be seen or to hide:

I don't know why the hair was so significant, but it was. Well, it certainly concealed her, because she was curled over and it did hide her from any… from the other people around…. She was six foot tall! She was a small person, but immediately there was a presenting person for me.

The use of vision and imagery as a figure of speech was also notable throughout all the therapists' narratives of their experiences. Tracy talked of "seeing the impact" and all participants talked of "wait and see". Visual language was also used in describing an absence

of some kind or a lack of vision when thinking about the emerging implicit data. Lorna talked about a "blind feeling in me" and "blind spots" in her awareness:

Is it my stuff or have I got a bit of blind spot?

Resonance

There was a sense for all the participants that the experience of emerging implicit data differed from usual feelings and experiences at assessment. The power and dramatic aspect of the experience gave a qualitatively different feel, a more profound feeling the therapists recognised as "resonance". Lorna consistently used the word "resonance" to describe these particular experiences at assessment, while others used words such as "attunement" (Ian), "connection", "at oneness" (Rachel), "a very profound feeling" (Rachel) and "a moment of meeting" (Lorna).

Resonance with a client's emotional state or material was described by all the participants as a sought after aspect of therapy and a valuable aspect of the implicit experience coming to their awareness at assessment. Rachel identified that she actively pursued a sense of resonance with her clients at assessment:

In assessment I am looking for that feeling that is fundamentally different.

All therapists recognised the co-created aspect of resonance and how their internal dialogue about the new client's issue was crucial to creating the optimum conditions for resonance to occur. Rachel was able to articulate well what other therapists talked of. She described how she actively tried to create the right conditions to enable her to be more receptive to the implicit emotions and the clients' hidden story. These conditions seem to focus on creating a state of reverie or deeper attention that responds to the client's implicit state rather than just the narrative or the obvious surface presentation. She said:

So I have a question in my mind that helps me get into the state that I'm in with that client where I can pick up all those feelings and where I might have those sudden thoughts. Yeah. What I'm trying to do is to get me into a reverie state. I'm trying to get me into that state that isn't about listening because there are no words going on.

Although Rachel actively tried to facilitate the conditions to better enable resonance to occur, it was also recognised that often an experience of resonance comes out of the blue and without

the ability to predict or guarantee it occurring. Lorna highlights the unpredictable nature of experiencing resonance, or as she names it, "a moment":

> *I felt a connection there and I obviously hit the nail. I didn't know I was going to hit the nail on the head but he responded and therefore there was a moment.*

Reflecting upon the nature of the co-created relationship and the therapists' own part in that relationship seemed vital to having a deeper acceptance and understanding of the implicit experience coming to the therapist's awareness at assessment. Lorna illustrated this when she recognised the client's material may initiate a response in her that could be seen theoretically as countertransference, but there may also be some other form of communication that is connected with a shared knowing. A shared knowing that has meaning for both client and therapist separately and also together; this appears to be the deeper connection or communication that is identified as resonance. Lorna said:

> *I have to think about it not just as the countertransference but also what the voice might evoke in me. It may have resonance.*

Resonance was seen as a deep connection to the client, to a knowing or shared knowing of the client. It characterised a connection beyond the normal sense of being with a client but something more, being complex, significant and meaningful in and of itself.

> *I love that feeling where you feel like you kind of know something, this could be bodily... you just kind of understand. Just understand something that is so complex.* (Rachel)

Similarly Tracy was aware of a deep communication between the client and herself that was different from the usual and that alerted Tracy to her client's disturbed emotional state. This communication was dramatic and powerful and stayed with Tracy when the client left the session. Tracy told the story in the research interview as if she experienced the disturbance again, she used the present tense and seemed at times to be lost in the memory of her resonance with her client:

> *I know she's deeply disturbed… Erm… And I'm disturbed when she goes, I'm disturbed. And when I'm with her I'm disturbed. Before she comes, I'm disturbed. So there's a sort of a… yeah, disturbing thing that goes on.*

For the therapist to have a profound understanding of a clients' inner experience and to resonant with that state, even when deeply disturbing as it was for Tracy, offers the potential for more profound understanding of the client's experience and hopefully transformation for the client.

The therapists commented on experiencing resonance as beyond ordinary verbal interactions and communications, as Rachel comments:

> *When I am having those feelings I am actually putting words to it but what is more important is the actual sensation... that at oneness feel.*

Ian identified this experience as a connection to a physical sense or communication rather than a verbal communication:

> *Attuned to some kind of physical sense that the person's holding.*

Resonance often presents out of the blue and non-logically as Lorna illustrates:

> *Where that came from I don't know but that had resonance.*

The opposite of resonance was also noticed as a significant experience in the assessment especially by Ian who became alerted to a sense of the client being disjointed or strange in connection with him. The resonance or at oneness the therapists talked of may be seen as an equivalent with holistic associations, those associations that are deep, unconscious recognitions of patterns and structures held in long term memory (Dane & Pratt 2007). Resonance or holistic associations are not only experienced but are a sought after state to enhance the therapeutic relationship and process.

An anomaly

Anomaly to the usual experience at assessments was mentioned by all therapists as a powerful and dramatic aspect of emerging implicit data. The anomaly was in connection to a number of aspects of the therapists' experiencing a new client: the client's presentation seeming odd, difference from the therapist's expectations of the new client, a divergence from the usual pattern of meeting a new client, the therapist "stepping out" of their usual frame and an absence of the ordinary. A common theme for the therapists was the client's presentation being experienced as "odd" or not feeling right; it was the strangeness of the contradictory

presentation from the client that stood out. Ian describes the input of data from the client (what he was seeing and hearing) causing a "slightly odd feeling" that did not seem usual.

It's partly, it's a kind of blend, actually, of a sort of visual/auditory picture of what I might be seeing and hearing from someone. Rapidly followed by a kind of thought that "Oh, this seems a bit odd". (Ian)

The oddness may be an inappropriateness of behaviour for the therapy environment or in relation to the explicit presenting issue as Janis explains about a new client whose behaviour was incongruent to the content of what he was saying:

I think it was almost …the calmness and the un-troubled way that he was telling me these madness things.

Both Ian and Lorna commented on the client's presentation feeling at odds with the client narrative, and it was the feelings of anomaly within the client's presentation that stood out and initiated an alert.

I was listening but something was not sitting quite right and then when he was speaking about his affluence, alarm bells started to go off. (Lorna)

Sometimes I may be quite clear in my own mind that I've picked something up that doesn't quite stack up with what the person is actually verbally presenting. (Ian)

Incongruity of the presenting new client was not just in the difference between what the client said and did but also in the therapists' contradictory impressions or experiences of a new client that may occur at the same time causing an unsettled feeling for the therapist. Janis explained that a new client:

…had an ability to put herself over in quite a different way from what I saw sitting alone in that little corner.

This anomaly or contradictory data creates not only an unsettled feeling for the therapist at the time but in the re-telling Janis's story sounds slightly disjointed, contradictory and odd. The anomaly perhaps hints at a deeper disconnection in the client (and perhaps also in the therapist). The therapists acknowledged the anomaly was often the difference between their own expectations of the client (created from the initial contact, referral, the clients' voice on the

telephone or the email to arrange an assessment) and the experience of meeting the client face to face.

> *I was surprised because my expectation was that he was going to be a gentle man, and actually what I was hearing was a highly seductive man.* (Tracy)

> *She had an American accent and I just had a picture of her through her voice, what I imagined she would look like for example and she was the antithesis of my picture of her.* (Lorna)

Although this may be understood as purely therapist biases, the anomalies between therapist expectations and in person experiences of the new client were also considered as being possibly very significant to the ongoing therapy. All therapists were attuned and open to acknowledging their own prejudices and blind spots.

> *I guess that I am very aware that I have prejudices too or biases or leanings and judgements* (Lorna)

Therapists noticed the anomaly or divergence from the usual pattern when meeting a new client. Rachel went further and actively looked for an anomaly:

> *In assessment I am looking for that feeling that is fundamentally different.*

Although the therapists recognised the feeling of an anomaly, often being dramatic or powerful, it was also difficult to be precise about the nature of the incongruence. Understanding the nature of the anomaly took time for the therapists and possibly conscious attention to identify.

> *I didn't know what was happening. What I did know was that something was up. There's something here that's not in the norm.* (Tracy)

Ian did recognise the difference or the anomaly with one new client as being in *how* the client behaved:

> *They were a bit different, in terms of how they held themselves physically, how they entered the room, how they started conversation.*

The anomaly was experienced at times as "stepping out of the usual frame" of the therapist's behaviour during assessments.

I was stepping outside my more normal frame. (Lorna)

While others described this in terms such as being "pulled into something" (Tracy), Ian described his *urge* to act differently from his normal practice with a particular client:

I, with this particular person I felt … I felt an urge to want to get them into the room and the door shut before they carried on talking too much. It was like, when I opened the door, straight into a social dialogue. "OK, come on in!" Let's shut the door, sit down. So my urge was to want to structure things quite strongly and I think that's probably quite relevant in relation to the work.

The noticed anomaly was connected with an absence of the ordinary; the ordinary was either missing or not balanced in some way as Ian explains:

The feeling or the experience I most often have is like there's something missing. Yeah, just like there's something missing, there's something out of balance. (Ian)

But ordinariness in the face of extraordinary circumstances also stood out as an anomaly that was perceived by therapists as possibly significant implicit data beginning to emerge often in dramatic and powerful ways.

It was the ordinariness of this person …that definitely hit me. (Janis)

Theme 2 - What's going on here?

The theme *What's going on here?* highlights the therapists' process once the implicit experience has come into their conscious awareness. All participants questioned their experience, having an internal dialogue about what they experienced and how they could think about it. This theme is crucial in understanding the complexity of therapists' considerations and challenges concerning the emerging implicit data, not only in the moment but also as an ongoing reflective process. The sub-themes for this main theme are; *Where did that come from?* Surprise and questioning of material that suddenly emerges into awareness. *What am I bringing to the experience?* All participants held an intersubjective stance considering the possible impact and relevance of their own material on their experience of the client and vice versa. *Noticing things that I don't really understand yet* highlighted the inner conflict the

therapists recognised as the implicit data emerged. *Wait and see* was a uniform response to the data that was not understood but which may be of significance (or not), and lastly *Accepting the unknown/unknowable* - all therapists accepted it is not possible to know with absolute certainty and that allowing the unknown is essential to good practice, especially at assessment.

Where did that come from?

The therapists questioned their own experience as implicit data emerged to their conscious awareness, asking where the experiential data originated from, and what the purpose of the data is to them in that particular therapy assessment.

There was shock to find themselves experiencing the particular implicit data, as if it came from somewhere unknown, without invitation or expectation. This sense of surprise was highlighted in Theme 1- *Dramatic and powerful*. It was not only *what* the therapists asked or said to themselves but also *how* they expressed these thoughts; they were dramatic and powerful exclamations of surprise, wonder and curiosity about the emerging experience. Lorna exclaimed: "Where the hell did that come from?" and similar Janis said "Wow! What have I got here?"

Slowing down what appeared to be a very fast process (as highlighted in Theme 1- 'Speed'), the initial response was to register and acknowledge the often unsettling implicit data as it emerged. So rather than a dismissal, these experienced, senior therapists talked of noticing what was happening and allowing themselves to register the impact of the implicit material as they become aware of it.

The ability to recognise, or as Tracy terms it, to "clock" the emerging implicit data enabled therapists access to deeper levels of data relating to the specific client therapist interconnection. However noticing the experience was not taken for granted and many therapists commented how this was not as easy as it seemed. Recognising the importance of somatic sensation was crucial to awareness of the emerging implicit data, however the therapists commented on not noticing their bodily reaction as readily as they may wish.

> *I don't think I'm good at being terribly aware of the body sense but I think if I look back on it will... there will be a very initial body sense.* (Rachel)

> *I am not always aware of my bodily transference and countertransference as other people might be.* (Lorna)

The implicit experience often had the effect of unsettling therapists in some way, and there appeared to be a need for therapists to understand what happened and where the experience emanated from in order to regain some equilibrium. Ian exemplified this when he felt unsettled and did not know what was happening in the dyad when first meeting a new client:

> *Argh! What's going on here?*

It was as if Ian was out of control or "pulled" into an unknown situation. The uncomfortable feeling prompted the question to himself: "What's getting set up here?" He was curious and questioned the unconscious dynamic interaction between himself and the client (from his Transactional Analysis theoretical background). This exemplified a common response of being unsettled or unknowing due to the unexpected emerging implicit data. Being taken off guard by the experience seemed to create a need to re-adjust for therapists.

> *I did have to adjust and I did smile to myself and thought, Where the hell did that come from?* (Lorna)

All therapists showed intense interest in their own experiences and processes occurring on the boundary of conscious awareness. This boundary offered therapists an opportunity to access possibly crucial information about themselves, the client and the relational dynamic. Noticing and being curious about the emerging implicit experiences was important for all the therapists, exemplified by Lorna:

> *That's interesting what's coming up.*

Lorna's curiosity was matched by other therapists' interest in the sudden unusual experiences occurring at assessments.

> *I thought "Ooh" – there was just that slightly odd feeling that I guess sets my antennae off, thinking "Ooh! OK! – let's see what this person's like.(Ian)*

The register and interest in the emerging data was quickly followed either by the question "Where did that come from?" or "What is that about?" "Where did that come from?" was a question that some therapists found more problematic than others. Rachel recognised her surprise but was baffled by the origin of the implicit data, while Lorna, Tracy and Ian although asking the question "Where the hell did that come from?" (Lorna) also had a sense that the

implicit data was coming from the client as transference and understood their own experience as countertransference as part of a complex unconscious process between client and therapist.

> *Well I understand my reaction in terms of countertransference with the client. You know, I think that that's set up right … I mean, almost before we begin – before we begin. We're starting to communicate things non-verbally.* (Ian)

All the therapists questioned the meaning of the emerging implicit experience; curious about the purpose, meaning and relevance to the therapeutic process and treatment.

> *Well what's that about?* (Rachel)

> *I often will sit and reflect on it – what might that mean? What do I feel pulled to do here?* (Ian)

It was evident the therapists' curiosity did not waver over time, during the interview (years after many of the events), the therapists were still actively curious to gain further and deeper understanding of their emerging implicit experiences. The therapists still openly wondered about these past experiences. Ian felt the research interview was an interesting process in itself to help him focus more deeply on what happened when he became aware of emerging implicit material during assessments:

> *Do you know, actually this is quite an interesting process, because I think I do this quite automatically, but I'm not quite aware of all the stages of it.*

All therapists commented on the difference between how they reacted to implicit material now compared to when they were newly qualified. The therapists all recognised that over time they had become more willing to accept, be impacted and be curious about their own experience in the therapeutic dyad compared to their more limited response when novices; of more readily ignoring, dismissing or avoiding the emerging implicit material. Tracy exemplified this, referring to an early experience of the emerging implicit with an erotic content, she explains her reactions as a novice and now with more experience:

> *Yeah, I would have pushed that aside then…. Now, I wouldn't. A lot more training and a lot more awareness of eroticism, and how it plays out in the therapy room. I think back then, I wouldn't have been… I wasn't mature enough… I didn't know enough to accept that I could be sexually aroused in the dyad. And I would have argued against that*

vehemently, then. And now, I'm really aware that that eroticism plays out… in many of my relationships, probably in all of them at some level, but… I'm much more aware of it now, I'm much more aware to accept my part in that.

What am I bringing to the experience?

This sub-theme highlights the deeply held belief and practice of intersubjectivity in therapy and how the therapists' thinking process reflects their understanding of the impact of their own material on the therapeutic endeavour. The therapists' openness in the interviews to their own attributes, blind spots and pre-judgements, prejudices and stereotyping was not only revealing in terms of what therapists actually do, think and feel (rather than what they may pertain to do, think and feel) but also a refreshingly humble acceptance of their whole self.

All therapists recognised that their unique history and previous experience had a huge impact on how and what implicit experiences became available to them in therapy. Lorna felt her own personal history has a particular and direct impact on her ability to be attuned, empathic or intuitive with a client in the therapy:

I think about it too, in terms of our own personal wound, for example which might be what makes you more attuned, or empathic or intuitive.

Rachel, Lorna, Tracy and Ian recognised and identified their particular histories and experiences may be triggered with particular clients to enhance or open up a route for unconscious connection and communication. The early familiarity with a particular response or experience of interpersonal relating appeared to be regarded as an unconscious pattern that may be picked up in connection with the new clients' particular unconscious pattern.

It could be something that gets triggered in me from my past (Ian)

Lorna gave an example where she recognised a precise area of her own personal history was triggered with a particular aspect of client's presentation and behaviour in assessment:

So it must have been something [in me] *and I think it was probably something around money.*

Lorna continued to explain her understanding of the intersubjective aspect at the centre of the emerging implicit experience as intersubjective, where one person's material connects with the others to create a third shared subjective state.

> *I am clear that there must be something receptive in the other to pick it up. I call it Velcro. If I don't have the sticky bit of the Velcro it's not going to stick to me.* (Lorna)

Previous experience seemed to be important in honing the therapists' ability to be attuned or empathic. Tracy talked about her childhood experiences developing her ability to be attuned to signs of interpersonal danger. Therefore as a therapist her personal history enhanced her ability to have heightened awareness to possible interpersonal boundary issues. She described an incident where she immediately recognised her response to a male client who threatened (via sexual suggestion) the professional boundaries of therapist and client relationship. She says her early experience gave her an internal warning signal against the possible danger of a breach of interpersonal boundary. Tracy spoke about how her family of origin honed her ability to pick up possible dangers:

> *But there was a lot of stimulus, a lot of antisocial stuff going on in the family system. And so I think, even as a little one, that instinct had been honed. It was like, 'Beep! Beep! – Danger here!*

Tracy accepted and understood her honed instinct during the assessment, *knowing* there was a danger of a breach of boundaries with this particular client and knowing the particular form that breach could take. However, at the time (as a novice therapist) she was not able to see her own part in the inter-subjective process. She said:

> *I think sexually, I was aroused. Though I wouldn't have, back then, I wouldn't have wanted to have thought about that. I would have clouded it as... I would have pushed that aside then.*

As a novice therapist Tracy was unable to accept her own part in being excited by the erotic transference, even though she accepted her knowing about the particular danger this client posed. She gained a deeper understanding of her part as more time, experience and theoretical knowledge was gained, and now understands her own material as part of an inter-subjective process.

Rachel talked of her connection to animals and her early relational history impacting her ability to connect and "feel in tune" with clients. She felt this aspect of her history had an important positive influence on being able to connect with clients in a non-verbal way and perhaps at a deeper unconscious level.

Well because I am very interested and I like animals and dogs in particular, I can feel in tune with another animal that can't use human language and I can feel like... on the same wavelength. (Rachel)

The experience I had with my father actually, who was not a very verbal person but I think we understood each other on a very non-verbal level and that has also come from my own therapy. And I am sure that I am bringing that to bear (in therapy) and I like that feeling. (Rachel)

The therapists' knowledge and openness to their attributes highlighted an understanding of their part in the dynamic, thus allowing a greater possible understanding of what may be happening for the client and/or the relationship in the therapeutic assessment. Rachel said she was more able to notice things happening in the relationship very early on in the assessment, because she recognised her own attributes and monitored how those attributes were being impacted in relation to the client. Rachel gave an example of feeling as though she was "the boss" during the assessment, as this was not a position she actively sought out or felt comfortable with either philosophically or physically in therapy, it stood out. She detected the origin of her uncomfortable feeling coming from her own material and so was able to identify her own and in turn the client's possible part in the emerging experience. Rachel said:

I don't like being in charge…. that's why I noticed it.

Both Rachel and Lorna said their ability to be aware of bodily reactions and somatic experiences was not as honed as others and therefore had a negative impact on what they brought to the experience in terms of not noticing subtle somatic data.

I don't think I'm good at being terribly aware of the body sense. (Rachel)

I am not always aware of my bodily transference and counter transference as other people might be. (Lorna)

While Ian and Tracy suggested their bodily reactions were prized tools for their therapeutic work, giving important information about possible changes in the therapeutic dynamic. They said they could rely on the data being accurate and purposefully took note of their somatic experiences as part of the complexity of data informing them throughout therapy. Tracy identified her bodily reaction as a "gut response" that was essential:

> *It would be a gut response. Yes, it's in that gut! Yeah, this is a really important tool in my kit, and I'm sure it is for everybody, whether people are prepared to accept it or not. I don't know. But for me, it's really important.*

Ian understood his "*adaption in life*" as "*wait and see*" and felt this allowed him space and time to allow the emerging implicit data to develop and the meaning to emerge in a way that could be useful to his thinking, the client and the clinical work.

There was an acknowledgement from all therapists that implicit data emerging to the therapist's awareness was at times dismissed due to their own "dissociations", gaps in self-awareness, prejudices and stereotyping. Ian acknowledged the impact of his blind-spots or his *"own dissociations"* which were likely to direct the client and the therapy away from uncomfortable (for the therapist) emerging implicit material during assessment:

> *I do that (*dismiss emerging data)… *probably do that if there's something a bit uncomfortable for me here, I don't want to look at something. I guess eventually, I mean I might think about it in terms of my own dissociations, you know what is it I don't want to look at, what is the not-me here that I don't really want to engage with. In which case, is this client triggering something in me that I don't really want to look at? So I kind of signal back to the client "Look, that's not important", so they think "Oh, that's not important". They don't think that but they just go with it, so actually we never go there.*

Ian and the other therapists acknowledged the vital importance of first recognising their own blind-spots, using supervision to increase awareness of these issues, and to gauge the possible impact on the client and the direction of therapy.

> *And more and more and more of my supervision is about my stuff. Yeah the bits I want to avoid, where I'm dissociating. When I think working relationally, that's actually key. Uncomfortable as it may be.* (Ian)

All therapists recognised times when they pushed aside or did not attended to emerging implicit data due to their own unrecognised or unresolved material. The ability to talk about the unresolved material in the research interviews and the way they dealt with it was courageous but also essential for deeper connection of self and client in the therapeutic process. Lorna recognised her own unchecked or unrecognised prejudices and stereotypes impact clinical work and cause emerging data to be missed:

> *Your own prejudices, your own history, your own ignorance; all of that is in your own head when you are doing it* (Therapy*). Of course I don't always get it right and I miss things.*

Supervision was understood to be essential for therapists to talk about the client's issues and importantly about how the therapist gains and uses a deeper understanding of themselves in the therapeutic process. Tracy talked of seeking out a specific supervisor who was known to focus on the somatic reactions of the therapist in order to help her deepen her own awareness and understanding of her part in the therapeutic dyad.

Noticing things that I don't really understand yet (inner conflict)

All participants noticed things that felt "significant" in some way but were unable to fully explain why initially, and felt understanding came later. This acknowledgement of a significant implicit experience emerging was often at odds with a logical explanation and a number of the therapists felt an internal dilemma or conflict. This inner conflict was often the implicit experience not matching or fitting with previous knowledge or logic. Although the therapists all said their emerging implicit knowing tended to be correct, the data was not always given the weight of acceptance due to not being able to give a "logical explanation" and therefore may be ignored, put aside or not trusted. The therapists recognised that "knowing" and "understanding" were different, and the "knowing" may not always be understood initially.

