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A study of the working interface between two different therapy and counselling modalities in a low-cost service

Submitted by Mary Lister

To the University of Exeter as a thesis for the degree of
Doctor of Clinical Practice
in October 2016

First Supervisor: Dr Jean Knox
Second Supervisor: Dr Janet Smithson

Word count: 43,261

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I certify that all material in this thesis which is not my own work has been identified and that no material has previously been submitted and approved for the award of a degree by this or any other University.

Signed…. Mary Lister

Acknowledgements

Firstly, I would like to thank all the members of the low-cost service who participated in this study. Then my thanks to the independent observer and those who helped transcribe the focus group discussions.

At Exeter University, my supervisors and colleagues have worked with me on the choice of themes and have offered helpful scrutiny along the way. Help from the university librarians has also been invaluable.

Thanks also to a number of people who have read and proofread the text.

Lastly, thanks to my husband for undertaking the rollercoaster ride of a clinical doctorate with me.

Abstract

This is the account of a qualitative study of practitioners in a low-cost counselling and psychotherapy scheme in a rural town. The practitioners within the organisation have been trained in two major modalities, psychodynamic and humanistic. The aim of the research is to look at how the three key psychoanalytic concepts: therapeutic alliance; transference and containment are understood and employed by these practitioners with the aim of demonstrating the differences, similarities and meeting points between the modalities.

A total of twenty-eight participants met in six focus groups. These participants were already members of existing groups within the structure of the organisation i.e. the trustees, the management group and four mentor groups. The researcher was the Clinical Director of the service at the time of the study. She was the moderator in each group and an independent observer was present in each group.

The discussions were recorded and transcribed and a thematic analysis was then undertaken. The psychoanalytic concepts were adopted as top down themes each with six associated sub-themes. Three further major themes were identified namely: the power dynamics in the therapy relationship; reference to theory: barrier or bridge to communication, and the therapy relationship.

The thematic analysis revealed where the statements from the participants in the two modalities agreed, differed and/or demonstrated meeting points.

The study includes a reflexivity section focussing on the dynamics of the researcher as the director of the organisation throughout the process, the contributions of the observer in the focus groups and the reflections of the

participants about their experience in the focus groups. In addition, how the participants differed and what impact the research has had on the service was thought about in the context of the possible unconscious processes present in this work setting.

It was found that there were key differences in the way practitioners from each modality approached the psychoanalytic concepts, but there were also differences between practitioners of the same modality. The differences about theoretical language and experts were substantial. Overall, the participants were able to discuss the subjects and exchange differing viewpoints with enthusiasm and curiosity.

These findings are not generalizable to all psychotherapy services, but are likely to be relevant and transferable to those services, both voluntary and otherwise, that employ practitioners from different modalities. A conclusion was that it is not advisable to try and impose one way of working from one theoretical background onto another. This conclusion has implications for the service when providing training events, when matching practitioners with supervisors and when training mentors to lead and facilitate groups of practitioners from differing modalities. The study also offers contributions to the therapy world at large towards the contemporary thinking about the three psychoanalytic concepts, the timing of integrating therapy approaches, the value of mixed modality discussion groups, the obstacles to understanding that theoretical language can cause and the importance of the observation of the unconscious processes in such settings.

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A study of the working interface between the different therapy and counselling modalities in a low-cost service

Chapter 1

Introduction

Psychoanalytic psychotherapists are now facing an era where psychoanalytic trainings are receiving far fewer enquiries and national schemes such as IAPT, Improving Access to Psychological Therapies, promote methodologies other than psychoanalytic because they are considered to be both more cost-effective and more likely to be verified by outcome research. In the British Psychoanalytic Council's Autumn 2015 newsletter, *New Associations*, there is a report of an interview with the Chairs of the three registers of therapists and counsellors, the British Psychoanalytic Council, (BPC), the UK Council for Psychotherapy, (UKCP), and the British Association of Counsellors and Psychotherapists, (BACP). This interview shows evidence of the wish for the three organisations to be in dialogue (Browne, 2015 pp.12-13). The following study of the working interface between two modalities in a low-cost counselling and psychotherapy service in a small rural town occurs at a time when this progress is happening on a national scale.

The Low-Cost Service

The low-cost scheme under investigation is a small charity which relies on an average of 24 volunteer practitioners a year. They provide counselling or psychotherapy for one hour a week for up to two years to people living within travelling distance of the centre. Each practitioner has been trained or is in training with one of a number of different training institutions. The practitioners can be broadly grouped into two overarching theoretical orientations;

psychodynamic or psychoanalytic, and humanistic. This experience of a small service where practitioners from different modalities work alongside each other has given me the opportunity to study some of the ways that the practitioners think and work similarly and differently and how they manage differences.

This organisation with its specific community of counsellors and psychotherapists cannot be seen to represent the extensive, national network of practitioners. The number of different theoretical orientations nationally was estimated as 500 in 2006 (Winter et al, 2006 p. 315). The practitioners who have been working in a voluntary capacity for this organisation have been interviewed, but the selection of practitioners to the service has largely been dependent on the availability of trained and student practitioners within the area.

The service is set in a country town within a rural community. There are few opportunities for counsellors and therapists to train locally and some training establishments are in the nearest cities which are over 40 miles away. Other practitioners have moved to the country having trained in the London area several years before. There is one psychodynamic training centre and three humanistic institutions near enough to the organisation to make it possible for students to have training placements

The problem of comparing practitioners' outcomes

A decision was made to explore the working interface between the two modalities in this low-cost scheme rather than to attempt a systematic comparison of the outcomes of the work of the different therapists and counsellors from the various modalities. This decision was based on a number of factors. The evaluation system employed is the CORE outcome measure, CORE – 0M (Mellor-Clarke and Barkham,1996). On the end of therapy forms practitioners are asked to describe the nature of their intervention. When the

responses over a period of a year were examined within this organisation, it was noted that practitioners often entered more than one kind of intervention thus complicating any attempts at comparison between the discrete modalities. In addition, there was an insufficient number of completed end of therapy forms with which to achieve a credible and reliable statistical analysis of the outcome results.

The second difficulty with an outcome study comparing different therapy modalities is how to isolate one factor that is the sole contributor to a successful therapy. Roth and Fonagy reviewed all psychotherapy research and meta-studies in 1996 and added to this in 2005 (Roth and Fonagy, 2005). Some decades earlier the emphasis in outcome research had shifted from comparing the types of therapy employed to a concentration on the therapist rather than the method (Luborsky et al, 1986, & 1997). Roth and Fonagy concluded that various factors may have had a large influence on therapy outcome. These factors included the quality of the therapeutic alliance, the therapist's expertise, the therapist's training, their level of experience and their competence (Roth and Fonagy, 2005). These findings led Roth to focus on therapists' competences and to work towards the establishment of recognised areas of competence for the psychodynamic, humanistic and cognitive behavioural approaches (Roth, 2015).

Discord and Discourse

There is strong evidence from past experience that when analytical thinkers get together to discuss their work and their theoretical differences, it can cause discord and splits. In a recent reconsideration of the "Controversial Discussions", which led to the divisions in the Institute of Psychoanalysis 70 years ago, Hernandez-Halton suggests several factors that might have

contributed to the dynamics and the level of disagreement. She notes that the Institute was still mourning the death of Freud and she points out that the timing after the Second World War might well have added to the persecutory nature of the discussions because members had experienced actual persecution during the war (Hernandez Halton, 2015). Isaacs wrote after her involvement in the discussions:

> It does not matter who discovers which truth, provided that all truths are shared and acknowledged, that no group of workers claims to have dogmatic and private possession of the innermost secrets of truth…. The scientific freedom to oppose and dispute the details of new discoveries or new theories carries with it the obligation to admit mistakes and to acknowledge any change of views. It is not allowable to accept other people's contributions tacitly whilst openly asserting that their views are radically wrong or unorthodox (Isaacs, 1943, p. 154).

Covington has reviewed some of the arguments which have been made to explain the schisms that have arisen in depth psychology (Covington, 2005). The Jungian analytic world in London also split into three different organisations i.e. the Society of Analytical Psychology, the Association of Jungian Analysts and the Independent Group of Analytical Psychologists (Hubback, 2005). Eisold, like Britton, thought that what mattered was to which family tree an analyst belonged (Eisold, 2001). Britton has been quoted as saying: –" one negative consequence of the Gentleman's Agreement is that any analyst is first and foremost valued not according to his/her personal features but according to who his/her training analyst was!" (Gabbard and Scarfone, 2002. p. 454). Gold argued that a loyalty to a particular training approach gets in the way of adopting an integrative approach and is a manifestation of "a more general

tendency towards a tribal, ancestral affiliation, hero worship, or brand loyalty" which results in an outgroup or a "demonized and devalued other" (Gold, 2005 p. 376).

Covington's own view is that because the analytic profession "inevitably attracts practitioners who have suffered more narcissistic injuries than any other professional group", healthy narcissism gets overwhelmed by malignant narcissism (Covington, 2005 pp. 37-8). Gordon's position is more hopeful. Her title a quotation from Blake," Do be my enemy for friendship's sake", poetically introduces her opinion that arguing with a differing opinion helps us retain our identity, "it is the enemy who keeps us alert and on our toes ready to defend what one values" (Gordon, 2005 p. 29).

Alternative approaches to managing the differences between modalities and the differences within one modality

One solution to the difficulties that have arisen with the number of theoretical approaches available within the discipline of psychotherapy and counselling has been the integrative approach. The movement towards an integration of theoretical methods has been particularly championed in the United States by Norcross and colleagues. In 2006, Williams reported on the increasing emphasis on the integration of approaches in the account of the history of the psychotherapy section of the APA, the American Psychological Association (Williams et al, 2013 p. 132).

In the second instance, psychoanalysis institutions which had previously been riven with schisms began to explore how individual analysts might differ within this one modality. In 1983, Sandler began to think about how individual analysts actually undertake their clinical work. He pointed out how an analyst can unconsciously adopt certain principles of working that may contradict with his or her publicly held views and that these contradictory positions can co-exist

(Sandler,1983). Thus, an analyst could have both a public theoretical way of working and an implicit way.

In 2000, the European Federation of Psychoanalysts, realising that analysts from different countries probably worked in different ways, held two working parties to find out more about their differences and similarities. Out of the discussions several questions were raised:

> Why do models and theories in psychoanalysis seem to have such emotional implications for the analyst and/or for the psychoanalytic institutions? Are there any psychoanalytic (unconscious) reasons for choosing different paradigms (models)? What is the influence of language/culture on the creation and/or choice of different models? What is the role and meaning of preconscious theories in clinical practice? How can we collect evidence about them? Can we use supervision to produce evidence about their existence? What could the heuristic value of these preconscious theories be if they are recognised? How could we improve communication about clinical work using the feedback from these and other researches? (Tuckett et al, 2008 p. 265).

Tuckett then took on the task of designing the research project with the initial aim of comparing the clinical work of analysts from different countries. At the same working party, Canestri and his colleagues were tasked to examine systematically some analysts' work from different schools and countries to elucidate their implicit use of theory in relation to their public theoretical positions (Ed. Canestri, 2012). Both these studies are discussed in more detail in the following chapter, the Literature Review.

Recently the Confederation for Analytical Psychology held a conference looking at the meeting points between Humanistic therapy and Jungian therapy (Williams, 2014). In 2015, the Chair elect of the British Psychoanalytic Council described in *New Associations* the Council's willingness to now undergo a dialogue with their sister organisations. She writes "Some of the old cold wars are thawing fast and we are now working closely with our sister organisations such as the UKCP, the BACP, the ACP, the APP and many others…" (Morgan, 2015). This study was motivated by the wish on a local level for practitioners from different modalities to work together.

Background

In 2005, I set up the charity which is the low-cost service that offers low cost counselling or therapy to those people living within travelling distance of a rural town who cannot afford a private fee. When I moved from London to this town some years before the charity had been registered, there were very few psychodynamic or psychoanalytic practitioners in the area. At that time, I formed an academic reading group for those who held a particular interest in psychoanalytic theory.

In 2005, I asked the members of this long-standing reading group to be mentors within the low-cost service to facilitate peer group discussions for the practitioners and to become members of the management team. In consequence, the creation and shaping of this service has explicitly been influenced by my bias towards psychoanalytic theory. Therefore, my place as founder and director of the service has had a direct influence both on the work of the charity and this research.

Qualitative researchers have emphasised the need to recognise the inevitable subjective position of the researcher and the importance of including a reflexive

approach throughout the design and implementation of the research (Etherington, 2004), (Morrow, 2006), (Parahoo, 2006), (Hollway and Jefferson, 2007). The reflexive process has been described as “The researcher reflects continuously on how their own actions, values and perceptions impact upon the research setting and can affect data collection and analysis” (Lambert et al, 2010 p.322). In consequence, I will be pointing out at the different stages of this thesis my reflexive thoughts about my involvement in the shaping of the methodology, my relationship with the organisation and my theoretical position when considering the two different modalities.

Prior to this research project, my dilemma, as the clinical director of a small organisation, had been how to deal with practitioners who did not seem to know about or how to work with some key psychoanalytic tenets. Should we continue to suggest and teach psychoanalytic approaches to the therapists and counsellors? Otherwise, is there an alternative plan where we could recognise and include the views of the practitioners from the other modality? How best could we look at difference and create discourse rather than discord?

Cooper and Lousada have criticised psychoanalysts for assuming that psychoanalysis is the “master discourse” (Cooper & Lousada, 2010 p. 35). They have also referred to a provocative view expressed by Coleman (Coleman, 2006). “Psychoanalysts depend for their continuing self-esteem and hierarchical dominance upon being able to successfully project inferiority or weakness into psychoanalytic psychotherapists, who in turn do the same to the ‘counsellors’” (Cooper and Lousada, 2010 p. 36). Although literature exists that examines the influence of psychodynamic thinking on humanistic therapy, (Portnoy, 1999), the idea that psychoanalysts could learn from humanistic therapists has not to my knowledge been the subject of formal research before.

The voluntary service under study offers counselling and psychotherapy primarily to adults on a once a week basis for up to two years. Since its inception in 2005, the bias of the organisation has been overtly psychoanalytic and psychodynamic. The counsellors and therapists are required to take part in monthly mentor groups. As previously mentioned, these groups are led by a member of the clinical management team but the main purpose of the group is peer support. However, the membership of the groups is of mixed modality. I was the Clinical Director at the time the study took place, but have since handed over the role. Before this research project, there had been an emphasis within the organisation on teaching the practitioners about key psychoanalytic tenets and psychodynamic ways of thinking about their clinical work. However, it had become apparent that there were more humanistic practitioners than psychodynamic practitioners within the organisation, partly due to the fact that there is only one psychodynamic training centre within travelling distance of the service. Therefore, it was thought that there was a need to re-evaluate the approach of the predominantly psychodynamic hierarchy and a research project was planned to find out how the practitioners thought about certain key psychodynamic tenets. I thought that the group discussions of these psychoanalytic tenets would highlight the similarities, differences and meeting points of the different modalities. I outline the reasons for my choice of these concepts in the following pages but recognise that these concepts are central to the way I work as a therapist. I learnt about these concepts in my training as a therapist in the late 1980s and have continued to see their relevance in my clinical work. My understanding of each concept has been influenced by my clinical experience but also because of the development

of the ideas particularly by post-Kleinian psychoanalytic theory, in which they are central (Bott Spillius et al, 2011).

The aim of the research

The aim of this study is to look at how the three key psychoanalytic concepts: the therapeutic alliance; transference and containment are understood and employed by these practitioners in order to demonstrate the differences, similarities and meeting points between the modalities.

Research Questions

- What do the therapists and counsellors working in a small organisation say about the three psychoanalytic concepts: the therapeutic alliance, transference and containment?
- How does what they say illustrate the differences, agreements and meeting points of their different modalities?

The therapeutic alliance, transference and containment

The research plan involved using three psychoanalytic tenets as discussion points, namely the therapeutic alliance, transference and containment. These three psychoanalytic tenets were chosen because they have been recommended by many trainings to underpin good psychoanalytic practice, for example the DIT (Dynamic Interpersonal Training) a training at the Tavistock Clinic (Lemma et al, 2011) and the Severnside Institute Psychodynamic training in Bristol which was launched in 2015. The Bristol Psychodynamic training prospectus emphasises the importance of “key psychoanalytic clinical concepts”, including the dynamic unconscious, transference, counter-transference, psychodynamic approaches to assessment and selection for treatment options, regression, working through and the working alliance (www.sippsychotherapy.org).

Therapeutic alliance

The term therapeutic alliance was coined by Zetzel in 1956.

> A differentiation is made between transference as therapeutic alliance and the transference neurosis, which on the whole is considered a manifestation of resistance. Effective analysis depends on a sound therapeutic alliance, a prerequisite for which is the existence before analysis of a degree of mature ego function, the absence of which in certain severely disturbed patients and in young children may preclude traditional psycho-analytic procedure (Zetzel,1956. p. 369).

Much of the outcome research around the effectiveness of psychotherapy has highlighted the importance of the therapeutic alliance from the client's point of view. The therapeutic alliance and the therapeutic relationship have been considered to be major contributing factors in the therapeutic outcome studies, whichever model of therapy has been offered. Clients are more likely to co-operate with a treatment model whether cognitive, psychodynamic or medical, if a therapeutic alliance has been established (Ackerman and Hilsenroth, 2003). However, the picture remains complex. Roth and Fonagy suggest that:

> Across a range of therapies, the therapeutic alliance appears to make a small but consistent contribution to outcome. There can be a tendency for this relationship to be treated as a causal one, when in fact it is more commonly accepted that alliance acts as a moderating variable- ….it operates in a complex relationship with technique and other processes, with these variables acting and reacting in a temporal sequence (Roth and Fonagy, 2005 p. 464).

Various writers have pinpointed the origin of the concept of alliance to Freud's "The Dynamics of Transference" in 1912 (Horvarth and Luborsky, 1993, Crits-

Christoph and Connolly Gibbons, 2003). Here, Freud discussed the value of maintaining "serious interest" in the client to permit the healthy part of the client to form a positive attachment which would be unconsciously linked to positive relationships in the past. Thus, Freud placed the alliance within his theory of positive transference. However, in his paper a year later Freud appeared to modify his view to include, as Howarth and Luborsky put it: - "The ability of the intact portion of the client's conscious, reality-based self to develop a covenant with the "real" therapist…to undertake the task of healing" (Horvath and Luborsky, 1993 p. 561).

Transference

In 1940 in "An outline of psychoanalysis" Freud, defined transference:

> The patient sees in the analyst the return - the reincarnation - of some important figure out of his childhood or past, and consequently transfers on to him feelings and reactions that undoubtedly applied to this model… This transference is ambivalent: it comprises positive and affectionate as well as negative and hostile attitudes towards the analyst (Freud,1940 p. 38).

Handley notes that Freud in his original paper in 1912, (Freud,1912), speaks of transference in two different ways, firstly as a resistance and secondly as making infantile wishes manifest (Handley,1995 p. 49).

Some thirty years later, Sandler and colleagues mapped how the theory of transference has been developed in line with Freud's later theories that emerged after transference (Sandler et al, 1973). Racker has become inextricably linked with the subject of transference and countertransference because of his book of the same name which remains a key text book on the subject. He notes that several analysts including himself have devoted special

attention to transference since Freud's original work, for example Horney, (Horney, 1936), Klein (Klein,1932) (Racker,1968 p.79). More recently, Oelsner, (Oelsner Ed., 2013), has edited a collection of seventeen essays offering some contemporary approaches to the subject of transference and countertransference. Polledri summarises the contributions from the different authors including for example Etchegoyen's viewpoint that Freud "never fully understood the negative transference which he always saw as a resistance and not as a legitimate component of the psychoanalytic process" (Polledri, 2014 p. 544).

Containment

Containment as a general term

The term containment unlike the therapeutic alliance and transference has both a general meaning in the common vernacular and a more specific one in psychotherapy. When searching for an exact definition via the dictionary I was initially surprised by an emphasis on hostility and the reference to the United States policy of "Containment" of communism in the Cold War period from 1947. It was coincidentally during this period that Wilfred Bion first introduced the concept. I am including within the definition of containment, limit and boundary setting where the therapist or counsellor needs to contain hostility and aggression which he or she is either on the receiving end of or is needing to restrain in themselves. Henry points out that there are limited publications that link containment to aggression and limit setting (Henry, 2010). He examines the importance of limit setting in his clinical work with a young child and cites how important the therapy process of this kind of containment of aggression is with borderline patients.

Before looking specifically at Bion's precise concept, I think the term containment has more general implications for the low-cost scheme under study and that there is an overlap between containment and other psychoanalytic tenets. One of my major concerns that has been the motivation behind this research was that some practitioners appeared not to recognise the importance of holding the boundaries and maintaining the therapeutic frame. In my role as clinical director, I have regularly observed certain practitioners undermining the therapeutic frame by being obliging and changing the times of their clients' appointments, agreeing to see them fortnightly, and not being able to face the necessary confrontation of a client about non-payments.

The importance of establishing the frame and holding firm boundaries have been long-standing tenets of both counselling and psychotherapy, (Jacobs, 1988), (Storr,1979) and have been identified as two competences by the training for DIT, Dynamic Interpersonal Therapy (Lemma et al, 2011).

Containment as a psychoanalytic concept

Grinberg described Bion's theory of the "container-contained": "According to this model, the infant projects a part of his psyche, especially his uncontrollable emotions (the contained), into the good breast-container, only to receive them back "detoxified" and in a more controllable form" (Grinberg et al, 1993 p. 28). At a time of crisis and disintegration a person can feel contained by a practitioner's capacity to think about their predicament until they themselves can reflect again.

Containment within the organisation

The toxicity and hostility suggested in the dictionary definition of containment and within Bion's concept is pertinent to the low-cost scheme as a whole from the client upwards, through the practitioners, the management team to the

trustees. This study includes observations of this process within an organisation which have been informed by the work of Obholzer and Armstrong (Obholzer and Roberts, 1994), (Armstrong, 2005). This low-cost service has had to struggle with the necessary unconscious dynamics associated with the task of helping people, for example, when a vulnerable client attempts suicide during treatment or when, particularly in the early stages, a vulnerable practitioner can present with anxieties which need to be contained throughout the strata of the organisation.

The need for this research

It is now a common experience to learn of Improving Access to Psychological Therapies teams operating with Cognitive Behavioural Therapy workers and counsellors from differing modalities working alongside each other. In addition, voluntary counselling agencies are likely to offer a mix of theoretical orientations because of the varied trainings within their localities. This formal research project to explore the working interface between two modalities within a voluntary organisation has not been undertaken before. The advantage of undertaking this kind of study with a small organisation is that there is an opportunity to examine in fine detail the differences and similarities between theoretical approaches and ways of working. For management purposes, the investigation will provide a useful picture of the inevitable rivalries, disagreements and narcissistically held views. The findings are likely to be helpful in considering what training is necessary for group leaders or mentors and for the planning of training for the organisation as a whole. I suggest that these observations and findings will have a relevance to other organisations with a membership of practitioners with varied theoretical orientations and to the community of therapists and counsellors as a whole.

In the following chapter, I present my review of the relevant, available literature. In Chapter 3, I outline the methodology for the research which includes the choices of running focus groups and thematic analysis. The thematic analysis of the discussions can be found in Chapter 4. In Chapter 5, I have included the reflections of participants of the group, my own reflexivity as a researcher, and some thoughts about the unconscious processes within the organisation that could be in operation. In Chapter 6, I then review the findings from the thematic analysis in the light of the reflections in Chapter 5 and I place the findings in the context of the literature reviewed. In Chapter 7, I present my conclusions and recommendations.