Lorna talked of noticing something significant but not quite understanding what it meant during the assessment session. When "alarm bells start" she was convinced there was an unconscious process occurring around money but she was not able to explain it:

> *I was listening but something was not sitting quite right and then when he was speaking about his affluence, alarm bells started to go off.*

The internal dilemma for Lorna was of not understanding what the implicit data meant at the point of emergence, yet believing it had "resonance". Rachel's internal dilemma was different; she was not so immediately concerned about the meaning of the emerging implicit data but rather in understanding where it came from and how it could be correct. Rachel identified the dilemma when an implicit experience emerged to her conscious awareness; it felt "concrete" yet she did not understand how that could be so. The logical explanation was so difficult to come to at the point of emergence that trust in its accuracy was diminished or at least questioned and doubted.

> *It doesn't make sense to me that I can have such a concrete thought and be so confident that it's true just from the body language. It's the amazing confidence, you know that thought comes to me and I think ... I can't be 100% sure, but I am 99% sure it's right. I almost don't think that is possible.* (Rachel)

Lorna's dilemma was about meaning and Rachel's was about accuracy and origins of the implicit experience. Ian did not seem to have these overt dilemmas, he felt he could trust his emerging experience as it was often correct but may not understand it or be able to explain it for some time afterwards, but he trusted eventually an understanding would come.

> *I'm normally fairly right, from the outset. I don't … I might not know why I'm right to start with, but somewhere down the line I'll figure out.* (Ian)

Some of the therapists said previous knowledge and training aided an understanding of the emerging implicit. Lorna said her previous career as an actor developed and honed her skills at working intuitively and this was an aspect of her previous experience and knowledge that she brought to her therapy work. When previously Janis worked as a health visitor, her supervisor had encouraged her to trust her experience, and she brought this trusting of her emerging implicit experience to her therapeutic work. However Rachel felt her previous training as a scientist hindered her acceptance of the emerging implicit even when she had confidence her experience highlighted a truth of some sort:

> *The scientist background in me is saying 'How could you possibly pick out something so concrete?' And I don't know the answer.*

The dilemma for Rachel formed a dichotomy of experience verses logic, or perhaps right brain verse left brain dominance in the process of understanding implicit data emerging to awareness in assessments:

> *There's the confidence and the other side says "That's mad!"*

Rachel's dilemma highlights the problem of the dominance of left brain logic over right brain holistic experience and knowing, and whether to trust the emerging implicit experience or not. Tracy states her experience of emerging implicit has never let her down and yet she does not always accept and value it as accurate data:

> *It hasn't ever let me down… in terms of the outcome. What does let me down is that I don't bloody listen to it!*

The conflict of knowing the significance of something yet not understanding it logically or enough to feel confident to trust and use the data appeared frustrating for both Rachel and Tracy, yet for Ian the dilemma was more an issue of "Wait and See" (the next sub-theme). He recognised the probable significance of the emerging implicit without fully understanding it or being able to logically explain it until later:

> *I could tell you what my intuition was. Whether I could say "I think I'm right," I don't know. I'm much more likely to say to you "Oh, hang on. I want to check that out a bit more". I probably will be right.*

Rachel felt that not trusting her emerging implicit experience caused problems in the therapeutic work; by holding back the emerging implicit experience (either as data for thinking or more directly with the client) the work was altered or interfered with. She also talked of her desire to be able to trust these experiences more freely:

> *Well it's weird because I wish that I trusted them more because I do think it does interfere that I hold them back.*

There was an acceptance by all the therapists that there is a difference between "knowing" and "understanding" the emerging implicit experience, and all therapists were aware of noticing the emerging implicit experiences as having resonance or significance even though they did not understand what the meaning was or have a way of explaining the experiences.

> *I might be noticing things that I don't really understand yet* (Ian)

> *I'm normally fairly right, from the outset. I don't … I might not know why I'm right to start with, but somewhere down the line I'll figure out.* (Ian)

Tracy like Ian felt fairly certain the emerging implicit experiences were correct but, unlike Ian whose behaviour was to "wait and see"; she often acted against her *knowing* and was struggling to understand her actions:

> *And what I really… I really don't know why I accepted the invitation either, you know, in terms of saying "Yes" when my instinct was telling me to say "No". I haven't worked through that one yet.*

There was a quiet confidence from all the therapists that their emerging implicit experiences were accurate or had significance for the client and the therapy, yet there was reluctance to state overtly and confidently the accuracy or act upon this knowing, as thoughts, hypothesis or direction in therapy. The inner conflict all participants felt about their knowing verses their understanding was an ongoing process of trying to understand their experiences and their subsequent actions and direction in the therapy.

> *I suppose what I'm most interested in is why, when my instinct – which hasn't ever been proved wrong – why I override it.* (Tracy)

Janis accepted at times her experience of the emerging explicit was important and recognised the significance yet did not understand why that would be so. She was able to "know" or recognise something as a metaphor or as a leitmotif for a client without fully understanding the meaning at the time of the experience:

> *I don't know why the hair was so significant, but it was. Well, it certainly concealed her.*

Wait and see

All participants talked of waiting to see how the emerging implicit material could make sense before using it. They talked of "wait and see", "lodge it", "park it" and "hold it". How the participants expressed the holding and parking will be discussed more fully in Theme 3. It was clear, as seen from Theme 1, that the implicit experiences were dramatic, powerful and "concrete" but were often not fully understood initially. Therapists tried not to dismiss, or ignore the experience but tried to hold it with an open attitude until it became more understandable or/and more useable either explicitly or not.

Waiting for further data to aid the understanding of the emerging implicit was common for all the participants. Ian was clear about what he experienced but was hesitant to pronounce its accuracy or act upon the information too soon, even if he felt the experience would probably be of significance to the client and the work. He had explained this (Theme 2, sub-theme "*What do I bring to this?*") as his natural tendency or his own adaptation on life as *"I often wait and see."* His caution not to act upon the emerging implicit too soon was explained as a need to have more certainty or a need to give some time for the data to develop more fully:

> *I could tell you what my intuition was. Whether I could say "I think I'm right," I don't know. I'm much more likely to say to you "Oh, hang on; I want to check that out a bit more". I probably will be right.*

Although Ian talked of an active deliberate "wait and see", Rachel did not actively decide to "wait and see", it was more of an involuntary action where the emerging data persisted to remain in the periphery of her attention further into the therapy. Additional data from the client gave meaning and understanding to her emerging implicit experience:

> *Because I didn't know what to make of it, it didn't mean anything. But it did stay with me and then... I thought 'Well what's that about?' and I still, it still stayed in the background and I didn't take any notice and I didn't introduce it. In session three it kind of came up in terms of material. In terms of why he felt conflicted.*

Rachel talked of "wait and see" as a non-directed action towards her experience while others such as Ian were more consciously deciding to act upon their experience by holding it or parking it just outside of the focus of their attention. The experience was not forgotten or dismissed but held at a slight distance so as not to interfere with the process of therapy at that point when the experience is not fully understood or not fully available for use. The therapists talked of holding the emerging implicit if there was not a logical explanation until a "rationale" for the experience came to them over time.

> *It is something that I feel will be just.... A client will be talking at the beginning and I will think there has been abuse here, I will have absolutely no rationale to it and then I will park that feeling.* (Lorna)

Although the experience may be noticed as an interesting experience coming up it was then consciously held.

> *That's interesting what's coming up. And then I just lodge it. Just lodge it.* (Lorna)

Most of the therapists seemed content to park the emerging implicit without too much concern for hurrying a logical explanation. There was an acceptance for the emerging implicit material to develop and blossom into its full meaning with time, and that could not be rushed. Tracy suggested her ability to allow the experience to develop in its own time had been part of her

own development as she matured as a therapist, and that as a novice she was much more excited by the emerging implicit and her need to find out about it quickly:

So I think, at the beginning, because I'm honed for that kind of stimulation, I found it quite exciting. You know, it'd be like 'Oooh – something's going on here. I wonder what it'll turn out to be. There's something about this client… oooh!' It would really stimulate my interest. I think now, I'm much more laid back about it, and much more, Yeah, okay, I wonder what this about… And I wouldn't want to find it out so quickly.

There seemed to be a number of reasons for lodging or parking the experience; to gain more understanding of this sudden experience, to gain further data to confirm the accuracy of it and finally to find the appropriate time to use the emerged implicit directly in the clinical work with the client.

I just put it somewhere in the... what where, what do I call it...I don't want to use jargon, but the internal supervisor bit and my own filing system. (Lorna)

How and when the emerging implicit data was used was dependent on the therapist's orientation and personal style. All therapists felt that they did use the experience to aid their understanding and to develop their hypothesis of the client's particular issues, to guide how they interacted with the client, and in supervision as a means of understanding the unconscious process and some used the material explicitly with the client.

'Wait and see' before using the material directly with the client was based on a number of factors; the therapist felt the implicit message had to be clear enough to them to be of use directly with the client. Rachel said the emerged implicit data she experienced in assessment were often not fully understood by her initially and would be less likely to use them directly with the client but may begin to use the experience for her own understanding or her developing hypothesis.

Therapists felt that even if the implicit message was relatively clear to them and they had a good enough understanding of its possible meaning, the client may not be ready to hear this message and thus the possible intervention would fall on deaf ears and be lost.

I didn't feel it was appropriate to tell her immediately. (Janis)

Therapists actively waited for the right opportunity to use their emerged implicit experience to the best effect.

> *So I have to wait until I feel it would be an appropriate time to bring that in,* (Lorna)

> *I think in the first session they wouldn't be able to see it, that's my gut feeling.* (Rachel)

> *Sometimes I might just hold something and … no; I think eventually I bring it into the work.* (Ian)

Therapists recognised that even when the emerged implicit material was not directly used or shared overtly with the client it did form part of their thinking and considerations about the clients, and to that effect was useful.

> *Sometimes I don't share it I just hold that.* (Lorna)

Lorna talked of not just waiting to see but actively looking for clues and data that would support and make sense of her experience:

> *It's a gut reaction. Erm, and what happens in my head is I'm thinking, OK, so… when I'm working here… the person I'm working with here is causing me some confusion. I'm having a gut reaction, and I will start to look at the clues in order to see if I can define that down.*

Accepting the unknown/unknowable

All the therapists talked of the concept of the "unknown" or "unknowable" aspect of the emerging implicit experience; that some experiences will not, and perhaps cannot be known fully, explicitly or logically. There was both an acceptance of this concept and also a wonder and curiosity about the unknowable aspects of therapy.

There was a shared understanding by the therapists that implicit experiences emerging into their awareness were by their very nature unknown and perhaps unknowable in a fuller sense. Ian was aware that parts of his experience may become known to him while other aspects remain unconsciously held:

> *There's something else here and I don't know what it is.*

For Rachel, if there was no corroborating evidence or experience to support an implicit experience that emerged during assessment, there was a possibility those feelings or experiences may never develop into a knowable explicit form:

So those feelings could never become explicit.

Lorna talked of the *"mysterious question about how these things happen",* as if some things are beyond our capacity to know explicitly and are caused by forces beyond our control. However she felt *"usually there is some grain or some nugget"* of truth or resonance that may not be explainable.

Tracy had less of a mysterious notion about the emerging implicit, but felt there was something intangible about the experience which was not knowable. She talked about the quality of the voice or *how* something was spoken rather than *what* was said. This was echoed by others who talked of the "how" not the "what" of the experience, suggesting there was something escapable about the experience that could not be pinned down by words or logic. Tracy said:

It was something about his voice. It was something about the way he positioned why he wanted to see me.

From a theoretical perspective Tracy talked of the "known unknown", a reference to Bollas' (1987) 'unthought known' and Ian talked of the experiences not being conscious and therefore when coming to the therapist awareness as conscious material, cannot be fully known.

Well the theoretical understanding I put on it now is the different kind of transferences. That's how I would talk about it now. I would also talk about the "known unknown". (Tracy)

I think often, those sorts of things, because they're actually deeply unconsciously held, in some ways, or I think about it in terms of 'non-conscious', they've never really been conscious. (Ian)

There was a shared acceptance or tolerance of the unknown or unknowable aspect of experience which did not deter the therapists from their search for meaning and understanding but somehow allowed a greater freedom or stance with their client that was about not having to know everything but accepting what could be known and that some things could not.

Theme 3: The difficulty in naming the experience

The difficulty in appropriately and adequately naming the experience I was trying to investigate had been evident from the inception of this study; therefore it was unsurprising that this was also a difficulty for the therapists interviewed. Being able to talk precisely about the therapists' experience had been complicated by the different backgrounds, trainings, knowledge, experience, meanings and associations therapists gave to the words they used to describe their experiences. This was also compounded by a lack of a cohesive framework to communicate their experiences. Trying to find a single word or phrase that would be understood and acceptable to a large and varied group of therapists (and others) was surprisingly difficult and frustrating. The theme *Difficulty in naming the experience* exemplifies the struggle the therapists had trying to put words to their subjective experiences of the emerging implicit and the difficulty in communicating a complex and often profound experience to others. There are three sub-themes: *Playing with a wide variety of words to name a precise experience, The wholeness of the experience is beyond verbal language* and *Gestures aid verbal language.*

Playing with a wide variety of words to name a precise experience

All participants used a variety of names to try to communicate the experience of the emergence of implicit data at the assessment.

Table 2. Names each therapist used for the emerging implicit experience

Rachel	"gut feeling", "an experience", "Aha!", "transference", "instinctive feeling", "telepathy", "intrusive thought", "empathy".
Lorna	"attuned", "countertransference", "resonance", "a present moment", "a gut intuitive sense", "empathic", "intuitive".
Ian	"a big response", "a gut feeling", "countertransference", "intuitive", "attuned to"
Tracy	"a sense", "therapists intuition". "instinct", "gut reaction", "the known unknown", "a feeling".
Janis	"a sense", "a feeling", "instinct", "intuition".

It seems there were dilemmas for the therapists in naming their experiences at assessment; there was no consensus across all therapists about a single word or phrase that adequately described the nature of their experience and there was no consistency in naming their

experience within each of the therapist's narratives about their experience. Four out of the five therapists called their emerging implicit experience a "gut feeling" and "intuition", suggesting these names may be in common use already and there is at least some general understanding of the meaning and associated experiences. Some names are common in terms of contemporary psychotherapy and could be classed as current psychological technical language; found in contemporary theoretical literature concerned with psychotherapy. These are words familiar to many psychotherapists concerned with communicating their experiences and understanding of the unconscious process in psychotherapy.

Other names could be classed as commonly used language having no direct association with psychology or psychotherapy per se. Words such as: 'Aha!', 'gut feeling', 'a feeling' and 'a sense' are all used in everyday language and are not directly or exclusively used in psychotherapy. All therapists used a mixture of both technical and common language to aid their naming of their emerging implicit experience.

Some therapists played with the words to find which fit more accurately to their experience. Lorna uses a number of words that may be conceptualised as specific in therapeutic terms, to approximate her subjective experience of the emerging implicit:

> *Attuned, or empathic or intuitive*

The therapists all played with trying out words during the interview to find a more precise description and meaning to communicate their experiences. Trying to describe and explain her experience of emerging implicit data, Janis said it is "an instant feeling about people" and then "it was the instinct. I certainly had a feeling." She played with words, interchanging names to describe her experience throughout the interview, as if trying out names to find out which best explains the complexity of her emerging implicit experiences.

> *What I call instinct – nobody else would necessarily have. It's something about me, my unconscious or whatever… intuition or feeling.* (Janis)

Rachel's struggle to name her experience was apparent, she also hinted at the habitual use of the name 'experience' but perhaps without deeper consideration of its subjective meaning, and applicability for depth understanding of experiences with others:

> *And what's really happening for me is that I'm having an experience, and I think that's the word 'experience' that I tend to use. I'm having an experience with a client that I*

suspect is going to be important in terms of me understanding them and me working with them.

She then used the words "telepathy" and "empathy" but again it was as if neither quite fit with how Rachel needed to understand for herself and communicate her experiences in therapy and to others. Ian and Tracy both highlighted the inconsistency of precisely naming the experience in terms of using technical language verses more simple language. Ian initially talked of a "big response" then later named his experience in theoretical terms as countertransference, returning to the simpler language of "gut feeling".

[I]t might be me being proactive (in countertransference terms), or it might be reactive, so it could be either. And sometimes it's a blend of both, of course, so you know something of mine might get triggered. I guess, to put it in the sort of the simple language, it's that gut feeling about something, but I'm not always sure quite what it is at the time. (Ian)

As Lorna mixed simple, common language with theoretical and technical language it was as if she were testing out words and concepts to find a precise translation of her felt sense to a verbal language that could be understood and would make sense to others, professional and non-professional alike. Lorna exemplified the difficulty or perhaps the impossibility of completely mapping words directly onto experience saying *"the closest I can get"* as if there was something missing in her verbal account and that her experience was more than words can describe.

That's the closest I can get, there's something, obviously projective identification is part of countertransference but I think it was even more specific than that, I was taking on something that I would not normally take on, does that make sense? (Lorna)

[I]t was a vague formulation but again it was more of a gut or intuitive sense (Lorna)

Tracy was aware she had gained a technical/theoretical language to aid an earlier simpler language in naming her experiences, she said she used "instinct" and "a feeling" as simpler pre-professional descriptors that were replaced with professional terminology such as: "transference", "symbiotic invitation" and "the known unknown":

[D]ifferent kind of transferences. That's how I would talk about it now. I would also talk about the known unknown.

> *Whereas, you know, 10 years ago, I'd go into supervision and say "I've got a feeling," I'd now go in and I talk about a symbiotic invitation, or the transference and countertransference that's going on, or I talk about projective identification. You know, I've got the language now.*

In the interview as Tracy described her experiences she used "instinct" "sense" etc. and not the technical or theoretical language of "transference"; she only used the "theoretical or technical language" when reflecting on her use of language and when considering the naming of her subjective experience in a more precise or more professionally communicative language. This is an example of espoused theory rather than theory in practice (Argyris & Schon 1996); where therapists do something different from what they say they do.

Although both simple and technical language was used by all participants to aid their descriptions of the emerging implicit data emerging, neither was consistent and both appeared an approximation of experience, which was not totally satisfactory. Rachel continually tried to find words to describe her experiences but appeared suspicious of words being able to fully express her complex experience:

> *You just kind of understand, just understand something that is so complex, so… but so meaningful but that words would just destroy it.*

The lack of a common word or expression that adequately describes each of the therapist's subjective emerging implicit experience and can be understood by others may be due to the subjective meaning that words have for the individual therapists. Rachel talked of the meaning to her of the word 'intuition', thus preventing her from using it to describe her experience even when she understands logically the word 'intuition' would describe her experience:

> *Yes because I don't tend to use the word intuition although I think it is describing what I'm describing. I suppose the word intuition to me tends to mean something I can't make sense of at all.*

From Rachel's scientific background she had needed to make sense of her experiences and to describe her experience as 'intuition' suggested to her that sense and meaning would not to be found.

Lorna exemplified a common dilemma regarding the complexity and intangibility of the unconscious process that occurs within the therapeutic dyad being difficult to pin down and

describe. She used 'intuitive' to describe the process in which she works therapeutically within the assessment:

Again I'd say it's more intuitive.

I think in a way it is because psychotherapy is so mysterious in a way, because unconscious dynamics are not tangible.

Lorna identified that for her the word 'intuition' had a meaning associated with a mysterious process but could easily be misconstrued to mean a mystical or magical phenomena and therefore may create a negative connotation within therapeutic consideration and discussion:

[C]alling it intuition makes it sound so hocussy, pocussy.

The connotation of the mystical or magical may be regarded by therapists as less scientific and therefore to be avoided, especially as psychotherapy and counselling psychology are relatively new endeavours compared to medicine or nursing where intuitive processes are more readily accepted, discussed and researched.

Although Ian used a variety of words to describe his experience, he did not show the same sort of discomfort with the word 'intuition'. He did not associate intuition as other worldly or suspicious. He was more straightforward with his use of the name intuition, as if it was an ordinary, acceptable label of naturally occurring experiences:

I certainly have an intuition, right at the beginning. I think what I'm saying is, I have an intuition right at the beginning that often proves to be right.

Ian's acceptance of the name intuition to describe the emerging implicit experience at assessments seems to be founded in his Transactional Analysis training and an understanding of Berne's study of intuition during army assessments:

But that's where he [Eric Berne] *started with all of his original thinking, of course. Because he did all those army assessments and it was the first three minutes. And he says that in one of his books, in fact.*

It appeared all the therapists found the names used were approximations for their experiences; the words did not and could not map exactly onto their subjective experience of the emerging implicit data at assessment.

All the words participants used came with connotations to their subjective experiences or beliefs; conventional words, learned/industry language, previous training/career influences, mysterious connotations, etc. So playing with words to try to fit a name to precisely explain the experience of the emerging implicit was a complex process. It involved the therapists reflecting on their subjective experience, trying to define their experiences and beliefs around non-conscious material and communication, and acknowledging their particular backgrounds and influences in terms of psychotherapy and in language use, meaning, exchange and development.

The wholeness of the experience is beyond verbal language

Participants talked as if words are approximations or translations of the experience, but not describing the wholeness incorporating the meaning of the experience. Tracy describing the emerging experience said '*It's a sort of transmission',* the '*sort of*' suggests *not quite* or *nearly*. The words cannot do the experience justice, as if verbal language only goes so far to fully verbally encapsulating the holistic nature of the experience.

Tracy highlights the struggle in or impossibility of trying to attempt an approximation or translation to describe the emerging implicit experience saying: *I can't even describe it.* The therapists suggested that words cannot describe or adequately translate or approximate certain experiences. Putting words onto an experience is a means of labelling or categorising but some experiences are difficult or even impossible to label and categorize with any hope of fully capturing the wholeness of the experience. Some experiences may be un-nameable but not unknowable. For Ian this was self-evident, he said:

> *Well I'm putting words to things that don't have words of course.*

The participants talked as if the emerging implicit experience may be beyond naming and verbal language. The seemingly appropriate common use of words may diminish or destroy the meaning of the experience. Therapists appeared to be cautious of using particular words even if they may at first glance be a usual descriptor:

> *I would use the word empathy and I'd agree it's the conventional word to use for what I'm describing but the reason I've steered clear of, is that the words break it down*

business. As soon as I say 'empathy' it feels like that seems to downgrade it or takes a part of it or doesn't really get the feeling of it. (Rachel)

Psychotherapy is a talking therapy and so it is important for therapists and clients alike to try to communicate and reflect their experience via a verbal medium. The therapists in this study clearly tried very hard to put words to these often *"very profound feelings"* (Rachel), albeit aware that words both in the therapeutic process and afterwards in reflection may be secondary to feeling states. Rachel explained in therapy she was actively trying to get herself into a state where words were not the priority, but where she in a reverie state would be able to connect with the client at a deeper non-verbal level:

I'm trying to get me into that state that isn't about listening because there are no words going on.

She argued that trying to put words onto this state of reverie or deep knowing and connection would destroy it:

You just kind of understand. Just understand something that is so complex, so… but so meaningful but that words would just destroy it.