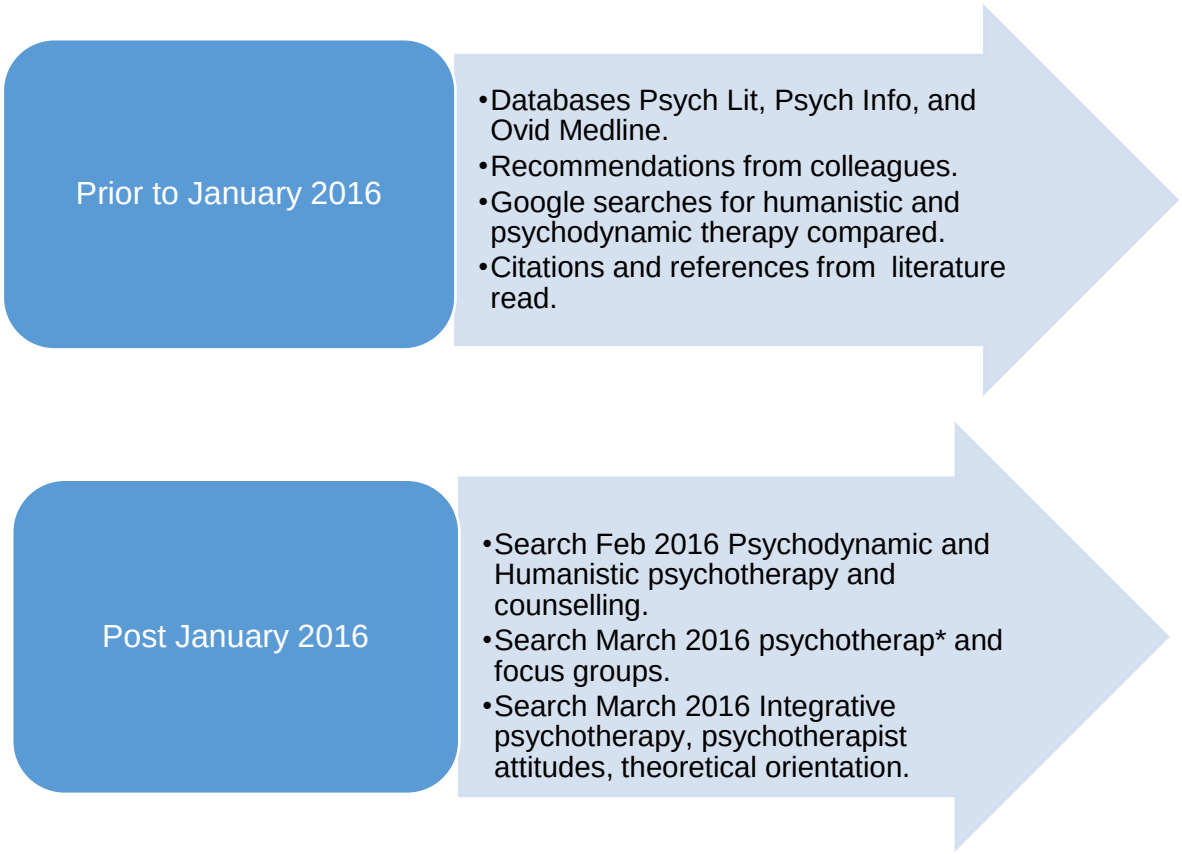
Chapter 2

Literature Review

This study was inspired by the practical experience of psychodynamic and humanistic therapists and counsellors working alongside each other in a voluntary service for low cost counselling and psychotherapy. The service has a predominantly psychodynamic management team. The aim of the research is to look at how the three key psychoanalytic concepts: therapeutic alliance; transference and containment are understood and employed by these practitioners in order to demonstrate the differences, similarities and meeting points between the two modalities in this setting. The findings will have implications for how the service is managed in future and be relevant to similar services with practitioners from differing modalities.

Although therapists from the humanistic tradition have thought about the influence of psychodynamic theory, research in the UK comparing these modalities seems to be limited. Set out below are the details of my search history. The systematic searches were carried out in February 2016 but other relevant literature had been looked for since the outset of the project in March 2014. Please see **Appendix 1** for the full details of the systematic searches.

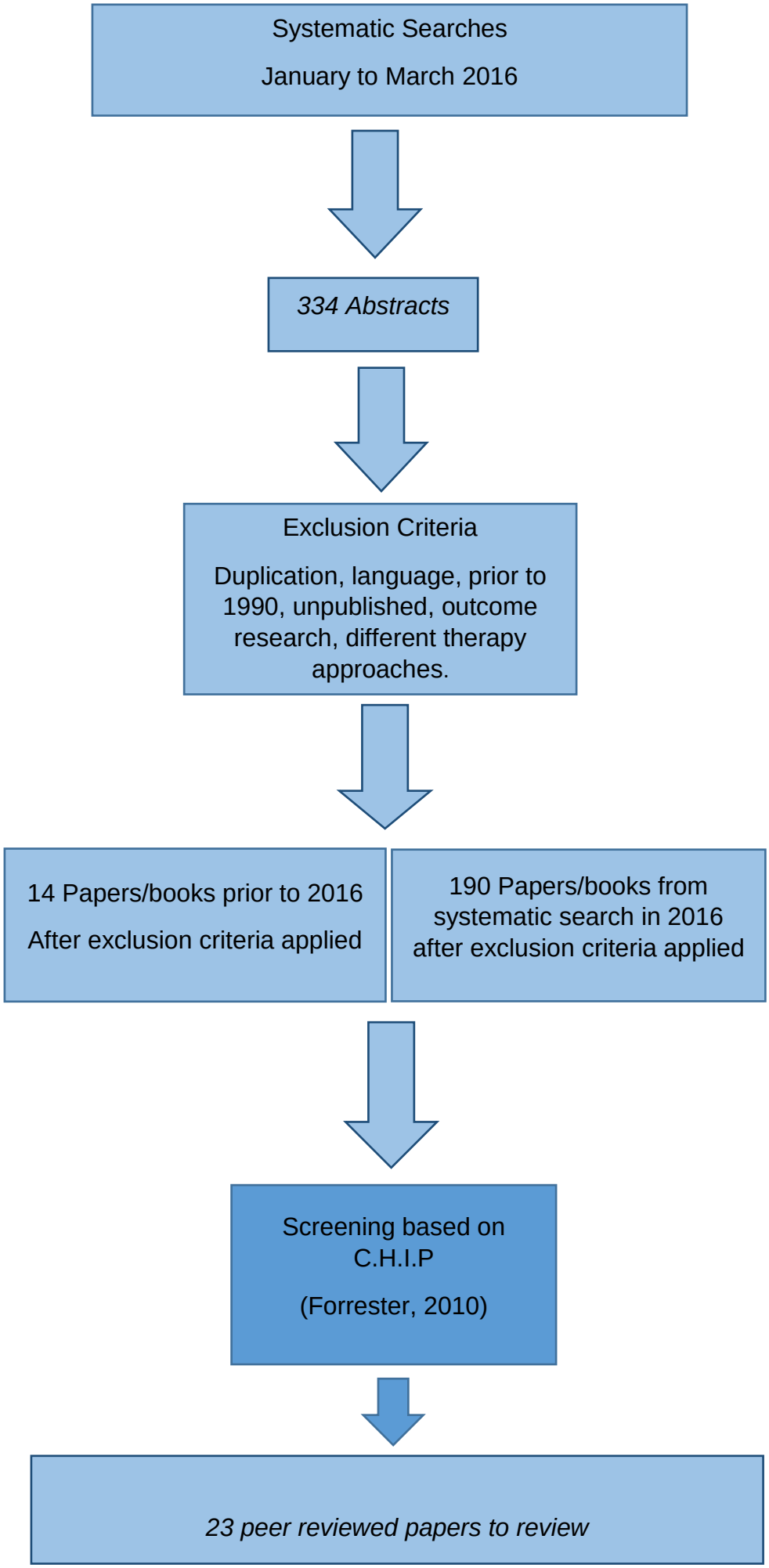
Figure 1 - Search History



The questions underpinning the literature search for studies to review have been:

- What work has been undertaken in the study of the interface between the two therapy modalities psychodynamic and humanistic?
- Are there any studies that systematically look at the theoretical differences between therapists of differing modalities?
- What research methods have been used?
- What is the quality of the study?

Figure 2 - Prisma flow diagram



In the Prisma diagram above, I illustrate the process of elimination both of papers trawled before 2016 and from the systematic search in 2016. Firstly, papers and books have been excluded under the exclusion terms: - duplication; written in a language other than English; dated prior to 1990; unpublished; outcome research; about other therapy approaches other than humanistic and psychodynamic. Secondly, I have used Forrester's tool CHIP i.e. Context, How, (methods), Issues, and Population, to screen out further the literature which does not have relevance to the present study (Forrester, 2013 p. 43).

With this study, I have not been able to seek to replicate or to follow on from previous findings because of the absence of any study like mine. The following review contains research and literature that I have selected which in my view has the closest relevance to this topic. No other qualitative study was found that explored the differences and similarities between these chosen modalities. In addition, none of the following researchers in the reviewed studies employed the methodology of focus groups or thematic analysis.

There has been a relative paucity of research that examines the differences between theoretical orientations. I presume that this has been largely due to a pressing need in recent decades for outcome research to show that therapies other than cognitive behavioural therapy can be effective. Perhaps also the cross fertilisation over the years has made some of the distinctions less clear. Shedler for example, has suggested that many of the facets of the psychodynamic are now valued by cognitive therapists (Shedler, 2010). In addition, the picture of the comparison of outcome for therapists of different orientations has been found to be confounded by other factors such as the quality of the therapeutic relationship and the competence of the therapist (Roth and Fonagy, 2005).

Review of Quantitative studies

The initial interest in practitioners' choice of modalities and questions about the value of an integrated approach occurred particularly in the United States. I have reviewed fifteen quantitative studies below. Please see **Table 1** on pages 31 to 48 for reviews of each quantitative study that I have selected. I have appraised these using the Effective Public Health Practice Project (EPHPP) appraisal tool for my assessments (EPHPP, 2010). The studies differ in size, scope and underlying aims.

The largest and most far-reaching research of psychotherapists' views has been undertaken by Orlinsky and colleagues, (Orlinsky et al, 2005), who aimed to examine the profiles of practising therapists, and to discover the factors which the therapists who were surveyed believed to have contributed most positively to their professional development and self-confidence. Orlinsky and colleagues designed an extensive questionnaire, the Development of Psychotherapists Common Core Questionnaire (DPCCQ) (Orlinsky et al,1991). This questionnaire has since been adapted and translated for use by numerous countries including Denmark and South Korea (Bae et al, 2011). One of the contributing factors to therapists' positive sense of their development in Orlinsky's original study was found to be that they had trained in other modalities some years after their initial core training. These therapists had not changed their theoretical orientation but had undergone further training in group, marital, or family therapy. The size and scope of this study was large. The underlying intention seems to have been to point out to the community of therapists on a nationwide basis how best to develop and sustain their confidence throughout their career. The findings are likely to have an influence on individual therapists' choices of post-qualification training.

Trends in Theoretical Orientation

There has been a swathe of research across the world using Orlinsky's questionnaire to identify the profile of practising psychotherapists in each country. For example, Coscolla's study in 2006 showed that the psychodynamic approach is still dominant in Spain (Coscolla et al, 2006). Jacobsen and colleagues in Denmark undertook two studies. The first was in 1993/4, when 80% of the sample was found to favour a psychodynamic approach. In the follow-up study in 2009 /2010 they found that the psychodynamic approach was still adopted by over 50% of the sample (Jacobsen et al, 2012).

Jaimes and colleagues also chose to examine any changes in preferences of theoretical orientation for trained psychologists in Québec (Jaimes et al, 2015). On this occasion, the researchers used their own survey method and not Orlinsky's questionnaire. They found that over a period of 20 years there was an increase in a preference for cognitive behavioural therapy and a decrease in preference for both psychodynamic and humanistic/existential therapies. The results in this Québec study show a moderate increase in a preference for cognitive behavioural therapy. Hunsley and colleagues studied the orientations of psychologists across the whole country of Canada and their results showed a much greater preference for cognitive behavioural therapy than in the Québec study (Hunsley et al, 2013). Levy and Anderson too found a similar change in preference in a longitudinal study of psychologists in the United States (Levy et al, 2013). These last authors expressed concern in their conclusions that training for psychologists is becoming less diverse and recommended that

students need to be provided with “diverse mentoring opportunities” (Levy et al, 2013 p. 217).

These studies of trends are large but the scope is less broad than the Orlinsky study. The underlying aim of the study of trends appears to be what the implications for the undergraduate training of psychologists and psychotherapists would be. The conclusions vary between a recommendation for a more pluralistic training in psychotherapy and the value of integrating approaches. Hollanders has mapped the history of humanistic therapy and describes the gradual emergence of the integrative school which has now become more formalised in the Psychotherapy division of the American Psychological Association (Hollanders, 2000). One recurring viewpoint is that it is preferable to learn one methodology well to begin with and then to branch out to explore other possible orientations. A smaller study by Hickman in Washington DC involved psychotherapists who had been trained for some years. The researcher found that the participants reported having been influenced by all the four orientations under study. However, they all also stated that one orientation had had the greatest influence on their work but the choice of the primary orientation differed between them (Hickman et al, 2009).

Boswell and colleagues in Pennsylvania have concentrated their study on psychology trainees only (Boswell et al, 2009). They too have used an adaptation of Orlinsky’s comprehensive questionnaire, the DPCCQ, to look at the preferences in orientation choices of the trainees. They found that the greatest single rating for an orientation was psychodynamic, but that the highest rating overall was for eclectic. Hollanders warns of the confusion that can occur between the terms integrative and eclectic. He provides a summary of the differences in the context of counselling and psychotherapy.” Eclecticism is

primarily technical, using and applying parts that already exist, in the same form. A-theoretical but empirical and realistic". Whereas integration is "primarily theoretical in its development, blending elements together into a unified whole" (Hollanders, 2000 pp. 32-33).

Personality traits and the choice of theoretical orientation

In the same study, Boswell also explored the links between personality and choice of orientation and found that therapists with psychodynamic and humanistic orientations scored higher on the NEO personality inventory for anger and hostility than the cognitive behavioural participants. In addition, the therapists who preferred a humanistic orientation scored higher for openness to feelings than the other groups (Boswell et al, 2009). In Canada, Ogunfowora and colleagues too have been interested in personality differences between the orientations, using a different personality inventory called HEXACO (Ogunfowora et al, 2008). One conclusion of this latter study was that the therapists of the humanistic/existential orientation were more likely to be open and conscientious. The therapists with the psychodynamic orientation were positively correlated with openness but negatively with agreeableness. The findings from these two studies cannot be compared as like with like because of the different instruments used and the difference between the samples. In Boswell's study, the participants are psychology students, whereas Ogunfowora's sample included both student and experienced psychotherapists. In a similar study in the UK, Winter and colleagues investigated the differences between psychotherapists' personal constructs and how these affected their choice of theoretical orientation (Winter et al, 2006, p. 315). They suggested that disagreements between psychotherapists of different orientations are often as a result of the emotional investment rather than a "cool scientific argument".

They examined the relationship between personal styles and philosophical beliefs. They used a repertory grid devised by Kelly in 1955 for use in psychotherapy sessions (Kelly,1955). They found that inner-directedness was associated with the psychodynamic approach versus outer-directedness within the cognitive behavioural approach, and that cognitive behavioural therapists tended to choose constructs concerning technical approaches; whereas psychodynamic therapists showed more concern for psychodynamic structure and processes.

With Winter's study, we see a shift from the underlying aim to inform training programs, as with the American and Canadian studies mentioned above, to another aim which is openly expressed i.e. the exploration of how differences can occur between modalities because of the therapists' personal styles. I think this study illustrates the greater stated concern in the UK about the problems and rifts that can occur between therapists of different theoretical orientations.

A standardisation of competences for Psychodynamic, Humanistic and Cognitive behavioural therapies

The work by Winter and colleagues is a rare example of research in the UK about the differences between the personal styles of therapists from different modalities. However, Roth has been a pioneer in the UK in identifying a method of standardising competencies within each modality since his discovery of the importance of the therapist's competence within their own modality in relation to a successful therapy outcome (Roth and Fonagy, 2005). The paper, which I have reviewed in **Table 1,** sets out to offer a valid tool to measure the different characteristics of the three modalities, psychodynamic, humanistic and cognitive behavioural therapy (Roth, 2015).

Roth asked groups of senior therapists from these three modality groups psychodynamic, humanistic and cognitive behavioural therapy to put forward a description of competences that they would expect a trained practitioner in their modality to possess. He then compiled a list of a hundred competences including an equal proportion of generic competences which were judged to be common to all three modalities. In the paper reviewed, Roth reports on his test of the tool's validity of these competences when practitioners from the differing theoretical orientations were invited to fill in a Q-sort which forces the participant to choose which competences are most characteristic of their clinical practice. Roth's Q-sort research has a direct relevance to the present study. In Chapter 6, the discussion, I set out the findings from this study in the context of the literature reviewed and there I outline where some of the distinctions found between the psychodynamic and humanistic theoretical practitioners' statements in my study coincide with the competences chosen by the different modalities in Roth's paper.

Further Comparisons between Theoretical Orientations

Two studies by Larsson and colleagues, (Larsson et al, 2009 & Larsson et al, 2013) and others by Holmqvist, (Holmqvist, 2015), Spektor, (Spektor et al, 2015) and Hopmann (Hopmann et al, 2011) all seek to differentiate between the theoretical orientations by exploring some more subtle differences. These differences include attitudes to spirituality/religiosity, accuracy with counter-transference, trends toward self-disclosure, views of the importance of the therapeutic relationship and preference for working with feelings. With each of these studies a self-styled questionnaire has been employed and the data is from self-report only.

The later study by Larsson carries the most relevance to my present study (Larsson et al, 2013). They surveyed therapists from the four different theoretical orientations, psychodynamic, cognitive, cognitive behavioural and integrative/eclectic therapists. They examined the views of each modality towards their own orientation's work and towards the orientations of the other modalities, looking for stereotypes and prejudices. They found that therapists were much more accurate about the beliefs and attitudes of their own orientation than they were of the other orientations. The therapists were shown to have stereotypical views of the other orientations and to exaggerate the differences between themselves and the others.

Critique of the quantitative studies

The researchers who used the surveys reviewed here were seeking to find out the profiles, preferences and personality traits of therapists from different orientations. Most of these surveys have included more theoretical orientations than humanistic and psychodynamic and in particular cognitive behavioural therapy. Although various patterns can be detected, such as a decline in the interest in psychodynamic therapy, these studies do not build on the findings of each other or seek to replicate previous findings. Orlinsky has collaborated with other psychotherapists internationally via the Society for Psychotherapy Research in an attempt to standardise and replicate his large study of the profile of psychotherapists and the key factors that are beneficial to their development (Orlinsky et al,1991 & 2005). With a standardised method available internationally to ascertain trends in choice of theoretical orientation, it will be possible to compare at different times between countries as to which are the favoured orientations.

There are no studies where mixed methods have been used. I think the conclusions would have benefitted from including some examples of therapists' comments. In the Larsson study, discussions between therapists of the different theoretical orientations could have been recorded particularly to highlight the process of stereotyping (Larsson et al, 2013). It would also have been interesting to see what would have happened if the therapists from different orientations had talked together. For example, would their views and attitudes towards each other's modalities have changed after talking to each other?

Table 1 - Review of 15 quantitative studies based on EPHPP (2010)

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
Boswell et al, 2009	1. To what degree are different theoretical orientations endorsed by therapists in-training? 2. If therapists in-training identify with more than one theoretical orientation, what are the profiles of these integrative/combined approaches? 3. Do personality factors help predict self-identified orientations? 4. Does the program of study (counselling vs clinical) relate to different theoretical orientation profiles and if so what is the nature of these differences?"	46 out of the 70 psychology trainees invited	Development of psychotherapists Common Core Questionnaire (DPCCQ) to obtain the choice of orientation. (Orlinsky,1991) Cluster analysis for the endorsement of modalities for integration. For the personality profiles, the revised neo-personality inventory to identify personality factors. (Costa & McCrae, 1992).	The highest rating for single theoretical orientation was psychodynamic. The highest rating overall was for eclectic orientation. The highest endorsement for each group once they had selected their main orientation was for the humanistic approach. The humanistic systems dynamic and psychodynamic clusters were found to rate significantly higher than the CBT on anger and hostility. The humanistic systems dynamic cluster also rated	This is a study of counselling psychology students only. The number of questions addressed makes the focus of the study too broad.	Moderate

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
				significantly higher than CBT on openness to feelings.		
Larsson et al, 2009	The overall aim was to see how distant or proximate the orientations of Swedish licensed therapists are. They describe similarities and differences regarding a) Background factors b) Focus on psychotherapy c) Attitudes towards psychotherapy as an art/craftsmanship d) Scientific outlook e) What characterizes a good psychotherapist? f) How psychotherapy ought to be pursued.	571 therapists currently working with adults from 4 orientations: - psychodynamic; cognitive; cognitive-behavioural; and Integrative.	3 Sections of a questionnaire designed by the researchers the VEP-Q with questions about the therapists' 1. Background variables. 2. Important factors for being a good psychotherapist. 3. The importance of aspects of how psychotherapy should be pursued.	Almost all the therapists independent of orientation reported their main focus to be the relationship between the patient's behaviour, thoughts, and feelings. All orientations also focused on the patient's attitudes to the therapeutic relationship. CBT therapists were significantly less inclined to concentrate on thoughts and feelings and the therapeutic relationship but more likely to focus on behaviour.	The questionnaire used was self designed and not the one adopted by other countries - like the DPCCQ (Orlinsky,2005). The authors acknowledge that their sample could not be compared with the international study by Orlinsky et al (2005) because the distribution of modalities within the sample differed.	Moderate

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
				The CBT therapists regarded psychotherapy as less of an art/craftsmanship and more of an applied science. The psychodynamic therapists often held a hermeneutic position, and integrative therapists held the hermeneutic position fairly often and seldom held a positivistic empirical position. The majority of CBT therapists preferred a positivistic approach. The CBT therapists rated four items differently on what constitutes a good psychotherapist. They had higher ratings on the		

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
				importance of the theoretical orientation and lower ratings on the importance of the therapist's personal therapy, the therapist's personal qualities and the therapist's capacity to trust their intuition.		
Larsson et al, 2013	The aim was to detect and compare stereotyped or even prejudiced views among psychotherapists of different theoretical orientations.	416 Swedish psychotherapists of four different orientations	The VEP – Q questionnaire. (Larsson et al 2010).	Psychotherapists estimated the attitudes of therapists of their own theoretical orientation much more accurately. Large misjudgements were regularly found when therapists estimated the beliefs and attitudes of therapists belonging to orientations other than their own.	As with Larsson's previous study the questionnaire used was self designed.	Strong

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
				Psychotherapists were shown to hold stereotyped views of practitioners of other orientations and to exaggerate the differences between their own orientation and others.		
Holmqvist, 2015	To examine the frequency and types of self-reported self-disclosures among Swedish psychotherapists. Has the trend towards more relationally and interpersonally orientated ways of working changed how psychodynamic therapists in Sweden operate?	300 therapists were approached randomly from the National Board of Health and Welfare's register of licensed therapists within three age bands. 183 agreed to participate. 67 therapists were less than 46 years' old 61 were between 46 and 56	An adapted form of the counsellor disclosure scale TCDS. (Edwards et al 1994)	Questions about professional training are disclosed quite frequently whereas questions about issues such as sexuality and traumatic experiences are mentioned infrequently. CBT therapists disclose more often about their trainings than psychoanalytic or psychodynamic therapists. The differences between orientations about	The disclosure scale relies on self-reports. There is some confusion as to whether the difference in disclosure of personal details and training is related to the age or orientation of the participants.	Moderate

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
		55 were older than 56 years. There were 20 psychoanalytic, 62 psychodynamic, 64 CBT, 19 systemic family therapy, and 18 other orientations.		personal matters were statistically significant. CBT therapists revealed more about their lives than psychoanalytically and psychodynamic orientated therapists.		
Spektor et al, 2015	Does a psychodynamic orientation increase a practitioner's accuracy with countertransference insight into different diagnoses better than other theoretical orientations?	The sample consisted of a total 411 participants. 26% psychodynamic 33% CBT 6.5% family systems 6.9% humanistic/existential 1.2% behavioural 20% eclectic	A demographic survey including a question concerning primary theoretical orientation. The diagnostic dimensions and counter-transference survey DDC, (Gordon et al 2015).	The psychodynamic orientation correlated positively with a greater use counter-transference with psychotic patients and borderline patients. The use of CBT or behaviour orientation resulted in a less accurate countertransference. Humanistic/existential participants showed a	All the information was self-reported. It is unclear where the sample was obtained from so there is a question how representative and replicable the study can be.	Moderate

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
		6.5% other		positive correlation with an expected countertransference for psychotic patients but not with borderline patients. Across theoretical orientations, no significant correlations were found for the erotic countertransference expectation.		
Hopmann et al, 2011	The research aims to ascertain the place of religiosity/spirituality in psychotherapy practice and training. Is there a difference in importance of religiosity/spirituality between the theoretical orientations?	1700 therapists were approached. The researchers attempted to make the sample representative by making sure therapists from a cross-section of theoretical orientations were invited.	Self designed questionnaire with 29 items.	Nearly 2/3 of the sample have had spiritual experiences. 50s% of them describe themselves as spiritual or religious. A clear significant difference was found between theoretical orientations. cognitive-behavioural and psychodynamic therapists found S/R	The concepts of religiosity/spiritualit y are difficult to operationalize.	Moderate

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
		The final sample was made up of 895 accredited psychological psychotherapists from all areas of Germany.		less important than integrative and humanistic therapists.		
Hickman et al, 2009	To examine psychotherapy process as reported by expert integrative psychotherapists.	24 experts in psychotherapy integration	Demographic questionnaire that assessed professional background training, practice settings, and theoretical orientation. Participants rated their work with one patient using the Psychotherapy Process Q set, the PQS (Jones et al 1993).	Most therapists reported that they had been influenced to some degree by all four orientations, but almost ¾ indicated that only one orientation was a salient influence.	The small size of the sample. The authors reported that they failed to gather information on the racial/ethnic background of participants or clients. The research was based on the retrospective account of work with one client	Moderate
Orlinsky et al, 2005	To enable therapists to describe themselves	534 Novice therapists	Development of psychotherapists Common Core	Results of the self estimates of the attainment of mastery.	The study relies on self-report only.	Strong

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
	professionally and personally. To study the positive and negative developments in the therapists' careers and to outline the contributing factors.	549 Apprentice 774 Graduate 1429 Established 1074 Seasoned 373 Senior	Questionnaire. DPCCQ (Orlinsky,2005)	Novice group 3% Apprentice group 4% graduates 10% Seasoned 37% Seniors 50%. The positive influences on development included: – the experience of their own therapy and the therapy with clients. The strongest predictor of cumulative career development was the breadth and depth of the therapist's experience with cases in diverse treatment modalities. That is working with a group and individual or couple therapy rather than one modality in its own.		