Rachel hinted at a kind of specialness about the emerging experience; the complexity, perhaps a profound understanding and wholeness to the experience. A number of therapists used the word "resonance" to describe the emerging implicit experience, suggesting holistic associations or recognition of deep patterns or rhythms between therapist and client.

It was something…it was organic. Where that came from I don't know but that had resonance. (Lorna)

For the therapists it appeared that although words did not fully express their emerging experiences metaphors gave a better flavour of the experience and the meaning that was attached. Metaphors were used both in the interview to describe the emerging implicit experience to me the interviewer, and also by the therapist in the moment of experiencing the emerging implicit, as Janis relates when greeting her new client in the waiting room:

I don't know why the hair was so significant, but it was. Well, it certainly concealed her, (Janis)

The hair as a metaphor was significant for Janis as it let her feel and know something different about this client even before she entered the counselling room. The client being concealed or hidden by her mass of hair struck Janis as significant; an important knowing about the client, which incorporated a deeper understanding about how this client needed to be hidden in plain sight. The hair was a decoy for the client but a conduit for accessing non-verbal knowledge about the client for Janis.

During the research interview, Ian described something of the emerging implicit experiences he often noticed, there was "something missing" and "out of balance":

> *The image that I had in my mind as I was saying that, as you were asking, was like imagining a set of scales, and I'm hearing the version of what's in one end of the scales.*

The metaphor of the scales Ian used conveyed a much rounder sense and understanding of what he noticed of emerging implicit experiences. The metaphor offered a comparison of an ordinary object that had some similarity to the experience being described, providing access to possible deeper meaning. When we cannot communicate something directly the metaphor offers a conduit for our imagination to make meaning and have access to knowledge that may otherwise be out of our grasp. The metaphor allows us to feel and know something differently. Ian's metaphor of the scales alludes to what is present and what is not present in the emerging experience. This instantly locates this experience as dynamic, the therapists' part, the clients' part and the third incorporating both as a whole, a more complex feeling picture than descriptive words can recreate. Lorna similarly used the metaphor to enrich and bring to life her experience of her new client when she says:

> *I opened the door to a male client and I had only just started seeing male clients and he was posing outside the house. He had his knee up against the tree and his hat tilted down in a very James Dean kind of pose.*

Using "James Dean" as a metaphor, Lorna immediately saw aspects of this client as a rebel, sexually attractive, a challenge and seductive. Her use of the James Dean metaphor brought her story to life giving it a vivid and rich feel.

Gestures aid the verbal language

With the difficulty of naming and verbalising some of the experiences, I became aware of how the therapists communicated both verbally and non-verbally during the research interview. I was struck by the non-verbal intonations, tone, the differences in volume, and rhythm of the

therapists' accounts. At those times when linguistic communication was at its most difficult, or excitable, para-verbal behaviour increased, as did an increase in noticeable gestures and body language.

It appeared there were a number of commonly used gestures to aid verbal language or to explain something that appeared beyond verbal description. Gestures were used as a shorthand for language, to emphasis the verbal explanation or description, to show where feelings were held in the body and to show more complex thinking processes that occurred rapidly.

All therapists used hand gestures to aid their verbal narratives with such regularity and ubiquity that much of the gesturing went consciously unnoticed much like everyday communications, however some gestures stood out not just to me but also to the therapists themselves. Rachel exhibited an example of consciously and overtly using hand gestures to explain something that was far too complicated or convoluted to be expressed in words. As Rachel was explaining her experiences of emerging feelings of *wrongness* with a new client and her inability at the time to understand what was happening, she began to act out with her hand gestures what she felt was happening in the dyad:

> *Yes, fundamentally. It felt like we were always doing that* [As she says this she moves her hands past each other without touching, and then continues] *never doing that,* [And then moves her hands together to join, touch and gently hold, while saying] *never meeting*.

Rachel's demonstration gave a more whole sense of her experience than her words alone could do. In the gestures there was an impression of the force or magnetic pushing apart of the two hands (therapist and new client) and gentleness of the hands moving towards each other, touching and making contact. In the first movement there was a sense of opposition, strife and perhaps aggression, compared to a calm, smooth and attuned sense to the second gesture. As I try to describe the impression I gained from Rachel's seemingly simple hand gestures, I am aware that the description could be more detailed and yet still not completely represent the communication I received from her. So the hand gestures were able to communicate some sense of the complexity of an experience more directly and perhaps accurately than words could do in this instance. There was a nuanced aspect to the gestures that gave a deeper understanding of just how very particular the therapist's feelings were at this specific time. This nuanced communication was not always so evident in the verbal language, or perhaps it was

more difficult to achieve and the playing with different words and phrases (as described above) was a means towards a more nuanced and particular description.

Gestures had the effect of emphasising the therapists' narratives. As Lorna said "*it was so powerful feeling coming up*" she pointed her hand in an upward inflection to her chest. This not only showed me where she might be feeling something but also the strength and direction of the feeling. The gesture together with her verbal statement left me in no doubt about the power of her feeling and the dynamic nature of the feeling that began in her chest and moved upward towards her throat. The gesture brought to life vividly and richly her story of *how* implicit experience emerged. Similarly Ian enriched his narrative about his experience of an emerging implicit experience by demonstrating what he was saying:

> *It's a kind of tightening… what else is there? I sometimes … sometimes I can notice that I might have a quite a sort of, I suppose a fixed smile for the moment, sort of okay right.*

As Ian said this, he smiled widely with only his mouth rather than a real 'Duchanne smile' that engages the eyes too. Although this gesture added to his narrative giving me a sense of the forced and rigid behaviour it was not quite right and he continued both verbally and gesturally to try to communicate to me the full impact of experiencing the emerging feeling saying: "sort of Argh, what's going on here?!" He stiffened his body, pushing his shoulders back and looked as though he was pinned to the chair. This second gesture or rather an exaggerated mimicry was dramatic, startling and a little comical, but I did get the powerful sense that he was being forced or held back in a way that was uncomfortable for him. When I say: "It looks like you're pinned!" Ian acknowledged with a nod that he had communicated exactly what it felt like. I put the words to his gesture to complete his communication of his experience. Of course I am aware this is still an approximation or translation of Ian's experience but by using gestures he was able to demonstrate an experience that may have not been named.

Gestures were very useful in directly communicating where a feeling or experience was located within the body. Sometimes therapists were aware of their gestures, at other times gestures were carried out without the awareness of the therapist as if a habitual action in communication. As Janis told me of her feeling of fright at meeting a new client she continually touched her breastbone with her right hand but was seemingly unaware of her action until I brought it to her attention.

> Janis: *I wasn't frightened of him – I was frightened for him.*

> Carole: *And you did this?* [I copied Janis' actions, pointing to the chest area] *… You pointed to your chest quite a few times – was it, did you feel it there?*
> Janis: *I did. Categorically! There were lots of feelings!*

Janis had not realised that she had been directing me to the area of her body she had experienced the dramatic and powerful feelings, by her hand gestures. Janis's gesturing enabled the intensity of her felt sense to be communicated and the specific location of those feelings to be identified without her having to verbally explain. In this way gesturing aided a more complex description and meaningful explanation of her experiences than words alone could do. In many ways this was exactly the same activity that occurs in everyday life and the therapy room where clients tell their story via both verbal and non-verbal means and where the therapist is able to see the accompanying gestures that aid the clients' story. It is very important to highlight this non-verbal data that gives the therapist and/or researcher a great deal of information that enhances the meaningful understanding of the clients'/participants' subjective experiences.

Similarly Ian gestured where he felt his 'gut reaction' by using the flat of his hand in a circular motion on his lower abdomen, even though he was unaware of the action.

> Ian: *Somewhere I had a gut reaction to … a bit of fear?*
> Carole: *Where would you feel that gut reaction? Would you feel it in your gut?*
> Ian: *Well, I'm putting words to things that don't have words, of course.*
> Carole: *That's what I'm trying to investigate. But as you did that, you put your hand to your gut as though 'gut reaction' could tie in with that*

Although Ian was aware he was "putting *words to things that don't have words"* he was unaware in that moment he was telling me more about his experience from his actions. It was as if he was overtly telling me verbally his thoughts and reflections while inadvertently telling me about his experience and feelings with his actions. This seems to be both hemispheres working in harmony, the left-brain relating via verbal language the thinking and narrative while the right-brain is demonstrating with bodily movements the experience of the felt sense of the emerging experience. Together a fuller more complex understanding is achieved than just one form of communication can deliver.

Tracy appeared more in tune with her bodily reactions and noticed in the moment what was happening to her and drew my attention to it as well as reflecting on what that meant for her understanding of the emerging implicit experience. Tracy's verbal narrative alone seemed

sparse at times taken without the gestures and the enacting of her emerging implicit experience. As Tracy talked about locating in her body the anxiety associated with an emerging implicit experience, she consciously deliberately points to her solar plexus to show where she experienced the somatic feeling:

> *And, when I feel anxiety, that's where I feel it. Solar plexus…yeah, right in the solar plexus. And, did you just see the way I…? It's that kind of…*

As she said this she took a deep breath and looked as though she had suddenly become aware of other somatic sensations. In the moment she looked surprised and looked towards me to see if I had noticed too. I said: "A deep breath." In the moment we both acknowledged we had noticed Tracy's breathing changed:

> *Yeah. There's something about the breathing, it gets disturbed in that.*

It appeared gestures aided Tracy's account of how she experienced the emerging implicit by highlighting the location of the somatic associations. In deliberately paying attention to her own gesturing she enabled a further connection with her somatic experience that brought to her attention (and mine) an aspect of the experience (the disturbed breathing) that had not been put into words previously.

One of the most striking uses of gesture in the research interviews was while the therapists talked about how they managed the emerging implicit during the session. All therapists talked of "parking" the implicit data that emerged, as a means of holding the information in the background but not having to directly attend to it in the session. Rachel talked of "holding it in the background" and while she said this she held her cupped left hand behind her left ear. While she talked of something emerging into an "Aha!" moment she brought her open right hand forward as if waiting for a ball to fall into it. In this first interview I brought the therapists attention to what I noticed but it did not go further than noticing it at that stage.

> Rachel: *So what I am trying to do is hold it in the background, so if something emerges that fits it, that there'd be an "Aha!" period.*
> Carole: *It is interesting what you're doing because you are saying with your left hand that you are holding it in the background*
> Rachel: *Yes*
> Carole: *And you are saying with your right hand when something emerges.*

Similarly Lorna also used her left hand to *park* the emerged implicit data out of her focal attention during the session. As she talked she raised her left hand to behind her left ear as though almost throwing something behind her. Lorna was aware of the action and was able to explain how she understood the gesture in terms of her ongoing process during the assessment session.

> Carole: *And when you* did *that, I am interested what you did, with your left hand you parked it over your left shoulder*
> Lorna: *Yes, thinking it's just behind here*
> Carole: *Just behind your left ear*
> Lorna: *Just behind my ear that is where my filing system is, pre-conscious but it's, it's just stored, stored, it's on hold.*

I found myself wondering about the actions of the left and right hands. It appeared that the action of using the left hand to hold the implicit material that has just emerged to conscious awareness behind the left ear, out of focal attention but stored for later conscious reflection was common with all therapists. The left hand seemed to be dealing with the implicit material, that was affectively laden and as yet not fully conscious, while the right hand seemed to make gestures about reflecting on the implicit material. This seems as though the left hand is holding the right-brain material while the right hand is holding the left-brain material.

5 Discussion

The aim of this research was to gain a deeper understanding of therapists' emerging implicit experiences in assessments and how those experiences were reflected upon, understood and worked with (or not) within assessments and ongoing psychotherapy process. An important aspect of this study was also how these emerging implicit experiences were named and what language was used to reflect upon and discuss these experiences by the therapists.

In this discussion I aim to give my understanding of the meaning and importance of these findings in relation to other studies and dialogues concerning emerging implicit experiences. I considered this study an exploration of emerging implicit experiences that would contribute to the ongoing dialogue concerned with human experience and communication at the edge of consciousness. I aim to highlight the contributions to that dialogue as well as acknowledge the limitations of the study, suggest further related research questions, and discuss implications for training and clinical practice.

The study's findings

The findings of the research can be summarised under three main themes:

1- *A powerful and dramatic experience.* The therapists experienced the emerging implicit as powerful and dramatic, standing out from other experiences in the assessment. The therapists experienced the emerging implicit as a rapid process that came without warning and could not be anticipated or created at will. These emerging implicit experiences presented a number of features suggesting this was a holistic experience causing the therapists to view the emerging implicit experience as significant.

2- *What's going on here?* The therapists' thinking and responses to the emerging implicit experiences were complex and full of dilemmas. The therapists understood this as an intersubjective and dynamic experience where they paid attention to the clients' subjective experiences alongside being attentive to their own experiences. They all identified the dilemmas between experiencing something significant while not immediately (or possibly ever) understanding the meaning of that experience. The therapists in this research highlighted the complexity of the emerging implicit experience and the complexity of their thought process in therapy assessments.

3- *The difficulty in naming the experience.* These findings highlight the great difficulty in naming the experience and talking about the experience in order to communicate some sense of its profound and significant feeling. Verbal language was seen as not able to communicate the full impact of the experience and therefore gestures, body language and metaphors all aided conscious communication.

Although this study was not ascertaining whether or not therapists experienced the emerging implicit during the assessment (therapists were purposely chosen), it was clear from the therapists' accounts that they considered emerging implicit phenomena to have occurred during assessments, and not just further into therapy once a working alliance had been established. This is important to highlight, as much of the research on emerging implicit experience has tended to focus on experiences occurring after a working alliance has been established. This study has close associations with the work of Petitmengin-Peugeot (1999), Charles (2004) and Swanepoel (2008) whose research explored the processes involved in the emerging implicit experience (they named intuition) to develop a deeper understanding of the implicit in clinical work. By focusing on what happens implicitly at assessments, this study found implicit phenomena emerging even before either therapist or client had spoken. In this study therapists experienced the emerging implicit from the first moments of meeting and not just once working alliance has been established, as has been found in other studies (Petitmengin-Peugeot, 1999; Charles, 2004; Swanepoel, 2008). This study of emerging implicit experience links research on first impressions (Ambady & Skowronski, 2008) with work on *now moments* and *moments of meeting* (Stern et al., 1998) highlighting the question of what is happening implicitly between therapists and their client from the outset of therapeutic engagement. Members of UKCP (Maier, 2015) are currently undertaking national research regarding therapists' experience of moments of meeting, therefore it will be interesting to note whether emerging implicit moments of meeting are recorded at assessment. I will now discuss each of the three main themes in more detail.

A powerful and Dramatic experience that stands out

Distinction between phenomena

The findings for theme 1 - *A powerful and dramatic experience (that stands out)* correspond with Dane & Pratt's (2007) characteristics for intuition (rapid, non-conscious process, holistic, affectively charged). The sub-themes might be seen as descriptors that map onto well-established characteristics of intuition; *Dramatic and powerful* and *An alert* correspond with affectively charged, *Speed* with rapid, and *Imagery, Resonance* and *Anomaly* with a holistic aspect. The non-conscious process characteristic was acknowledged from the inception of the

research, as the research asks about the experience of the *implicit* at the point it emerges into conscious awareness. These descriptors also correspond with research on intuition (Swanepoel, 2008; Charles, 2004; Welling, 2005), suggesting this and other studies are able to identify and differentiate emerging implicit experiences (such as intuition) from other experiences therapists may have during therapy with their clients.

To some extent the descriptions by the therapists also correspond to Stern's description of a 'now moment' as *'unfamiliar, unexpected in their exact form and timing, unsettling or weird'* (Stern et al., 1998: 910). Stern suggests a now moment subjectively feels like a 'moment of truth' (Stern et al., 1998: 910), which may be similar to a sense of certainty noted by Shirley & Langan-Fox (1996) in relation to experiences of intuition.

Similarly the findings of theme 1 correspond in part to a more contemporary notion of projective identification where the emotional interaction within a dyad acts as a bridge to empathy and intuitive understanding (Hinshelwood, 1991). Hinshelwood (1991: 200) suggests that this implicit phenomenon 'befalls the therapist, in which he is made witness of some experience of his patient, in a way he does not foresee'. The *weird* experiences, either as alert or anomaly, are unsettling in terms of experiencing the other's feelings and thoughts (Ogden, 1982).

These findings align with previous research that found intuitive experiences were qualitatively different from other non-conscious processes (Welling, 2005; Bohart, 1999; Charles, 2004) to the extent that they appeared noticeable because of the difference from the normal pattern. The recognition of the emerging experience as *standing out* may parallel Welling's 'detection phase' (2005) in his phased approach to the intuition process. The *standing out* characteristic provides therapists with bottom-up, experiential data that began to identify the specific, unique dynamic relationship and form of implicit communication occurring at the assessment.

Stern et al. (1998) suggested a now moment is qualitatively different from other moments in therapy, standing out as an affectively 'hot' moment where relational states are altered or risk alteration. The now moment also possesses a phased process (*pregnant, weird and decision* phases) although Stern pays less attention to phenomenological aspects of the phases in comparison to Welling's (2005) research. The therapists' descriptions of emerging implicit experience map onto experiences and understandings of intuition in the literature in a more detailed way than projective identification and now moments. However there does appear to be an overlapping of the three concepts: intuition, projective identification and now moment.

There is a question as to whether emerging implicit experience named as intuition is simply countertransference. From these and other research findings (Bastick, 2003; Charles, 2004; Swanepoel, 2008) it would appear there is considerable crossover between the two phenomena. Although the concept of countertransference accounts for the characteristics found in the emerging implicit experience, countertransference does not precisely define characteristics to make the distinction between similar but separate phenomena. I would suggest countertransference is an umbrella concept incorporating many distinct phenomena that therapists experience in relation to their client. Intuition may be seen as one of many separate phenomena described as a countertransference process. Other countertransference processes being projective identification, now moments, attunement etc. may have overlapping features as well as unique features.

If we are to have a meaningful dialogue and develop further research about therapists' experiences and reflections it is important to be able to distinguish precisely between these different processes or phenomena. The distinctions between intuition, projective identification and a now moment are not so clear at present and need further consideration and specific research. Part of that enquiry would also be centred on theoretical context, definitional issues, the language psychotherapists and counselling psychologists use, and how we can discuss these experiences across psychotherapy modalities and different fields of psychology.

Correspondence of findings to intuition research
Feeling of contradiction

Bohart (1999) and Welling (2005) both acknowledge 'the feeling of contradiction' that accompanies the emerging implicit experience. The therapists' register of something happening that was out of the ordinary or different parallels Reik's (1948) warning signal, alerting him to pay attention. May & Barnard (2006: 15) comment that an incongruity between the two types of processing forms 'is in itself informative', and may lead to a sense that something does not *feel right* and thus a need to re-evaluate. The therapists in this study talked of their emerging implicit experience as Reik talked of intuition, as an alert or a signal for possible danger, using terms such as "alarm bells start to go off" (Lorna) and "sets my antennae off" (Ian). I suggest this also corresponds with evolutionary psychology (Cosmides & Tooby, 1992) where such feelings can be seen to be a mechanism designed by evolution to ensure an individual attends to specific environmental stimuli for benefit or survival. The ability to experience alerts and to respond rapidly to environmental dangers holds an evolutionary benefit according to Buss (1991). It is argued that right-brain to right-brain communication is fast and useful for novel complex situations (Schore, 2012), an example of which would be the psychotherapy assessment. The

affectively charged nature of the therapists' experiences as *powerful and dramatic* may be understood by the work identifying neural networks concerned with affect, and the connection of emotions with non-conscious processing being similar to the neural bases of intuition (Damasio, 1994; 2000; Lieberman, 2000; Schore, 2000).

Embodied response

The embodied response to the emerging implicit process recognised and reported by all participants can be understood through a neurological lens as an embodied mind where the activation of the central and automatic nervous systems is embedded in unconscious processing. Ian talked of his body "tightening" and "a gut reaction" to the emerging implicit experience before thought or conscious reflection could take place. Earlier research highlighted bodily associations with intuition; Petitmengin- Peugeot's (1999: 62) research found a main theme of 'Modification to the relation to the body'. Charles's (2004) participants (therapists) used diaries to report their intuitive reactions to their clients, which resulted in the sub-theme *Bodily unease*. Swanepoel (2008) found that her participants reported feelings of somatic connection that were perceived by the participants as essential to the intuitive process.

It has been argued that psychotherapy is an embodied activity (Gendlin, 1991) where therapist and client have embodied awareness (Fogel, 2009). It is thought therapists respond to their internal states or somatic markers (Damasio, 1996) and at the same time to the moment-by-moment relational dynamics with the other. This emphasis on the embodied experience is vitally important in psychotherapy assessments especially as protocols may become more dominant. Bottom–up processes focus on emotional and sensory data rather than prioritising top-down schemas, ideas or manualized ways of thinking about the client. I take Marks-Tarlow's (2012) stance that too much reliance on top-down processes in therapy leads to closed minds and clinical work that does not follow the moment-by-moment sensory data of the relational dynamic essential to the process of change.

It appears that some literature and clinical training may lead to therapists attending more to some forms of information processing than others. However Teasdale and Barnard's (1991) Interactive Cognitive Subsystems (ICS) framework assumes there are several kinds of information processing modes that work together and hold equal importance. They suggest that two of the cognitive subsystems are implicational (implicit, non-verbal meaning that integrates sensory and bodily inputs and captures affective states) and propositional (specific meaning expressed verbally). The ICS framework offers a view that two of the routes to meaning; implicational and propositional work together to compliment each others' processing operations

rather than compete with each other. From this perspective therapists would be encouraged to hold equal value to the different processing modes.

A rapid process

The speed at which the emerging implicit experience occurred was recognised by all the participating therapists, in terms of how fast the experience emerged and how rapidly it occurred after meeting their new clients. Previous research suggests our first responses to others happen not in minutes or seconds but in milliseconds. Bar, Neta and Linz (2006: 276) say 'people base their first impressions of others on whatever information is available within the first 39ms'. An evolutionary perspective argues decision-making is rapid to respond to possibly dangerous environments (Buss, 1991). Bar et al. (2006: 269) comment; 'rapidly formed first impressions can facilitate our survival and interaction with the environment'. From an attachment perspective the rapid implicit transmission of affect between mother and infant is a constant regulatory process supporting the infants' developing brain. It is believed that this enables the emotional mechanisms to cope with stress and challenges throughout their lifespan (Schore, 1994; 2003). From these perspectives, the therapists may have used the mechanisms of survival, interpersonal regulatory processes and interaction with novelty in the world to rapidly accumulate data about their new clients. These mechanisms are by their very nature implicit.

The feeling of certainty

Assessments involve a time of high density of information both explicit and implicit, therefore it is imperative we understand how we process this information and what data is noticed or not. Therapists are required to make complex judgements about new clients; their risk, core issue, needs and direction of treatment. Being able to make rapid intuitive judgements about risk with a new client was seen by all the therapists as important; both for their own safety (as with Tracy) or for clients (as with Janis's client). However the continual question of accuracy of intuitive judgements remains. I take Claxton's (2003) caution that the feeling of certainty may not indicate accuracy but could be a useful indicator for further enquiry. The complexity of possible meanings for any emerging implicit experience suggests decision making or interpretation too early may compromise the development of full meaning and accuracy. This also draws attention to the therapists' ability to stay with the unknown (and their own somatic data) for periods of time even if uncomfortable (Bollas, 1987). An important area of further research may be clinical intuition in relation to risk prevention, and how therapists use somatic data to gauge intersubjective implicit communication around safety, for the client and therapist.