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
Coscolla et al, 2006	To examine the theoretical orientations of a group of Spanish psychotherapists to reveal information about the ongoing shift from modern to post-modern cultural attitudes. Will most therapists strongly endorse just one theoretical orientation or will they show tendencies towards integration/eclecticism?	179 trained psychotherapists stop	The DPCCQ questionnaire. (Orlinsky, 2005) Table 4 of the DP CCQ surveys the psychotherapists ' current theoretical orientations.	The most common salient theoretical orientation chosen was analytic/psychodynamic i.e. 57% analytic/psy 23% systemic 21% cognitive 18% humanistic 11% behavioural. Spanish therapists strongly support their own chosen theoretical orientation.	The study is reliant on self-report. The sample cannot be considered to be representative.	Strong
Jacobsen et al, 2012	To collect data about the background, clinical training, theoretical orientation, and other characteristics of Danish psychologist psychotherapists. To see if there are changes in theoretical orientation between the	158 psychologist psychotherapists in 1993 – 95 sample. 385 valid responses to 1370 questionnaires in 2009-2010 sample.	The 2009 Danish version of the DPCCQ questionnaire.	I have listed the results of the theoretical orientations solely. In the 1993-95 sample the analytic/psychodynamic orientation was most prevalent by far (80%). humanistic 32%	The authors noted that neither sample was drawn randomly from the larger population of psychologist psychotherapists and therefore cannot be seen as representative samples.	Strong

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
	two samples collected independently in 1993-1995 and 2009-2010.			systemic 19% cognitive 9% behavioural 3% In the 2009-10 sample the analytic/psychodynamic orientation was salient for just over 54% of the sample, cognitive orientations were also 54%, the behavioural orientation was more prevalent than in 1993-95 at 12% and the humanistic orientation was lower at 12%. The duration of practice was significantly correlated with the theoretical orientation for the 2009-2010 therapists but not for the earlier group.	The first two authors have a psychodynamic orientation and considered their approach might be biased	

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
				The mean Likert scale ratings showed a greater inclination still towards analytic/psychodynamic approach. Thus the overall influence of the psychodynamic approach was still dominant.		
Jaimes et al, 2015	To examine the self-assigned theoretical orientations of Québec's clinical psychologists over 20 years. The hypothesis is that cognitive behavioural therapy has increased in popularity.	Two samples obtained through the Order of Psychologists of Québec, OPQ, Registration Board. 1993: 5552 registered clinical psychologists 2013: 8608 registered	Using existing records collected by OPQ. Where psychologists had been given a choice of six orientations to categorize themselves.	During the 20 years, psychologists increasingly chose cognitive behavioural therapy as their primary approach while identification with other approaches declined. **CBT** 2013: 38% 1993: 18.4%) **Existential-Humanistic**	The details of orientations are dependent on self-report. The data has been collated in an aggregated form and not as a longitudinal analysis. The sample of Québec psychologists cannot be	Strong

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
		clinical psychologists		2013: 21.7% 1993: 28%) **Psychodynamic-analytic** 2013: 21.5% 1993: 26.4%	generalized to represent the whole of Canada.	
Levy et al, 2013	An expansion of the examination of Psychotherapy Theoretical Orientations, (PTO), by using longitudinal data from 22 years. To ascertain if there is a decrease in psychodynamic and humanistic orientations and an increase in cognitive behavioural therapy.	The sample was gathered from the insider's guide to graduate programs in clinical and counselling psychology over a 22-year period. The size of the sample is unclear.	Hierarchical linear modelling (HLM) to analyse the linear rate of change for the five most common theoretical orientations.	The CBT faculty increased at a highly significant rate of change mounting to 2.5% per two-year reporting unit. The remaining three individual orientations all significantly decreased during this twenty-year period.	This is a purposive study (i.e. the sample has not been randomized), in training patterns for psychologists. The choice of theoretical orientation relies on self-report.	Moderate
Ogunfowora et al, 2008	1. Conscientiousness and agreeableness will predict preference for the cognitive – behavioural orientation.	493 participants. Consisting of 274 currently practicing	The theoretical orientation profiles scale – revised, TOPS – R. (Worthington	1. The cognitive–behavioural orientation was incrementally predicted by conscientiousness	The online approach limited the numbers of respondents.	Moderate

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
	2. Openness to experience will predict preference for the humanistic/existential orientation. 3. Openness to experience will predict preference for the psychodynamic/psychoanalytic orientation. 4. Is there a difference between the student and experienced practitioner responses?	psychotherapy practitioners and 219 students.	et al 2003) which was adapted to include questions on other modalities. The HEXACO personality inventory (Ashton et al 2004). This model includes the following factors honesty – humility, emotionality, extroversion, agreeableness, conscientiousness and openness to experience.	2. The humanistic/existential orientation was incrementally predicted by openness and negatively by conscientiousness 3. The psychodynamic orientation was incrementally predicted by openness and negatively by agreeableness. 4. Preliminary analyses revealed that practitioners scored significantly higher than students on honesty, humility and openness to experience; whereas students scored	They were unable to determine the precise response rate. It is not possible to know if the sample was representative of the psychotherapy community.	

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
				significantly higher on emotionality.		
Winter et al, 2006	To examine the hypotheses that therapists of different theoretical orientations differ in inner-directedness, personal construct, humanistic, and psychodynamic therapists being the most inner-directed and cognitive-behavioural therapists the least. That therapists of different orientations differ in philosophical beliefs, personal construct, systemic, and humanistic therapists being the most constructivist and cognitive-behavioural therapists the most rationalistic. That there is a greater commonality within therapeutic orientations	1153 of the UK Council for Psychotherapists (UKCP) therapists of different orientations were approached. The response rate was 9.9%. i.e. 115	The Direction of Interest Questionnaire (DIQ) (Caine, et al 1982). The Therapist Attitude Questionnaire – short form, TAQ (Neimeyer et al, 1997) The Repertory grid listing 16 therapeutic approaches. (Kelly, 1955).	Cognitive/behavioural therapists were found to be significantly more outer-directed than therapists of all other orientations. Psychodynamic therapists were the most inner-directed and significantly more so than hypnotherapists. Neurolinguistic psychotherapists were more rationalist than psychodynamic, personal construct, and humanistic therapists. On the repertory grid most therapists tended to view their	Although the initial sample approached was randomized it is arguably not representative of the UKCP membership as certain therapists chose to answer the questionnaire.	Moderate

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
	than between different orientations.			own approach more positively. There was a greater commonality of construing within as opposed to between orientations. Overall conclusion ” The findings would suggest that heated disputes between therapists may occur because any challenge to therapists’ preferred theoretical orientation is likely to imply a challenge to their personal style and fundamental philosophical beliefs”.		
Roth, 2015	The study explores the validity of a set of competence frameworks for cognitive behavioural	111 psychotherapists	Q-sort of a hundred items drawn from frameworks	Participants from all three modalities were significantly more likely to identify items	The possibility of subjective bias is recognized by the author.	Moderate

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
	therapy, humanistic and psychodynamic therapies.		representing each of the modalities and including a generic section.	drawn from their own modality framework as “characteristic”. They were all significantly more likely to eschew competences from other frameworks. There was a significant difference in endorsement of generic items partly because the rate of the psychodynamic endorsements was particularly low. None of the humanistic competencies were endorsed as characteristic by CBT or psychodynamic therapists.	The original competences were selected by groups of senior people in each modality. The author made the selection of the 100 competences including the choice of the generic set. The sample may not be representative as therapists were recruited via email advertisement.	

Reference	Questions/Aims	Sample	Methodologies	Findings	Limitations	EPHPP Rating
				None of the psychodynamic competencies were endorsed as characteristic by CBT therapists but humanistic therapists endorsed the psychodynamic competence related to the ability to tolerate ambiguity in the client's communication.		

How can the difference be thought about?

In some of the studies listed above, writers such as Winter, (Winter et al, 2006), Boswell (Boswell et al, 2009), and Ogunfowora, (Ogunfowora et al 2008), looked at how various aspects of a therapist's personality contributed to their choice of theoretical orientation. I think that as with comparisons within outcome studies, it is very difficult to isolate one factor that makes a person choose to train in one kind of therapy rather than another. The choice of orientation might be based on intellectual satisfaction and interest in research. It might be based on which courses are available within travelling distance or the training of their personal therapist. Unconscious and personal factors related with personal or family trauma might lead a person to choose a more in-depth therapy. Religious belief or spirituality might lead a person to choose transpersonal or Jungian therapy.

These studies did not examine practitioners from the different modalities working alongside each other, which is what my study sets out to do. In addition, the researchers have not on the whole concentrated on differences based on the modality's approach to the human predicament, theories of development and therapeutic engagement. The following qualitative studies do address the issue of differences in theory and practice albeit within the one modality of psychoanalysis.

Review of three qualitative studies

In **Table 2** on pages 58 to 60, I have reviewed three qualitative studies using CASP (2013). Although these books examine comparisons within the practice of psychoanalysis, they have contributed not only to the study of a comparison between practitioners but also to the awareness of the importance and stimulation that discussions of comparisons in clinical approaches can bring

about. In addition, the studies are particularly relevant to my present study as they employ the use of group discussion as part of the methodology.

The studies by Tuckett and Canestri were initiated by a working party of the European Psychoanalytic Federation in 2000. These studies, Tuckett's about clinical comparisons, and Canestri's about theoretical differences, were tasked with the following questions and aims in mind.

> Why do models and theories in psychoanalysis seem to have such emotional implications for the analyst and/or for the psychoanalytic institutions? Are there any psychoanalytic (unconscious) reasons for choosing different paradigms (models)? What is the influence of language/culture on the creation and/or choice of different models? What is the role and meaning of preconscious theories in clinical practice? How can we collect evidence about them? Can we use supervision to produce evidence about their existence? What could the heuristic value of these preconscious theories if they are recognised? How could we improve communication about clinical work using the feedback from these and other researches? (Tuckett, 2012 p. 265)

Tuckett's collaboration with the European Psychoanalytic Federation resulted in an extensive and comprehensive study of the way psychoanalysts work in Europe and further afield (Tuckett et al, 2008). Small groups of psychoanalysts met during each conference. One psychoanalyst presented their work and the others observed. Tuckett used a grid to structure the observers' perceptions and aimed initially to reveal the similarities and differences between psychoanalysts' ways of working. The remit changed over a number of years. Comparisons between psychoanalysts became less of a priority and attention was transferred to a closer study of the difference between how an analyst

thinks he or she works and how he or she is observed to work. The examination was achieved through the observation of a comprehensive clinical presentation. In some of the chapters in both of Canestri's books, clinical presentations have been made by one analyst and have been commented on by one or more psychoanalyst from different countries (Canestri Ed., 2012), (Canestri Ed.,2006). In the same vein as Tuckett's, study, these authors' aim is to answer the question, "Do analysts do what they say they do?", and in Canestri's conclusions the simple answer is "No" (Canestri Ed., 2012 p. 157).

These studies illustrate, in my view, how difficult it is to present qualitative findings without overwhelming the reader with a great deal of information. I think there is by necessity a tension between maintaining depth and offering a concise picture. What these studies share with my own is the willingness for therapists with different ways of working to share their views with others and to be open to recognising the similarities and the differences. Tuckett, Canestri and their colleagues asked their participants to present their clinical work in depth to other analysts. This process was lengthy and took place over a number of years. It also would not have been possible without a good degree of trust between participants. In contrast, my study of the low-cost scheme with therapists and counsellors from different orientations involved one-off focus group discussions over a short period of time in the life of the organisation. Participants in the focus groups were asked to talk about theoretical concepts in the first place with the opportunity of sharing clinical examples later if they chose to do so.

Jungian and humanistic concepts compared

In **Table 3** on pages 61 and 62**,** I have looked at six papers from a Jungian/Humanistic conference which was arranged by the Confederation for

Analytical Psychology in October 2014. These papers were then published in 2015 in *Self and Society.* Despite the number of studies which have compared the theoretical orientations as reviewed in **Table 1** and **Table 2**, these conference papers are unusual in that concepts from two different theoretical orientations have been compared. In this instance the Jungian and Humanistic modalities are compared rather than the Psychodynamic and Humanistic in my study. The speakers attempt to look at concepts such as individuation and self-actualisation alongside each other. The published papers do not include any discussion from the floor but I have included them because this is a rare example of a public attempt to think about the similarities and differences between two theoretical orientations.

I considered using the guidelines for the peer review of journal articles for these conference papers but decided on an adaptation of CASP (2013). In addition, I have added a rating as used when reviewing quantitative studies with the EPHPP (2010).

In the first conference paper reviewed, Rowan compares the Jungian concept of individuation with the humanistic concept of self-actualisation (Rowan, 2015). Individuation is a central concept in Jung's approach to psychotherapy. It has recently been described as

> The recognition of that which is not ethical within the self" and this "recognition represents the integration of the shadow, a step toward incremental advances in the self's movement towards greater states of integration and wholeness. This is the individuation process and it is predicted on a prospective view of the self in which the self's capacity to change, growth and development are understood and experienced as

> being suffused with a sense of purpose and meaning (McFarland Solomon, 2010 pp. 328-9).

Maslow's process of self- actualisation signifies a movement towards authenticity. Elsewhere, Rowan uses Bugental's description of authenticity.

> By authenticity I mean a central genuineness and awareness of being. Authenticity is that presence of an individual in his living in which she is fully aware in the present moment in the present situation….. Authenticity has three functional characteristics: 1. The authentic person is broadly aware of himself, his relationships, and his world in all dimensions. 2. The authentic person accepts and seems to go to meet the fact that he is constantly in the process of making choices, that decisions are the very stuff of living. 3. The authentic person takes responsibility for his decisions, including full recognition of their consequences (Rowan and Jacobs, 2002 p. 127).

In the conference paper, Rowan sets out to compare the concepts but argues that they are very different and that Maslow's concept of self-actualisation can be evidenced by research but that no such research exists in relation to individuation. The paper is limited to a theoretical discussion without illustrations of differences of clinical approaches.

Smith on the other hand, does include a clinical example to illustrate the key point he is making about the nature of change in the therapeutic process (Smith, 2015). He suggests that the emphasis on inter-subjectivity can lead to the conclusion that it is only the relationship within therapy that brings about therapeutic change. This viewpoint can exclude a theoretical underpinning of both Jungian and humanistic thinking. Both the concepts of individuation and self-actualisation, Smith contends, emphasise the psyche's own capacity to

change. He quotes Rogers as saying" the organism has one basic tendency and striving – to actualise, maintain, and enhance the experiencing organism" (Rogers, 1951 p. 487). In addition, Smith points out that both Berne, the transactional analyst, and Jung have been influenced by the thinking of Heraclitus, the Greek philosopher, who thought that there is an innate essence that drives the living organism towards healing.

Smith draws from Samuels' summary of Jung's theory of the opposites and the transcendent function which can act as a bridge between opposing realities so that a third possibility can transpire (Samuels, 1985). Smith then argues that the therapy relationship that recognises the therapist's wounded healer can facilitate change but should also include the "client's essential contribution to change" (Smith, 2015 p. 5). In Jungian terms, this change could be described as the process of individuation where the person is able to face and accept his or her "shadow" side.

I think this paper has a strong argument and is well written. However, two differences between humanistic and Jungian psychotherapies seem to have been implied rather than made explicit. Firstly, Jung's theory of the structure of the psyche which includes both the personal and archetypal unconscious. Secondly, Jungian psychotherapy includes the shadow side of the personality. Smith implies including both of these ideas in his clinical practice when he quotes Jung before giving his clinical example.

> I must emphasise, however, that the grand plan on which the unconscious life of the psyche is constructed is so inaccessible to our understanding that we can never know what evil may be necessary in order to produce good by enantiodromia, and what good may very possibly lead to evil (Jung, 1948, para 397).

Both Smith and Rowan highlight working with unconscious processes as the key difference between Jungian and humanistic therapies. Hargaden in her discussion of the similarities between Jung and Buber also highlights this distinction (Hargaden, 2015). The existence of the unconscious is one of the areas where Jungian and psychoanalytic psychotherapy have some agreement despite the differences between Jung and Freud over the structural understanding of the psyche. Hence, this distinction is likely to be evident in my present study comparing humanistic and psychodynamic or psychoanalytic therapies. In addition, the Jungian emphasis on the shadow side of the personality again resonates with how important the recognition of aggression is in psychodynamic thinking. The place of aggression, as implied in Smith's paper, appears to be absent for the most part in humanistic thinking.

Heuer's contribution to the conference took a different route (Heuer, 2015). In her paper, she distinguishes between bodywork where the therapist works with the physical experiences *per se* and the approach to physical symptoms within psychotherapy where the understanding of the meaning is sought. In addition, she refers to her PhD work where she is examining clinical texts and is suggesting, like Tuckett and Canestri have in the studies of psychoanalysts' work, as discussed above, that the therapist's implicit approach differs from their explicit approach. Heuer's conclusions include that neither Jungian or humanistic psychotherapy is as benign as reported.

The contribution of the Jungian/humanistic conference papers

Although discussions about differences between theoretical orientations must have been going on to some degree "behind closed doors", it is rare to find a debate that has been published. In fact, Williams described how long it took to get this Jungian and humanistic conference arranged (Williams, 2015). The

initiative by the present leadership of the British Psychoanalytic Council, (BPC), to have more communication with the UKCP and BACP might break down some of the assumptions and conflicts.

When a writer such as Rowan or Smith looks in closer detail at one or two concepts that might be shared between two modalities, I think it highlights how difficult it is to embrace in-depth many orientations. I have been aware whilst working within the low-cost scheme under study that books are referred to by the different modalities which were unknown to me. Similarly, texts that I hold dear are unknown to these colleagues. It would be an impossible quest in my view to expect therapists from one modality to fully comprehend another's body of theory. However, the endeavour is both academic and socially motivated; to look at the similarities and differences can be productive in furthering understanding of another's position but also in stimulating one's own position.

Conclusions

Although as reviewed above there have been quantitative studies looking at the trends in preference for certain modalities and the difference between orientations with certain attitudes such as readiness to self-disclosure, these studies have not involved discussion groups where the differences might be recognised, provoke thought and stimulate development. The surveys or questionnaires all relied on self-report without other input from observers, colleagues or supervisors.

The work by Canestri and Tuckett examines intensively and extensively differences in the way psychoanalysts work. These studies offer a challenge to any practitioner to question the implicit theories that underpin their clinical work. They provide useful training tools for supervisor and trainee to observe how clinical work is actually being undertaken. In endeavouring to answer the

questions set by the European Psychoanalytic Federation Working Party the intended outcome is to foster better communication and understanding between analysts on an international scale.

A motivation behind the present study of a low-cost scheme is to consider the best way of facilitating reflective and effective practice for psychodynamic and humanistic practitioners working alongside each other. The differences in approaches to psychoanalytic concepts and the possible crossovers with humanistic ways of working are of interest in themselves. The larger quantitative studies reviewed above present a picture of the profiles and preferences of psychotherapists, psychologists and psychology students and the findings have relevance to the training institutions and organisations. However, unlike the EPF studies and the present study, the quantitative studies place far less responsibility on the participants' own reflections on the way they work in the face of different opinions. The conference looking at similarities between Jungian and humanistic psychotherapy gave a unique opportunity to observe therapists from two different modalities talking and thinking together. In a climate where the number of psychodynamic practitioners is reducing, where integrative training is common, and where organisations include practitioners from different modalities, I believe that my study stands alone as an endeavour to look more closely at the differences between the two modalities of Psychodynamic and Humanistic therapies. My research does not follow the pattern of any previous research in this area. It is original because of my choice of methods and because of its qualitative approach to how therapists and counsellors from different modalities work along-side each other. I suggest that no other study, yet discovered, offers this unique snapshot of therapy practitioners from two different modalities in their workplace.

Table 2 - Review of qualitative studies based on CASP (2013)

Reference	Aims	Sample	Methodology	Potential bias	Analysis of findings	Value of research	CASP Rating
Tuckett, 2008	Initial aim was to compare ways of working between the different schools of psychoanalysis. Final aim was to "map the range of theory in psychoanalytic community as a whole".	10 groups of 12 psychoanalysts who attended annual conferences of the European Psychoanalytic Federation. Total number of participants is unknown.	Case presentation by a senior analyst observed by other psychoanalysts with a moderator presiding. Structured questions for observers based on a grid devised by the author.	Researcher met with the working party and adjusted the methodology in response to feedback from the participants each year.	An awareness of the different approaches between psychoanalysts in different parts of the world. The difference in the degree that transference is worked within analysis. A difference between the two views whether therapy works through the repetition of the past deprivation and lack of good objects, or whether the analyst can	The development of trust internationally to compare ways of working. When an analyst can see what might be the strengths and weaknesses of their approach and the difference between how they think they work clinically and how they are	Strong

Reference	Aims	Sample	Methodology	Potential bias	Analysis of findings	Value of research	CASP Rating
					provide a better experience.	observed working. To witness other techniques and thereby reflect upon their own approach.	
Canestri Ed. 2006	The aim is to provide a fresh perspective on the relationship of theory and practice in psychoanalysis.	The method of scrutinizing another analyst's work is ongoing in peer groups and for training purposes. This book gives one example.	A method of mapping private/implicit theories involving six vectors. (Canestri et al 2006) The 6 vectors are: • topographical • conceptual • "action" • "object relations of knowledge" • coherence versus contradiction	The analyst who maps the other's work is aware of their subjective position and is self-reflective about their own style of working.	There is a detailed clinical example and a mapping process. One of the points raised is within the vector coherence versus contradiction. The observer notes that the patient's omnipotence can be seen both as a defence and	This method of study demonstrates how complex identifying any therapeutic approach can be. It not only shows convergences and divergences between rival theories, but	Moderate

Reference	Aims	Sample	Methodology	Potential bias	Analysis of findings	Value of research	CASP Rating
			• developmental vector		also in Winnicott's terms the baby's need to be omnipotent.	also differences between implicit and public theories.	
Canestri, Ed. 2012	To examine systematically some analysts' work from different schools and countries to elucidate their implicit use of theory in relation to their public theoretical positions.	Three clinical presentations by different analysts and responses by clinicians from different parts of the world.	A method of mapping (Canestri et al 2006)	Each respondent to the clinical work presented is aware that they bring to their observation their own implicit theories.	Individual responses to clinical material One analyst notes that within the topographical vector the issue of payment is prominent and that unlike the British inclination, the American analyst does not choose to take up the signs of a negative transference.	Encouraging difference and self-reflection.	Moderate

Table 3 - Review of Jungian/ Humanistic Conference papers using an adaptation of CASP (2013)

Reference	Theory and Concepts compared	Discussion and Conclusions	Value and rating
Rowan, 2015	Jung's concept of Individuation with Maslow's concept of Self-actualisation.	The author cites research projects which in his view confirm Maslow's theory. Individuation has not been so thoroughly researched as a concept. Individuation has a spiritual dimension which self-actualisation has lacked until the work of Wilber and his concept of the "subtle self" (Wilber, 2000).	**Moderate** A valuable exploration of the spiritual aspect of individuation. Less coverage of the implications for the differences in clinical practice.
Hargaden, 2015	Theories of Martin Buber and Carl Jung. Particularly the authentic self and the importance of the relationship.	In the author's view, early developmental experiences for both thinkers have influenced their theories. Carl Jung however includes the unconscious aspect of the relationship.	**Moderate** The author studies a supervision session with one of her supervisees. This gives her the opportunity for self-reflection and to evaluate possible different approaches.
Smith, 2015	"Wounded healer" Humility Self-actualisation Individuation.	Both Jungian and humanistic approaches recognize the need for humility and the concept of the wounded healer. There is a commonality in the concepts of self-actualisation and	**Strong** A well thought out paper with a depth of understanding of Jungian and humanistic theories. A well put argument that therapeutic change is not solely brought

		individuation as both include that the psyche strives in a positive way to achieve its potential. The difference between these two concepts is Carl Jung's inclusion of the unconscious aspect and the shadow side of the personality.	about by the therapy relationship but includes the psyche's own capacity for change.
Heuer, 2015	An analytic approach to body experiences versus Neo-Rheichian body work.	The analytic attitude searches for the meaning whereas the bodywork concentrates on the experience. The author refers to her doctoral research on implicit theoretical bias suggesting that both Jungian and humanistic approaches are not necessarily benign when case material is analysed.	**Moderate** Useful in questioning the disparity between explicit theory, implicit theory and actual practice.
Williams, 2015	Gestalt and Jungian approaches to dreams.	The Gestalt view that people in a dream can represent aspects of the dreamer is similar to the Jungian idea of the subjective interpretation.	**Moderate** It gives an introduction to the conference and the difficulties of getting the two modalities together.