Holistic characteristics

The holistic aspect of the intuitive outcome incorporates three sub-themes: *imagery, resonance* and *anomaly.* Imagery involves the images and vignettes the therapists experienced in their mind's eye, the importance of the first glimpse of a new client and the way therapists talked about their experiences via imagery and metaphor. Finlay (2015) suggested the use of imagery allows for a depth and subtlety in the relational dynamic and a means to access pre- and non-verbal aspects of clients' experiences. Imagery was found to be a common aspect of intuitive outcome in previous research. Petitmengin-Peugeot (1999) identified imagery as a sensorial form of intuition, further commenting these were most often internal images, such as those Lorna described.

The first glimpse of a new client was highlighted by the therapists and may provide what Clarkson (2003) talked of as a golden opportunity to experience the new client fresh. This may suggest the first glimpse is important for therapists to note in assessment especially in terms of risk, but may also be useful for accessing clearly the clients' core themes, which drive their presenting difficulties. The first glimpse also relates to Ambady's work (1993; 2001; 2008) where accurate judgements are made based on very small amounts of data. Of course this contradicts the caution suggested earlier, but being able to identify and hold information in order to reflect and assess for accuracy, usefulness and meaning are skills of therapists, skills to be continually honed.

The ways in which therapists talked of their experiences were full of imagery and metaphors e.g. Ian's *'scales'* metaphor that captured his experience of the difference between the presence of the client and the emptiness of what was not known yet. This evocative image told me more of his experience than if he were to explain in great detail. The metaphor either visual or verbal speaks to the heart of our emotions, creating meaning and transforming experiences (Marks-Tarlow, 2012). Modells' (2003) understanding of metaphors as bridging disconnected experiences to create somatic templates fits with the metaphorical language and stories used by the therapists in this study.

The resonance therapists talked of may be seen as an equivalent with holistic associations that are deep, unconscious recognitions of patterns and structures held in long-term memory (Dane & Pratt, 2007). Holistic associations are suggested to be one of the defining characteristics of intuition, therefore *resonance* highlighted by the therapists may be seen as a core aspect of intuition. Resonance incorporates attunement, 'now moments' (Stern et al., 1998) and affective regulation (Schore, 2003) between therapist and client often resulting in profound moments of meeting where transformational change occurs (Stern et al., 1998). Resonance or holistic

associations were not only experienced by the therapists in this study, but were sought after states to enhance the therapeutic relationship and process. Rachel understood that by trying to create a state of reverie she was more able to achieve a resonance with the client. From a dialogical perspective, meeting in the I-Thou relationship (Buber, 1958) or person to person (Hycner, 1993) is considered to foster moments of profound connection or resonance that offers a fundamentally different experience of meeting.

Rachel's notion of a state of reverie relates to Bion's (1967) concept of *reverie*, and is consistent with Winnicott's (1971) notion of *potential space,* a means to make sense of what was happening in the unconscious process. This is where physiological and affective states are being attuned to by the therapist when words and language are incapable of expressing the depth and complexity of experience.

The presence of resonance suggests the potential for deep connection between therapist and client that is usually associated with periods of trust and the establishment of a good working alliance. That resonance can occur so early in the assessment session poses questions about what constitutes deep connection and an establishment of working alliance. Research consistently shows moderate but reliable association between a good working alliance and positive outcomes in therapy (Hovarth & Symonds, 1991; Karver et al., 2006). This research looked at a period of time before working alliance had been established. This poses further questions of what level or type of alliance is necessary for the implicit communication of profound states of being (or Stern's 1995 *key metaphor*) to be transmitted from client to therapist. Further research questions could enquire how working intuitively, or with implicit communication corresponds or impacts the establishing of working alliance.

Anomaly is the third aspect of the holistic characteristic therapists in this study found prevalent. Tracy understood anomaly as noticing a difference to the normal pattern. The anomaly is consistent with Welling's (2005) pattern recognition theory of intuition. Deviation from an expected pattern would alert attention for further consideration to the situation. Deviation from an expected pattern draws attention to the often forgotten unconscious subjective biases, prejudice and schemas that we all may hold. The anomaly also highlights the intersubjective nature of communication at assessment. It is crucial to reflexive and reflective learning that therapists are alert and mindful to the experience of anomaly, as it may enable access to the possible unconscious material coming from both client and therapist.

The therapists' subjective experiences of the emerging implicit corresponded with previous research and literature concerned with identifying the main characteristics of intuition. Although

there are some crossovers with the phenomena of the findings of this study and the concepts of countertransference, projective identification and now moments, these are limited in comparison with the research findings, literature and current concepts of intuition.

The emerging implicit experiences described in this research can be identified closely with the experience of intuition as characterised across modalities and fields of study. Having an agreed set of characteristics enables further study and dialogue to address specific areas of intuition research that may shed light on how intuition is used in therapy. That intuition can occur during the assessment and at the very beginnings of assessment sessions is important to note, as this has implications for training and who is employed in services to undertake assessments. These findings identified the therapist's belief in the importance and complexity of attunement to the ability to access the client's *key metaphor* (Stern, 1995) during assessments. This I suggest requires experienced and sensitive therapists to make use of the implicit alongside the explicit communication occurring during these first moments of meeting.

What's going on here?

The second theme *What's going on here?* represents therapists' questioning of the emerging implicit experience; it also represents what therapists reflect upon and their reflexive process during the assessment. It is vital for therapists to reflect on what and how they think, how they make decisions and interventions in therapy in order to assess what works, with whom and when (Roth & Fonagy, 1996). These findings shed light on the complexity of the therapists' experience and thinking process as implicit material comes to conscious awareness. Identifying and acknowledging the reflective and reflexive processes taking place during assessments is significant in aiding ongoing improvements in skills and knowledge. Swanepoel's (2008) research emphasised the complexity of the intersubjective activity surrounding intuition in psychotherapy. Similarly this study acknowledges the role of intersubjectivity and the complexity of emerging implicit experiences occurring in assessments.

As with Welling (2005) and Petitmengin-Peugeots' (1999) research on intuition, the therapists in this study reported a phased process to the emerging implicit experience. They reported that their somatic experience was followed by conscious register of the experience, then an acknowledgement of the impact, the intensity and direction. They said this was followed by reflections on the experience and a re-adjustment before action or decision. Decisions and actions in relation to the client and therapy were described as often being held back, as we see in the sub-theme *'Wait and see'*.

Slowing down the process and taking note of the phases of the emerging implicit experience appeared important to the therapists' reflective practice of often automatic responses. The research interview offered an opportunity to make conscious the process of thinking that may become lost without mindful attention. Mindful attention that encourages reflexivity was assessed as vital to professional development and learning (Sandelowski & Barroso, 2002; Bager-Charleson, 2010). Being mindful meant therapists noticed what happened to them, their somatic responses, accompanying thoughts, reflections in the moment and afterwards. By reflective self–awareness the therapists were able to notice what was happening within themselves, between them and the client and within the wider context. This reflective self-awareness has been seen to promote transformational learning, and an absence has been considered to seriously impede meaningful understanding and the progress of therapy (Bager-Charleson, 2010; Atwood & Stolorow, 1996).

Therapists asked the question "Where did that come from?" as the emerging implicit experience came to their awareness without invitation and was seen at times as intrusive. This differed from Petitmengin-Peugoet's (1999) work, which talked of the *"welcoming"* in of intuitive experiences. This difference could be accounted for in terms of whether therapists actively try to create conditions for intuition to occur, or not. Although Rachel did try to create a state of reverie, she was still surprised and challenged by the emerging implicit experience when it occurred. The difference may also be connected with the individual therapists' expectations, beliefs and relationship to emerging implicit experiences. Ian, Lorna and Tracy were more open to accepting the emerging implicit experience as intuitive, normal, expected and useful aspects of therapy, unlike Rachel who seemed to be more challenged by her emerging implicit experience. These individual differences in how the emerging implicit experience are reflected upon may suggest further research that explores individuals' belief systems, previous training and knowledge and how these earlier experiences impact concepts of implicit knowing. The issue of knowledge hierarchy may also play a role in the acceptance of implicit knowledge. The prefacing of logic and rational knowledge over implicit knowledge has been a prevalent theme since the enlightenment. And yet even with the advances in cognitive and neuro-science in explaining how the brain works and how we gain knowledge, the wider cultural supremacy of the logical minds persists (McGilchrist, 2009).

An aspect of interest was in recognising the personal qualities of the therapists and how their own life stories impacted their beliefs and processing of information and experiences. A question that arose in this research was: *How does previous training/career impact therapists' experience of intuition?* Although I did not pursue this particular line of questioning in this research in part due to confidentiality issues, this would be a further area to explore. One

therapist had been an actor previously. She acknowledged this meant she was more easily in touch with working imaginatively, using her bodily experiences and her intuition in the process of acting. The direct transfer of skills from one occupation to another is one aspect to consider further. More significant are the unconscious underlying belief systems and processes of thinking that direct and drive how she (we) conceptualise human experience and interaction. During the research process, this recognition of individual differences and past experience chimed with my own history, philosophical and political stance. My particular beliefs concerning emerging implicit experiences as intuition and understanding of what and how I respond more acutely to certain presentations and clients, has been accentuated through the process of this study.

The therapists' accounts recognised the intersubjective nature of their experiences, so instead of thinking in terms of a projection of the clients' material onto them, the therapists conceptualised their experiences in line with a system of reciprocal mutual influence (Atwood & Stolorow, 1984; Sander, 1995). This perspective allowed the therapists to be curious about their own experiences including blind spots, prejudices and biases. This ability to be reflective and reflexive may be seen as indicative of a deep level of self-awareness, which might be connected to their personal therapy, training and supervision. These therapists' ability to remain open to their own material even when faced with difficulty or the unknown enables us to gain an insightful understanding of the complexity therapists face in clinical work.

Working intuitively means working at the edge of consciousness according to Marks-Tarlow (2012). For this and other studies (Petitmengin-Peugeot, 1999; Charles, 2004; Swanepoel, 2008) there was a focus of attention on acknowledging and staying with the experience driven data. When Janis said *'Wow! What have I got here?'* it appears she is not just asking about what the client is bringing, she also seems to be focusing her attention to her somatic experiences in relation to the client. It has been suggested that staying with the experiential data is the crux of working both intuitively and relationally, corresponding to the work of many contemporary psychotherapists (e.g. BCPSG, 2002, 2008; Maroda, 2010; Benjamin, 2004; Marks-Tarlow, 2012). I would suggest that remaining experience-focused longer rather than trying to attach an interpretation enables experience to deepen and meaning to develop. This links with a number of concepts regarding profound meetings of therapist and client at somatic, often sub-conscious levels. Orbach (2004) talked of relational psychoanalysis as relating via our somatic reality. For Bollas (1987) *getting lost with the client* for periods of time was crucial before the reflective process of identification and interpretation. This is similar to Maroda's (1998) *surrender,* the therapist allowing themselves to be impacted by the clients' unconscious

material in order to fully understand the complexity and profundity of the clients world: b*eing with* a client rather than trying to think about and interpret the clients' experiences.

The sub-theme *What am I bringing to the experience?* focuses on therapists' deep belief and commitment to intersubjectivity in therapy. It seems that the therapists' openness to their own inter-psychic and intra-psychic processes enabled them to begin to grapple with the complexity of meeting the other. I believe the therapists' material and the clients' material meet and overlap to create a unique connection, creating a possible opportunity for implicit experiences to emerge. All therapists talked of their part in the emerging implicit experience with the client. Working intersubjectively, at the edge of consciousness is related to Buber's (1966) concept of *the between*, Ogden's (1994) concept of *the third* and Benjamin's (2004) process of *creating thirdness*.

In my view the need for therapists to be working reflexively and to attend to their own unique and particular history, philosophy and beliefs is essential to creating opportunities for emerging implicit moments to be recognised and reflected on sensitively. In this study the therapists commented on how supervision had increasingly been focused on developing their own increased self-awareness. This brings into focus how we consider training and ongoing supervision. However it is imperative to distinguish between the training of clinical procedures, protocols and accompanying theoretical schemas, and training to develop an ongoing process of mindful awareness to self, other, environment and to the current theoretical dialogue. The former is training in how to *do* while the latter is training in how to *be*.

By being and talking openly about their ongoing thinking process the therapists showed how working psycho-dynamically involved difficulties and dilemmas of working with the unknown and at the edge of consciousness. The therapists' accounts highlighted the inner conflict occurring during times of emerging implicit experience that strikes at the heart of how and what they know. Inner conflict had three components in this study; certainty verses logic, what it means to know and accuracy.

The therapists all talked of their feelings of certainty about the emerging implicit experience, but this was often not easily explained or qualified by the available data at the time. The sense of certainty corresponds to Shirley & Langan-Fox's (1996) work identifying *certainty* as a core characteristic of intuition. However the conflict the therapists experienced and how they thought through this dilemma is more in line with Claxton's (2003) appeal for caution. The feeling of certainty may represent a somatic maker (Damasio et al., 1991) that denotes further enquiry rather than an indicator of accuracy. It is crucial to note that research on accuracy and intuitive

decision-making is often related to specific simpler tasks (e.g. Iowa Gambling Task). While the psychotherapists' task is to develop complex understanding of a client, the decision-making and direction of treatment are often slower processes undertaken after a great amount of reflection and consideration. The exception is when a client presents as at risk. A relevant area of further research may be the role of the emerging implicit experienced in connection with intuitive decision-making and its accuracy in risk situations both in the assessment and therapy as a whole.

An important question coming from this study is *What type of knowing is best?* It was evident the therapists in this study understood they used multiple ways of knowing (Jeffery, 2012). However priority was given to some ways of knowing over others, suggesting the therapists may habituate to attending to certain ways of knowing or have a hierarchy of knowing. A hierarchy of knowing was most clearly represented by Rachel who, although convinced her intuition was correct, questioned its' usefulness and often would not use it. Her inner conflict centred on whether somatic knowing was as reliable, valid, trusted or simply understood as much as an explicit, cognitive, reasoned process of knowing.

The conflict between intuition and logic, experienced by the therapists, could be seen as the dichotomy between left and right brain processes. However, just as with the Cartesian dichotomy, a conceptualisation of intuition as just a right-brain process and logic as just a left-brain process is too simplified an account of conscious and non-conscious processes. From the therapists' accounts in this study they perceived their experiences of intuition to be complex. An interesting future study would try to gauge how intuitive knowing and the reflective stage occur, and to explore the complex inter-reliant process between the two.

Another issue strikes a political and commissioning imperative of needing to quantify what happens in therapy. There is a danger that in the need to quantify and pin down what happens and what works, we may lose sight of the necessary implicit elements so crucial for transformational change. The emissary may overshadow the master (McGilchrist, 2009). Further research focusing on what happens and what works in therapy needs to actively focus on the implicit dimension as a crucial aspect of change.

Relational psychotherapy is steeped in the prizing of knowledge coming from the minute observations of the moment-by-moment interchange between therapist and client. This experiential and somatic knowing is then reflected upon from the analytic perspective. Relational psychotherapy is widely accepted and an established form of clinical working. However the therapists' hierarchy of knowledge suggested in this study raises questions about

what forms of knowledge are attended to, and what hierarchies of knowledge persist without adequate reflective attention.

Working intuitively at the edge of consciousness means there is no rulebook or mechanised formula that can be followed. But this does not necessarily mean that research cannot investigate these processes or that frameworks cannot be developed to help professionals reflect on what is occurring at the edge of awareness. Jeffery's' (2012) research on clinical intuition in marriage and family therapy was concerned with the common experience of intuition not being adequately addressed by therapists. He argued therapists do not know what to do with intuitive experiences when they occurr, thus prompting his study to develop a guideline to help therapist navigate decision-making. The guidelines prompt an awareness raising and questioning for the therapist when faced with clinical intuition, rather than give directions and procedures of how to work clinically.

Rea (2001: 97) comments; 'we know very little about the use of intuition in psychotherapy'. This research offers an opportunity to hear these therapists recount their emerging implicit experiences at assessments and consider if this may be considered clinical intuition. I believe it is important for the profession to share the *process* of what happens in the closed confines of the therapy room and vital that clinicians try to share their emerging implicit experience, as it is so difficult to capture by its very nature. I suggest dialogue that is centred on practice based evidence will more readily lead to a deeper understanding of the complexity of both explicit and implicit interactions, leading to improved, more transparent practice for therapists and better outcomes for clients.

The difficulty in naming the experience

This research highlighted the difficulty in naming emerging implicit experience and putting language to experience for these therapists. Previous research by Petitmengin-Peugeot's (1999) found participants had difficulty putting words to their intuitive experiences while they 're-lived' their experiences in the research interviews. Rea (2001) also found that verbal communication lags behind experience and understanding. The difficulty of putting language to experience in this study not only showed language lagged behind experience but language could not describe some experiences fully. The difficulty in naming the emerging implicit experience brought into focus the use of gesture and body to aid verbal language, and the use of metaphors.

This research highlighted the therapist's difficulty in precisely naming their emerging implicit experience. Many different names for the emerging implicit experiences were used and there

was no consistency across and within each therapist's interview. However all therapists did use the name *intuition* at times to describe their emerging implicit experiences. Using varied names to describe an intuitive experience was previously described by Sprenkle (2005) where multiple names were used to discuss a particular experience. The difficulty in finding an accurate name for the emerging experience was apparent to the therapists as they struggled to articulate their emerging experience.

By un-naming the experience (Van Manen, 1999) in the research information and during the interview process, it may appear I created confusion or difficulty around the language of the emerging implicit experience. This may have had some impact, but I suggest this highlighted the difficulty in naming rather than created the difficulty. Although the name *intuition* was used by all the therapists it was not used consistently or with conviction, and other names were constantly inter-changed. By un-naming the experience and using instead the phrase *emerging implicit experience* the research interview offered an opportunity to explore the hidden meanings, assumptions, beliefs and biases around the names the therapists used. By paying particular attention to this difficulty, this research offers an opportunity to consider the problem of naming, definitions and more general use of language for implicit experience. Previously these issues have been mentioned as an aside in other research studies (Welling, 2005; Charles, 2004) but rarely explored further.

An interesting point to note is how and when different names were used. Ordinary everyday names such as "gut reaction" or "a feeling" were used when describing the experience, while more technical or theoretical names were used when reflecting on the experience. This use of different types of language is an aspect of the changing context of the discussion from description to reflection. "Gut" and "intuitive sense" are common simple language compared to the technical language of "projective identification" and "transference", which would not necessarily be understood by those outside the psychotherapy world. Lorna was conscious of using "jargon" that could distance her from her client and her own experience. Reik also warned against the use of "Psychoanalese" (Reik, 1948: 458), a form of psychoanalytic jargon that can distance one from experience and from insight into human experience.

However the word *intuition* was not used as a technical or reflective word but as simple, everyday language, suggesting perhaps a lack of confidence in its definition, meaning and ability to communicate complex processes. The difference in how the therapists used language in this study may be illustrated by theory-in-use (in this study language-in-use) compared to espoused theory (espoused language) (Argyris & Schon, 1974). This gap between *espoused* and *in-use* may indicate the potential for learning about how therapists actually talk (and

perhaps think differently in action compared to reflection) and to consider what creates the difference. The difference may be that of definitional issues, biases, implicit prejudices, beliefs or something else. Mindful awareness to these difficulties and differences may encourage further enquiry and learning.

The hidden beliefs, assumptions and biases were brought to light by the un-naming process of the research interview. Each therapist had a number of subjective hidden assumptions, beliefs and biases revealed during the interview process. Ian for example, held the belief that some experiences cannot be named. While both Tracy and Rachel had beliefs concerning the hierarchy of knowledge, logical ("scientific") knowledge having greater status than implicit knowing.

The definition and meaning of intuition was fraught with complications for the therapists in this study. This mirrors an ongoing definitional issue within intuition research, in psychotherapy and beyond (Jeffery, 2012; Welling, 2005; Sinclair, 2011). This research suggests there are further questions to explore about how the role of previous training, careers, beliefs and experience impacts the therapists' ability and willingness to use the word intuition. Previous experience undoubtedly has an impact on how people use particular words and language to express their experiences. The cultural context in which we develop concepts to understand our world is crucial to how we develop language to express those experiences (Sapir-Whorf hypothesis, 1956). An implication of this is how the training of therapists may encourage an ongoing reflexive stance, whereby mindful attention to implicit biases and beliefs are part of ongoing learning, professional and personal development.

The lack of consistent and precise naming suggests a possible lack of unified definition and understanding of the nature of intuitive phenomena within the psychotherapy field. Most previous intuition research studies (Welling, 2005; Charles, 2004; Swanepoel, 2008) have commented on the difficulty in defining the implicit experience, especially from the perspective of psychotherapy disciplines. Recent intuition research (Jeffery, 2012; Sinclair, 2011) have focused on more integrated and multi-disciplinary perspectives in order to develop a unified definition and an integrated framework of intuition. Sinclair (2011) looks at intuition from a multi-disciplinary perspective with the aim of cross-pollinating knowledge and research on intuition. A research perspective focusing on reconciling conflicting views and developing opportunities to understand intuition as *direct knowing* would offer therapists a better position to consider intuitive experiences in therapy. From a more collaborative perspective meaning and naming could be considered holistically.

From this research project I have developed a definition for intuition that may be useful for clinicians working in psychotherapy settings to consider emerging implicit experiences. I have drawn on and been mindful of a multi-disciplinary perspective that will cross psychotherapy and psychology modalities. I have incorporated the four characteristics from Dane and Pratt (2007), the sense of certainty from Shirley & Langan-Fox (1996), the non-sequential aspect of processing and the awareness of the body to develop a working definition for intuition as follows:

> *Intuition is a non-sequential information-processing mode, perceived through emotional and physical activation, which rapidly comes into conscious awareness and results in direct knowing without the conscious use of reasoning or deliberation, and has a sense of certainty.*

Language of experience

Putting language to experience is a primary task for psychotherapy, in order to create meaning. The difficulty in putting language to implicit experience is a complex problem that has long concerned psychotherapists (e.g. Hobson, 1985), psychologists (e.g. Lakoff & Johnson, 1999) and philosophers (e.g. Whitehead, 1968; Polanyi, 1967) alike. Johanson and Kurtz (1991: 1) said; 'they [words] never capture precisely what is. We get lost in words. They can separate us from experience, imposing alien meaning on it, instead of being congruent with it'. This potential loss of meaning is an important part of the difficulty that some of the therapists in this study talked of.

The difficulty in naming the emerging implicit experience also gave rise to the wider issue of putting language to subjective lived experience. Whitehead (1968: 109) spoke of 'The great difficulty of philosophy is the failure of language.' He argued that language fails because we have to express what is new and unknown in terms of what is old and known. I suggest this failure of language was the same for the research therapists when they tried to verbalise their emerging implicit experiences.

One issue the therapists talked of was the holistic nature of their emerging implicit experience, where all senses and knowing were experienced at the same time, but how do we express this? Language is linear, one word expressed after another (Hobson, 1985). We do not experience in a linear fashion so we immediately have a problem in expressing the wholeness of our

experiences. Language and experience are two domains and as such cannot be mapped onto each other fully; something is lost. There is a gap. The gap was most notably expressed by Rachel when considering her experience may be broken down by words. Lacan (1977) had a more extreme view of the gap between language and experience as manifesting in *the murder* of experience. The perspective of words destroying experience, although extreme, may be hinting at those experiences that have not been symbolically coded, such as in implicit relational knowing (BCSPG, 2002). Knowing about how to be with another, or '*ways of being with'* (Stern, 1985) are ways of knowing that generally operate outside conscious attention, without being translated into verbal language. This form of knowing 'has never been put into words, has never needed to be, or never could be.' (BCSPG 2008: 129).

Psychotherapy is a talking therapy where words are powerful. They can name and create meaning; bring understanding to complex experiences and bring connection and recognition between individuals. However, psychotherapy incorporates some knowing, experience and ways of being that are not, cannot and will not be put into verbal language. This tension between experience and language is one aspect of the difficulty in naming, discussing and researching emerging implicit experiences.

There was a clear distinction between implicit experience that was direct, subjective and lived through (BCSPG, 2008) compared to the therapists' verbal expressions of their experiences. The verbal expressions were delayed, viewed as reflections from outside the experience. In the interviews the therapists displayed this distinction or gap, as when Tracy's breathing changed as she began describing her emerging implicit experience. Slowing down and attending to the process it was clear experience occurred, physical markers were noticed (even pointed to) before verbal expression was activated. The verbal lagged behind experience (Rea, 2001). Or as Whitehead (1968: 49) says: 'Language halts behind intuition.'

The gap or disjunction between the implicit experience and verbal language is seen as the 'crucial property of emergence' (BCPSG, 2008: 143). It is not that the difficulty is getting in the way of verbal expression of the experience but it is a necessary component. The gap or disjunction is an essential part of the whole gestalt bringing meaning to the reflected and verbalised emerging implicit experience.

To maintain the meaning of implicit experiences Van Manen (1999) suggests we need to think and use language for tone and pathic understanding of the intuitive or implicit experience. To do this we need to be primarily experience-focused rather than theory focused with clients. Van Manen (1999) suggests words need to be more tentative, but I suggest, rather than tentative,

words may need to be more freely experimented with and reflected upon, as was the case in this study. BCPSG talk of the 'sloppy work to find the *'right'* words' (BCPSG, 2008: 137). The interchanging of words demonstrated by the therapists in this study was similar to this 'sloppy work' of trying out words to find a verbal match to their intuitive experience. This process is dynamic, involving the mutually responsive interaction of speaker and listener. Existing phrases or pieces of language are experimented with to gain the best fit and thus the best communication of often profound experiences to the listener. This messy experimenting phase of communicating was accompanied by gestures and non-verbal language in an attempt to capture the wholeness of the experience. I suggest this is akin to the 'intention unfolding process' described by BCPSG (2008).

When verbal language struggled to sufficiently describe the implicit experience, the therapists became more creative and imaginative in their desire to communicate. The therapists described their emerging implicit experiences as metaphors; they used metaphors in their clinical work and in the research interview. Metaphors occur at multiple levels. Primary metaphors are fundamental implicit notions about our self, others and the world (Lakoff & Johnson, 1999), such as: good is up. At another level the metaphor is direct, explicit and part of the content of an encounter such as Ian's use of the weighing scales metaphor.

We construct our world via our perceptions and categories of thought. The metaphor is not just a figure of speech or thought but an elementary process in the structure of experiencing our world (Lakoff & Johnson, 1980). From the Greek *metaphora*, meaning transfer; metaphors have the capacity to transfer meaning, to bridge gaps and present new ways of seeing and knowing the world. The therapists talked of the metaphors associated with the emerging implicit experience. Lorna used the metaphor of seeing her new client as James Dean. In this momentary image bringing together two domains (new client and James Dean), Lorna performs a synthesizing operation creating a new way of thinking, experiencing and later reflecting on her client's key issue. The intuitive experience led Lorna to find her new clients key metaphor- *the seducing rebel*. When meeting a new client Stern (1985: 282) suggests 'the primary task is to find the narrative point of origin – invariably the key metaphor.'

The complexity and wholeness revealed by metaphors is linked with metaphorical thought, which has been suggested is a right-brain activity rooted in emotions and the body (McGilchrist, 2009). The primary location of implicit processing, intuition and metaphorical thinking in the right brain suggests these processes may derive from the same mental material and are intricately linked. Metaphorical thinking links 'language to life' (McGilchrist, 2009: 115) and it appears the therapists in this study demonstrated how metaphors enabled the verbal language to express

complex, profound emerging implicit experiences occurring in the assessment. Not only did the metaphor express the experience, it also brought the experience into vivid rich and full life for me, the researcher. This is the crucial difference between being informed of others' experience and getting a sense of the lived experience of another. The former is about information, the latter about communication and connecting.

With the difficulty of putting verbal language to experience, all the therapists became more creative and more active in their intentions to communicate the meaning of their intuitive experiences. Gestures and gesticulations were increased to convey semantic meanings (Efron, 1941/1972). Non-verbal communication (NVC) became more overt in the desire to express experience. In many ways the therapists aided their spoken communication with gestures, facial expressions and body postures. This means of using both verbal and NVC has been researched extensively (Argyle, 1975; Ekman, 1972; Mehrabian, 1968). NVC aids speech, replaces speech and, signals attitude and emotional states (Argyle, 1975). This research demonstrates how the non-verbal aspect of communication appeared to be the mainstay of interaction within the research interview dyad (researcher and participant), rather than the verbal exchanges. The implications for how we collect data from research interviews and clinical assessments suggest NVC is given more emphasis, alongside explicit communications.

All the therapists in this study used the same action to represent how they held the intuitive information behind their left ear with their left hand. This key gesture seemed to represent a common response to the *wait and see* of the emerging implicit data. Further research could explore how common or key gestures and body language relates to emerging implicit experiences. It would be interesting to see if we have primary bodily metaphors (gestures/actions) in a similar way that Lakoff & Johnson (1980) talked of primary verbal metaphors.

From the therapists' accounts they sometimes appeared to be impacted more by the NVC than by the dialogue when meeting a new client at assessment. This was evident in the therapists' stories of their experiences at assessment. At times during the research interview I also seemed to experience the NVC as having more impact on me, than the therapists' verbal narrative. The difference between the impact and importance of NVC compared to verbal communication was discussed in research by Mehrabian (1968) and by Argyle, Alkema and Gilmour (1971). Argyle et al. (1971) found that when there was a difference between the NVC and verbal messages, the NVC was five times more powerful. The difference between the impact of NVC and verbal communication is worth re-iterating especially in light of how psychotherapy is researched and discussed. The BCPSG researchers have been at the

forefront of research emphasising the non-verbal within psychotherapy and transformative change for clients. In light of this it seems unsurprising that putting words and verbal language to emerging implicit experiences would be problematic. Therefore the desire to communicate and reflect upon experiences needs to engage all forms of communication: this is truly a creative, holistic and complex business.

Strengths, Limitations and Future research

A strength of this study was the use of qualitative methodology; it provided the opportunity for these therapists to voice their subjective experience of the emerging implicit at assessments. This area of research has been previously neglected in the literature. As a methodology, IPA appeared to fit well with the aims of this study, producing a rich and detailed description and understanding of these therapists' experiences and their ways of making sense of those experiences. The process of data collection and analysis in IPA is akin to the way I see data collection and analysis taking shape in psychotherapy. Therefore my position as researcher was in line with my position as an integrative psychotherapist, both philosophically and more practically.

IPA offers an idiographic approach, therefore definitive or positivist answers are not sought. This research offers an opportunity to engage with rich, vivid and subjective experiences of the five therapists interviewed. These findings cannot be generalised to the wider population of therapists but they may resonate with others' experiences of the emerging implicit at assessments to create further insight, reflection and dialogue. The strength of idiographic and experience-focused research is that it dovetails into the core work of psychotherapy.

There may have been some confusion regarding not overtly naming the experience of the topic of the study. This has been addressed earlier but this may have had an impact on the selection process. Finding a means to recruit participants without imposing a definite name or label for the phenomena in question was fraught with difficulties. Participants had to define the term *emerging implicit experience* initially in order to assess if they could participate in the study. This may have deterred some people from participating. I suspect there may also have been a process of the participants trying to second-guess the name or label I was avoiding using. Again this begs the question: How do we recruit participants when the study topic is how participants name the experience of the study?

A further consideration is the use of member validation, I chose not to check my interpretation against the therapists participating as I take the stance that there is no one fixed truth or reality.

(I showed all participants the direct quotes I wished to use and asked for further approval to do so). However I did use peers to check that my themes were rooted in the participants' data and that my interpretations of participants' experiences were not misleading or misrepresenting their stated experiences and understandings (Elliott et al., 1999; Yardley, 2008).

The primary limitation of this study was that only therapists' experiences were explored. A study that explored clients' experiences of the emerging implicit at assessments would be very useful, and a study using a therapist and client dyad would give an even more rounded understanding of what happens at assessments in terms of implicit processes such as intuition. However my particular questions and the origin for the research *Is my experience of the emerging implicit at assessment similar to other therapists?* was directed to therapists not clients. Research studying implicit processes such as intuition is difficult for a number of reasons, mainly because it is an implicit process. Intuition cannot be created or predicted and therefore must be explored in hindsight. This fundamental difficulty applies whether therapist or client is participating in the research.

My interest was in how therapists experienced, used and named their emerging implicit experiences. Other related questions that I considered, but chose not to follow were: *Does the therapists' intuition correspond with the clients' experience? How does the therapists' intuition make sense to the client? What is the clients' experience of intuition at assessment?* These are questions for future research. Therapists may be able, or more familiar with reflecting upon the types of questions I was interested in asking in the research; these questions were akin to reflections within everyday reflective clinical practice. Further research could explore client/therapist dyads that have an established working alliance and who may be overtly working with their intuitive experiences in the therapy process. These intuitive experiences may have happened in the assessment or late in therapy. Again the difficulty is in not being able to predict these phenomena, so at present all intuition research is focused not on the process of intuition, as it is implicit but the outcome of intuition as it emerges.

Another limitation of this study was that the interviews used audio rather than video recording. In the audio much of the nuanced non-verbal communication was lost. I was able to comment within the interview when I noticed particular non-verbal communication and I did record my reflections on the non-verbal aspect of the interview straight after each interview. The choice to use audio rather than video was in the main an issue of confidentiality for the therapists interviewed and for their clients whose stories were included. Using video rather than audio could impact the therapists' willingness to talk openly and as freely as possible. The prospect of being videoed could reduce therapists' willingness to participate in the research. Videoing may

create more self-consciousness, hampering the process. Further research may consider the benefits of using video and this may be easier in a study where the participant is the researcher. Of course this still involves confidentiality issues concerning protecting the identity of any client material.

Contribution

This research has contributed to the literature on intuition in a number of ways. This study was able to use therapists' lived experiences of the emerging implicit to relate to established common characteristics of intuition, thereby linking this study to those of other studies (Dane & Pratt, 2007; Welling, 2005; Charles, 2004; Swanepoel, 2008). This further highlights the need for a more coherent base in terms of definition, nature and characteristics of intuition from which to have meaningful dialogue and to do further research within psychotherapy. By exploring the emerging implicit at assessments this study offers an extension to the timeframe from which to consider emerging implicit experiences such as intuition in therapy. In this study the therapists reported that they experienced implicit phenomena such as intuition during the assessment and also that these experiences occurred even before therapist and client spoke to each other. By describing the emerging implicit activity happening before words are spoken in this research, it is hoped this has resonance with other therapists, who may be mindful and consider their own experiences of emerging implicit in assessments from the very first moments of meeting. It is hoped that future research into the implicit in therapeutic activity will further consider clinical assessments and the very first moments of meeting.

This research considers examples of reflective practice and reflexivity within psychotherapy assessments. Primarily this research describes the complexity of these therapist's thoughts, reflections and decision-making occurring from the outset of the therapeutic encounter, and hopefully this will have relevance and resonance with other clinicians.

By exploring therapists' reflection on their experiences in the moment, afterwards in supervision and in hindsight in the research interview, we gain insight into the reflexive process, and how it continues over time. This process is centred on the therapists gaining greater awareness of their own material, their blind-spots, skills, biases, prejudices, attitudes, philosophical, spiritual and political stance etc. This research offers rich examples of how therapists connect with clients in a dynamic and intersubjective ways, and how being impacted creates moments of opportunity to access implicitly held knowledge. The findings highlight the therapists' ability to withstand and/or accept not knowing. This is a contradictory notion for many especially where knowledge equates with power. The therapists in this research exemplify the literature of Bollas

(1987), Bion (1967) and Maroda (2010), but not just within the main body of the therapy but from the first moment of meeting their clients.

This research has drawn attention to the difficulty the therapists had in naming and defining the emerging implicit experience as intuition. By un-naming the phenomena this research was able to explore some of the hidden meanings, beliefs, biases and prejudices that impacted the use of certain words such as intuition within the psychotherapy context for these therapists. My hope is that this will prompt other clinicians and therapists to ponder their own use of words and the hidden meanings and beliefs that are attached.

This research has brought together understandings from different fields of research (educational, social, developmental, cognitive, experimental and management psychology, and philosophy) to gain a more comprehensive understanding of communication in assessments. The drawing together of different disciplines to get more complex understandings of phenomena was an important aspect of this research. Schore (2000; 2010), McGilchrist (2009) and Sinclair (2011) have shown a way of utilising the vast amounts of available research knowledge about the human condition to give frameworks from which to understand the intimate process of therapeutic engagement and implicit experiences. I found this holistic approach increased my awareness of the complexity of the phenomena researched here, and expanded possible means of understanding human connection and communication.

Clinical Implications

The importance of these research findings to clinical practice and further research incorporate a number of aspects. There are three main implications of this research: on training, supervision and personal therapy; on how assessments are considered; and how we communicate in assessments. There is currently a widespread acceptance of the essential nature of psychotherapy being intersubjective, where the relationship between the therapists and client is central to positive outcomes (Storolow & Atwood, 1992; BCPSG, 2002; Maroda, 2010; Schore, 2010). Emerging implicit experience (such as intuition) as part of that intersubjective and non-conscious communication and process occurring between client and therapist was not at question. If intuition is occurring within milliseconds of therapist and client meeting as indicated, how do therapists develop their skills to notice, reflect upon, to use and communicate these experiences?

Essential to this is the need for therapists to develop a deeper understanding of the nature, definition and place of intuition within the complex process of human communication, both implicit and explicit. This deeper understanding must incorporate theoretical dialogue based in

research findings and experiential activity. Integrating rational thought processes and experiential therapeutic practice may enhance ongoing learning and development for therapists, which I suggest may improve outcomes for clients. Therefore it is essential for the therapist to have a deep (and ongoing) understanding of their self (Rea 2001), this I suggest comes from both a rigorous training (experiential and theoretical) and commitment to personal therapy and clinical decision-making processes. For the UKCP psychotherapists' extended personal therapy is a requirement of qualification however other routes for therapists and counselling psychologists do not necessarily demand this. For therapist working relationally, it is essential to have a deep understanding of ones' own process, biases, assumptions, attachment issues, dissociated states etc. to be able to engage with the client for the client's benefit. It was both encouraging and inspiring that the psychotherapists in this study talked about the importance of their supervision to their ongoing personal and professional development. Supervision enables therapists not just to learn and think theoretically but also to continue to expand one's own ability to be intimate with oneself and other(s). Developing a deep understanding of oneself, being able to be open and accepting of internal emotional states, external cues and doing so in relation to another, may create the possible environment for increasing intuitive activity. I suggest this would be a further area of research that may shed light on possible conditions to promote implicit communication and intuitive activity.

The importance of this research for assessments is concerned with; when the assessment begins, types of data collected, attention to hierarchies of knowledge, how to reflect and record these implicit aspects of assessment and who is most suitable to perform assessments. Attention to the first moments of encounter is vital in the therapeutic process; this may be via email, telephone, written referral or in person. This research acknowledges the importance not just of the explicit information but more importantly the therapists' appropriate reactions to the implicit dimension. In my view the ability for therapists to pay free-floating non-judgemental attention to all their responses to the client is a developed skill and attitude. This comes with deep knowledge of oneself (Rea, 2001) and a mature sense of theoretical understanding. Therefore consideration is required as to who assesses new clients. This research suggests assessments are carried out by practitioners who confidently and actively engage with the complexity of human communication at all levels, rather than a technician who follows mechanised protocols.

In a time where mechanisation of therapeutic activity is quantitatively increasing, especially in commissioned services, it is essential to be mindful of the implicit dimension and how that information is attended to, reflected upon and noted in the process of assessments. Measures, formatted notation and monitoring of clients need to be complemented by the therapists'

reflections of the implicit process emerging at assessment. In this way a more holistic approach offers unique and individual consideration to client and their particular needs (Wampold, 2010).

The implications of this research also involve the ways in which therapists attend to and reflect upon ways of communicating. Mindful attention to implicit and non-verbal communication is reiterated in the findings of this research, as a means of attending to the clients' issues that are out of conscious awareness. Working relationally and intuitively means working on many levels, conscious and non-conscious, verbal and non-verbal. Implicit in this is the need to pay attention to the metaphors that emerge in the therapeutic dyad, and the words and language, which may distance or inform us about our self and the other.

Reflective note

The process of conducting this research has had a great impact on my clinical work. The subjective experiences of the psychotherapists interviewed resonated with my own. This enabled me to further develop my clinical practice by focusing my attention on my own phenomenological data in the moment with clients, to reflect on the metaphors that emerge regularly and to question and consider the language I use more sensitively. The psychotherapists in this study provided good examples and role models in *being* with their clients and being non-judgemental, open and curious about often un-comfortable feelings in connection with the client. I appreciate their generosity and openness in sharing their experiences.

As I was carrying out this research I found myself continually linking the insights from the therapists' stories to my own experiences, clinical work and to my interest in literature and fine art. Artist James Turrell's quote from his Deer Shelter Skyscape (2006) at the Yorkshire Sculpture Park particularly resonates with me:

> *In working with light, what is important to me is creating an experience of wordless thought.*

By reflecting on intuition in a lateral way, I have a sense of my position in relation to this non-conscious process that has intrigued people across time and disciplines. I feel I am able to situate myself from an integrative psychotherapists' perspective but I am also making connections across to other disciplines interested in implicit human experiences. This research has opened up new areas from which I can consider intuition and continue to ask questions about implicit processes and communication. From both a personal and professional stance I

have wrestled with the difficulty of allowing and accepting the unknown and the unknowable aspects of experience such as 'wordless thought'. I have found it a challenge to allow experience without judgement and to try to remain open to my own biases, potential blind spots and hidden beliefs. But by accepting the struggle I have found a way of keeping a more open reflexive stance.

Conclusion

The aim of this research was to explore psychotherapists' lived experience of the emerging implicit at assessments, and how therapists understood, reflected and discussed these experiences. The findings highlight the complexity of the emerging implicit experience and the complexity of human experience and communication. This research not only described the dramatic and powerful experience of intuition occurring at assessment sessions, but importantly shows that some psychotherapists believe that they experience intuition even before we say hello to each other. The psychotherapists participating in this study gave rich detailed and vivid accounts of their reflective process during assessments, in supervision and with ongoing curiosity. This insight into how therapists reflect on their experiences and choice points is enlightening in itself. The study captured the experience of putting language to a largely implicit experience such as intuition as fraught with difficulty. The difficulties of naming intuition were centred on definitions and understandings of the nature and meaning of the phenomena. The difficulty in naming intuition also brought attention to a more general difficulty in putting language to experience. My hope is that this research will begin to open up a more collaborative dialogue concerning implicit processes such as intuition in psychotherapy. It is also hoped that a dialogue about what actually happens in assessments will be stimulated in order to learn more effective ways of relating with clients to attain better outcomes.

6 References

Addis, M., Cardemil, E. V., Duncan, B. & Miller, S. (2006) Does Manualization improve therapy outcomes? In J. C. Norcross, L.E. Beutler & R. F. Levant (eds.), *Evidence –based practices in mental health.* Washington, DC: American Psychological Association. pp.131-160.

Ainsworth, M. D. S., Bell, S. M., & Stayton, D. J. (1971) Individual differences in strange-situation behavior of one-year-olds. In H. R. Schaffer (ed.) *The origins of human social relations*. London and New York: Academic Press. pp. 17-58.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (1978) *Patterns of attachment: A psychological study of the strange situation*. Hillsdale, NJ: Erlbaum.

Ambady, N., LaPlante, D. & Johnson, E. (2001) Thin-Slice Judgements as a measure of interpersonal sensitivity. in J.A. Hall & F.J. Bernieri. (eds.) *Interpersonal Sensitivity Theory and Measurement.* London: Lawerence Erlbaum Associates.

Ambady, N. & Rosenthal, R. (1993) Half a minute: Predicting teacher evaluations from thin slices of nonverbal behaviour and physical attractiveness. *Journal of Personality and Social Psychology.* 64(3), 431-441.

Ambady, N., & Rosenthal, R. (1998) Nonverbal Communication. In H. Friedman (ed.), *Encyclopedia of Mental Health.*

Ambady, N. & Skowronski, J. (eds.) (2008) *First Impressions.* NY: Guilford Press.

Ambady, N. & Weisbuch, M. (2010) Nonverbal behavior. In S. T. Fiske, D. T. Gilbert and G. Lindzey. (Eds.). *Handbook of Social Psychology.* New Jersey: John Wiley & Sons, pp. 464-497.

Argyle, M. (1975) *Bodily Communication.* London: Routledge.

Argyle, M., Alkema, G., & Gilmour, R. (1971) The communication of friendly and hostile attitudes by verbal and non-verbal signals. *European Journal of Social Psychology.*1: 385- 402.

Argyris, C. & Schon, D. (1974) *Theory in practice: Increasing professional effectiveness.* San Francisco: Jossey Bass.

Argyris, C. & Schon, D. (1978) *Organisational learning: A theory of action perspective.* Reading, Mass: Addison Wesley.

Arkes, H.R. (1981) Impediments to accurate clinical judgement and possible ways to minimize their impact. *Journal of consulting and clinical Psychology.* 49(3): 323-320.

Armstrong, P. S. *(*2000*) Opening gambits*: *The first session in psychotherapy*. Northvale, NJ: Jason Aronson.

Aron, L. (1996) *A Meeting of Minds. Mutuality in Psychoanalysis*. Hillsdale, NJ: The Analytic Press.

Atwood, R. D. & Stolorow, G. E. (1996) The Intersubjective Perspective. *Psychoanalytic Review*. 83: 181-194.