Chapter 3

Methodology

This is a study of a low-cost scheme where therapists and counsellors from two different modalities work alongside each other. The purpose of the study is to investigate the similarities and differences between the theoretical approach and clinical practice of these psychodynamic and humanistic practitioners. The research questions are.

- What do the therapists and counsellors working in a small organisation say about the three psychoanalytic concepts: the therapeutic alliance, transference and containment?
- How does what they say illustrate the differences, agreements and meeting points of their different modalities?

The practitioners were asked to discuss three key psychoanalytic concepts within focus groups. These discussions were first analysed using a thematic analysis. Then, the findings have been further interpreted within the contexts of the researcher's own reflexivity, the participants' reflections on the focus groups and the unconscious dynamics of the organisation.

Research Procedure

A submission was made to Exeter University and to the trustees of the low-cost charity for ethics permission outlining the proposed procedure and the attention paid to ensuring the confidentiality of the participants. Please see Appendix 2 for the application to the trustees.

In the first instance a pilot focus group was run with a group of colleagues outside the organisation in June 2014. Then, all of the 28 people who were working in the low-cost scheme were invited to participate in six focus groups.

Two of these participants were not clinicians. All the practitioners had the opportunity in their mentor groups to discuss the proposed research in advance, to air their anxieties and to ask questions. It was made clear in the invitation that attendance at the group was not obligatory.

Thompson and Chambers write about the kinds of ethical issues that can arise when I as Clinical Director and founder of the organisation am undertaking the research. "There may be subtle risks of coercion or conflicts of interests, such as where one party wishes to show a service in a particular light or has an "axe to grind" about a particular type of intervention" (Thompson and Chambers, 2012 p. 31). I think that the bias towards the psychodynamic approach had been evident to the practitioners, management team and trustees prior to the research project and that the focus group discussions were intended to give them the opportunity to debate and disagree with the status quo. It was inevitable however, that many participants would seek to please me by saying what they thought I wanted to hear.

As all the practitioners were working on a voluntary basis at the time, the fear of losing their posts if they did not cooperate was less powerful than if they had been receiving a salary. Trainees, however, might have been worried that if they did not attend it would affect the success of their placement. In chapter 5, I will discuss further the participants' possible motivations for being involved and the probable impact of my position on what they chose to say in the focus groups.

The choice of participants was purposive. The focus groups were made up of the groups that already existed within the organisation, namely the group of trustees, the management team, and the four mentor groups without their mentors. Please see Appendices 3 & 4 for the invitation letter and the

information sheet. The structured part of each focus group lasted for an hour, with some time at the beginning for introductions and at the end to give the participants the opportunity to comment on their experience of the group discussion. The six groups were held between August and December 2014.

I, as the researcher, moderated and audio-recorded all six focus groups. In order to check for person bias, further observations were recorded by an assistant moderator who was an outsider to the organisation. I recruited this person because she had been working for several years as a probation officer and I was aware of her attention to detail. In addition, she was not acquainted with any of the volunteers. Please see Appendices 5 & 6 for the moderator prompt and assistant moderator guidelines. The questions I put to all 6 groups are as follows:

- Does the term therapeutic alliance (transference / containment) have meaning for you? Does it make sense to you?
- Do you use it in practice? Please include anonymised clinical examples if you like.

In the first focus group, I split each question into two as recorded above but it soon become clear that it was better to ask both parts of the question together.

Focus Groups

The use of focus groups has been a well-recognised method to study people's views and attitudes since the 1940s when sociologists began to study audience reactions to radio programmes (Merton and Kendall, 1946). This method has only relatively recently been adopted by psychologists, for example Wilkinson's use of focus groups in health research (Wilkinson, 1998). Many of the focus groups in the field of psychology have focused on the clients' or service users' experiences. I considered this method best suited to find out the views of the

practitioners. I thought that group discussions would stimulate more ideas than individual interviews and that the differences between their views would be more evident. In addition, I envisaged that my role in a group would be less active and that individuals would feel less put on the spot to provide "right answers". Focus groups are considered to be a "relatively egalitarian method, more naturalistic and closer to everyday conversation" (Wilkinson, 2004 pp. 180-181). Another advantage of this method is that the interactions also "allow respondents to react to and build upon the responses of other group members" creating a "synergistic effect" (Stewart and Shamdasani, 1990 p.16)

After thirty years of running focus groups, Morgan and Kruegar have provided a comprehensive guide and I have used their focus group kit as a helpful framework for setting up the groups (Morgan and Kruegar, 1998)

Thematic analysis of focus group discussions

I have chosen thematic analysis as the main method of analysing the focus group data. This choice is based on the need for a flexible methodology. I have chosen to explore firstly what the participants have said about the psychoanalytic concepts themselves and secondly to move on to identifying some common themes which would further demonstrate the similarities and differences between the psychodynamic and humanistic approaches. From the outset because of my observations as Clinical Director over the years, I have expected there to be differences in the way the practitioners approached the importance of containment and the relevance of a client's transference to the practitioner.

Epistemological position

One virtue of thematic analysis as a method is that it is not wedded to one particular epistemological position. For this research, I have decided to approach the data using a critical realistic approach (Forrester, 2013).

Lund wrote about critical realism, "The phenomena studied in…research are not completely constructions… but correspond to real entities or processes which exist independently about us" (Lund, 2005 p. 118). Joffe also suggested that this approach is well matched to theories with weak constructionist tenets. She wrote," Weak constructionism assumes that how people engage with a particular issue is socially constructed although the issues themselves have a material basis" (Joffe, 2012 p. 211).

The use of thematic analysis was originally developed in the 1970s by Holton, who has been described as a physicist and historian (Merton, 1975). Bryman points out that the search for themes has been adopted by many social scientists and is compatible with many approaches to data analysis including grounded theory (Bryman, 2014). This method has been particularly championed in this century by Braun and Clarke for psychology (Braun and Clarke, 2006). Also, Bryman refers to the introduction of a more systematic form of thematic analysis termed the Framework approach in 2003 where themes and subthemes are mapped on a table like a spreadsheet (Bryman, 2013).

There has been an increase in the use of thematic analysis in the field of mental health. For example, Gilburt and colleagues' have studied service users' experiences of admissions to psychiatric hospital, (Gilburt et al, 2008), and Allen and colleagues have studied participants' subjective experience of mindfulness-based cognitive therapy for the treatment of depression (Allen,

2009). Fereday and Muir-Cochrane have studied practitioners rather than patients using this method when they looked at the assessment of nursing clinicians and the ways in which the Nurses Board of South Australia evaluated performance feedback. Using thematic analysis, they analysed the focus group discussions of nursing clinicians and clinical managers and the Board's review policies and procedures (Fereday and Muir-Cochrane, 2006).

The strengths and weaknesses of thematic analysis

Although thematic analysis is widely used in the fields of sociology and psychology, it has been viewed as a rather simplistic and shallow approach to data which is particularly appropriate for junior researchers to use as it is simple to grasp. Braun and Clarke have outlined some of the strengths and weaknesses of the method (Braun and Clarke, 2014). The advantage in this study, as previously stated, is the flexibility of the approach means that thematic analysis can be compatible with my epistemological position of critical realism. Alhojailan has offered a recent critique of the method (Alhojailan, 2012). He has suggested that this method is particularly useful when dealing with a number of participants' contributions and for comparing between groups and different timescales. He concluded:

> …thematic analysis offers the flexibility for starting data analysis at any time during the project, where there is no association between the data gathered and the result of the process itself. More importantly it provides the flexibility for approaching research patterns in two ways, i.e. inductive and deductive (Alhojailan, 2012 p. 45).

Braun and Clarke too add that a strength of the method is that "the results of TA can be accessible to an educated wider audience (for this reason, TA can be an appropriate method for participatory approaches, where the participants have a

role in the analysis of the data they help to generate…" (Braun and Clarke, 2014 p. 180). The practitioners in the present study have not been explicitly involved in action research where the findings from the focus groups will be taken back for further discussion (Bryman, 2012 p. 709). However, practitioners have shown interest in reading the findings after the study has been completed and a straightforwardness in the presentation of themes will help render the findings more accessible.

Clarke and Braun have also listed a number of weaknesses of the method including that thematic analysis lacks "the substance of other theoretically driven approaches", "has limited interpretation power" and that there is a "lack of concrete guidance for higher-level, more interpretive analysis" (Braun and Clarke, 2014 p.180 Table 8.2). The form of thematic analysis that I have used has been informed by the work of Braun & Clarke as well as summaries of the technique provided by Joffe, (Joffe, 2012), and Alhojailan (Alhojailan, 2012).

Reflexivity and the unconscious dynamics of organisations

According to Finlay and Gough "the root of the word "reflexive" means "to bend back upon oneself" and in research terms this can be translated as thoughtful, self-awareness analysis of the intersubjective dynamics between the researcher and researched" (Finlay and Gough Ed., 2003 ix). As I shall discuss further in Chapter 5, this "thoughtful self-awareness" is central to the work of psychoanalytic psychotherapists where particular attention is paid to the unconscious processes between individuals, within groups and in organisations. Therefore, to add some further depth to the thematic analysis and in recognition of the central place that unconscious processes hold in psychoanalytic thinking, I have included in my methodology an exploration of the reflections both of myself as the researcher but also of the group participants themselves.

Thematic analysis is seen by Braun and Clarke as a subjective process for both researcher and participants. "They're not robots; we're not robots – we're all living, breathing, subjective human beings, partial in our knowledge, and flawed" (Braun and Clarke, 2014 p. 36).

I have chosen to focus on the psychoanalytic theories of unconscious processes within organisations to add to my interpretation of the findings. This part of my analysis of the process captured in this study of the low-cost organisation has been informed by the work of those psychoanalysts who have been consultants to and observed organisations (Hinshelwood and Skogstad, 2000), (Obholzer and Roberts, 1994), and (Armstrong, 2005). These approaches with which I aim to complement the thematic analysis will be presented in Chapter 5 after the chapter on thematic analysis.

Thematic analysis: the procedure

All the transcripts of each group were studied in turn on numerous occasions and checked alongside the audio tapes. Then various categories or codes were gathered from the texts with the aid of N-Vivo. Firstly, the concepts of therapeutic alliance, transference and containment were used as top-down categories. Then further categories emerging from the discussion of the concepts were noted. The themes that commonly occurred across the groups were recorded with particular reference to when ideas were expressed in a similar way. In addition, the participants' reflections on the group processes were collected at this stage. Appendix 7 contains the list of nodes which I developed from scanning the transcripts repeatedly.

Then, as recommended by Braun and Clarke the transcripts were looked at and thought about in terms of candidate themes i.e. themes arising from the coding of the contents which may be revised later on. (Braun and Clarke, 2014).

The first three themes discussed in this analysis are “top down” themes, derived from the theoretical research questions. I imposed these first three themes on the discussions as it was my view that the discussions of the three concepts therapeutic alliance, transference and containment would show up differences between the modalities. These first three themes could therefore be termed “top down themes” or “theoretical themes”. However, to ensure these are not understood as emerging themes, I use the term “concept” for these three research-driven top-down themes. The term “theoretical” theme has been used to refer to this kind of theme where the choice of theme has been driven by the “analyst’s interest in that area” (Boyatzis, 1998), (Hayes, 1997), (Braun and Clarke, 2006 p.12).

Three further candidate themes were chosen because they became prominent when I read and re-read the transcripts. A topic that arose out of the discussions and was chosen because it seemed to engender strong feelings was equality within the therapy relationship. This topic became the fourth theme which is entitled: ***Power dynamics in the therapy relationship***. A common comment made by participants was about the use of theoretical language. In the analysis, I paid particular attention to how both theoretical language and participants’ references to theoretical experts could be experienced as a barrier to communication. Hence, the fifth theme was entitled: **Reference to theory: barrier or bridge to communication and understanding.** The sixth theme was identified at a later stage after the initial thematic analysis of the focus group discussions of the three concepts. I have called this theme **The therapy relationship.**

Checks for reliability and validity

There have been four opportunities to check my choice of themes with colleagues. Firstly, the candidate themes were discussed individually with both supervisors. Secondly, the data was taken regularly to learning sets. The learning sets took place three times a term, were comprised of three peer doctoral students on the same course and were led by a tutor with a particular expertise in research methods. Thirdly, I met with two peers on the same doctoral program on a number of occasions and they had the opportunity to look in depth at my choice of themes and subthemes. Lastly, I presented my research to a larger group of fellow students and supervisors on a number of arranged training days.

The six themes retained their relevance after these discussions and continued to do so as I began to organise, analyse and interpret the data. In the next chapter, Chapter 4, I present the thematic analysis of the discussions of the practitioners from two modalities working alongside each other with the aim of showing the similarities and differences in their approaches to psychoanalytic theory and clinical work.

Chapter 4

The Thematic Analysis

Research questions

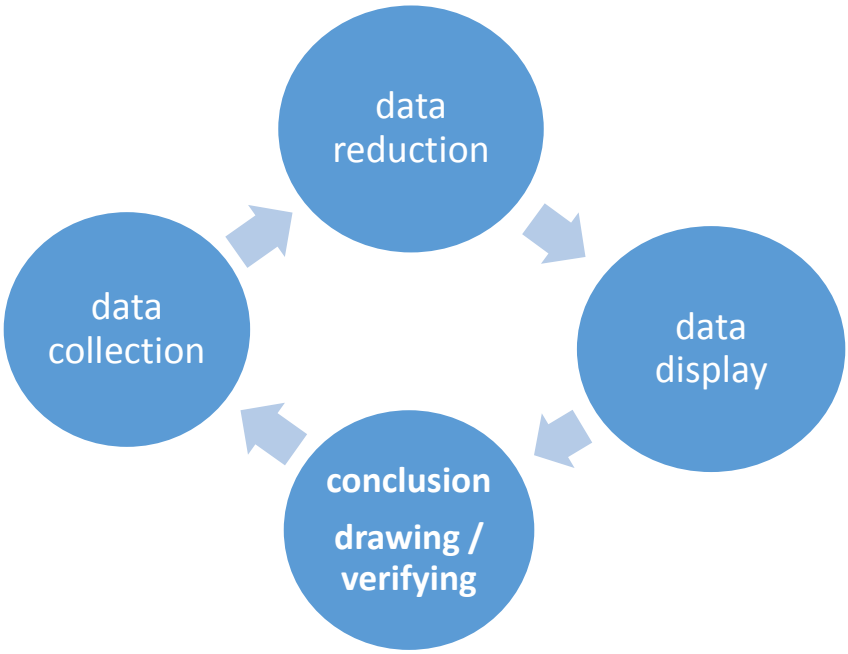
In Chapter 1, I put forward the research questions for this study of a low-cost counselling and psychotherapy organisation, where psychodynamic and humanistic practitioners work alongside each other. The questions were:

- What do the therapists and counsellors working in a small organisation say about the three psychoanalytic concepts: the therapeutic alliance, transference and containment?
- How does what they say illustrate the differences, agreements and meeting po.ints of their different modalities?

Thematic analysis

In Chapter 3, Methodology, I argued that thematic analysis is the appropriate method of analysis for this study as the data is being interpreted from a critical realist viewpoint. I also suggested that this thematic analysis is a particularly helpful method when looking at and comparing the differing perspectives of a number of participants. The aim of this chapter is to present in detail the three linked steps of the process of thematic analysis as proposed by Miles and Huberman (Miles & Huberman, 1994) and summarised by Alhojailan, “data reduction, data display and data conclusion- drawing/verifying” (Alhojailan, 2012 p. 41). Please see Figure 3 for a diagrammatic representation of this process. This diagram shows how the process is iterative and not linear but circular. In consequence, further data collection and analysis can follow the initial findings.

Figure 3 Phases of thematic analysis



Data reduction

After the discussions in the focus groups had been transcribed, I worked through the transcripts both manually and with the use of N-Vivo software to begin to organise, code, and reduce the data. Please see Appendix 7 for the list of codes worked with during this period of the reduction of the data.

Choice of themes

Three topics for discussion had already been chosen i.e. the therapeutic alliance, transference, and containment. These three key tenets in psychoanalytic theory were the imposed focus on the discussions, with the view that they would serve as catalysts to explore the similarities and differences between the psychodynamic and humanistic modalities. The intention was to see what the participants did say about the concepts, as their perceptions would highlight the differences in approaches and might also contribute to contemporary discussions in the wider arena of therapy about the concepts

themselves. This process provided step one in the analysis of the focus group discussions.

The concepts were not used as deductive themes. If they had been used in this way, I would have prepared a set of answers to be used as a check list to note their occurrence in the discussions. Instead, the initial coding exercise with N-Vivo led to the identification of six themes for each concept. These have been illustrated below in Figures 4, 6, & 8.

Three further themes arising from the patterns of data were also included at later intervals:

- Power dynamics in the therapy relationship
- Reference to theory: barrier or bridge to communication and understanding
- The therapy relationship

These themes could be termed as inductive, as they were not imposed but observed in the data. The first theme listed above was chosen because there were some thoughtful discussions about power dynamics and expertise which in my view demonstrated a key difference between the modalities that my research questions were aimed to find. The second theme was chosen as so many references to theory and language were observed to occur across and within the groups. However, the choice was also influenced by my conviction that the issue of theory as a barrier to communication has key significance. The last theme was identified at a later stage of the analysis as an overarching theme that emerged from the analysis of the discussions about the three concepts.

Data display

Three tables have been created to present the comments that were made about each concept across the groups. The complete tables can be found in Appendices 8-10. The findings have been summarised in Tables 1a - 3a which are included in the text below. In Table 4, Appendix 11, I outline the fuller comparisons between the modalities concerning the theme of power dynamics and these have been summarised in Table 4a. In Tables 1-4 and Tables 1a-4a, three columns have been given headings to the three positions in the discussions i.e. psychodynamic on the left, humanistic on the right and meeting points in the middle. Where the participants from both modalities have agreed about a theme this is indicated in their respective columns. For example, in Table 4a below, the entry in both modality columns for the theme contract and boundaries is “both important”.

The heading “meeting points” is not intended to describe an area of similarity or agreement between the speakers from each modality. Instead I use this category to cover an area where the viewpoint of a member of either modality leans towards or recognises the value of the opinion of the practitioner of the other orientation. Where there has been such an inclination towards the other orientation, the direction of the lean is illustrated by arrows below the comment. The modality of the contributor in the meeting point column has been entered after their quotation. Figures 11 and 12 below illustrate the differences and overlaps between the modalities when a theoretical concept or writer is referred to. The fuller versions of these comparisons can be found in Appendices 12 and 13.

The quotations in the tables have been collected from participants across the different focus groups and therefore from the different existing groups within the

organisation, the trustees, the management group and the four mentor groups. To emphasise that the quotations do not necessarily come from the same group, all participants have been given a code depending on which focus group they have been a member of e.g. DG1 where D stands for the organisation, G for the name of the group leader and 1 for the particular member. These quotations have been tidied up to take out repeated words and hesitations et cetera and are therefore not exactly as in the transcript.

The concept the Therapeutic Alliance

Figure 4 sets out the themes arising from the discussions of the therapeutic alliance in the six focus groups. There were six themes which I have described as follows:

- comfort/discomfort
- positive and negative transference
- contract and boundaries
- work context
- working alliance or relationship
- alliance with organisation

All these themes had not been chosen beforehand but were selected after listening to the audio recordings and after repeated readings of each transcript.

Figure 4 The Therapeutic Alliance

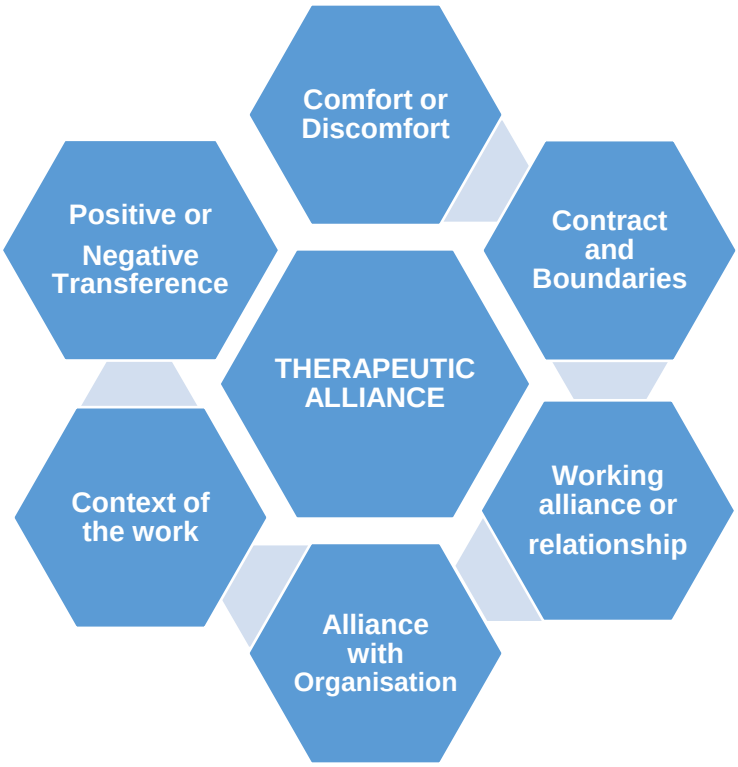


Table 4**,** The Therapeutic Alliance in Appendix 8, shows the contents of the discussions for each theme with the psychodynamic contributions on the left, the humanistic contributions on the right and the meeting points in the middle. Table 4 includes the verbatim comments made by participants from the different groups. Table 4a below summarises the similarities, differences and meeting points.

Table 4a - Therapeutic Alliance similarities, differences and meeting points

Theme	Psychodynamic	Meeting point	Humanistic
Positive & negative transference	Transference		
Comfort/discomfort	Can include feeling discomfort	Comfort is important >>>>>>>> PSY	Needs to feel comfortable
Work context		Work context can make a difference >>>>>>>> PSY	Work context
Alliance with the organisation	Splitting	Alliance with organisation <<<<<<<< HUM	
Contract & boundaries	Both important		Both important
Therapeutic relationship or working alliance	Can be both		Can be both

Areas of disagreement about the therapeutic alliance

Theme: Positive and negative transference

There is only one sub-theme within the therapeutic alliance where there was neither agreement nor a meeting point between the modalities. On Table 4a, the positive and negative transference is entered in the left column solely because only the psychodynamic participants discussed the relevance of both the positive and negative transference to the therapeutic alliance. One participant from the management group said:

> *"I'm not sure that I would necessarily dispute any of that, but I think it is very hard, isn't it, sometimes to differentiate I suppose between what is transference or positive transference or negative transference and what*

is therapeutic alliance or treatment alliance, or I think it is sometimes referred to as sort of the real relationship.... that goes on".

Meeting points

Theme: Comfort/Discomfort

The humanistic participants emphasised the need for the client to feel comfortable in order to form the therapeutic alliance at the start of working together. In contrast, one psychodynamic speaker suggested that feelings of discomfort might not necessarily be an obstacle to beginning therapy with someone. One psychoanalytic speaker shared an experience of choosing between two analysts, where she chose someone with whom she was more comfortable. The following focus group extract includes her account. (PSY) after speakers denotes them as psychodynamic and (HUM) denotes them as humanistic.