Bager-Charleson, S. (2010) *Reflective Practice in Counselling and Psychotherapy (Counselling and Psychotherapy Practice Series).* Padstow: Learning Matters.

Bager-Charleson, S., & Van Rija, B. (2011) *Understanding assessments in counselling and psychotherapy.* Exeter: Learning Matters.

Bar, M., Neta, M. & Linz, H. (2006) Very First impressions. *Emotion.* 6(2), 269-278.

Bargh, J. A., & Morsella, E. (2008) The unconscious mind. *Perspectives on Psychological Science.* (3), 73-79.

Barkham, M., Evans, C., Margison, F*., et al.* (1998) The rationale for developing and implementing core outcome batteries for routine use in service settings and psychotherapy outcome research. *Journal of Mental Health. 7,* 35-47.

Bastick, T. (2003). *Intuition; Evaluating the Construct and its Impact on Creative Thinking.* USA: Stoneman & Lang.

Beebe, B., Jaffe, J., Lachmann, F., Feldstein, S., Crown, C., & Jasnow, J. (2000) Systems models in development and psychoanalysis: The case of vocal rhythm coordination and attachment. *Infant Mental Health Journal.* 21(1–2), 99–12.

Beebe, B., & Lachmann, F. (l988) The contribution of mother-infant mutual influence to the origins of self- and object representations. *Psychoanalytic Psychology.* 5(4), 305-337.

Beebe, B. & Lachman, F. (2002) *Infant Research and Adult Treatment: Co- Constructing Interactions.* Hillsdale, NJ: The Analytic Press.

Behrens, K. Y., Hesse, E., & Main, M. (2007) Mothers' attachment status as determined by the Adult Attachment Interview predicts their 6-year-olds' reunion responses: A study conducted in Japan. *Developmental Psychology. 43(6)*, 1553.

Benjamin, J. (2004) Beyond doer and done-to: An intersubjective view of thirdness. *Psychoanalytic Quarterley.* 73, 5–46.

Berne, E. (1949) Intuition and ego states. *The Psychiatric Quarterly.* 23, 203-226.

Bion, W. R. (1967). Notes on memory and desire. *Psycho-analytic Forum.* 2(3), 271 - 280.

Boadella. D. (1987) *Lifestreams: An introduction to Biosynthesis.* Hove, UK: Routledge.

Bohart, A.C. (1999) Intuition and Creativity in Psychotherapy. *Journal of Constructivist Psychology.* 12, 287-311.

Bollas, C. (1987) *The shadow of the object: Psychoanalysis of the unthought known.* London, UK: Free Association Books.

Bond, T. (2004) *Ethical Guidelines for Research counselling and psychotherapy.* UK: BACP

Bordin, E. S. (1975) The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice.* 16(3), 252-260.

Bornstein, M. H., Suwalsky, J.T.D. & Breakstone, D.A. (2012) Emotional Relationships between Mothers- and Infants: Knowns, Unknowns, and Unknown Unknowns. *Dev Psychopathol.* 24(1), 113–123.

Boston Change Process Study Group. (1998) 'Non-interpretive Mechanisms in Pyschotherapy: The something More than Interpretation'. *International Journal of Psychoanalysis.* 79, 903-921.

Boston Change Process Study Group. (2002) Explicating the implicit: The local level and the microprocess of change in the Analytic situation. *International Journal of Psychoanalysis*. 83, 1051-62.

Boston Change Process Study Group. (2008) Forms of Relational Meaning: Issues in the Relations Between the implicit and Reflective-verbal Domains. *Psychoanalytic Dialogues,* 18, 125-148.

Boucouvalas, M. (1997) Intuition: the Concept and the Experience. In R. Davis-Floyd & P. S. Arvidson (eds.). *Intuition: The Inside Story Interdisciplinary Perspectives*. New York: Routledge.

Bowlby, J. (1969) *Attachment and loss, Vol.1: Attachment*. New York: Basic Books.

Bowlby, J. (1988) *A secure base (2nd ed.).* New York: Basic books British Psychological Society. (2010).

British Psychological Society. (2010) *Code of Human Research Ethics*. Leicester: BPS [Online] Available from:
http://www.bps.org.uk/sites/default/files/documents/code_of_human_research_ethics.pdf
[Accessed on 10/06/2015]

Bruch, H. (1974) *Eating Disorders: Obesity, anorexia and the person within*. New York: Basic Books.

Buber, M. (1958) *I and Thou,* (transl. by R. G. Smith), Edinburgh: T. and T. Clark.

Buber, M. (1966) *Between Man and Man*. New York: Macmillan.

Bucci, W. (1997) *Psychoanalysis and Cognitive Science: A multiple code theory*. NY: Guilford Press.

Buss D.M. (1991) Evolutionary personality psychology. *Annual Review of Psychology.* 42, 459–491.

Cannon, W.B. (1927) The James-Lange theory of emotions: A critical examination and an alternative theory. *The American Journal of Psychology*. 39, 106–124.

Carruthers, P. (1996) Simulation and self-knowledge: a defence of the theory-theory. In P. Carruthers & P.K. Smith, (eds.). *Theories of theories of mind.* Cambridge: Cambridge University Press.

Caspar, F. (1997) What goes on in a psychotherapist's mind? *Psychotherapy Research.* 7(2), 105-125.

Castelfranchi, C., & Poggi, I. (1990) Blushing as a discourse: Was Darwin wrong? In W. R. Crozier (ed.), Shyness and embarrassment: *Perspectives from social psychology.* Cambridge, England: Cambridge University Press. pp. 230-251.

Chalmers, D. (1995) Facing Up to the Problem of Consciousness. *Journal of Consciousness Studies.* 2(3), 200–219.

Charles, R (2004) *Intuition in Psychotherapy and Counselling.* London: Whurr Publishers Ltd.

Chused, J. F. (2007) Non-verbal communication in psychoanalysis: commentary on Harrison and Tronick. *Journal of American Psychoanalytic Ass.* 55, 875-882.

Clarkson, P. (1993) *On Psychotherapy.* London: Whurr Publishers Ltd.

Clarkson, P. (2003) *The therapeutic relationship (2nd edition),* London: Whurr Publishers Ltd.

Claxton, G. (2003) *The Anatomy of Intuition. in The Intuitive Practitioner. On the value of not knowing what one is doing.* Maidenhead: Open University Press.

Clore, G. L. (1994) Why emotions require cognition. In P. Ekamn & R. J. Davidson (eds.). *The nature of emotion: Fundamental questions.* New York: Oxford University Press. pp. 181-191.

Cohen, N. J., & Squire, L. R. (1980) Preserved learning and retention of pattern analyzing skill in amnesia: Dissociation of knowing how and knowing that. *Science.* 210, 207–209.

Cooper, J. & Alfille, H. (eds.) (1998) Assessment in Psychotherapy. London: Karnac.

Constantino, M. J., Castonguay, L. G., & Schut, A. J. (2002) The working Alliance: A flagship for the "scientist-practitioner" model in psychotherapy. In G. S. Tyron (ed.) *Counselling based on process research: Applying what we know.* Boston: Allyn & Bacon. pp. 81-131.

Cosmides, L. & Tooby, J. (1992) Cognitive adaptations for social exchange. In J. Barkow, L. Cosmides, & J. Tooby (eds.). *The adapted mind: Evolutionary psychology and the generation of culture.* New York: Oxford University Press.

Cozolino, L. (2006) *The Neuroscience of Human Relationships: Attachment and the Developing Brain.* New York: Norton.

Crick, F. & Koch, C. (1990) Towards a neurological theory of consciousness. *Seminars in The Neurosciences.* 2, 263-275.

Crotty, M. (1996) *Phenomenology and nursing research.* South Melbourne, AU: Churchill Livingstone.

Damasio, A. R. (1994) *Descartes' Error: Emotion, Reason and the Human Brain*. New York: Grosset/Putnam.

Damasio, A. R., (1996) The somatic marker hypothesis and the possible functions of the pre-frontal cortex. *Transactions of the Royal Society, London*. 351, 1413-1420.

Damasio, A.R. (2000) *The Feeling of What Happens: Body, Emotion and the making of Consciousness.* London: Vintage.

Damasio A. (2003) Mental self: The person within. *Nature.* 15, 423(6937): 227.

Damasio, A.R., Tranel, D. & Damasio, H. C. (1990) Individuals with sociopathic behavior caused by frontal damage fail to respond autonomically to social stimuli. *Behav Brain Res.* 41, 81–94.

Damasio, A. R., Tranel, D. & Damasio, H. C. (1991) Somatic markers and the guidance of behaviour: theory and preliminary testing. In Levin, Harvey S., Eisenberg, H. M. & Benton, A. L. (eds.). *Frontal Lobe Function and Dysfunction.* Oxford: Oxford University Press. pp. 217–229.

Dane, E. & Pratt, M. G. (2007) Exploring intuition and its role in managerial decision making. *Academy of Management Review.* 32, 33-54.

Dane, E. & Pratt, M. G. (2009) Conceptualising and measuring intuition: A review of recent trends. *International Review of Industrial and Organisational Psychology.* 24, 1-40.

Darwin, C. (1872/1965) *The Expression of the Emotions in Man and Animals*. New York: Oxford Univ. Press.

Davis, J. T. (2001) Revising psychoanalytic interpretations of the past: An examination of declarative and non-declarative memory processes. *International Journal of Psycho-Analysis.* 82, 449–462.

Denman, C. (2005) What is the point of a formulation? In C. Mace (ed.). *The Art and Science of Assessment in Psychotherapy.* London & New York: Routledge. pp. 159-173

Denzin, N. K. (1997) *Interpretive Ethnography: Ethnographic Practices for the 21st Century.* Newbury Park, CA: Sage.

Department of Health. (2014) Achieving Better Access to Mental Health Services. Gov.uk . Available from*:* https://www.gov.uk/government/uploads/.../mental-health-access.pdf *[Accessed on 22/01/2015]*

Dorpat, T. L. (2001) Primary process communication. *Psychoanalytic Inquiry*. 3, 448-463.

Eatough, V. & Smith, J. A. (2008) Interpretative phenomenological analysis. In: Willing C, & Stainton-Rogers W (eds.) *The Sage handbook of qualitative research in psychology*. Los Angeles, Sage. pp. 179-194.

Edelman, G.M. (1992) *Bright Air, Brilliant Fire. On the Matter of the Mind.* New York: Basic Books.

Edelman, G. M. (1987) *Neural Darwinism: the theory of neuronal group selection.* New York: Basic Books.

Efron, D. (1941/1972) *Gesture, race and culture.* The Hague: Mouton.

Ehrenberg, D.B. (l974) The "intimate edge" in therapeutic relatedness. *Contemporary Psychoanalysis.* 10, 423–437.

Ehrenberg, D.B. (1992) *The Intimate Edge: Extending the Reach of Psychoanalytic Interaction.* New York: Norton.

Ekman, P. (1972). Universal and cultural differences in facial expressions of emotion. In J.Cole (ed.) *Nebraska symposium on motivation.* Lincoln: University of Nebraska Press. pp. 207-283.

Ekman P. (1992) An argument for basic emotions. *Cognition and Emotion*. 6,169–200

Ekman, P., Davidson, R. J., & Friesen, W. V. (1990) The Duchenne Smile: Emotional Expression and Brain Physiology II. *Journal of Personality and Social Psychology.* 58(2), 342-353.

Ekman, P., & Friesen, W. V. (1978) *Facial action coding system*. Palo Alto, CA: Consulting Psychologists Press.

Ekman, P., Friesen, W. V., & Hager, J. C. (Eds.). (2002) *Facial action coding system. Manual and investigator's Guide.* Salt Lake City, UT: Research Nexus.

Elliot, R., Stiles, W. B., Llewelyn., J. A., Firth-Cozens, J. A. & Margison, F. R. (1990) Assimilation of problematic experiences by clients in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training.* 27(3), 411.

Elliot, R., Fisher, C. T. & Rennie, D. L. (1999) Evolving guidelines for publication of qualitative research studies in psychology and related fields*. British Journal of Clinical Psychology*. 38, 215-229.

Erskine, R.G. (2008). Psychotherapy of Unconscious Experience. *Transactional Analysis Journal,* 38:128-138.

Evans, J. St. B. T. (2008) Dual-processing accounts of reasoning, judgment and social cognition. *Annual Review of Psychology.* 59, 255–278.

Evans, J. St. B. T. & Stanovich, K. E. (2013) Dual-Process Thoeries of Higher Cognition: Advancing the debate. *Perspectives Psychological Science.* 8(3), 223-241.

Evans, K. & Gilbert, M. (2005) *An Introduction to Integrative Psychotherapy.* Basingstoke: Palgrave Macmillan.

Feasey, D. (2005) *Therapy: Intimacy between strangers.* Palgrave Macmillan: New York.

Finlay, L. (2015) *Relational Psychotherapy: Engaging process and Theory in Practice.* West Sussex: Wiley-Blackwell.

Finlay, L. & Evans, K. (2009) *Relational-Centred Research for Psychotherapists. Exploring Meanings and Experience.* West Sussex: Wiley-Blackwell.

Finn, S. E. (2007) *In our clients' shoes: Theory and techniques of therapeutic assessment.* Mahwah, NJ: Lawrence Erlbaum Associates.

Finn, S. E. & Tonsager, M. E. (1997) Information Gathering and Therapeutic models of assessment: Complementary Paradigms. *Psychological Assessment*. 9(4), 374-385.

Fogel, A. (2009) *Body Sense: The science and Practice of embodied Self-awareness.* New York: Norton.

Fosshage, J. (1994) Toward reconceptualising transference: theoretical and clinical considerations. Int Journal of Psycho-Anal. 75(2), 265-280.

Fosshage, J. (2005) The explicit and implicit domains in psychoanalytic change. Psychoanalytic Inquiry. 25(4), 516-139.

Freud, S. (*1905*) Fragment of analysis of a case of Hysteria. In J. Strachey (ed. and trans.), *The standard edition of the complete psychological works of Sigmund Freud. Vol. 7*. London: Hogarth Press. pp. 1-22.

Freud, S. (*1910*) The *future* prospects of *psychoanalytic therapy*. In J. Strachey (ed. and trans.), *The standard edition of the complete psychological works of Sigmund Freud*. *Vol. 11*. London: Hogarth Press. pp. 139-52.

Freud, S. (1915), "The Unconscious", In J. Strachey (ed. and trans.), *The standard edition of the complete psychological works of Sigmund Freud. Vol. 14*. London: Hogarth Press. pp. 159-217.

Fuchs, T. (2004) Neurobiology and psychotherapy: an emerging dialogue. [Online} Available from: https://www.klinikum.uniheidelberg.de/fileadmin/zpm/psychatrie/fuchs/neurobiology_pt.pd [Accessed on 12/12/2015]

Fuchs, T. & De Jaegher, H. (2009) Enactive intersubjectivity: Participatory sense- making and mutual incorporation. *Phenomenological Cognitive Science*. 8, 465–486.

Gabbard, G. (1990) *Psychodynamic psychiatry*. Washington, D.C.: American Psychiatric Press.

Gallese, V., Eagle, M.N. & Migone, P. (2007) Intentional attunement: mirror neurons and the neural underpinnings of interpersonal relations. *Journal American Psychoanal Assoc.* 55(1), 131-76.

Gazzaniga, M.S. (1985) *The Social Brain.* New York: Basic Books.

Gazzaniga, M.S. (1998) *The Mind's Past*. University of California Press.

Gelso, C. J., & Carter, J. A. (1985) The relationship in counseling and psychotherapy: Components, consequences, and theoretical antecedents. *The Counselling Psychologist.* 13, 155-243.

Gendlin, E.T. (1984) The client's client: The edge of awareness. In Levant, R. L & Shlien, J. M. (eds.), *Client-centered therapy and the person-centered approach. New directions in theory, research and practice*. New York: Praeger. pp. 76-107

Gendlin, E.T. (1991) Thinking beyond patterns: body, language and situations. In den Ouden, B. & Moen, M. (eds.), *The presence of feeling in thought,* New York: Peter Lang. pp. 25-151.

Gendlin, E.T. (1993) Three assertions about the body. *The Folio*. *12*(1), 21-33.

Gendlin, E.T. (2003) Beyond postmodernism: From concepts through experiencing. In Frie, R. (Ed.), Understanding Experience: Psychotherapy and Postmodernism. London: Routledge. pp.100-115.

Ginot, E. (2001) The holding environment and intersubjectivity. *The Psychoanalytic Quarterly.* 70, 417– 446.

Ginot, E. (2007) Intersubjectivity and neuroscience: Understanding enactments and their therapeutic significance within emerging paradigms. *Psychoanalytic Psychology.* 24(2), 317-332.

Greenson, R. R. (1992) *The technique and practice of psychoanalysis, Volume 1*. London: Hogarth Press

Grobstein, P. (2005) Making the Unconscious conscious: A Bi-directional Bridge between Neuroscience/Cognitive science and Psychotherapy? Cortex, 41: 663-668

Heidegger, M. (1927/1962) *Being and Time*. Oxford: Blackwell. (Translated by J.Macquarrie and E. Robinson).

Heinmann, P. (1950) On counter-transference. *International Journal of Psychoanalysis*. 31, 81-84.

Herman, J. L. (1997)*Trauma and recovery*. New York: Basic Books.

Hinde, R. A. (1972) *Non-verbal Communication.* New York: Cambridge University Press.

Hinshelwood, R. D. (1991) *A Dictionary of Kleinian Thought,* 2nd ed. London: Free Association Books.

Hobson, R. F. (1985) *Forms of Feeling.* London: Routledge.

Hodgkinson, G. P., Langan-Fox, J. & Sadler-Smith, E. (2008) Intuition: A fundamental bridging construct in the behavioural sciences. *British Journal of Psychology.* 99, 1-27.

Horvath, A. (1994) Research on the alliance. In A. Horvath & L. Greenberg (eds.), *The working alliance: Theory, research and practice.* New York: Wiley. pp.259-286.

Horvath, A., & Symonds, D. (1991) Relation between the working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology*. 38,139-149.

Husserl, E. (1936/1970) *The Crisis of European Sciences and transcendental phenomenology.* (Translated by D. Carr) Evanston, Il: North Western University press (Original work published in 1936).

Hycner, R. (1993) *Between Person and Person: Toward a dialogical psychotherapy.* New York: Gestalt Journal Press.

Jaffe, J., Beebe, B., Feldstein, S., Crown, C.L., & Jasnow, M. (2001) Rhythms of dialogue in infancy: Coordinated timing in development. *Monograph of the Society for Research in Child Development*. 66 (2), Serial No. 131).

James, W. & Lange, C. G. (1922) *The emotions*. Baltimore: Williams & Wilkins Co

Jeffery, A. (2012) The Clinical Intuition Exploration Guide: A Decision-making Tool for Counselors and Supervisors. *The Family Journal: Counselling and Therapy for Couples and Families.* 20(1), 37-44.

Johanson, G. & Kurtz, R. (1991) *Grace Unfolding: Psychotherapy in the Spirit of the Tao-te ching.* New York: Bell Tower.

Jung, C. G. (1928) *Contributions to Analytical Psychology.* [Online] Available from: http://www.academia.edu/8179417/Jung_C._G.__Contributions_to_Analytical_Psychology_1928__ [Accessed on 22/02/2015].

Kahneman*,* D. (2011) *Thinking*, *fast and slow*. New York: Farrar, Straus and Giroux.

Kahneman, D., & Frederick, S. (2002) Representativeness revisited: Attribute substitution in intuitive judgment. In Gilovich, D. G. T. & Kahneman, D. (eds.), *Heuristics and biases: The psychology of intuitive judgment.* Cambridge: Cambridge University Press. pp. 49-81.

Karver, M. S., Handelsman, J. B., Fields, S., Bickman, L. (2006) Meta-analysis of therapeutic relationship variables in youth and family therapy: the evidence for different relationship variables in the child and adolescent treatment outcome literature. *Clinical Psychology Review.* 26, 50-65.

Kegan, R. (2000) What forms transforms? A constructive-developmental approach to transformational learning. In J. Mezirow and associates (eds), *Learning as Transformation*. San Francisco: Jossey-Bass. pp.3-34.

Keltner, D. & Haidt, J. (1999) Social functions of emotions at four levels of analysis. Cognition and emotion. 13 (5), 505-521.

Kihlstrom, J. F. (1984) Conscious, subconscious, unconscious: A cognitive perspective. In K.S. Bowers, & D. Meichenbaum, (eds.), *The unconscious reconsidered*. New York: John Wiley & Sons. pp. 149-211

Klein, M. (1946) 'Notes on some schizoid mechanisms.' in *The Writings of Melanie Klein,* Volume III. Hogarth. pp. 1-24.

Kroenke, K, Spitzer, R, & Williams, W. (2001) The PHQ-9: Validity of a brief depression severity measure. *JGIM*. 16, 606-616.

Kruglanski, A. W. & Gigerenzer, G. (2011) Intuitive and Deliberate Judgements are based on Common Principles. *Psychological review.* 118(1), 97-109.

Lacan, J. (1977) The Function and Field of Speech and Language in Psychoanalysis, (Transl. by A. Sheridan). *Écrits: A Selection.* New York: W.W. Norton & Co.

Lakoff, G. and Johnson, M. (1980) *Metaphors We Live By.* Chicago: University of Chicago Press

Lakoff, G. and Johnson, M. (1999) *Philosophy in The Flesh: the Embodied Mind and its Challenge to Western Thought. New York:* Basic Books.

Lambert, M. J., & Bergin, A. E. (1994) Therapist characteristics and their contribution to psychotherapy outcome. In A. E. Bergin. & S. L. Garfield, (eds.). *Handbook of psychotherapy and behavior change (4th ed.).* New York: John Wiley & Sons, Inc. (Original work published 1983)

Lane, D. A. & Corrie, S. (2012) Making Successful Decisions in Counselling and Psychotherapy: A Practical Guide. Open University Press

Langs, R. (1999) *Psychotherapy and Science.* London: Sage pub.

Lazarus RS. (1991) *Emotion and Adaptation.* New York: Oxford Univ. Press

LeDoux, J.E. (1996) *The Emotional Brain: The Mysterious Underpinnings of Emotional Life.* New York: Simon & Schuster.

LeDoux, J. (2002) *Synaptic Self: How Our Brains Become Who We Are.* New York: Viking.

Lieberman, M. D. (2000) Intuition: a social neuroscience approach. *Psychological Bulletin.* 126, 109-137.

Lieberman, P. (2007) The Evolution of Human Speech. Its Anatomical and Neural Bases. *Current Anthropology.* 48(1), 39-66.

Lerner, J. S., Li, Y., Valdesolo, P. and Kassam, K. S. (2015). Emotion and Decision Making. *Annual Review of Psychology.* 66(33),1–33.

Little, M. (1950) Counter-Transference and the Patient's Response to it. *International Journal Psychoanalysis.* 32, 32-40.

Lyons-Ruth, K. (1998) Implicit Relational Knowing: Its' Role in Development and Psychoanalytic Treatment. *Infant Mental Health Journal.* 19(3), 282-289.

Lyons-Ruth, K. (2000) 'I sense that you sense that I sense.' Sander's recognition process and the specificity of relational moves in the psychotherapeutic setting. *Journal of Infant Mental Health.* 21, 85-98.

Maier, K. (2015) I think it can help to improve my work as a therapist, *The Psychotherapist.* 60, 36-37.

Main, M. (1995) Recent studies in attachment: Overview with selected implications for clinical work. In S. Goldberg, R. Muir, & J. Kerr. (eds.). *Attachment theory: Social, developmental, and clinical perspectives*. Hillsdale, NJ: Analytic Press. pp. 407-475.

Main, M. & Solomon, J. (1986) Discovery of a new, insecure disorganized/disoriented attachment pattern. In Brazelton, T. B. & Yogman, M. (eds.). *Affective development in infancy.* Norwood, New Jersey: Ablex. pp.95-124.

Main, M. & Solomon, J. (1990) Procedures for identifying infants as disorganized/disoriented during the Ainsworth strange situation. In Greenberg, M. T. Cicchetti, D. & Cummings, E. M. (eds.), *Attachment in the preschool years*. Chicago, IL: University of Chicago Press. pp. 121-160.

Marcus D.M. (1997) On knowing what one knows. *Psychoanalytic Quarterly,* 66, 219-241.

Marks-Tarlow, T. (2012) *Clinical Intuition in Psychotherapy: The Neurobiology of Embodied Response.* New York and London: W.W. Norton & Company.

Maroda, K. J. (1998) *Seduction, Surrender and Transformation*. Hillsdale, NJ: The Analytic Press.

Maroda, K. (2005) Legitimate gratification of the analyst's needs. *Contemporary Psychoanalysis.* 41, 371-388.

Maroda, K. J. (2010) *Psychodynamic Techniques Working with Emotions in the Therapeutic Relationship.* New York: Guilford Press.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000) Relation of the therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology.* 68, 438–450.

May, J. & Teasdale, P. J. (2006) Reasoning with Complimentary pathways, not competing processes. Available online at https://www.researchgate.net/publication/311562772 Accessed on 24/06/2017

McGilchrist, I. (2009) *The Master and his Emissary: The Divided Brain and the Making of the Western World.* London: Yale University Press.

McLeod, J. (1999) *Qualitative Research in Counselling Psychology.* London: Sage.

McNeill, D. (2000) *Language and gesture.* New York: Cambridge University Press.

McTaggart, L. (2011) *The Bond. Connecting Through the Space Between Us*. New York: Free Press.

Mearns, D. & Cooper, M. (2005) *Working At Relational Depth in Counselling and Psychotherapy.* London: Sage Publications.

Mehrabian, A.E. (1968) Communication without words. *Psychology Today.* 2, 52-56.

Mehrabian, A. (1971) *Silent messages*. Wadsworth, California: Belmont

Mehrabian, A., and Ferris, S.R. (1967) Inference of Attitudes from Nonverbal Communication in Two Channels. *Journal of Consulting Psychology.* 31 (3), 48-258

Meltzer, D. (1986) On First Impressions. *Contemporary Psychoanalysis*. 22, 467-470.

Merleau-Ponty, M. (1945) *The Phenemenology of Perception (*2nd revised edition 2002). London: Routledge.

Miller, D.J., Spengler, E.S. & Spengler, P.M. (2015) A Meta-Analysis of Confidence and Judgement Accuracy in Clinical Decision Making. *Journal of Counselling Psychology.* 62 (4), 553-567.

Milton, M., & Corrie, S. (2002) Exploring the place of technical and implicit knowledge in therapy. *The Journal of Critical Psychology, Counselling and Psychotherapy*. 2(3), 188-195.

Mitchell, S. A. and Aron, L., (eds.). (1999) *Relational Psychoanalysis: The Emergence of a Tradition*. Hillsdale, NJ: The Analytic Press

Modell, A. (2003) *Imagination and the Meaningful Brain*. Cambridge, MA: MIT Press.

Moran, D. (2000) *Introduction to Phenomenology*. London: Routledge

Nahum, J.P. (2005) The "something more" than interpretation revisited: Sloppiness and co-creativity in the psychoanalytic encounter. *Journal of the American Psychoanalytic Association.* 53, 693-729.

Norcross, J.C. (ed.) (2011) *Psychotherapy relationships that work* (2nd ed.). New York: Oxford University Press.

O'Donohue, W. & Henderson, D. (1999) Epistemic and ethical duties in clinical decision-making. *Behaviour Change.* 16(1), 10-19.

Ogden, P., Minton, K., Pain, C. (2006) *Trauma and the Body: A Sensorimotor Approach to Psychotherapy.* New York: Norton.

Ogden, P., Pain, C., Minton, K., & Fisher, J. (2005) Including the body in mainstream psychotherapy for traumatized individuals. *Psychologist-Psychoanalyst.* 25 (4), 19-2.

Ogden, T. H. (1979) On Projective Identification. *International Journal of Psycho-Analysis.* 60, 357-373.

Ogden, T. H. (1982) *Projective Identification and Psychotherapeutic Techniques.* Oxford: Jason Aronson Inc.

Ogden, T. H. (1992) *The Primitive Edge of Experience.* Northvale, New Jersey: Jason Aronson Inc.

Ogden, T. H. (1994) The Analytic Third: Working with Intersubjective Clinical Facts. *International Journal Psychoanalysis.* 75, 3-19.

Orbach, S. (2004) What can we learn from the therapist's body? *Attachment & Human Development.* 6(2), 141-150.

Pally, R. (2005) Non-conscious prediction and a role for consciousness in correcting prediction errors. *Cortex: A Journal Devoted to the Study of the Nervous System and Behavior.* 41(5), 643-662.

Pally, R. (2007) The Predicting Brain: Unconscious repetition, conscious reflection and therapeutic change. *The International Journal of Psycho-analysis.* 88, 861-881.

Panskepp, J. (1998) *Affective Neuroscience. The Foundations of Human and Animal Emotions.* New York: Oxford University Press.

Panskepp, J. (2006) Examples of application of the affective neuroscience strategy to clinical issues. In: J. Corrigall, H. Payne. & H. Wilkinson. (eds.) *About a body.* New York: Routledge. pp. 33-49.

Petitmengin-Peugeot, C. (1999) The Intuitive Experience. *Journal of Consciousness Studies.* 6 (2-3), 43-77.

Polanyi, M. (1967) *The Tacit Dimension.* New York: Anchor Books.

Premack, D. G. & Woodruff, G. (1978) "Does the chimpanzee have a theory of mind?" *Behavioral and Brain Science.* 1 (4), 515–526.

Racker, H. (1968) *Transference and Countertransference*. London: Hogarth.

Rea, B.D. (2001) Finding Our Balance: The investigation and clinical Application of Intuition. *Psychotherapy.* 38(1), 97-106.

Reich, W. (1949/1970) *Character Analysis.* New York: Farrer, Straus and Giroux.

Reik, T. (1948) *Listening with the Third Ear: The inner experience of a psychoanalyst*. New York: Grove Press.

Roth, A. D. & Fonagy, P. (1996) *What Works for Whom? Critical Review of Psychotherapy Research.* New York: Guildford Press.

Rothschild, B. (2003) *The body remembers Casebook: Unifying methods and models in the treatment of trauma and PTSD.* New York: Norton

Rowan, J. (1993) *The Transpersonal: Psychotherapy and Counselling*. London: Routledge

Rowan, J. (2002) Three levels of empathy. *Self & Society*. 30(4), 20–27.

Sandelowski. M., & Barroso, J. (2002) Finding the findings in qualitative studies. *Journal of Nursing Scholarship.* 34(3), 213-220.

Sander,L. (1995) Identity and the experience of specificity in a process of recognition. *Psychoanalytic Dialogues.* 5, 579-593.

Schachter, S., & Singer, J. (1962) Cognitive, social and physiological determinants of emotional state. *Psychological Review.* 69(5), 379–399.

Schacter, D. L., & Tulving, E. (1994) What are the memory systems of 1994? In Schacter, D. L. & Tulving, E. (eds.), *Memory systems.* Cambridge, MA: MIT Press. pp. 1-38.

Schore, A.N. (1994) *Affect Regulation and the Origin of the Self: Neurobiology of Emotional Development.* Hillsdale, NY: Lawrence Erlbaum Associates

Schore, A.N. (2000) The self-organisation of the right brain and the neurobiology of emotional development. In Lewis, M. & Granic, I. (eds.). *Emotion, Development, and Self-organisation, Dynamic Systems Approach to emotional Development.* Cambridge University Press. pp.155-185.

Schore, A.N. (2003) *Affect Disregulation and disorders of the self.* New York: W.W. Norton & Company, Inc.

Schore, A. (2004) Advances in Neuropsychoanalysis, Attachment Theory, and Trauma: Implications for Self Psychology Available from at http://www.integra-cpd.co.uk/wp-content/uploads/cpd-resources/Schore_2004_Neuropsychoanalysis.pdf [accessed on 20/05/2015]

Schore, A. (2009) Relational trauma and the developing right brain: An interface of psychoanalytic self psychology and neuroscience. *Annals of the New York Academy of Sciences.* 1159, 189-203.

Schore, A.N. (2010) The Right Brain Implicit Self lies at the Core of Psychoanalysis. *Psychoanalytic Dialogues.* [Online] Available from: http://www.allanschore.com/cvDetail [Accessed on 17/5/2012].

Schore, A. N. (2012) Introduction in Marks-Tarlow, T. (2012). *Clinical Intuition in Psychotherapy: The Neurobiology of Embodied Response.* New York and London: W.W. Norton & Company.

Schore, J. R. & Schore, A. N. (2008) Modern Attachment Theory: The Central Role of Affect Regulation in Development and Treatment. *Clinical Social Work Journal.* 36(1), 9-20.

Searles, H. F. (1973) Concerning therapeutic symbiosis. *Annual of Psychoanalysis.* 1, 247-262.

Shirley, D. A. & Langan-Fox, J. (1996) Intuition: A Review of the Literature. *Psychological Reports.* 79, 563-584.

Shoai, S. (2014) Clinical Interviewing: Intake, Assessment, and therapeutic Alliance with John Sommers-Flanagan and Rita Sommers-Flanagan (Institutional/ Instructor's Version). Mill Valley, CA: Psychotherapy.net. [Online] Available from: http://www.psychotherapy.net/data/uploads/52dec76fb9c06.pdf   [Accessed on 10/01/ 2015].

Siegel, D.J. (1999) *The developing mind: Toward a neurobiology of interpersonal experience*. New York: Guilford Press.

Siegel, D.J. (2006) An interpersonal neurobiology approach to psychotherapy: How awareness, mirror neurons and neural plasticity contribute to the development of well-being. *Psychiatric Annals. 36(4),* 248-258.

Sinclair, M. (Ed) (2011) *Handbook of Intuition Research*. Cheltenham: Edward Elgar Publishing Ltd.

Smith, A.J., (1996) Beyond the Divide between Cognition and discourse: Using interpretative phenomenological Analysis in Health Psychology. *Psychology and Health.* 11, 261-271.

Smith, J.A., Flowers, P. & Larkin, M. (2009) *Interpretative Phenomenological Analysis. Theory, Method and Research.* London: Sage Pub.

Spitzer, R. L., Kroenke, K., Williams, J. B. W. & Lowe, B. (2006) A Brief Measure for Assessing Generalized Anxiety Disorder: The GAD-7. *Arch Intern Med.* 166, 1092-1097.

Sprenkle, J. (2005) Defining intuition: A framework for understanding intuition in psychology. *Dissertation Abstracts International*, *66*(2-B), pp.1186.

Squire, L. R. (1994) Declarative and nondeclarative memory: Mul-tiple brain systems support learning and memory. In D. Schacter. & E. Tulving. (eds.). *Memory systems* Cambridge, MA: MIT Press.

Stanovich, K. E. (1999) *Who is rational? Studies of individual differences in reasoning.* Mahwah, NJ: Erlbaum.

Stanovich, K. E., & West, R. F. (2000) Individual differences in reasoning: Implications for the rationality debate. *Behavioral and Brain Sciences*. 23, 645–726.

Stern, D. B. (1983) Unformulated Experience. *Contemporary Psychoanalysis.* 19, 71-99.

Stern, D. B. (1997) *Unformulated Experience: From Dissociation to Imagination in Psychoanalysis.* Hillsdale, NJ: The Analytic Press.

Stern, D.B. (2008) On having to find what you don't know how to look for. Two perspectives on reflection. In: E. L. Jurist, A. Slade. & S. Burger. (eds.). *Mind to Mind: Infant Research, Neuroscience and Psychoanalysis.* New York: Other Press. pp. 398-413.

Stern, D. N. (1985) *The Interpersonal World of the Infant.* New York: Basic Books.

Stern, D. N. (1995) *The Motherhood Constellation: A Unified View of Parent-Infant Psychotherapy*. New York: Basic Books.

Stern, D. N. (2004) *The Present Moment in Psychotherapy and Everyday Life.* New York: W.W. Norton & Company.

Stern, D. N. (2005) The Psychic Landscape of Mothers. In S, F. Brown. (ed.) *What Do Mothers Want?* Hillsdale, NJ: Analytic Press.

Stern, D. N:, Sander, L. W., Nahum, J. P., Harrison, A. M., Lyons-Ruth, K., Morgan, A. C., Bruschweiler-Stern, N., & Tronick, E. Z. (1998) Non-interpretive mechanisms in psychoanalytic therapy. The 'something more' than interpretation. (The Process of Change Study Group). *International Journal of Psychoanalysis.* 79(5), 903-21.

Stern, S. (1994) Needed relationships and repeated relationships: An integrated relational perspective. *Psychological Dialogues.* 4, 317-346.

Stolorow, R. D. & Atwood, G. E. (1992) *Contexts of Being: The Intersubjective Foundations of Psychological Life.* Hillsdale, NJ: Analytic Press.

Stone, M. (2006) The analyst's body as a tuning fork: Embodied resonance in countertransference. *Journal of Analytical Psychology.* 51, 109-124.

Stumpfl, M. R. (1998) Chapter seven. Transference and countertransference in the assessment consultation. In J. Cooper & H. Alfille. (eds.) (1998) Assessment in Psychotherapy. London: Karnac. pp. 107-113.

Swanepoel, L. (2008) *Just Between the Two of Us. Clinical Intuition as a non-Conscious Process.* Doctorate in Counselling Psychology and Psychotherapy by Professional Studies. Accessed at Metanoia Institute Library.

Tallman, K. and Bohart, A. C. (2008) The Client as a Common Factor: Clients as self-healers. In Hubble, M. A., Duncan, B. L. & Miller, S. D. (eds.), *The Heart &Soul of Change. What works in Therapy.* Washington, D.C.: American Psychological Association.

Barnard, P.J., & Teasdale, J.D. (1991) Interacting cognitive subsystems: A systemic approach to cognitive–affective interaction and change. *Cognition and Emotion.* 5, 1–39.

Trevarthen, C. (1998) The concept and cooperation in early infancy: In S. Braten. (ed.), *Intersubjective communication and emotion in early ontogeny.* Cambridge, UK: Cambridge University Press. (pp.15-46).

Tronick, E. (1989) Emotions and emotional communication in infants. *American Psychologist.* 44(2),112-119.

Tulvig, E. (1985) Memory and Consciousness. *Canadian Psychology.* 26(1),1-12.

Van der Kolk, B (1994) The Body Keeps the Score: Memory and the Emerging Psychobiology of Post Traumatic Stress. *Harvard Review of Psychiatry*. 1, 253-265.

Van der Kolk, B.A., Pelcovitz, D., Roth, S., Mandel, F., McFarlane, A., & Herman, J.L. (1996) Dissociation, somatization, and affect dysregulation: The complexity of adaptation to trauma. *American Journal of Psychiatry.* 153(7), 83–93.

Van Manen, M. (1999). The Pathic Nature of Inquiry and Nursing. In I. Madjar. & J. Walton. (eds.). *Nursing and the Experience of Illness: Phenomenology in Practice.* London: Routledge. pp. 17-35.

Van Rijn, B. (2015) *Assessment and case formulation in counselling and psychotherapy.* London: Sage Publications Ltd.

Wallin, D. J. (2007) *Attachment in psychotherapy.* New York, NY: The Guilford Press.

Wampold, B. E. (2010) The research evidence for the common factor models: A historically situated perspective. In B. L. Duncan, S.D. Miller, B.E. Wampold & M.A. Hubble. (eds.), *The heart and should of change: Delivering what works in therapy* (2nd ed.). Washington, DC: American Psychological Association. pp. 49-82.

Wachtel, P. L. (1980) What should we say to our patients? On the wording of therapists' comments to patients. *Psychotherapy: Theory, Research and Practice*. 17,183-188.

Warnecke,T. (2009) The therapeutic modality of touch and statutory regulation. *Self & Society*. 37 (2)

Welling, H. (2005). The Intuitive Process: The Case of Psychotherapy. *Journal of Psychotherapy Integration.*15(1), 19-47.

Westen, D. (1999) The scientific status of unconscious processes. [Paper presented on June 13, 1999, at the Annual Meeting of the Rapaport-Klein Study Group. [Online] Available from: http://www.psychomedia.it/rapaport-klein/westen99.htm [Accessed on 12/09/2015].

Whitehead, A. N. (1968) *Modes of Thought.* New York: Free Press.

Wilkinson, M. (2010) *Changing Minds in Therapy: Emotion, Attachment, Trauma and Neurobiology.* New York: Norton.

Willig, C. (2001) *Qualitative Research In Psychology: A Practical Guide to Theory and Method,* Buckingham: OUP.

Winnicott, D. W. (1947/1957) Further thoughts on babies as persons. In Hardenberg, J. (ed.), *The child and the outside world: Studies in developing relationships*. London, England: Tavistock Publications Ltd. (pp. 134-140). (Original work published 1947).

Winnicott, D. W. (1971) *Playing and reality.* New York: Routledge.

Yardley, L. (2000) Dilemmas in qualitative health research. *Psychology and Health.* 15, 215-228.

Young, C. (2006) 150 Years On: The history, significance and scope of Body-Psychotherapy today. *Int. Journal of Body, Movement & Dance in Psychotherapy*. 1,

7 Appendix

Appendix 1- Research Advert

Appendix 2 - Direct mail to possible participants

Dear…….

My name is Carole Blythe. I am undertaking a research project for my doctorate in Counselling Psychology at Metanoia Institute. I am sending you this information in the hope that you may be interested in the subject area and be willing to be interviewed as part of the research.

I am interested in exploring therapists' experience when assessing clients. I am particularly interested in experiences that include a "felt sense" of the new client, an embodied 'feel', or what could be called a 'gut reaction'. I am interested in the nature of what seems to be *knowledge* of a new client – but which can emerge apparently out of nowhere.

I am interested in what therapists call these experiences and how they think about and use (or not) them, and the information they seem to convey: in the therapy, their supervision, and with peers.

If you are interested in the subject area and would be willing to be interviewed for an hour please email me.

Thank you for taking time to read this information.

Best wishes

Appendix 3 - Research Participants Information sheet

METANOIA INSTITUTE & MIDDLESEX UNIVERSITY

RESEARCH PARTICIPANT INFORMATION SHEET
(Version 1, 25/11/2011)

Psychological Therapist's Experiences of the implicit dimension during the assessment Process

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 us 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 reading this.

The purpose of the study

This study aims to explore Psychological Therapist's experiences of the emergence of the implicit dimension during the assessment process.

I am not trying to ascertain whether implicit information emerges or not, but rather to explore *how* it emerges for therapists.

I will focus on how individual therapists attempt to understand and give meaning to their subjective experiences of the emerging implicit, within the assessment. This will include considerations of their theoretical framework, their philosophical stance and their belief systems regarding the nature of inter-personal communication.

I aim to explore if and how therapist's use these experiences as data for understanding the client and how that impacts (or not) the therapeutic process. I aim to explore how therapists name their experiences.

The study is likely to be completed within the next 18 months (by June 2013).

Why have you been chosen?

I intend to interview 8-10 participants, who are members of the UKCP or the BPS: qualified psychotherapists and/or counselling psychologists. As a participant you will be an "expert" psychological therapist; meaning a therapist who is qualified and has been working "consistently" for 10 years.

As this research is aimed at ascertaining the therapist's reflections and understandings of implicit experience it is vital that your reflective and reflexive skills have become second nature.

It is also vital that you are working within a theoretical framework that draws on the use of unconscious process as part of the therapeutic engagement and as part of your clinical thinking.

I aim to contact counselling and psychotherapy agencies and services within the UK to recruit the psychological therapists who undertake assessments within the service.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part 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.

What will happen to me if I take part?

If you take part in this research your involvement will entail being interviewed for about 1 ½ hours. You will be asked to talk about your experiences during psychotherapy assessments, and I will ask questions about your experiences and your reflections on the experiences.

The interview will be audio recorded and then transcribed. I will send you a copy of the transcript for you to read and check that what was recorded and transcribed was your intention, giving you an opportunity to correct or delete any information you are not happy for me to use in this research.

At a later date when I am writing up the research findings I will contact you again to ask for your explicit permission if I aim to use any of your direct quotes from the interview.

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 member of the audit team.

What do I have to do?

Taking part in this study entails your willingness to talk openly about your experiences during assessments in a recorded interview (1.5 hours). It also requires your willingness to be contacted subsequently during the research period as outlined above.

What are the possible disadvantages and risks of taking part?

There are no known or anticipated risks in participating in this research project.

What are the possible benefits of taking part?

I hope that participating in the study will be an engaging and interesting experience. The information generated from this study may help to further develop the psychotherapeutic assessment process, but such outcomes cannot be guaranteed.

Will my taking part in this study be kept confidential?

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.

The audio recording, the transcript and any consent and contact details will be stored in accordance with the U.K. Data Protection legislation.

What will happen to the results of the research study?

The results of this research will be published as a doctoral thesis and will be held in the

Metanoia Institute library, and it is possible that articles based on the research will be published in academic and practitioner journals. Participants will not be identified in any publication, report or presentation of this research.

Who has reviewed the study?

The Metanoia Research Ethics Committee has reviewed this study.

Contact for further information

The researcher: Carole Blythe at: Carole@caroleblythe.co.uk

The research supervisor: Patricia Moran at: Patricia.Moran@metanoia.ac.uk

Research institute:
        Metanoia Institute
        13 North Common Road
        Ealing
        London
        W5 2 QB
        020 8579 2505

Thank you for taking part in this study.

(Both the research and participant keep one copy each of the information sheet and a signed consent form.)

Appendix 4 – Consent form for participants

CONSENT FORM

Participant identification Number:

Title of Project: Psychological Therapist's Experiences of the implicit dimension during the assessment process

Name of Researcher: Carole Blythe

Please initial box

1	I confirm that I have read and understood 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 reason, If I choose to withdraw, I can decide what happens to any data I have provided.	
3	I understand that my interview will be taped and subsequently transcribed	
4	I agree to take part in the above study	
5	I agree that this form that bears my name and signature may be seen by a designated auditor	

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Name of participant   Date   Signature

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Researcher   Date   Signature

(1 copy for participant, 1 copy for researcher)

Appendix 4 – Consent form for participants continued

Form for assessing criteria of participants:

Criteria for participants	Please tick
Are you a UKCP registered psychotherapist?	
Are you a BPS registered counselling Psychologist?	
Have you been working consistently as a therapist for 10 years +?	
Do you regularly undertake assessments of clients?	
Do you work from a theoretical perspective that includes consideration of the unconscious process?	