Focus Group Extract 1: Comfort/Discomfort

DT2 But I, I agree with you really, M, because you get into another area, somebody doesn't feel comfortable with you - that that could be indicative of a general discomfort, maybe if I moved to another therapist I'll avoid this discomfort, but actually if there is a discomfort about around perhaps the intimacy of the process, of erm, any sort of therapy, then it's going to come up with whoever you're with. But I just it reminded me of the comfort thing, of when I first sort of did my training, and obviously you have to go into psychoanalysis yourself and you're given the name of one or two people you know to go and see, and I went to see one person who was a very,very, Kleinian analyst, and shown into her consulting room and she made a gesture, you know, so there

were several chairs in there, and I sat in a particular chair because I had pulled a muscle in my back, and she immediately made some kind of.eh interpretation- (PSY)

DT3 Right. (HUM)

DT2 - about why I had sat in this upright chair, you know, was this to do with control, and I thought and I.... [out-breath] sort of thought about it a bit and I said well actually no, I pulled muscle in my back and this is actually the most comfortable chair for me to sit in. But then when I found the analyst that I eventually worked with, um, after the first session with her I came away with the impression that she was wearing slippers, and I thought, oh I like that! [laughs] You see what I mean? (PSY).

Theme: Work Context

The context in which the work is carried out was the topic of discussion in more than one group. One suggestion was how do you form a therapeutic alliance with someone who is being forced to attend a session, for example in a prison setting. A number of the participants worked both privately and in the NHS or an IAPT team, and the humanistic participants expressed the view that it was essential to form a therapeutic alliance in these settings.

Having listened to the discussion, one psychodynamic thinker conceded that in a different setting he would be more explicit about the treatment alliance, thus leaning towards the humanistic practitioners' viewpoint.

"I think it sort of depends a bit, you know I was thinking about the difference I might think about it here and I might think about it in NHS work, but I think in brief work perhaps where...you know where there tends to be err perhaps more of an agenda in terms of agreed aims and

things you are working towards, which I think establishes the idea of the treatment alliance and working towards achieving the stated aims and objectives in the process, perhaps a bit differently than doing longer term open ended type of work...I think it's something about perhaps in brief or NHS work ...needing to be more active I suppose um in the way that I might work. Trying to as you say I would take perhaps some responsibility of it more responsibility ...the way for ...that engagement rather than sort of maybe thinking about it in terms of somebody's defences or resistance or ambivalence or whatever, um".

Theme: Alliance with the organisation

In certain instances, a client or patient can hold a positive view about an organisation as a whole and a negative view about a certain practitioner. In other instances, the reverse can occur. An example of this split might be where a client complains that the organisation expects him to pay a donation if he does not attend his session but he emphasises that he does not see it as the practitioner's fault. The choice of this theme, entitled an alliance with the organisation, came out of the discussion between a humanistic and a psychodynamic practitioner. A humanistic participant described how this process can occur, and this description, in my view, is a meeting point between the modalities as the view leans towards the psychodynamic concept of splitting mentioned by her psychodynamic colleague. The idea of splitting was first put forward by Klein when describing the primitive defences in the paranoid schizoid position (Klein, 1946). The thinking is that the good and bad experiences have to be kept separate in order to preserve the good.

Areas of agreement

Theme: Boundaries

The participants from both modalities agreed on the importance of contract and boundaries. A similar theme has been selected from the discussions of containment and there is some overlap between them. This theme will be addressed more fully under the theme of containment.

Theme: Therapeutic Relationship or Working Alliance

The discussions about the theme relationship or alliance, produced the most controversy about the concept itself, but also a good deal of agreement and meeting points amongst the participants. In the following extract the humanistic speaker voices his confusion over the concept and whether it refers to the relationship or the working alliance.

Focus Group Extract 2: The Therapeutic Alliance

DG3 *Well I'm just a bit confused actually. I'm not really sure whether I, I'm not really sure what, when we say the working – the therapeutic alliance, is that the word to be used? (HUM)*

Mod *Ummm*

DG3 *What… (HUM)*

DG4 *That means (HUM)*

DG3 *…we really mean by that. Is that the same as the therapeutic relationship or I mean it implies to me that somehow there is a mutually held sort of understanding that we're working towards, sort of therapeutic goal.*

DG2 *uhum (HUM)*

DG3 *So I'm not sure if I really consciously try to develop that though it seems that there is that there is a relationship there but it's not sort of really out*

in the open and agreed, like an alliance would be agreed. I mean in other sort of areas of life if you have an alliance with someone, you sort of are working together towards the same sort of goal and the sort of the sort of trust and agreement in that so, yeah, I'm just explaining what it sound – I'm speaking I sound confused about the...so, that's where I'm at, at the moment (HUM)

DG1 Confused about the wording of what the actual… (HUM)

DG3 Yeah, and...so when the question is do you use it, I'm a bit, I don't quite understand that question I suppose [laughs]. I think you know that as DG4 was saying, it seems that whole [...] that relationship of trust and...Is essential, you know, a lot more than the basics of essential for the work, so in that sense I suppose I use that... (HUM)

Discussion of themes and meeting points in relation to the therapeutic alliance: a fluid concept

I think the above extract, where the participants discuss the confusion between the terms therapeutic alliance and therapeutic relationship, is one example of the kind of question that emerged from this research around the thinking about the concepts themselves. What seemed to me at the outset the least controversial concept, the therapeutic alliance, itself raised questions which demonstrated the fluidity of the concept.

Prior to the research, I had not been aware that the notion of the positive transference was preferable to the therapeutic alliance for psychoanalytic therapists. The two participants who made this distinction had been trained in psychoanalytic psychotherapy. In contrast, the therapeutic alliance is seen as a separate and necessary entity by the humanistic speakers, who do not mention transference in this context. The American psychoanalyst, Meissner, devoted a

chapter in his book about the “Therapeutic Alliance” on the overlap between transference and the therapeutic alliance (Meissner, 1996). He described how the transference can have a negative effect on the real relationship between the patient and analyst, whether the transference be positive or negative. Meissner argues that the infantile transference, the patient’s wish for infantile needs to be entirely met, blots out the reality of the therapist as a person.

The humanistic participants in all of the focus groups did not refer to a connection between the therapeutic alliance and transference. The emphasis in their contributions was placed on the importance of the working alliance and of the relationship. The term “working alliance” was coined by Greenson (Greenson,1965). Clarkson, a key writer within the humanistic tradition, gives a comprehensive account of the importance of establishing a “working alliance”, and sees the formation of this alliance as essential (Clarkson, 1995).

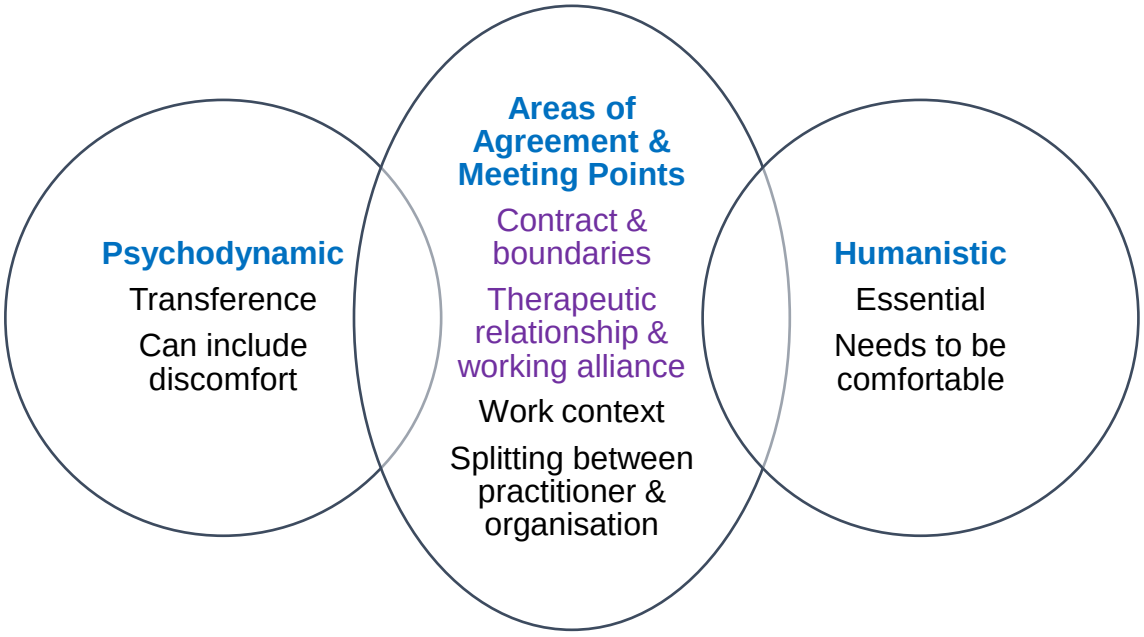
> An effective working alliance contains the necessary ground agreements between psychotherapist and client, without which the psychotherapeutic work could not take place. Without it there can be no genuine assumption of responsibility for the client, nor any genuine long-term engagement on the part of the clinician. It guarantees the physical, contractual and time space (Clarkson, 1995 p.32).

Thus, both modalities remained true to their traditions - the psychodynamic orientation favours transference understandings and the humanistic tradition emphasises the importance of the authentic relationship itself.

Figure 5 summarises the number of areas of agreement and meeting points that have been identified from the discussions about the therapeutic alliance. The areas of agreement are highlighted in purple and the meeting points only denote an inclination towards the opinion of the other modality and not

agreement. However, there remains a strong distinction between the modalities about the relevance of the positive or negative transference to the concept of the therapeutic alliance. Also, there is a difference shown between the two modalities about the need for the client to feel comfortable with the therapist in order for the therapeutic alliance to be established.

Figure 5 Areas of agreement and meeting points for Therapeutic alliance

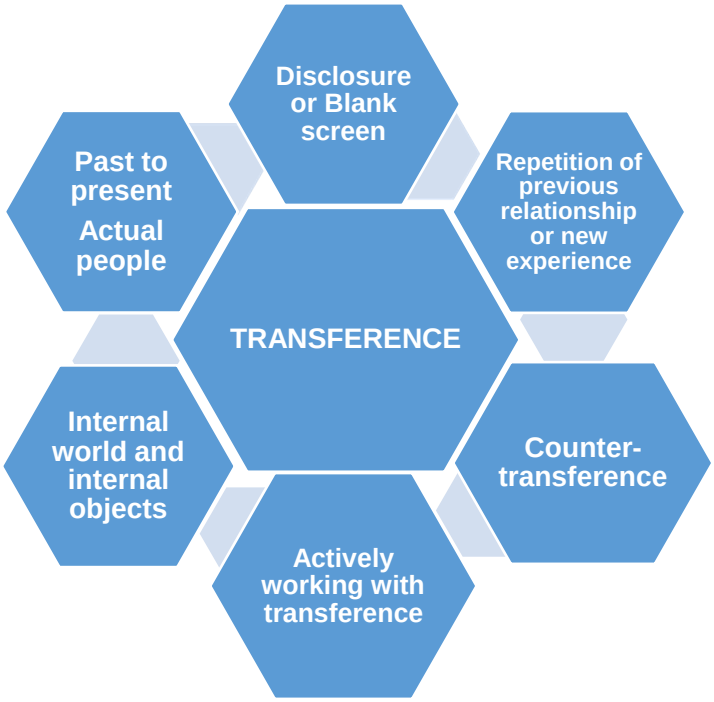


The concept Transference

I noted six themes arising out of the discussions of the concept of transference. (please see Figure 6 below). The themes have been named:

- past to present
- disclosure/blank screen
- the repetition of past relationships or a new experience
- actively working with the transference or just being aware
- counter-transference
- transference of internal world/object relations.

Figure 6 Transference



In Table 5 in Appendix 9, Transference, the participants' contributions have been tabulated in the same way as before, with the psychodynamic contribution in the left column and the humanistic on the right. Entries in the middle column show where there have been meeting points in the discussions. In Table 5a below, I have summarised the findings to show where there are points of agreement, disagreement and meeting points.

Table 5a Transference

Theme	Psychodynamic	Meeting points	Humanistic
Past to present	Key people in the past affect present relationships	People from your past influence your present relationships <<<<<<<< HUM	"Early relationships have formed the way you see; you relate to people generally"
Repetition of relationship or new experience	Repetition	Reflecting about repetition or relationship <<<<<<<< HUM	New relationship

Theme	Psychodynamic	Meeting points	Humanistic
Working with transference	Interpretation of transference	Depends on the client <<<<<<<< HUM	Maybe aware but don't interpret
Counter-transference	Counter-transference	Inter-subjectivity <<<<<<<< HUM	Counter-transference
Self - disclosure/blank screen	Emphasis on not disclosing		Blank screen does not fit with real relationship
Internal world/object relations	Internal world		

Areas of agreement and meeting points

Theme: Past to Present

In the theme, past to present of actual people, there is some agreement and the humanistic speaker's thoughts in the middle column show an agreement with the psychodynamic position. I think this agreement between the modalities shows that this aspect of transference is more accessible to therapists who are not predominantly psychodynamic in contrast to the idea of transferring internal objects, or parts of oneself.

Theme: Repetition of relationships or a new experience

The entries under the theme, "repetition of relationships or a new experience" demonstrate the differing positions between the two modalities. However, the humanistic speaker's reflections which have been summarised in the middle columns of both Table 5 in Appendix 9 and 5a above show an openness to considering both positions.

> *"So if I read psychodynamic theory where… it seems, to me, at least I understand it, where there's an idea to encourage the transference and to… I guess it comes from that idea of the therapist being a blank screen*

and therefore encourage the transference to be projected onto that. And I don't use it in that way, but yet I think it's operating all the time. And I think the person-centred approach would be to try to discourage the transference from happening in that way and to have a person-to-person relationship or a unique relationship with that person, and try and get beyond, behind or something what they are regularly doing to kind of have a new and different, totally different type of relationship that's about who they really are. But and while I might see that as an incredible aim to have this relationship that's different from any other, I think it's happening all the time, that the way they behave in therapy or counselling is similar to the way they behave in the relationship."

The idea that one can give someone a more creative experience of the relationship is more consistently linked to the humanistic theoretical viewpoint rather than a psychodynamic approach. Nevertheless, this sub-theme has been a recurring topic in the world of psychoanalysis also. For example, the debate in psychoanalysis began with the advent of self psychology in the United States in the 1970s, (Kohut, 1977), and emerged more recently within the recent discussions between psychoanalysts promoted by the European Federation of Psychoanalysts (Tuckett, 2008).

Theme: Actively working with the transference

The contributions from the different speakers talking about actively working with the transference that appear in Table 5, in Appendix 9, show up the distinction between the modalities with one humanistic participant taking up a middle position that she might interpret the transference sometimes. These differences can also be found, however, amongst psychodynamic practitioners for a number of reasons. Maybe a psychodynamic practitioner is aware of the

transference but prefers not to work so intensively with all clients or patients. Alternatively, psychodynamic practitioners will make an informed decision to work with the transference with some clients or patients rather than others where they deem the intervention to be more appropriate. Thirdly, as suggested by a psychodynamic practitioner in one of the focus groups, transference interpretations may be over-encouraged and incorrectly prescribed by supervisors.

> *"But I think it is an overused word, and people, supervisors will say what's a transference, which sometimes means - how do they get on with you. I don't think they are right in using that phrase er in that way."*

Theme: Countertransference

Countertransference appears to promote the most agreement between the participants. Both the psychodynamic and humanistic quotations on Table 5 in Appendix 9 imply that the speakers do work with the countertransference. There is also a shared opinion that it is difficult to separate transference from countertransference. The psychodynamic speaker in the middle column of Table 5a argues that countertransference is used more often and better understood by psychodynamic practitioners than the transference.

There has previously been opposition within the humanistic tradition to the concepts of transference and countertransference as recorded by Clarkson (Clarkson, 1995 pp. 70-1). The following quotation from one humanistic trainee suggests that the concept of countertransference has now become more acceptable. The humanistic participant refers to the influence of intersubjective systems theory and the importance placed on countertransference within her training.

"But also I think, especially the training that I'm doing, it's all about countertransference as well. So it's hard to just talk about transference, because especially at B they've got… they are very into all this intersubjective systems theory. So countertransference, it can't be separated so easily".

Areas of disagreement

Theme: Disclosure/Blank Screen

The theme "disclosure/blank screen" shows little agreement between the modalities. This topic incites particular interest in one focus group and the extract below shows their discussion in more detail. The exact wording of the transcript has been retained. The acronyms, DM3 et cetera have been kept in order to keep a record which group this discussion occurred in. In addition, the acronyms HUM and PSY have been entered after each speaker's contribution to identify their modality as humanistic, HUM, or psychodynamic, PSY.

Focus Group Extract 3: Disclosure/Blank Screen

DM3 *You were saying… That's right. Yes, DM5 was saying she doesn't answer questions from her clients, the personal ones, because of the nature of your structures. I do. I ask them why they want to know it and then I answer it. (HUM)*

DM5 *So that's quite a big difference, actually. (PSY)*

DM2 *I'm slightly shocked. I thought… I get what you are saying. What are they thinking if I live nearby, is that because I'm in the community, or do they want me to live further away so you can keep their secrets much more clearly? (HUM)*

DM5 *And I'll try and be friendly about… I don't do the thing, but, "It's interesting you are asking that. Why are you asking and what's it mean?" (PSY)*

DM3 *Which I would do. (HUM)*

DM5 *But I wouldn't actually give the information. (PSY)*

DM2 *Whereas I will tend to give it. (HUM)*

DM5 *I was interested that M (the moderator) wanted me to give a client my mobile number. I couldn't do it. I tried. I thought it through and I just couldn't do it. I'm so, sort of, just can't do that. (PSY)*

DM3 *So how do clients get in touch with you? (HUM)*

DM5 *I have a, sort of, answering number that they can leave me a message on. (PSY)*

DM3 *A service? (HUM)*

DM5 *Yes. But it's something about not wanting to give away something personal. (PSY)*

DM3 *Yes. I don't give my clients my personal mobile; I have my business one. (HUM)*

DM5 *but I think there's more to it, something about the training of keeping yourself [over-speaking]. (PSY)*

DM4 *And that's probably what you call containment. (HUM)*

DM5 *But it used to be called - what was it called - blank something? (PSY)*

DM4 *A blank screen. (HUM)*

DM5 *A blank screen. And it's not quite that. And there is a way that you can do that by looking really…pulling a face. Yes, I suppose I*

have to manage that blank screen all the time by being a blank screen but, sort of, not making it punitive or… (PSY)

DM3: Persecutory. (HUM)

DM5 Yes. (PSY)

DM4 That's interesting. Because I can't really recall a client actually asking about me. You get a client who, sort of, asks, 'How are you?' and they'll take on the caring role and that's part of… they have this worry or concern about people generally and will just say, 'Fine, but how are you?' sort of, bounce it back. But I don't recall ever being asked, kind of, personal details. There are things that I choose to disclose, perhaps, for therapeutic reasons. There's a lot that I don't disclose. I'm working with a client at the moment who has issues with her child who is just starting school, and my background is a teacher working with special education needs and so I know a lot about the scenario that she is working through, but I'm not choosing to disclose my alternative professional expertise because I don't think that's relevant to our relationship. (HUM)

Discussion of the theme self-disclosure/blank screen

Although this theme was only discussed in one group, it has been chosen because of the level of feeling and interest it aroused, and because I think it represents a well-recognised division between the psychoanalytic approach and other approaches which are more person centred. The psychodynamic participant's statements provoke some disagreement in the other speakers who in this extract are all humanistic. However, once they begin to discuss the issue, it seems that there are less differences between them than they at first

thought. The psychodynamic speaker DM5 expresses her own ambivalence about the strictness of the “blank screen” and the humanistic speaker DM4 gives instances where she would not reveal information about herself.

Eagle’s critique of countertransference demonstrates one of the complexities of the debate within the psychoanalytic community about the blank screen when he writes:

> My main thesis, is that, quite ironically, in reacting against the classical blank screen view of the analytic situation and presumably conceptualizing the therapeutic relationship more as an interactional two-person process.., many contemporary psychoanalytic theorists have essentially produced a new and more subtle version of the blank screen analyst and a new version of a one-person psychology, with the analyst, rather than the patient, now as the primary focus of attention (Eagle, 2000 p. 27)

What Eagle is suggesting here is that the therapist’s counter-transference is overvalued to the extent that the patient gets lost under the therapist’s psychology.

<u>Theme: Inner world and internal objects</u>

It did not come as a surprise to me that the only references to the inner world and object relations were made by psychodynamic participants. These concepts are particularly central to contemporary psychoanalysis following the influence of the theories of Klein and Fairbairn. What the terms inner world and internal objects also point to is another difference in emphasis between the psychodynamic and humanistic ways of working that is working with unconscious processes.

Comments on the findings re the discussion of transference

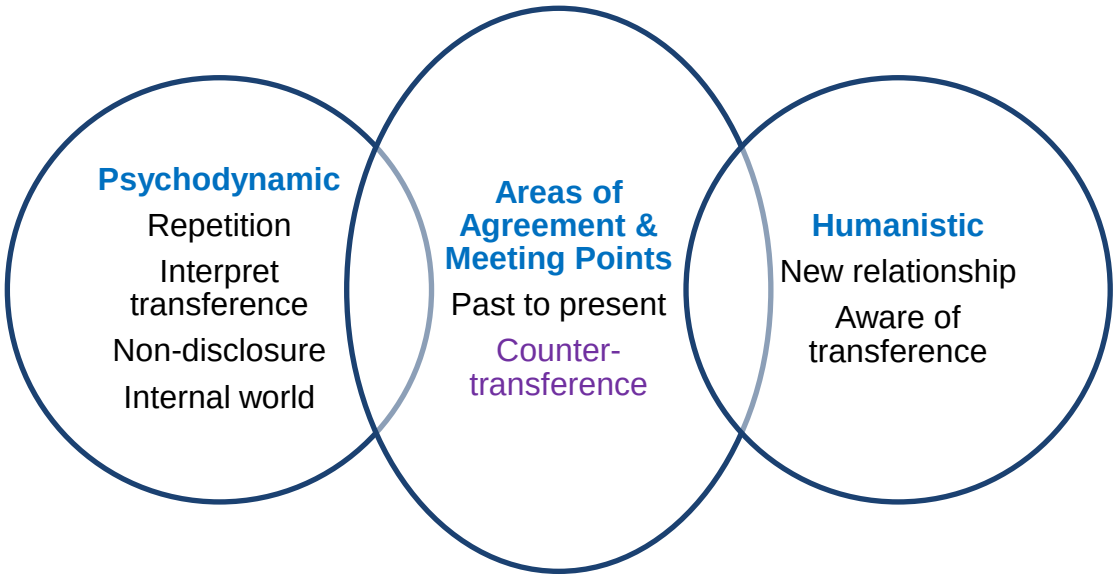
As one might expect, the concept of transference showed up divisions between the modalities. Although some practitioners found it a difficult concept to grasp, it was generally recognised as a clearer and more robust concept in comparison with the therapeutic alliance and containment. A detailed examination of the literature about transference can throw up a number of different perspectives but it is beyond the scope of this study to provide a comprehensive review of the debates about transference.

It was a common occurrence in many of the discussions for a participant to note how the three concepts of therapeutic alliance, transference and containment overlap, and to find themselves talking about one concept when the moderator's question had been about another. On some occasions, it became clear that it did not matter what the set questions were as the particular focus group would talk about what particularly concerned them, as with the extract above about disclosure and the blank screen. However, in contrast, another group DE, discussed transference with such enthusiasm that I as the moderator, found myself implying that they could have spent the whole time talking about transference: - "I'm going to move us on. But I had the feeling that I could have just asked you about transference and countertransference".

The picture provided in Figure 7 below follows on logically from Figure 5 which depicts the summary of differences about the therapeutic alliance. Figure 7 shows also that there is a difference in approach to transference between the modalities. This difference is perhaps not surprising as transference is a distinctly psychoanalytic concept. As in figure 5, the meeting point is in purple and does not denote agreement but rather an inclination towards the other modality. Within this concept, the point of agreement and meeting point are

again about concepts originating in the field of psychoanalysis. There is a strong distinction between the psychodynamic and humanistic entries. The psychodynamic participants referred to working with the transference, the idea of an internal world, and the idea that therapy is based on working with how past relationships get repeated. In contrast, the humanistic participants mainly referred to being aware of the transference rather than working with it and a view that the therapy relationship can be a new and restorative experience.