Appendix 5 - Hand written notes (Rachel)

1	I know something about them getting in the way, 95% I wouldn't. So
2	ignoring those few I would know something of the background of,
3	I would not. So for me it's going into the waiting room, that's quite
4	important. Because sometimes you can't find someone, cause they're
5	tucked in a corner. There has been one occasion when I've stared at someone,
6	and said their name, and they kind of were looking at me with some sort of
7	recognition but I didn't notice it and that's really interesting. So that's part
8	of the assessment and then I take them into the room and then I sit down with
9	them and I give them a little bit of a blurb and I give them the CORE questionnaire
10	and then it's all quiet while they fill that in and I think about it. So that's the first
11	part of the assessment and that's where your bit comes in most. But in the assessment
12	session I will ask quite a few questions so I won't just wait, I'll ask questions.
13	*In terms of how you view the data that you use in the assessment, clearly there's a*
14	*lot of data that they are filling in terms of the CORE form and the direct questions,*
15	*the explicit data so that's part of it. So what I'm interested in is, what the implicit stuff is, and your experiences of that.*
16	So, I need to tell you a little bit about how it's changed and well, so if I am
17	sticking with where I was; there's something about the way someone gets up
18	or the way somebody looks at you and very often I am already thinking: shy,
19	confident, angry, whatever, they haven't spoken a word.
20	So then they come in...
21	*This is all the pre-verbal stuff?*
22	Yes this is all the pre-verbal stuff and then they come into the room,
23	to be honest I don't think I'm not consciously thinking it at that point.
24	I would say retrospectively I'd kind of recognise that. At that point all
25	I'm interested in is getting the person from there to the room, so there's a lot
26	going on but it's at the back of my mind not the front of mind at that point.
27	*So when you're going to the waiting room and you're saying their*
28	*name you know Jo Blogs, are you, you're aware of finding that person*
29	*and at one level but...*
30	But there is something else going on at another level
31	*At that point in time when you are in the waiting room that doesn't register*

Appendix 6 - list of emerging themes (Rachel)

- Implicit Experience (IE) interferes experience in waiting room-
- boundaries of assessment
- recognising the anomaly
- conditions of IE to occur
- observing clients behaviour-
- language/spoken word
- communication before words
- IE emerges without Cs attention
- awareness changes over time
- recognises exp is UnCs
- levels of experience/processing
- speed of IE
- change of attention/levels of focused attention
- not focused attention
- therapists' experience, understanding and belief.
- Naming "gut feeling"
- metaphor "getting a picture"
- how, bodily sense
- "emotional sense"
- the how-descriptive
- th's own history/personality informs the experience- why it's noticed.
- feeling comes quickly
- no explicit data
- description of HOW Th feel
- initial understanding (theoretical framework) indicates future process.
- Th accepts her IE & is confirmed by clients explicit data
- Th already *knew* (felt) about client before Ex info.
- naming the experience
- Th's understanding is complex & multi layered
- observation of behaviour & interpersonal interaction (object relations)
- another layer of theoretical understanding
- understanding using a number frames
- experience is UnCs.
- speed- experience is too fast for words
- the feeling first then thoughts (Process)
- theoretical understanding
- feelings first, then thoughts.
- focused attention on Qs about client

- Th already knows something "guessed it" before explicit confirmation.
- speed of the knowledge coming to awareness.
- two types of experience.
- description of experience as "weird"
- IE is an anomaly
- understanding of the IE changes over time
- Th's awareness and self-reflecting
- description of the IE (words)
- IE felt
- use of data
- dismissing (filtering useful/ meaningful data?)
- lack of understanding in the moment
- IE could not be easily dismissed.
- reflection in the moment
- at a Cs active level but it was still there
- th did not use it *overtly*
- IE became important (was that because or despite trying to dismiss it?)IMPACT on THERAPY
- th's growing feeling about the experience.
- different types of IE
- What is the difference?
- confidently asserts there is a difference between types of IE
- description-THOUGHT
- speed
- Th's focused attention
- Other type(B)
- th's reflexivity
- accuracy of IE (B)
- Is transference used to understand both types of IE?
- is like- the therapist's"knowing"
- therapist trying to make sense of the other (actively trying to understand the other –theory of mind)
- a way of trying to know
- -recognition of a way of being (pattern recognition)
- previous knowledge
- previous knowledge?
- finding a way to understand and make sense from the experience
- descriptive of experience

- previous training is at odds with the IE and understanding/meaning making
- acknowledges the accuracy and "concreteness" but has trouble understanding how it works. Also limiting her understanding to "body language"
- accuracy and truth
- can't believe the accuracy she experiences
- conflict in the understanding of Th's knowing and understanding of that knowing. Different parts of Th- "emotional feeling part and the scientist part
- scientist part-could that be the LH rational/logical aspect of therapist? The experience does not make sense to the "scientist part" which is her foundation of knowledge.
- -emotional knowing and intellectual/science knowing
- the two sides seem to oppose
- training & theoretical background
- training and means of understanding the world
- Th understands transference because of and in terms of science background- science is how th makes sense of experience
- not overtly but as a means of pulling data together to get "a feeling of the person"
- Theory of mind- understanding clients world view
- understanding the inter-relational aspect of client
- USE of DATA- -not in first session
- psychodynamic theory
- Th recognises her early experience as being important
- description of IE
- HOW therapist uses implicit data- to inform herself but not to use overtly.
- uses in supervision but not as matter of course
- speaks in psychodynamic language "transference feelings"
- discussing IE is supported and taken seriously in supervision

- as a thought
- unexpected, startling thought
- therapists surprise and questioning of her thoughts
- the thought was unusual
- experiencing a strong reaction but not understanding it fully
- use of data in supervision
- impact on the therapy
- open mind to whether thought got in the way or other reason- still questioning
- open mind to whether thought got in the way or other reason- still questioning. LIVING WITH NOT KNOWING
- Th body language
- co-created nature of the relationship- explained in terms of C/T & T
- -co-created nature of the relationship- explained in terms of C/T & T
- understanding the IE thoughts in relation to therapists own position – where the "I" is in the experience
- th's understanding of how she experiences and understands
- recognises that there is a bodily experience first
- Th experiences as emotions
- in hindsight client able to re-connect with her experience and begin to analyse it in terms of connectedness to the client
- difference between awareness in the moment and awareness in hindsight.
- HOW th experiences
- HOW th experiences
- use of experience in communicating/ language used
- reflexivity about therapists way of working/experiencing
- th's understanding of implicit process
- Th recognises the importance of bringing herself into the relationship and connection more overtly
- process of what happens when meaning is unclear/or lost
- th recognises there are unknown experiences occurring at times.
- difficulty around the complexity of inter-relational connections/ difficult to sort out

- –when something is too complex/difficult to pull apart and analyse the therapy suffers
- OVER time understandings become clearer/
- explicit data helps make sense of Implicit experiences
- in time therapists feelings are altered in some way by the explicit data.
- time and added explicit data aid clarity of IE
- clarity may take a number of sessions
- the way the therapist talks/ language
- th uses word "emotion" but does not clarify which emotion
- th understands there is an emotional response to the client
- description of the th's feelings
- the naming of IE
- th understanding of intuition
- naming IE as "experience"-not much precision
- the quality of the experience/ the "guess" again
- the type of IE that are dramatic come in thought form, but the thought feels like

- USE of DATA, "hypothesis" sounds like a scientific word/concept from th's previous education.
- USE OF DATA- trying not to accept too quickly but hold it in mind
- not letting data interfere
- if data is confirmed there is a moment of recognition
- CB noticed the interesting body language used by participant as she was talking-left hand =right brain (RH deals more with holistic experiences - Mcgilchrist)
- Right hand = left brain waiting for definite concrete confirmating data.
- *It is interesting what you're doing because*
- not trusting the IE, fearful that it will "get in the way"
- therapist aware of the dual processing/ complexity of processing (Lucia Swaneople's stance ?)
- not trusting the IE on it's own waiting for confirmation or not

- Type B IE not common
- the accuracy of the type B IE
- description
- description and Naming
- when the gut feeling didn't get to be confirmed the understanding was that client and therapist were on different wave lengths- not connected
- When IE was wrong or not confirmed, therapist did not understand the client- no connection and therapy outcome was poor.
- *when initial IE was never confirmed*
- therapist demonstrates hands missing each other to demonstrate how she understood her and her client missing each other- no connection
- sometimes therapist and client "miss" each other and even supervision does not help understanding of why.
- Th recognises she could make an understanding fit but that would not wholly satisfy her making sense of the experience
- the accuracy of IE can come from the client explicitly- but sometimes this does not happen and the therapists experience cannot become explicit or confirmed.
- the IE fact was confirmed early on but the significance did not emerge until later in the therapy.
- in this incident the IE was at the crux of the clients issues- but this is not always the case
- a really concrete example-A THOUGHT
- but not at the crux of the work.
- Intrusive thought, a thought that has been implanted by another
- an example of IE thought
- th recognises that an experience may be different to other experiences –having more significance
- the IE has the quality of being "weird" not normal
- it was part of the work; although Th thought the experience may be significant- it was only of limited significance

Appendix 7 - 10 themes with possible sub-themes (Rachel)

<u>Interview 1 - Main Themes</u>

<u>1) Description of the implicit experience</u>
- Startling
- Speed
- Weird
- Intrusive
- Concrete
- Sense of oneness
- Fundamentally different
- Not normal
- Pre-verbal stuff
- Sharpened
- Dramatic

<u>2) Optimum conditions to experience implicit experience</u>

- Therapist asking the right questions about the client/changing the question if conditions change.
- Silence
- Relaxed
- A reverie state
- A state that isn't about listening because there are no words
- Being receptive
- Being open to careful observing of self and other
- Therapist and client on the same wavelength
- Mixing of the client and therapist
- Similar world view

<u>3) Therapists personal qualities</u>

- Important/significant non-verbal relationships: animals, father
- Therapists awareness of their own process: thoughts, feelings, un &usual
- Importance of the therapists in the relationship-what the therapist brings
- Therapists recognition of the impact they have on the therapy
- Previous training/career impacts understanding of implicit experience

<u>4) Therapists relationship to the implicit experience</u>

- Significant and important occurrence
- Internal conflict; (based on previous training/career)
- Wish to trust the IE more
- Acknowledge change in self over time- trusting/accepting experience more

<u>5) Response to Implicit experience</u>

- Trying to dismiss the experience
- Questioning-"What's that doing there?"
- "Hold" the information in the background
- "Holding" in the left hand behind left ear
- Dilemma of "Knowing " yet not understanding>>HOLD + WAIT
- Sense that Implicit experiences interfere with therapy as it is not understood, so not able to use

<u>6) Trying to understand the experience</u>

- Understanding via theory: transference, good object, unconscious brain, biology, systems, different levels of processing
- Difficulty knowing how the "knowing" has arrived
- Trusting the knowledge but not totally trusting feelings/emotions
- Difficult to analyse in the moment, hindsight increases awareness

7) Explicit Evidence/conformation of the implicit experience

- Dilemma 1- Therapist waits for confirmation-if confirmation received= "already knew it", but if no confirmation the implicit experience may still be crucially significant. Therefore confirmation not that same as significance.
- Dilemma 2 – there is an unknowable, un-nameable quality to the implicit experience which means investigation and analysis (& ???)Problematic.
- Difficult to understand but still feels significant

8) What is the implicit experience data and how to use it?

- Implicit experience can be the crux of the problem
- Implicit experience becomes the focus of the therapy
- Implicit experience part of the problem
- Implicit experience is used as a hypothesis, for interpretation, as "part of a picture of the feel for this person"
- Not directly used

9) Naming the experience

- Words "just destroy it"
- Words/naming does not/cannot fully express it but downgrades it.
- Words used: experience, gut feeling, Ahah!, a very profound feeling, an emotional sense, telepathy, empathy
- Words not used: intuition

10) Discussing with others

- Supervisor takes it seriously
- Therapist more reserved about speaking about IE-but it does come out
- Ambivalence- perhaps because it is so much is unknown about the implicit experience

Notes	Line	Transcript	Themes
Beginning of recording missed as recorder didn't start straight away-	P1,1 2 3	I know something about them getting in the way, 95% I wouldn't. So ignoring those few I would know something of	getting in the way –
her understanding of how she sees assessments-the whole process explicit and implicit	4 5 6	the background of, I would not. So for me it's going into the waiting room, that's quite important. Because	Implicit Experience (IE) interferes
	7 8	sometimes you can't find someone, cause they're tucked in a corner. There	experience in waiting
prompt to ask about implicit	9 10	has been one occasion when I've stared at someone, and said their name, and	room-
context and how it's changed-stays with older style/more experience, already names emotions and non-verbal communication	11 12 13 14 15 16	they kind of were looking at me with some sort of recognition but I didn't notice it and that's really interesting. So that's part of the assessment and then I take them into the room and then I sit down with them and I give them a little	going into the waiting room, that's quite important.-boundaries of assessment
I make explicit the pre-verbal (should be non-verbal) to clarify Acknowledges the complexity of process and that it is not all overtly conscious, there are tasks to do Confirming that we are both talking/thinking about different levels of attention/ processing What's P1 aware of?	17 18 19 20 21 22 23 24 25	bit of a blurb and I give them the CORE questionnaire and then it's all quiet while they fill that in and I think about it. So that's the first part of the assessment and that's where your bit comes in most. But in the assessment session I will ask quite a few questions so I won't just wait, I'll ask questions. *In terms of how you view the data that*	I didn't notice it and that's really interesting-
	26	*you use in the assessment, clearly*	
P1 runs through the practicalities until there is silence. Consciously asking what she knows about the client, P1 is consciously breaking down the behaviour and her understanding of the multi-layered processes. Talks of getting a feel that links in with the Theory that the boundary to Cs and unCs is the body and "the feel"	27 28 29 30 31 32 33 34 35 36 37 38	*there's a lot of data that they are filling in terms of the CORE form and the direct questions, the explicit data so that's part of it. So what I'm interested in is, what the implicit stuff is, and your experiences of that.* So, I need to tell you a little bit about how it's changed and well, so if I am sticking with where I was; there's something about the way someone gets up or the way somebody looks at you and very often I am already thinking:	recognising the anomoly
Checking who the feel is-"emergent" Description of how she experiences but not what I thought as a bodily sense.	39 40 41 42 43	shy, confident, angry, whatever; they haven't spoken a word. So then they come in... *This is all the pre-verbal stuff?* Yes this is all the pre-verbal stuff and	then it's all quiet while they fill that in and I think about it.-
	44	then they come into the room, to be	
Brings herself right into the discussion with "I don't like being in charge" making this idiographic P1's laugh sounds like the experience is unfathomable, talks about the process in the session and her interpretation Transference. P1 is not surprised that she feels what the problem is and thinks of it as transference Clarifying what she calls it and so how it is conceptulaised Psychodynamic/ psychoanalytic theory	45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60	honest I don't think, I'm not consciously thinking it at that point. I would say retrospectively I'd kind of recognise that. At that point all I'm interested in is getting the person from there to the room, so there's a lot going on but it's at the back of my mind not the front of mind at that point. *So when you're going to the waiting room and you're saying their name you know Jo Blogs, are you, you're aware of finding that person and at one level but...* But there is something else going on at another level *At that point in time when you are in the*	conditions of IE to occu

Appendix 9 – Excel sheet with further notes/themes (Rachel)

	Sheets	Charts	SmartArt Graphics	WordArt
◇	B	C	D	E
54	really. And in a way I am because I am coordinating the session, but I have a	the logic of feeling "in charge" "because coord	process of Th understadning/	
55	very uncomfortable feeling about, OK how... how... she's going to hand	very uncomfortable feeling intensity of the fe	HOW-intensity of the feeling	Theme 1- physical
56	everything to me and I'm not sure what I'm going to do about that.	I'm not sure what I'm going to do about that i	process- uncertainty about what to do	Theme 2 noticing things I don't understand yet
57	And obviously it is going to be a big part of the transference work and then she	"transference".	theoretical framework, and understanding goes to future process	
58	starts telling me her issues and really I'm not in the slightest bit surprised	not surprised when IE is confirmed overtly/exp	Process- confirmation of knowledge	
59	because the issue is: under confident, can't talk to people, is always in the			
60	background. So exactly the feeling that I've already had.	"exactly the feeling I've had already".-	the process over time, 1st IE and then the explicit	
61	*And you are calling that the transference?*			
62	I am calling that the transference. Yes.	I am calling that the transference.-	naming IE transference	theme 3- playing with words
63	*So that is how you would think about it and...*			
64	It is how I would think about it, in terms of psychological feelings but my	"psychological feelings".-	understanding in terms of theory	
65	Biological background does come in too. So I am also thinking of it as	"biological background comes into it"	complex adn multi-layered understanding	theme 2-what am I bringing to the experience
66	I've read her body language and she's read my body language and then she's given me a	"I've read her body language and she's read n	reading body language- a way of understanding	theme 1-physical
67	position. So I suppose that is almost systems actually. So yes I am thinking of it	"systems"	another layer of understanding /theory	
68	as transference but for me there is a biological awareness that is...	Transference and biological awareness-	layers of theoretical understanding	
69	that's what I'd done, so it doesn't feel mysterious.	"doesn't feel mysterious"	understanding	
70	*Right, so it's not something kind of magical so it's down to some primitive*			
71	*ways we interact, and the ways we communicate?*			
72	Yes. I've seen it as my... yes, unconscious brain but I've seen it as biological.	"unconscious brain"	understanding the biology	
73	My brain picking it up, but because the brain works so fast I haven't been	"the brain works so fast"	process & understdndng-the speed of biological functions of brain	
74	able to put it into words so that becomes the transference for me. So that is the	"put it into words" "transference"	understanding-theory & naming	
75	feeling that I actually notice and then I put it into thoughts in terms of.... So,	Notice the feeling and then put into words		
76	I see it as me picking it up, yes unconsciously so in a kind of stroke Freudian	"me picking it up, yes unconsciously" -	process is unconscious	
77	stroke biological sense. So then I feel that as emotion, that I then transfer that into thoughts.	"Freudian stroke biological sense".	mixture of Freudian theory and biological knowledge, feelings then thoughts	
78	so I am thinking about "What is this client like?" "What are the issues going to be?"	"I am thinking about ... "the problem	focused attention on the "problem" of the client	
79	Like I said I'm not surprised what the problems going to be, in fact I've guessed it.	"I'm not surprised what the problems going to	process/understanding -not surprised when IE is confirmed overtly	

#	Transcript	Notes	Themes
80	I'm thinking that's what she's going to say. When I ask why she's come to		
81	counselling she's going to say I haven't any relationships, very shy.		
82	So very quickly... what sort of time span are you thinking in terms of?		
83	Two minutes.	"Two minutes."	Speed of the IE	theme 1-speed
84	(7.48)So within two minutes you've got a kind of got a stab at what the crux		
85	of her coming in, is about?		
86	So those are the more obvious ones, so occasionally there are the ones that do feel	"the more obvious ones," & "more serious an two types of IE		
87	more serious and take me by surprise and I really don't quite understand them.	"more difficult to understand"	Understanding can be difficult	theme 1- P&D
88	I remember once somebody coming in and I can't remember what the problem was			
89	some academic problem something fairly concrete. But while they had been			
90	sitting there doing the questionnaire I'd been thinking 'And your parents are	"I'd been thinking 'And your parents are divorc Thinking a concrete thought		
91	divorced', which was just weird because that is so concrete and not one I would	"just weird"	Feeling	Theme 1- P&D
92	normally have. Anyway he said the problem a bit later. I asked a few	"not one I would normally have.".	an anomaly	Theme1 - anomaly
93	questions			
94	and he said his parents were divorced and I was... and that didn't	client confirms IE knowing	client confirms IE knowing	
95	appear to be a problem but like by session three it becomes like part of our			
96	understanding about his conflict. And I found that one of the most startling ones	"it becomes like part of our understanding abt IE became part of the understanding of the clients pro	theme 1- P&D
97	because it felt like my experience of it was like a thought that had just come into	a thought coming into head without attention/logic seemed irrelevant		
98	my head completely irrelevant and 'What's that doing there?'	"Whats that doing there?"- questions the IE	therapist questions the IE	Theme 2 -where did that come from?
99	So the thought that the parents are divorced was a thought...?			
100	Yes and I know that a lot of parents are divorced but it was the way that thought		tried to explain logically- trying to find an understanding	
101	came and it's not like the things I normally ask myself and it was so, it was like	"it's not like the things I normally ask myself"	an anomaly	
102	words in my head. It was almost a schizophrenic experience; it was almost like	"a schizophrenic experience".	dramatic description	Theme 1- P&D
103	hearing a voice in my head. It was so weird.	"hearing a voice in my head. It was so weird"	dramatic description	theme 1-P&D
104	And was it saying it over and over again or was it just once?			
105	No			
106	But strongly?			
107	Yes in fact I dismissed it I thought 'That's a weird thought' 'I'll just dismiss that	"That's a weird thought" "I'll just dismiss that o Tried to dismiss the thought(IE) because Th doesn't un	Theme 2 -noticing things I don't understand wel

Appendix 10 – Main themes and sub-themes:

Theme 1- A powerful and dramatic experience (that stands out)

Sub- themes:

1. Dramatic and powerful
2. An Alert
3. Physical
4. Speed
5. Imagery
6. Resonance
7. Anomaly

Theme 2 - What's going on here?

Sub-themes:

1. Where did that come from?
2. What am I bringing to the experience?
3. Noticing things I don't really understand yet
4. Wait and See
5. Accepting the unknown/unknowable
6. Accepting the unknown/unknowable

Theme 3 -The difficulty in naming the experience

Sub-themes:

1. Playing with words to name a precise experience
2. The wholeness of the experience is beyond verbal language
3. Gestures aid understanding

Appendix 11 - Example of a Main Theme, with first sub-theme and quotes (including line number)

Theme 1 - A powerful and dramatic experience (that stands out)

Sub themes: Dramatic and powerful:

Rachel-
91- (it) was just weird because that is so concrete
102- It was almost a schizophrenic experience; it was almost like hearing a voice in my head. It was so weird.
127- It feels like an intrusive thought and I think it comes suddenly.
233- it felt like one of these startling thoughts it was like "WHAT!"
437-it came again like an intrusive thought that somebody had just put into your head.

Lorna
87- they were just two really charged ones that I remember
235- it was clearly a very powerful exchange
250- it was like something got pulled up and
474- I think I was shocked

Ian
44-Bang!
188-threatening
101-I felt an urge to want to get them into the room and the door shut before they carried on   talking too much
185- I was right on edge at that point

Tracy
265- the impact was strong
450- I suppose it's kind of deeply disturbing for me to pick up the level of disturbance in somebody else.

Janis

163- *Wow, what have I got here?* sort of feeling.
201- that definitely hit me.
92- something that happened to me, and it is dramatic and it was very powerful