Figure 7 Areas of agreement and meeting points for Transference

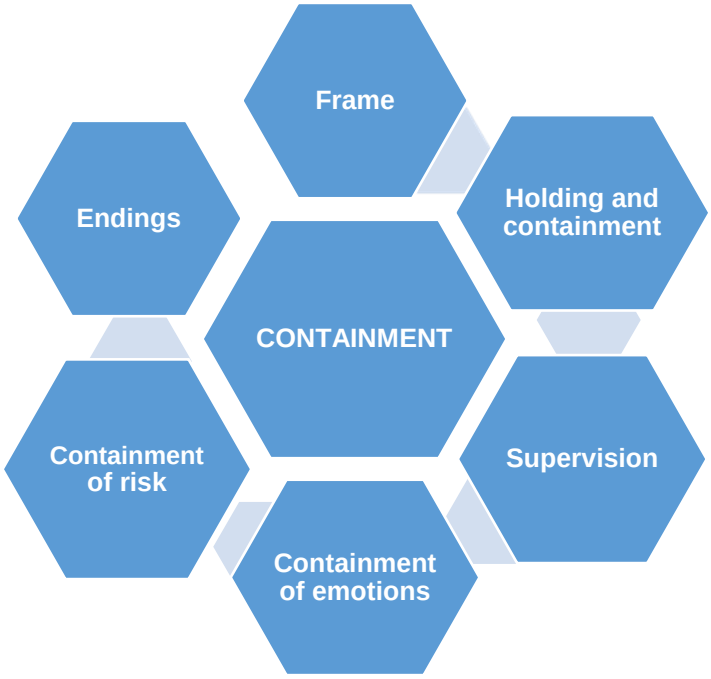


Containment

The six themes for containment in Figure 8 emerged from the initial analysis and retained relevance through subsequent readings of the transcripts. The themes are:

- the frame
- holding and containment
- the ending of sessions or therapy as a whole
- supervision
- containment of emotions
- containment of risk

Figure 8 Containment



In Table 6 in Appendix 10, the six themes have been listed with the same columns as in the previous tables denoting psychodynamic participants, the meeting points and humanistic participants. Table 6a below contains a summary of the themes showing agreement, meeting points and disagreement.

Table 6a Containment

Theme	Psychodynamic	Meeting Points	Humanistic
The Frame	Needs to be there as may be challenged	Learning how important the initial contract is <<<<<<<<< HUM	Emphasis on safe place for relationship
Value of supervision	Helps contain the work & anxiety		Helps contain the work & anxiety
Containment of emotions	Containment of grief & anxiety		A place to be angry
Containment of risk	The need for the therapist to contain anxiety re risk		The client needs to contact their GP
Endings	No view expressed		Planning for the end of a session and end of therapy

Theme	Psychodynamic	Meeting Points	Humanistic
Holding & Containment	There is a difference between Winnicott and Bion's ideas	But is containment the same as holding? That reminds me of Winnicott. <<<<<<<<< HUM	Holding a client in a safe place has got the most potential for growth.

Areas of agreement and meeting points

Theme: The Frame

The theme, the frame**,** produced general agreement across the modalities. However, there is a subtle difference between the psychodynamic and humanistic emphasis. Where the humanistic speaker on the right seems to be concentrating on the safety and relationship issues the psychodynamic suggest that a firm boundary could also help to deal with issues of separation anxiety between sessions, feelings of total dependency on the therapist or the need for containment of hostile or aggressive feelings.

Extract from Table 6: The Frame. (For full Table 6 please see Appendix 10)

The Frame	**DT4** Contracting is actually providing a containment, but then there are interesting examples about what happens when the client actually wants to break the contract in some way by actually asking for an additional session, or telephoning you.	**DE4** those initial boundaries and that aspect of containing a relationship, I'm realising how important that is and how important it is for me to feel confident about all those kind of arrangements and setting them out. **HUM**	**DG3** to help create an environment which is safe and in which the relationship can develop and the work can take place, but... and so the sort of importance of keeping boundaries in place and not you know breaking them

This practical approach to the subject is in keeping with the theme, Contract and Boundaries, under the theme the Therapeutic Alliance, in Tables 4 & 4a.

Themes: Supervision, Containment of Emotions and Risk

The value of supervision, the containment of emotions and the containment of risk were all seen as important areas of containment. The value of supervision was mentioned often particularly when a practitioner saw the value of holding on to his or her reactions to their client's feelings.

> "And I think for me, as well, is about the importance that supervision plays in all of that when you contain the work, and actually, how much I draw on supervision sometimes, especially when I'm really wrestling with something, and things. Actually, how that really helps me to contain the work as well, in that there is a place to be able to… not only can I think about it on my own in my own, sort of, processing and things, but actually it can be then thought about somewhere else, and actually about what is being evoked and having that different perspective that then comes to that. That's how I think containment actually reaches beyond"

The thoughts about the containment of risk showed a subtle difference between the speakers' approaches. A psychodynamic speaker concentrates on her own psychological need to contain her anxiety about the risk of her client's suicidal impulses…

> *"I also have a client who is suicidal and has made several attempts, and it's being able to contain that for me to bear her and also to bear myself in all this. To be contained, to be a container and at times I find it very hard. And yet I do the best I can do".*

…whereas a humanistic speaker refers to the need to set up a team approach and to make a client aware when they should contact their GP in times of crisis.

The difference in approach could be between the individual practitioners' style of working, but I do think it shows a difference in an emphasis on thought rather than action. It could be argued that the psychodynamic practitioner would be looking more closely at their need to restrain from action, whereas the other speaker does not seem to have thought about the implications of referring their client to someone else in times of crisis.

Theme: Endings of a Session or Therapy

It was noticeable that only the humanistic participants talked about the importance of preparing for the ending of a session or the therapy as a whole. I have not listed this as an area of disagreement as the absence of any comment from the psychodynamic participants does not necessarily indicate lack of agreement. One reason for the difference in emphasis on the ending could have arisen because some of the humanistic practitioners were more likely to undertake shorter term work.

During my involvement with the training in the 1990s with the British Association of Psychotherapists, (now part of the British Psychotherapy Foundation), and in the present decade with The Severnside Institute of Psychotherapy, I have heard similar complaints from trainee therapists about the lack of input on ending therapy. A recent search on PEP web produced thirty articles and many of these had been written within the last decade (Psychoanalytic Electronic Publishing). In consequence, there appears to be now a better recognition in the field of psychoanalytic psychotherapy of the need to think more carefully about endings.

Theme: Holding and Containment

The discussion of holding and containment brought out two different positions represented by the two entries in Table 6a in the left and right hand columns. The psychodynamic speaker differentiates the idea of holding and the theories of Winnicott from Bion's theory of the container/contained. Whereas the humanistic speaker only refers to holding the client in a safe space. In the middle column in Table 6, in Appendix 10, there are two meeting points where one humanistic participant raises a question about the difference between holding and containment, and another participant wonders about their similarity. The impetus to compare Winnicott's theory of holding and Bion's theory of container/contained is not a new one. The question and thoughts in the middle column mirror a number of writers' questions, particularly of those thinkers in the "independent" or "middle" group of the Institute of Psychoanalysis (Wright, 2005), (Symington and Symington, 1996). As with the concept of transference, the thinking about the relationship between these two theories has been extensive and therefore cannot be represented fully within the limits of this study. For example, in 2014, the relationship between holding and containment was the subject of a series of lectures at Essex University.

Ogden offers two clinical examples to illustrate his comparison of holding versus container/contained. He outlines how, in his view, at the core of "Winnicott's holding is a conception of the mother's/analyst's role in safeguarding the continuity of the infant's or child's experience of being and becoming over time" (Ogden, 2004 p.1362). In contrast, Ogden argues that Bion's approach implies that the container is a process which involves dream-thought or unconscious thought. "Bion's container -contained at every turn involves a dynamic emotional interaction between dream -thoughts, (the contained) and the

capacity for dreaming, (the container) "(Ogden, 2004 p.1362). Parry disagrees with Ogden saying "that it is not merely a case of viewing the same process from different perspectives" (Parry, 2011 p. 6). He argues that Winnicott and Bion have two different models of the mind. He maps out the similarities and differences between the two developmental concepts. He then uses a clinical vignette taken from the work of Khan, (Khan, 1960), and links the work to Winnicott's theory of holding. And contrasts this work with a vignette from Steiner's work, (Steiner, 2000), drawing on Bion's theory of container/contained. Essentially, Parry emphasises how holding can be seen as a receptive process where interpretation is to be avoided and how containment is seen as an active process where the affects between patient and therapist are continuously being thought about.

It is perhaps not surprising that in this study the perceptions recorded about holding resonate more with the humanistic practitioners as it involves a more receptive process. Whereas Bion's concept is promoted by some psychodynamic participants who work actively with" beta elements" to contain and make sense of distress. Grinberg summarises Bion's term beta elements as being "Those sense impressions and emotional experiences that are not transformed. These elements are not appropriate for thinking, dreaming, remembering, or exercising intellectual functions usually related to the psychic apparatus (Grinberg et al, 1993 p. 44). However, in Table 9, Reference to Theoretical Experts, in Appendix 13, Winnicott is referred to by both modalities. A key difference between the modalities that emerges when contemplating this theme of holding versus containment is the psychodynamic preoccupation with infantile states which has already been suggested when thinking about transference. It was noticeable that psychodynamic participants used

references comparing their patients' experiences with that of a baby. The following quotations give examples of two psychodynamic practitioners endeavouring to put into words the process of containment using the analogy of infantile experiences firstly with a bird and secondly with a baby.

> *"I use the analogy of a mother bird and the baby bird. And so, a baby bird can't digest sort of worms to begin with, whatever. So, the mother takes it in, digests it and then, gives it back to the baby bird in the format that it can then tolerate, and begin. .."*

> *"But it is used, it is used all the time, I mean if you do, if you do see, you know, when you go shopping or you're on the bus and you see a baby that can't be comforted, or you know, your own children or whatever and it's just screaming and screaming and screaming and (outward breath)....you know, and actually what's happening to that baby is it's, it's, it's psychically falling to pieces, it's experiencing some sort of catastrophic state of being and I think that just containing it, umm, stops it falling to pieces and we do that with adult patients as well, you know, it's 'you're not falling to pieces... you're not going to fall to pieces... and 'I can understand what you are saying, and at the moment you can just be reassured by that, and that in time you too will understand'."*

Containment as an ambiguous concept

My choice of the term containment was as a result of a bias with which I approached the research, because of my role as Clinical Director within the organisation at the time. My dual role as researcher and clinical director will be considered in more detail in the next chapter on reflexivity. Although in psychoanalytical theory the container/contained has a key place as a process

coined by Bion, a broader understanding of the term can also be used. My particular application of the term in relation to this small low-cost counselling and therapy service involves containment both on an individual basis of therapist and counsellor with their client or patient, but also containment within the organisation of the kinds of dynamics that occur within an institution that aims to help people.

As with the words psychotherapy and depression, containment can be used either as a specific or an umbrella term. It is understandable, therefore, that the broad use of the term containment could lead to some confusion. The concept sparked off the most controversy in the focus group discussions and was the least recognisable concept to the humanistic participants. The following comment was made by a non-clinical member of the organisation.

> *"There were lots of definitions but there were a dozen definitions but none that made sense, and it didn't seem to be a general definition, whereas the others were fairly well defined. I literally said I couldn't find a general definition, if anything, containment on the internet and things was all about war and things containing outbreaks of people or plagues or anything, so it wasn't in anything to do with what you do at all, so that it is a general word that that you've got a special meaning for."*

In another group, a humanistic practitioner has a similar reaction to the concept to start with. Her humanistic colleague tries to enlighten her but then appeals to me, the moderator, *"Well I don't know ask M".*

Focus Group Extract 4: What is Containment?

DG1 *Never heard of it. No idea what it means (HUM)*

Mod *So it doesn't make sense to you?*

DG1 *No (HUM)*

Mod *It doesn't have any meaning?*

DG1 *Never heard of it (HUM)*

DG4 *I think, I think, I might be wrong, but I think it's about containing safety in the relationship and the therapeutic process and boundaries and erm, but I think it's constant all the way along, I don't think you do it at the beginning, I think it has to be either subconsciously or consciously visited in each session really (HUM)*

DG1 *Oh, it's literally containing your client, is that what it is? (HUM)*

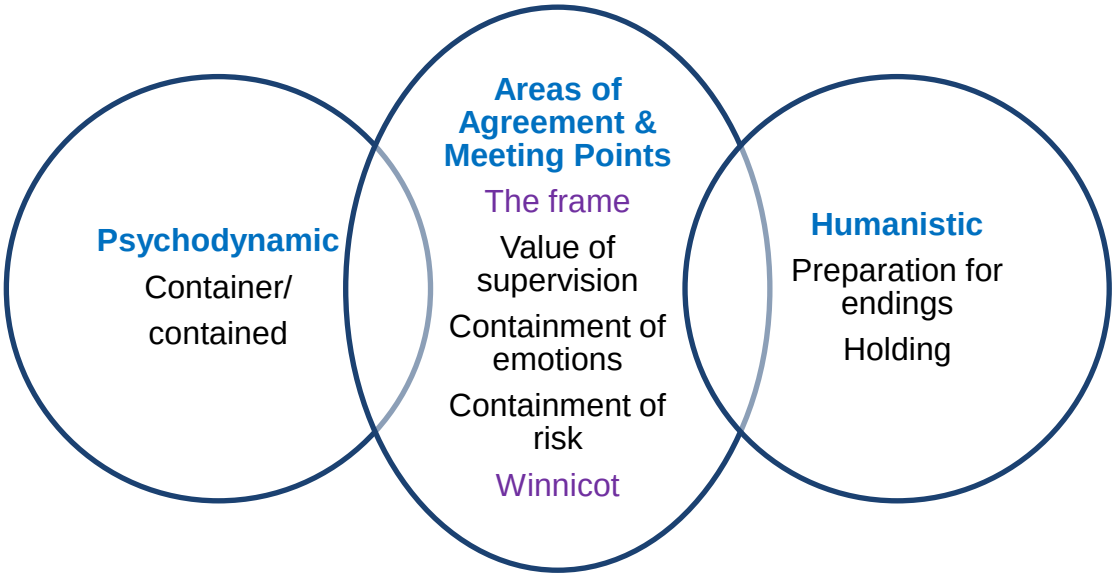
DG4 *Well I don't know, ask M. (Mod). I don't – it's not just the client, it's the… (HUM)*

Although the concept of containment provoked scepticism in one participant and some bewilderment in others as I have previously described in this Chapter, the concept produced the greatest commonality and the most meeting points as set out in Figure 9. Nevertheless, one of the major dividing factors between the practitioners' approaches to containment was based on the specific psychodynamic understanding of the concept of containment or container/contained as coined by Bion.

In Chapter 1, I described my understanding of the concept of containment which included a broader understanding of the concept as well as Bion's description of the unconscious process of container/contained. I think it is appropriate to add

here more information about the development of the precise psychoanalytic concept as it is a key area of division between the two modalities.

Figure 9 Areas of agreement and meeting points for Containment



Hinshelwood has mapped out the history of the concept showing how the original Kleinian theory of projective identification, "in which one person in some sense contains a part of another" has been developed further. Hinshelwood's original explanation remains in the New Dictionary of Kleinian Thought (Bott Spillius et al, 2011 p. 280). Bion recounts the process of container/contained in his work with a particular patient:

> Throughout the analysis, the patient resorted to projective identification with the persistence suggesting it was a mechanism of which he had never been able sufficiently to avail himself; the analysis afforded him the opportunity for the exercise of a mechanism of which he had been cheated… there were sessions which led me to suppose that the patient felt there was some object that denied him the use of projective identification…. there are elements which indicate that the patient felt that parts of his personality that he wished to repose in me were refused

> entry by me…. When the patient strove to rid himself of fears of death which were felt to be too powerful for his personality to contain he split off his fears and put them into me, the idea apparently being that if they were allowed to repose there long enough they would undergo modification by my psyche and could then be safely reintrojected (Bion, 1959 p. 312).

I think this clinical exposition of Bion's illustrates the contrast between the two modalities because he as the psychoanalyst is concentrating in such an intense way on the internal processes of his patient's mind and the responses within his own mind. The therapist or analyst focuses far more on the individual and shows less attention to outer events and influences.

Theme of Power Dynamics

A lively discussion in one focus group alerted me to the importance of the theme of power dynamics as a focus of division between the two modalities. The first topic presented was about the use of the term "patient" or "client" to give a name to the person in therapy. The second debate was about how much the therapist is the expert. This focus group extract is included in full below on pages 114-6. Once this theme was noted, I found other strands of this theme in the other focus group transcripts**.**

The theme has been divided into four sub-themes:

- patient or client
- the expert
- balance of power
- therapist or client/patient led

In Appendix 11, Table 7 sets out the thematic analysis showing the theme of power dynamics using the participants' quotations. With this theme, there were no direct areas of agreement. There were some clear distinctions between the participants' ways of working but also meeting points for each sub-theme. In Table 7a below I have provided a summary of the approaches.

Table 7a Power Dynamics

Sub-theme	Psychodynamic	Meeting point	Humanistic
Patient or client	We call them patients or clients.	I am not comfortable with the word patient >>>>>>> PSY	We call them clients
The Expert	We have technique and understanding to offer.	Rogers emphasis on the client being the expert but the client believes we have expertise. <<<<<<<< HUM	Not comfortable to be the expert
Balance of power	We have power	Equals in a shared task >>>>>>> PSY	The balance of power needs to be thought about. Client can choose not to answer
Therapist or client/patient led	Assessing if you can work with them	I'd go where the client goes >>>>>>> PSY	I am led by the client. I presume they know what is best for them.

Areas of agreement and meeting points

<u>Sub-theme: Patient or client</u>

In one focus group, a humanistic participant brought up the issue of the use of the word "patient". There is a recognisable distinction between the psychoanalytic approach and many other modalities in the use of this word

rather than client. In the focus group extract below I include the discussion around this sub-theme. The thematic analysis of this discussion shows a meeting point where one psychodynamic participant responds with some agreement and dislike for the word “patient”.

Sub-theme; The Expert

The discussion about the expert shows two different humanistic positions. One in the right column who “*would not be comfortable*” being seen as an expert, and one in the middle column who believes that *“they come to us because we have a level of expertise”.*

> *“And that’s where I sometimes struggle with person-centred, because when you look at some of the original Rogers stuff, and he was talking about the client is the expert in the room, absolutely; the client is the expert in the room. However, that can be very tricky, because clients come to see us because they believe… I believe they come to see us because we have a level of expertise and they want to make use of our expertise.”*

In the left column, a psychodynamic participant discusses her dilemma and concern for her patient. The process of her reflections and consultation with her supervisor demonstrate to me her implicit assumption that there will be some expertise to assist her in understanding her patient.

Sub-theme: The Balance of Power

With the third sub-theme, participants have touched on the issues of power and equality in their work. The implications from the humanistic participants’ viewpoints are that the client should and can have equal power or at times hold

the balance of power. One psychodynamic participant expresses her own viewpoint that there is an equal relationship between client and therapist.

Sub-theme: Therapist or Client/Patient led

Although this topic arose independently of the three concepts under discussion, it was not surprising that the humanistic position would favour the work being client led because one of the founders, Carl Rogers, is renowned for his nondirective and client centred approach. I think that if some of the statements in the right column had been made in a different focus group, there might have been a more active debate between the modalities. The psychodynamic practitioner in the left column I think clearly demonstrates that she believes in the importance of the therapist's assessment as to whether the client can be psychologically minded enough to gain from the intervention. A humanistic speaker from one group questions the helpfulness of adhering to a non-directive approach is a general rule. Whilst, a psychodynamic speaker from a different group leans towards a more humanistic stance, "*And even practising psychodynamically, I'd go where the client goes".*

The following extract, which includes references to the sub-themes Patient or Client and The Expert, presents the subject of power dynamics as it arose in one focus group. As indicated by the first speaker, this has been discussed in the pre-existing mentor groups several times. The modality of each speaker is again denoted after their contribution to the discussion.

Focus Group Extract 5: Patient or Client

DM4 *Something that we've discussed many times in this group is… I suppose this is going back, actually, to the nature of therapeutic alliance. But working humanistically, it's very much an equal partnership, and we work with clients… And within the mentor*

group, DCM1, from a psychodynamic background, talks about patients and the, sort of, difference in power balance. And that… I mean, it's very simplistic. But those words 'patient and client', I would never work with the patient. I work with the client. I work with DM2 or DM3, who is my client. And that's something that we've commented on, I think, many times, and I would not be comfortable me being seen as the expert. It's very much that the word 'client' is their own expert. (HUM)

DM1 *I think there is something the client being their own expert, but I think there's a part of me that would argue that is it really equal, because actually they are coming in. There's a fee, there are boundaries, and those sort of things. So actually, within the work, we aim to actually that it's a partnership, but there is a mismatch between, actually, about what I will provide - actually I'm only available during this time and there's a fee and there's exchanging, there's a contract from… a better word, whether you actually give a contract to your client or not. Actually, there is something that goes on.*

So I think that, for me, there is something. How we hold, perhaps, that power, or not, as the case may be, but I think it is still there. And actually the clients also have a power, because they have the power not to turn up, not to engage and all of those things. ***(****PSY****)***

DM5 *and they are coming to us for our expertise. They are not going to their friends in the pub; they are coming to us because we give them something. But I agree about this patient thing, and I just*

started this training as a… it's like a… I can't remember what it's called. Anyway, everybody says 'patient' and I don't like it, but I find myself doing it just because everybody is talking… And there is a power relationship, but I don't understand that. I don't understand why we have to use that word. Because I suppose, for me, how you hold the power is really important. And, as you say, the power is a two-way thing. ***(****PSY****)***

DM3: And I think, for me, there is a capacity for being equal, because I provide a service the same way that my plumber provides a service. And that I don't think of myself, or my plumber, as any higher or lower, powerful or not powerful, but he's far better than me at pipe work and I'm far better than him at sorting out a drama triangle. ***(****HUM****)***

[Laughter]

DM3: It's about, you know, we are in the service industry. ***(****HUM)*

DM5: But there is a power when it comes to mending the pipes, in that you are going to defer to him. So there's always… Maybe we are just saying there's all these powers. (PSY)

DM3: Well, it's about skills. He's a professional practitioner in that; I'm a professional in this. ***(****HUM****)***

DM2: But actually using that image of a plumber, his aim isn't ultimately to teach you how to mend your own pipes. (HUM)

Comments on Focus Group Extract 5

In this verbatim extract the participants reflect upon the long-standing psychoanalytic tradition of the use of the term "patient". Primarily the use of the term originates from the wish to link psychoanalytic work to the medical

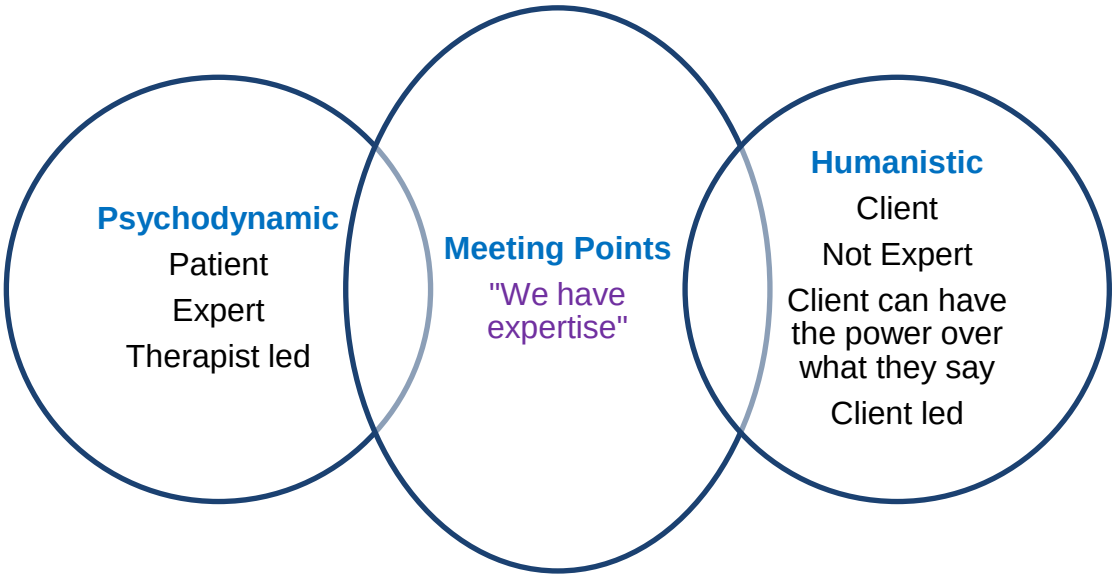
tradition. Over the years, other terms have come into being for example Jungians tend to use “analysand”, counsellors say “clients” and mental health workers have adopted the term “service users”.

The discussion shows both agreement and disagreement between the modalities but also that the debate is not split into concrete ideas and separate camps. Although the tone at the beginning is “them” and “us”, the humanistic speakers come to a point where they agree that the therapists have skills and some expertise. In addition, in my view, the extract shows the group members’ capacities for a lively debate and to be interested in each other’s viewpoints.

I have also chosen this particular extract as it demonstrates again the important difference between the psychodynamic emphasis on technique and the person-centred emphasis on the person.

As outlined above, the theme of power dynamics initially became apparent when one practitioner brought up the fact that certain practitioners called “patients” those people to whom she would refer to as “clients”. Within this theme of power dynamics, there were many differences. It has not been surprising to find that humanistic therapists with trainings which have often originally been founded on the ideas of Rogers would choose to be led by the client. In comparison, the psychodynamic position has been founded on the psychoanalytic technique where the therapist is expected to have some additional understanding of a person’s predicament to offer the person and some technical approaches which have been underpinned with theories of unconscious processes.

Figure 10 Meeting points for Power Dynamics



The sub-theme Self-Disclosure/Blank Screen which has been listed as a theme arising out of the discussion of Transference could also have been placed within this theme of Power Dynamics. Both discussions of the theme Self-Disclosure/Blank Screen and the sub-theme Patient versus Client have been included in full previously. These discussions in my view provided good examples of how practitioners from the two modalities were able to discuss differences without withdrawing to a defended place in which difference would have become absolute and they would be the only one with the correct answer. Similarly, the quotation used to sum up the meeting point within this theme of Power Dynamics i.e. “We have expertise”, shows an individual practitioner’s capacity for self-reflection and tolerance for ambiguity.

Theme: Reference to theory: barrier or bridge to communication and understanding

When undertaking the N-Vivo coding, the code which I called “language” brought up over a hundred references. This number of references was greater for “language” than any other individual code. My choices for including the

pieces of transcript for this code were based on either when therapeutic language arose as a topic for comment or discussion, or when actual therapy terms were used by the participants. Later in the process, I took note of references to theoretical experts to complement this theme.

Table 8, in Appendix 12, shows the theoretical terms used and these have been mapped according to the modality of the term and speaker. My argument is that theoretical language and reference to theoretical concepts can serve as barriers to communication and understanding between professionals within different fields of knowledge and in this instance between the therapists and counsellors from the two modalities.

This theme encompasses how references to specific theoretical terms or experts can show up the differences between the participants' approaches to their clinical work. Differences, in my view, which arise because of the different trainings and courses that participants have attended. These training bodies have provided different input on the understanding of human development and psychotherapy techniques. I have also included within this theme the varied views of the participants towards recognising that these differences in theoretical language and theory exist and whether, in their view, they provide an obstacle or barrier to fully understanding another practitioner's way of working.

Focus Group Extract 6: I have got a different language

> *DM5 I think it's very important that. There are three key concepts that I would work with all the time. I was actually quite interested last week. You sort of seemed to say that, yes, that you didn't know what it meant. (PSY)*

DM2 Yes, I didn't. But I have come away and realised that I've got a different language, totally different language. Totally different. (HUM)

In this group discussion, the recognition of an underlying difference in the use of language between them led the participants to recognise this difference and understand that this arose from the differing theoretical foundations of their trainings and approaches to therapeutic work. This recognition was not evident in all the focus groups. The following focus group extract shows one group's way of dealing with the difference. Here the psychodynamic speaker considers that "it amounts to something similar". Whereas the humanistic speaker considers that once the different ways of expressing the different approaches are grasped and better understood, then communication between the modalities is possible.

Focus Group Extract 7: Language as a barrier

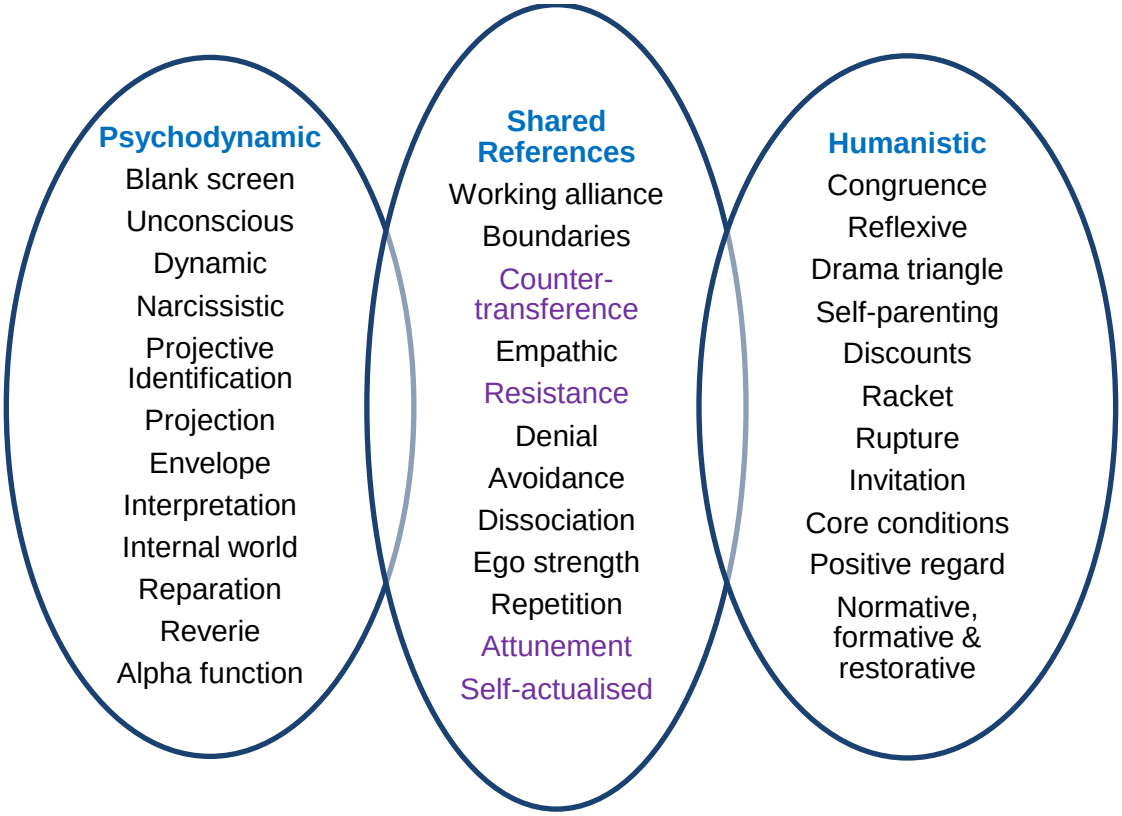
DT1 Because as we've discussed different topic then the names given to things are quite slippery, they mean different things to different people, we can't disagree yet because we aren't clear about what the person actually means, but I assume that that would come, in time, as we come to know each other's ideas better. (HUM)

DT2 Um but in a way I mean the whole thing is about being in a room with a patient and um trying to understand the understand the communication with that patient and their and understand their understanding and problems, so I mean whether we understand the concepts in the same way, I'm sure that on some level they are pretty similar, we just have a different intellectual ....kind of

framework for it, or a different word. You know. We could sometimes be speaking different languages but it amounts to something quite similar I think. (PSY).

Figure 11 below shows the references to theoretical language made by the participants across the groups.

Figure 11 Theoretical Language



From all 6 focus groups, a total of 37 separate terms were used at least once. Of these, 13 terms were exclusively referred to by humanistic participants and psychodynamic participants claimed ownership of 12 terms.

The 12 terms which the speakers from the two different modalities seemed to have agreed upon at times are: - working alliance, boundaries, counter-transference, empathic, denial, avoidance, dissociation, self-actualised, attunement, ego-strength, resistance, and repetition. Two psychodynamic participants appear to have been influenced by humanistic theory and concur

with the terms attuned and self-actualisation. In Table 8 in Appendix 12, two humanistic participants, rather reluctantly it seemed by the way they have put their views across, refer to the concepts resistance and repetition. Here a humanistic speaker talks about his work in the field of drug and alcohol misuse:

> *"And one of the resistances to it, if you want to call it a resistance, is for something within their self-care system to say to them this is a trick. They spend their lives suspecting the outside world, yeah? It's a phase. It's not to say you give into it, but it's how to manage that phase. It's a very powerful phase. It's to actually make that step outside the protective system, the drugs, the alcohol, whatever it is, into a relationship with a real person. And it's not that they are right, it's actually what is happening for them."*

The term unconscious was originally claimed by speakers from both modalities, but the following response of the humanistic speaker does not seem to suggest that they speaking with the same understanding.

Focus Group Extract 8: Theoretical Language

DM5 *I mean, I suppose then psychodynamic counselling, we tend to think of unconscious communication maybe more than in other ways. (PSY)*

DM3 *I'm very unaware of the unconscious; I'll bring it into the room. (HUM)*

DM5 *It's just a [over-speaking]. (PSY)*

DM3 *There's unconscious, subconscious and conscious. And it's all there. It's all the somatic response in my body and inviting clients to note what's going on for them. (HUM)*

This exploration of references to theoretical language offers another example of how much the meeting points are created by humanistic practitioners using words that originate in psychoanalytic/psychodynamic theory. It could be argued that these words and terms are familiar to the humanistic therapies because the therapies have been influenced by psychodynamic thought. Another argument might be that many of the humanistic training courses are integrative and include some psychodynamic theory. A third possibility is that the terms in the overlap area are more accessible and readily understood than the terms under the psychodynamic or humanistic headings. Another reason for the overlap of certain terms within this theme of language could be thought of as the intersubjective way of understanding the therapist's relationship with their client or patient. The movement in psychoanalysis towards the relational model places concepts such as empathy and countertransference into a more central position in some psychodynamic practitioners' clinical work. This movement within the psychodynamic modality then is more in accord with the humanistic modality which places great importance on the relationship between therapist and client.

In 1987, the Journal of Integrative and Eclectic Psychotherapy was devoted to the consideration of the different languages employed within the different modalities of therapy. Messer pointed out how difficult it was to compare one psychotherapy research project with another, because of the differences in types of measurement and the different concepts and terms used (Messer, 1987). In the same journal issue focussing on this idea, Messer offered a critique of the proposal for a common language which had been suggested by others (Driscoll, 1987), (Ryle, 1987), (Strong,1987). He argued that the difficulty is that therapy languages convey different ideologies, and suggested

that the value of different viewpoints and clashes is that they can stimulate ideas rather than limit creative discussion. In my study, specific theories and language that were talked about both aroused curiosity and interest and also closed down the interchange between the participants at different times.

In another group from the extract above, the following comments from a humanistic participant suggest that the discussion has helped her learn more about the psychodynamic approach despite the language barrier.

> *"I think what was coming up for me is that it's almost at times like a linguistic discussion. We work in different ways, but the commonality is certainly there. The language can be a bit of a barrier. There's a lot of words, the psychodynamic modality, that are quite alien to me. That has been really quite a positive experience I think to find… to be able to start to explore that commonality. And really, for me, it's not to get too hung up about what you call it – you call it one thing, I call it another thing. It's the core of the work that you are doing, and you are not to let language or training become a barrier to that."*

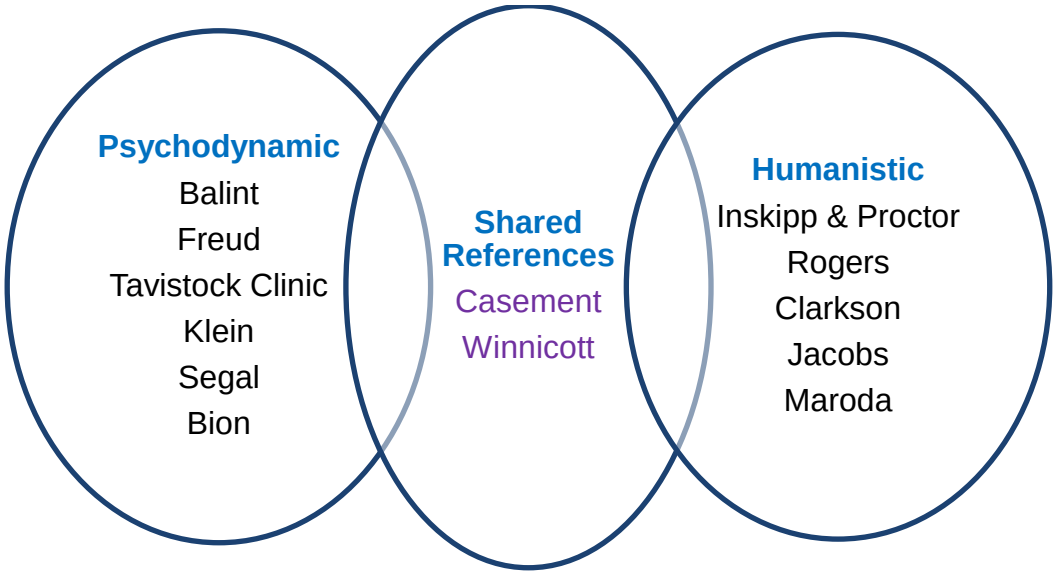
Reference to Experts

In Table 9 in Appendix 13**,** each reference to a particular theoretician or institution made by practitioners from either modality has been recorded. As mentioned above, some of the writers and thinkers can be closely linked to the theoretical language referred to in Table 8 in Appendix 12 and Figure 11. It is immediately noticeable that the references made create a big divide between the two modalities.

When working with the transcripts and raw data on selecting the themes, this exploration seemed less important perhaps because the differences were to be expected. However, it was at the point of writing up the findings that I

discovered what a striking difference between the two modalities that this theme demonstrates. In Figure 12, Reference to Theoretical Experts, the lists of different names in the right and left columns show a clear difference between the modalities.

Figure 12 Shared references to theoretical experts



Out of the 11 references, only two were made by practitioners from both modalities: Patrick Casement and Donald Winnicott. These two thinkers can be classified as part of the Independent group in the Institute of Psychoanalysis, and their views seem to be more accessible to the humanistic participants in this study. One humanistic participant has reflected on the approach of Carl Rogers, suggesting that she is critical of his non-directive style being a hard and fast rule. Her viewpoint was also recorded under the theme, Power Dynamics, and the sub-theme The Expert in Table 7a.

I thought it would be relevant to see how many references to theoretical experts had been made by therapists or counsellors still in training. Out of the 28 participants, six practitioners were in training or undertaking further training at the time that the focus groups ran. One participant, for example, was training

as a psychotherapist having completed a counselling training. When looking again at Table 8 in Appendix 12, it does look as though many of the detailed references to theoretical experts have been made by practitioners in training. For example, one psychodynamic speaker who was in a psychodynamic counselling training at the time, differentiates between Freud's theory of the analytic pact and Balint's later contribution.

> *"That's what was going through my mind, actually, because are we talking about an analytic pact, or are we talking about a relationship, a more, sort of, human relationship, which comes later with Balint and all of those people? Because Freud talked about an analytic pact, oh, way back, 1920. For him it was about money, the room, attendance, how long does it last. So simply the essence of what we would call, I would call, the frame – "*

It makes sense that practitioners in training would be likely to give more theoretical references when they talked about the concepts. However, other factors such as a personal preference for thinking and intellectual interest could be present. In addition, people who have trained several years earlier might struggle to remember an exact reference, as evident in the entry for Klein and Segal in Table 9 where the speaker cannot quite remember if Klein or Segal wrote a certain paper.

I think the gap between the psychodynamic and humanistic references to theoretical experts is highly relevant to the assumptions, stereotypes and misunderstandings formed between modalities. In my view, it would be impossible to have a thorough knowledge of all the texts available. On a practical level, the library at the low-cost scheme has a cross-section of some of

the texts both psychodynamic and humanistic. It is noticeable that practitioners from each modality recognise certain authors but are unfamiliar with others. Whittle offered an explanation for the splits between psychology and psychoanalytic psychotherapy:

> neither side reads the literature of the other. They don't try to; it does not seem interesting or relevant… It seems profoundly misconceived… It is the gap between different sub cultures, encompassing different belief systems, practices and institutions, vocabularies and styles of thought (Whittle, 1999 p.236).

In this instance, too, it is likely that participants from both modalities have not read the work of some of the experts from the other. For example, I have never come across the work of Inskipp and Proctor. In addition, after I had run the focus groups and whilst writing this thesis I suggested to the academic reading group, many of the members of which are in the management team of the organisation, that they read a chapter by West on Eclecticism and Integration in Humanistic Therapy outlining the history of humanistic psychotherapy (West, 2000). I believe they did this in my absence and when I asked one member about her thoughts she showed no enthusiasm about the chapter at all saying it was rather long.

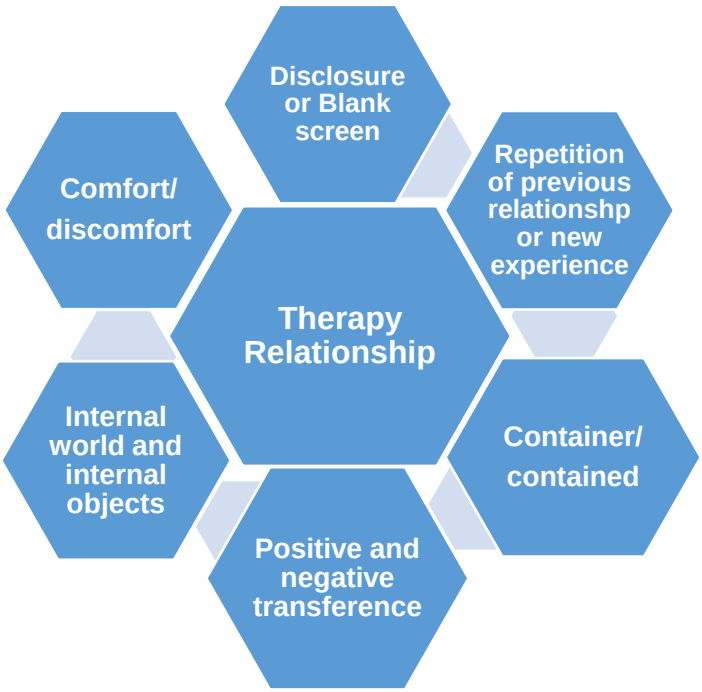
The sixth theme: The Therapy Relationship.

Prior to the research, I would have expected to see in my findings many of the broad sweep comparisons between psychodynamic and humanistic theoretical positions that I will refer to at the end of this chapter. For example, the psychodynamic approach which is underpinned by psychoanalytic theory includes an acceptance of the importance of unconscious processes within individual therapy such as transference and projective identification. Thus, I

could have pinpointed a theme called working with the unconscious. However, I chose to explore the difference in the views between the modalities towards the therapy relationship. This choice was made towards the end of the study and for two reasons. Firstly, this overarching theme arises from the re-consideration of the themes from the discussion of the three concepts the therapeutic alliance, transference and containment.

I have chosen two themes that I recognised after the therapeutic alliance was discussed namely the existence of the positive and negative transference and comfort/discomfort. These themes have already been displayed in Table 4a above on page 82. The overarching theme also encompasses three themes which I discerned from the discussions of transference because the discussions in the focus groups were memorable, potent and reflective. These have been recorded in Table 5a on pages 90-91 i.e. disclosure/blank screen, the repetition of past relationships or a new experience, and transference of internal world/object relations. Lastly, the theme of container/contained as displayed in Table 6a on pages 100-101 has been included. The grouping together of these themes highlighted a difference between the modalities which can be recognized theoretically and clinically both in the service under study but also on a wider scale both nationally and internationally (Rowan and Jacobs, 2002), (Clarkson, 1995), (Shedler, 2010).

Figure 13 The therapy relationship



In Figure 13 above, I have displayed the themes which have led me to the choice of this overarching theme.

The other reason I have highlighted this theme was because the subject resonated with me personally throughout the writing of the thesis. It raised what I still consider to be the unanswerable question of how therapy works. The idea first had impact on me when I was moderating the focus group where one humanistic practitioner reflected on whether the therapist inevitably repeats the pattern of his client's past relationships or whether he can provide a "real" relationship. This reflection has already been recorded in pages 87 to 88 above. Here the humanistic practitioner wonders if he as a counsellor can offer his client a reparative experience by giving him the opportunity of a new and healing relationship.

The contributions of all the humanistic speakers which lie behind these themes in Figure 13 all point to the existence of a "real relationship" between the

therapist and client. Clarkson writes “The person-to person relationship is the real relationship or core relationship - as opposed to object relationship” (Clarkson, 1995). Here Clarkson’s use of the term “object relationship” refers to a psychoanalytic understanding of an inner world transference. Clarkson also refers to Jung’s viewpoint that analysis is fundamentally about two people with similar life struggles. Clarkson quotes Jung “Learn your theories as well as you can, but put them aside when you touch the miracle of the soul” (Clarkson, 2000 p. 312). A humanistic participant echoed this view of Clarkson’s:

> *DM3: Isn’t the process between two human beings? And therefore, actually, it doesn’t really… it, kind of, doesn’t matter how we label it, as long as we are ethical, compassionate, whatever our professional body’s framework tells us to. But the kind of nuance is I’m as human with the same DNA as everyone else here.*

A similar view was expressed in a different group by a psychodynamic practitioner. This view has already been referred to above in the context of the theme of reference to theory as barrier or communication.

> *DT2 Um But in a way, I mean the whole thing is about being in a room with a patient and um trying to understand the understand the communication with that patient and their and understand their understanding and problems, so I mean whether we understand the concepts in the same way, I’m sure that on some level they are pretty similar, we just have a different intellectual kind of framework for it.*

Thus, there is not a totally clear distinction between the two modalities about the degree to which the therapy relationship could be thought of as a “real” relationship. However, the emphasis in the psychodynamic approach is to work with the inner world and so the therapist’s prime task is to explore with the patient a world which is real in terms of phantasy or imagination. The internal world has been described as:

> “The internal world, largely unconscious, is populated by objects that in the deep unconscious are very concrete and become more representational closer to consciousness. These objects are in a set of organised and structured relationships with each other according to the logic of the two positions. Unconscious fantasy is a state of activity of one or more of these internal object relations (Bott Spillius et al, 2011 p. 521).

The following statement made during the discussion of transference by a psychodynamic participant refers to this complex work with an inner reality of a patient’s mind. This focus on her patient’s inner world shows the contrast between the ways of working between the humanistic and psychodynamic practitioners.

> *DG5: To do with their internal world, what they they’ve taken in from their childhood. And I guess there’s – yeah, there’ good transference – sometimes you can be the good mother or the good father and sometimes the bad father the bad mother and how that informs your work as well and how to put to make an interpretation and when to make an interpretation, for the client to understand more about their internal world and their relationships.*

Reflections on my part in the choice of this theme

Although ostensibly I was seen by the participants in this study to reside within the psychoanalytic modality, I trained as a Jungian. As my training was with an institution that taught developmental Jungian theory which incorporates childhood experiences and analytical ideas, in many ways the psychoanalytic modality still fits. However, my Jungian training can place me in a position which is perhaps more open to the humanistic approach towards the therapy relationship. I can see that despite the fact that I work with transference and an inner world in my own clinical work, I would also recognise that there is a mutuality in the therapy relationship between therapist and patient that technique does not completely cover.

Jung himself emphasised the importance of being aware of the transference and the need for an analyst to have undergone his or her own analysis (Jung,1955/61 para. 449). I would not advocate self-disclosure by the therapist or a surrender of the analytical attitude. I agree with Wiener, a contemporary Jungian analyst, who wrote “It is easy to confuse authenticity, where analysts make themselves emotionally fully available to their patients, with a too “real” relationship that compromises the analytic and ethical attitude, making it difficult to maintain a non-judgmental, safe psychic container in which patients may discover more about themselves (Wiener, 2010 p. 87).

Distinctions within the psychodynamic and humanistic modalities

It is beyond the scope of this thesis to examine in depth the different approaches within the two modalities other than to point out some of the differences within each modality that are particularly relevant to this study.

Humanistic counselling and therapy

I had not sufficiently appreciated before undertaking this research that the term humanistic covers many differing approaches which share some commonalities. West suggests that “Perhaps humanistic therapy is best seen as an umbrella term for a range of overlapping but in some respects very different therapies” (West, 2000 p.220).

At the time of the research within this low-cost scheme there were 16 practitioners who came under the broad modality of humanistic, but these included person-centred, integrative, transactional analysis, and psychosynthesis practitioners. Subtle differences in their responses to the discussions were evident, but these differences did not change the overall picture of the distinctions between the humanistic and psychodynamic approaches.

West offered his view of the basic tenets that humanistic therapists hold in common. Firstly, that “people are ok” and with the right kind of support will “discover their innate decency”. Secondly, humanistic therapists share a holistic approach which encompasses “body, emotions, mind and spirit”. Thirdly, the conviction that people can change and develop means that humanistic therapists concentrate on the growth of the client rather than on symptoms. Fourthly, “people are spiritual” without necessarily ascribing to a religion. Lastly, people not only act out of deficiency but also because of curiosity, creativity and a desire to achieve and experience (West, 2000 p.220).

Subtle differences in the responses between the humanistic participants in this study to the discussions were evident, but these differences did not change the overall picture of the distinctions between the humanistic and psychodynamic approaches. For example, it was noticeable that the two practitioners who were

transactional analysts referred more often than the other humanistic practitioners to theoretical terms within their practice. These have been recorded in Figure 11 above i.e. Reflexive, Drama triangle, Discounts, Racket, Invitation, Normative, Formative & Restorative. In one focus group, a participant who had trained in transactional analysis used the term "invitation". As she described the process of invitation, it seemed to me to describe a way of working that was closer to the use of transference than her other humanistic colleagues.

> *"But I think mostly it's about being aware of …those invitations. So, as I said, with that client that had been abused in many, many, many different situations, really looking out for those signals where she's inviting me to be quite…very directive. And I used some words in the session that really just didn't feel comfortable… didn't sit with me at all, and it wasn't until afterwards I thought, you know, I've responded to an invitation to be very dictatorial, which absolutely wasn't appropriate for that client. Yes."*

At other times the expertise of the practitioners was inferred and I have interpreted the contribution as such. For example, the two participants who were trained transactional analysts used terms specific to transactional analysis to describe their practice, and it is my understanding that the therapist might describe some of these terms to their clients thus imparting their expertise. In contrast, the practitioners who described themselves as solely humanistic referred to terms such as 'unconditional regard' and 'congruence' and these terms would not need to be passed on to their clients.

Psychodynamic and psychoanalytic therapy and counselling

The distinction between counselling and psychotherapy has been a long-standing issue within the counselling and therapy community. Jacobs notes

that the former BAC debated the inclusion of psychotherapy in 1993, (Jacobs, 1994 p. 80), which then became the BACP in the year 2000. He suggests in the same article that there is not such a division within the person-centred domain as with psychodynamic thinking. However, a division between humanistic counselling and therapy was evident in the present study. There were three humanistic participants in the same focus group. Two of these participants had trained as humanistic counsellors at a nearby institution at which the third participant was also attending a different course on humanistic psychotherapy.

Jacobs argues that the term psychoanalytic psychotherapy in comparison with psychodynamic has been perhaps more preferable to medical therapists, whereas lay counsellors prefer the description psychodynamic. (Jacobs, 1994 p. 86). According to Spurling, "Freud wondered in 1926 whether there might be a band of social workers who would be trained analytically in order to be able to "combat the neuroses of civilization"" (Spurling, 2009 p.3), (Freud, 1926, pp 249-50). Psychodynamic counsellors could fit this description. Some of the distinctions between psychodynamic and psychoanalytic have been argued on the basis of how often a person is seen, whether the couch is used and how much the therapist works with unconscious processes such as the transference. Jacobs argues that:

> psychodynamic can be used to refer to a model which describes the way or the manner in which the personality is formed and functions, whereas psychoanalytic refers both to a method of studying psychodynamics and to a method of framing how the personality is formed and how it works (Jacobs, 1994 p. 89).

The Severnside Institute of Psychotherapy has recently added a psychodynamic training to their curriculum. Their stated rationale for psychodynamic psychotherapy is:

> Psychoanalytic psychotherapy has traditionally been orientated towards intensive clinical work, which involves three or more sessions each week and open-ended duration of therapy. In many contemporary settings for psychotherapy, particularly in the public and voluntary sectors, it is often not feasible or appropriate to work in this way. Drawing on psychoanalytic thinking, psychodynamic psychotherapy has emerged in which therapy is conducted on a once- or twice-weekly basis, and sometimes using a time-limited contract (Severnside Institute, 2015).

The broad term of the psychodynamic modality within this study does encompass both psychoanalytically and psychodynamically trained and training practitioners. Two of the participants were psychoanalytically trained and one of these had trained as a child psychotherapist. The Severnside distinction in my view is appropriate when describing the psychodynamic practitioners as compared with the psychoanalytic practitioners in this study. However, the contributions from both the psychoanalytic and psychodynamic practitioners coincided and rarely differed. There was one occasion when I was not certain whether a psychodynamic speaker had been influenced by humanistic theory when she used the word “attuned”. Apart from this one occasion, both the psychodynamic and psychoanalytic speakers’ comments were congruent with their modality.

Possible themes which did not emerge as key findings in this research

Some humanistic practitioners and trainings include a spiritual aspect to the self. The following focus group extract shows a discussion between humanistic practitioners where one has raised the spiritual side to his work.

Focus Group Extract 9

DM2 And there are spiritual assumptions. That God is in favour of growth and stuff like that. I mean, that could be just my way of being, my belief system, but I do believe in spirit wanting to encourage people to be more, if that makes sense. For the best of them to come out.

DM3 Self-actualised.

DM2 Yes. But that's actually part of my belief in God. I'm only using the word God here… I would tend to use the word spirit, currently.

DM4 But working humanistically and more generally, it's a very, very positive way of working, isn't it, because we do believe what's fundamental is the room for growth and for people to move towards being the fully functioning person. And it's an incredibly optimistic, positive way of working.

This focus group extract also illustrates another key difference between the modalities. The comment by the last speaker refers to a distinction that is generally made between psychodynamic and humanistic approaches and between the psychodynamic and the Jungian approach, namely the emphasis on the positive. In this study, the discussions did not focus directly on this distinction. However, when the subject of containment was being discussed, there were statements made by the humanistic participants about the need to create a therapeutic space where the client can feel safe and trust the therapist.

In contrast, some psychodynamic speakers spoke of the usefulness of anxiety in bringing repressed material to the surface. However, these in my view were only subtle examples of the humanistic practitioners' more positive approach. Perhaps it was due to the choice of psychoanalytic terms discussed that this distinction of a more positive approach was less evident in this study Although one reference is made to "God" in the above extract by a humanistic speaker and some branches of humanistic therapy focus particularly on transpersonal experiences, there was not a clear debate about spirituality within the focus groups. Consequently, spirituality was not chosen as a theme when analyzing the discussions and I have not identified this as an area of difference between the modalities in this low-cost scheme.

I might have expected a contrast in approaches regarding aggressive or destructive impulses. There were references to an angry client, a therapist's anger and to clients' experiences of shame. There were also discussions about the anxiety caused by a client's suicidal feelings. However, practitioners from either modality rarely referred to aggression, hostility or destructive feelings. In my view, the umbrella term 'containment' would include a consideration of the need to contain hostile experiences and acting out, and the lack of reference to such experience is noticeable in its absence. The following isolated statement from a psychodynamic participant puts into words what I would have expected.

> *DG5: To be contained, to be a container and um at times I find it very hard. And yet....I do the best I can do that, but I think that's – and also I once had a very aggressive client who was very angry and to contain her anger without...without giving it back if you see what I – without retaliation, and once did a workshop called making the unbearable*

bearable and I think sometimes a lot of the time that the therapist has to contain the unbearable of the client.

There was also a surprising absence of reference to attachment theory in the discussions. This subject I am aware is included in at least one of the local humanistic training institution's curricula. One could argue that my choice of subjects to discuss might have steered the discussions away from this subject.

Resume of the thematic analysis of findings

In Figures 5, 7, 9, 10, 11 & 12 above there are diagrams which depict the areas of agreement and meeting points for the concepts the therapeutic alliance, transference, containment and for the themes of power dynamics and reference to theory: barrier or bridge to communication and understanding. What is particularly noticeable in all of the diagrams is that the subthemes in the overlap area are arguably nearly all psychodynamic in origin. As suggested in the Introduction, it appears that humanistic thinkers have been open to psychoanalytic theory over recent decades but the converse has less often been the case.

I had expected the discussion of the therapeutic alliance to produce the most agreement between the modalities. However, there was a strong distinction between the modalities where humanistic participants considered the therapeutic alliance to be essential, and the psychodynamic participants questioned the alliance, suggesting that a seemingly positive alliance could be based on a positive transference and that starting with a negative transference might be helpful in certain circumstances.

The difference between the participants from different modalities about transference was more as I might have predicted. Psychodynamic participants spoke more often about their use of transference in their work than their

Humanistic colleagues and referred to a more complex understanding of the concept linked to theories of an inner world and object relations.

Although containment was questioned by a non-clinical participant for being too vague a term with too many possible meanings, there was general agreement between the modalities about certain aspects of containment. They agreed that boundaries need to be maintained, that the practitioner helps the client contain feelings and that containment of risk of suicide is very important. The difference about the concept of containment took place in the theoretical arena when psychodynamic speakers referred to Bion.

The theme of The Power Dynamic arising from one humanistic participant's dislike of the word patient highlighted a difference between the modalities. This difference was not exclusively between the modalities, as some speakers from each modality reflected upon the inevitability of the power of the practitioner and the necessity that the practitioner has some expertise to offer.

The theme, reference to theory: barrier or bridge to communication and understanding, was, in my view, integral to the whole experience of the focus groups. On a macro level, participants thought about the different languages and there were differing opinions as to how much the different languages produced an obstacle to informed debate. On a micro level, there were numerous examples of references to terms and theoretical writers by each modality exclusively. The differences in terms often matched the theoretical expertise from which they had been derived.

Finally, the sixth theme demonstrates a divide between the theoretical approaches of the two modalities where the humanistic practitioners gave priority to the person to person quality of the therapy relationship (Clarkson,1995), (West, 2000) (Khan,1996) and the psychodynamic

practitioners gave priority to the phantasies about the relationship (Bott-Spillius et al, 2011). The psychoanalytic approach to the therapy relationship has developed over the last hundred years. Freud suggested that the therapy relationship involves projections of past relationships with key figures such as the patient's father or mother. Then through Klein's work with children the concepts of an inner world and object relations were developed "The relationships enacted in the consulting room were expressions of the child's efforts to encompass the experiences and phantasies of his daily life" (Bott Spillius et al, 2011 p. 517). This has led to a distinction between the modalities because the psychoanalytic approach concentrates on this inner world whereas the humanistic approach focuses on the two people who consciously try to work out the difficulties for the client together.

I think the findings highlighted the differences in influences on the practitioners' approaches to clinical work which must to a good degree still be impacting on their practice. This influence is likely to exist despite the research undertaken into the possible gap between implicit and explicit practice by Tuckett, (Tuckett, 2008), and Canestri, (Canestri, 2012), referred to previously in Chapters 1 and 2 of this thesis.

Chapter 5

Reflections: the researcher, the group and the organisation

In the previous chapter, I have concentrated on using a thematic analysis to draw out the similarities, differences and meeting points of the two modality groups under study. That analysis has provided a layer of understanding and some clarity about the differences and meeting points. However, as I, the researcher, am a trained analytical psychotherapist, it would be surprising if I did not choose to explore the findings in more depth. Gibson has recently pointed out that our work as therapists necessarily involves emotion (Gibson, 2015). Therefore, to exclude all thoughts about emotion and process would seem to cut ourselves off as researchers from our core analytic approach. I would add that if I do not address unconscious processes in some way, I am further divorcing myself from my usual way of thinking about analytical work. In this chapter, I aim to redress the balance to some degree, but I will not be looking at the individual participants' emotional or psychological profiles because that would be unethical as this exploration was not included in the stated aim of the research project. Instead, I will be adding a kaleidoscope of the reflections arising from the research process itself. This will include the observations of the observer in the focus groups and the reflections of the participants themselves about their experience of the focus groups. I will begin with my argument for the importance of reflexivity in qualitative research. Then I will report on my reflexive place within this research, drawing from my participants' thoughts about me and my personal reflections which were recorded at various stages of the project. In addition, I will reflect on some unconscious processes within the organisation and comment on the changes

that have occurred within the service perhaps as a result of the research. My view is that all these reflections can be combined under my approach to reflexivity. My aim is to understand what is being communicated both from the position of critical realism and from my clinical experience as a psychotherapist that informs me that unconscious processes cannot be fully understood.

Reflexivity

As psychotherapists, we are constantly reminded of the subjective nature of our clinical work. The emergence of the concept of countertransference was an important development in clinical practice. Heimann is renowned for her position in introducing countertransference as a working concept. She wrote: "when the analyst in his own analysis has worked through infantile conflicts and anxieties (paranoid and depressive), so that he can easily establish contact with his own unconscious, he will not impute to his patient what belongs to himself" (Heimann,1950 p.82). In a similar way, qualitative researchers have recognised that no research can be evaluated without considering the subjective nature of the observations, the context of the researcher and the danger of reading into the findings what one wants to see (Hollway and Jefferson, 2007 pp.65-68). Bryman points out that reflexivity has been given several meanings by different thinkers in the social sciences over recent years (Bryman, 2012 p. 393). Finlay too notes the number of different variants of reflexivity. She also points out that negotiating a self-reflective place as a researcher is by no means a clear process, hence she includes in the title of a paper "negotiating the swamp" (Finlay, 2002).

I consider some of the approaches to reflexivity to be particularly important in the context of my epistemological stance. I have chosen to take the stance of a critical realist which is in keeping with the approach to reflexivity which

acknowledges the gap between what is observed and what can be known. Bhaskar, the instigator of critical realism, refers to the “epistemic fallacy” meaning that there is a tendency to confuse that which exists with the knowledge we have about it (Bhaskar,1998 xii). Analytical thinkers in the clinical world such as Bion and Jung suggest that what the person tells us in words can only be representations of “true” psychic experiences. In his later work, Bion put forward his theory of transformations which occur in psychoanalysis for the patient and analyst to communicate about “O”, the ultimate truth, which he posits can only be understood by intuition (Bion,1965). Grinberg has summarised Bion’s conception of the process: “In psychoanalysis, when dealing with psychic reality or with the unconscious, we will apply the sign “O” to all that is unknowable about the patient, in other words, to his psychic reality, manifesting itself through multiple transformations” (Grinberg et al, 1993 p.75). Likewise, Jung’s theory of the transcendent function, (Jung, 1916), and his approach to symbols intimates that the full information about the psyche cannot be grasped directly by reason. He writes:

> A term or image is symbolic when it means more than it denotes or expresses. It has a wider “unconscious” aspect – an aspect that can never be precisely defined or fully explained. This peculiarity is due to the fact that, in exploring the symbol, the mind is finally led towards ideas of a transcendent nature where our reason must capitulate (Jung, 1961, p 185 para 417).

Similarly, in qualitative research it is not advisable to rely solely on the participants’ language to communicate their views and experiences. Reflexivity is then necessary to review any of the findings because, as Alvesson and Skoldberg put it, “language can be regarded as a blunt and equivocal

instrument, which shapes and perspectivizes rather than depicting or being totally dissociated from phenomena “out there”” (Alvesson & Skoldberg, 2009 p. 267).

Over the last thirty years there has been a move away from seeing the researcher or anthropologist as looking through an objective lens towards recognising the subjective position of the researcher (Geertz, 1988). With this in mind I have needed to examine how my attitudes as a researcher have been influenced by my own cultural, political and social background but especially my theoretical position in the analytic world and my role as director within the organisation. The possibility of bias from the outset means that all the choices about what questions are asked and who are invited to participate will have been influenced by my thinking. Hence, it has been important to keep running notes throughout the process in addition to written notes on the process after each focus group and at each reading of the transcripts. Reflexivity about my approach is to safeguard against becoming rigid about my choice of themes or my interpretations of the findings.

Thirdly, in order not to just stay with a superficial interpretation of the findings, the discipline of reflexivity recommends that the researcher thinks about different starting points and challenges earlier interpretations. As I am psychoanalytic and Jungian in my approach to psychotherapy, the existence of unconscious thoughts and processes cannot be ignored. As mentioned above, I decided from the start of the research not to analyse the individual participants’ contributions to the focus groups by exploring their possible unconscious communications or personal psychology. This approach would have been unethical as I had not received the participants’ informed consent to interpret their contributions in this way. In addition, this kind of interpretation could

amplify any infantilised feelings the practitioners already have within the organisation and could increase any persecutory anxieties i.e. their fears of being criticised and judged, that were already present because of being under observation. This is in accord with Finlay's views who wrote:

> Speaking as a therapist myself, I have to admit to often drawing on this type of reflexivity. It is second nature to examine my own motivations as a way of understanding another. I probe the therapeutic relationship and my own counter-transferences to reveal something more. Yet at another level I can see the problems are, by definition, hidden. Isn't it problematic to simply import therapeutic techniques into the research encounter without question? And who am I, simply by dint of my training, to be so sure when interpreting another's world? I am uncomfortable about the power I assume when explaining others' motives (Finlay,2002 p. 218).

Instead my chosen focus has been in this research on the unconscious dynamics which occur in this organisation and which I argue can be generalizable to other similar organisations.

The Dual Role of Clinical Director and Researcher

I think that as an observer of a low-cost counselling and psychotherapy service in which I was also the Clinical Director at the time, it has been essential to look at my subjective position during this research. I have been the person who chose the approach and the psychoanalytic concepts to discuss, therefore, it has been essential to present to and discuss these decisions with as many colleagues as possible.

I was also the moderator in the focus groups. It was consequently important to employ an independent observer from outside the low cost organisation.

Finally, despite working with colleagues and peers to check and discuss my choice of themes, my readings and interpretations of the themes will inevitably have some personal bias which may to some degree have been an unconscious bias. Although I have always been aware that I trained as a developmental Jungian psychotherapist, during this research I realised again that my hybrid of psychoanalytic and Jungian approach must have had some bearing on my choice of looking at the different theoretical orientations and their relationship with each other.

My dual role as Clinical Director and researcher

I believe that within this organisation my theoretical orientation has mainly been identified by the practitioners as psychoanalytic psychotherapy. It would therefore not be surprising to the participants that I would phrase questions from a psychodynamic viewpoint and choose the concepts therapeutic alliance, transference and containment. Alvesson and Skoldberg point out that what participants say depends upon the ideas they have about the interviewer and the interviewer's context (Alvesson & Skoldberg, 2009 p 287). In this instance, I have held a position within the organisation and the participants were very likely to put me in a position of authority. The transference towards me would be inclined to be of an early primitive nature i.e. I could be revered, envied, or experienced as a persecutory judge.

There could be a variety of reasons why people are motivated to be involved in research, for example payment, a reward, or because the participant wishes to help make changes in the delivery of a service. I did not offer a reward or incentive. Grant and Sugarman have pointed out the ethical dangers of using incentives when the participant has a dependent relationship with the researcher (Grant and Sugarman, 2004). In this research, I did not reward with

money. Refreshments were included and each participant was given a pen with the name of the organisation on it. As stated in the methodology chapter, participants could have felt that they had to come in case there would be repercussions for example a placement might be terminated. Grant and Sugarman also refer to "action motivated by responsibility or the way in which a role model or ideal can serve as a motivator" (Grant and Sugarman, 2004 p.719). In this organisation which runs because of the goodwill and ideals of the practitioners these motivators seem most apposite.

Certain participants expressed their enjoyment in having the opportunity to discuss theoretical issues as described below on page 152. Others took the opportunity to have a platform to disagree with their mentor and what they had experienced as an emphasis on psychodynamic practice, for example as described in Extract 5 on page 114. I felt that some participants felt that they should provide the right answers and expressed their anxiety that they were being unclear about three concepts under discussion. An example of this diffidence for one participant prompted the response from me "There are no right answers".

There were a number of occasions in each group where I became aware of a variety of attitudes towards me as the researcher and director. On occasions, the observer and I would note that certain members of any group would address their comments to me rather than to each other. In one group, one participant said, "That's the...that's the relationship between client and you? Yeah? Is that what you mean?" And I replied," Yes". Here, I had got hooked into being the authority. Although I resisted other attempts to be hooked in like this, it did not take away the participants' conviction that I would be the authority on the topics for discussion.

The wish to please me and give me what I wanted was sometimes transparent. In a different group from above, another participant asked “Is it appropriate? Is it what you wanted out of the sessions?” And after another focus group, a senior member of the organisation wondered if I had been disappointed by their group’s contribution.

As mentioned before in Chapter 1, the Introduction, the members of the management team of the low-cost scheme also have attended an academic reading group that I have run for several years. Thus, one participant in this focus group I think speaks for the others when he notes how silent I am in comparison with my participation in the reading group.

Focus Group Extract 10: Reflections on my different participation

DCM1 *I think the strange thing was having you here ‘cause it feels a bit like the reading group, but, but not I suppose participating this way*

DCM3 *[...] for a change*

DCM1 *That’s right [all laugh], waiting for you to come in at any point*

DCM3 *Must be weird for you Mary [laughs]*

Mod *Well, one of the things it is throwing up is the change in relationships, but there is a difference...I’m finding that feels. Yes, I’d normally be very garrulous...I’d normally talk much more, yes, yes.*

Agreement and disagreement within the focus groups

At the end of each group, all the participants were invited to comment on their experience of the focus group. The independent observer kept notes during each group. In addition, I as the researcher kept a project diary, made notes after each group and added further observations after studying the transcripts and listening to the audio-tapes. The following discussion is therefore based on the reflections of the participants in the groups, the observations of the observer in each focus group and my observations throughout the research. These sources overlap at many points.

On many occasions, the comments made by the participants at the end of each group added to the picture of the interface between the modalities as the participants made references to agreement, disagreement and their attitude to the differences between them. The experiences within the groups varied. It was not surprising that the trustees' group valued the opportunity of meeting more informally as they normally only meet once a quarter and work to a strict agenda. The majority of this group thought that they were more likely to disagree and were able to even disagree about whether they agreed or not. One speaker said:

> *"As we've discussed different topics then the names given to things are quite slippery, they mean different things to different people, we can't disagree yet because we aren't clear about what the person actually means, but I assume that that would come, in time, as we come to know each other's ideas better."*

Yet another participant in this same group thought that the differences were less important:

"But in a way I mean the whole thing is about being in a room with a patient and trying to understand the communication with that patient and their understanding and problems, so I mean whether we understand the concepts in the same way, I'm sure that on some level they are pretty similar, we just have a different intellectual kind of framework for it, or a different word. You know. We could sometimes be speaking different languages but it amounts to something quite similar I think".

During the management focus group, the observer noted that there was "more smiling". I thought that they had disagreed but in a subtler, more well-mannered way. One speaker suggested:

"Even though we all use these concepts I think we probably all understand them slightly differently".

The observer noted a number of times that some of these participants had their hands over their mouths. In reading her observation note, I recognise that this is one of my habits during clinical work and surmise that it might represent a toning down of what is being said, thus in keeping with a subtler form of disagreement.

In the mentor groups where the difference between the participants' responses to the concepts was more pronounced, most of the feedback about the experience was positive. There were exceptions in two groups. In both these groups, mention was made about the discomfort of being audio recorded. One throwaway comment was that the recording equipment looked like a bomb. In one of these groups, a participant complained of a headache at the end. In this same group, the observer remarked that I as the moderator was at one point "smoothing over issues". This observer's remark was because I made a

reassuring comment to a participant who said he was feeling vague about the concepts I had asked about. I replied "Well as I was saying there aren't right answers". Although my reply on the face of it appeared to be as a result of my being hooked into an individual's relationship with the researcher, the observer's comment that I was "smoothing over issues" could also be highlighting a level of conflict within this group that was less obvious and covert. It wasn't until some months later when I was in discussion with a colleague outside the organisation that I noted how I had dealt with potential conflict within the service. I then realised that I had started using the term "person" to denote what humanistic counsellors might call their "client" and psychoanalytic therapists would call their "patient". This particular difference and potential issue of conflict has been illustrated more fully in the previous chapter on the thematic analysis where members of one of the groups are provoked into discussing the distinction by a humanistic participant's dislike of the use of the word 'patient'.

In one focus group, the persecutory dynamics seemed to be less prominent. The exchange seemed more lively and both the observer and I were more positive about the experience of witnessing the discussions. For example, it seemed possible for this group to contain and consider what could have been seen as solely a provocative statement by one humanistic participant. The statement was made in the context of the subject of self-disclosure as described in Chapter 4.

> *"I have clients who come to me after they've been working with psychodynamic therapists, and the nature of the clients is that they feel they don't get on with the psychodynamic therapist. Yes. The last two clients I've had left because - and it's no one in this area – the*

psychodynamic therapist wouldn't share where they were qualified and my clients didn't know that they were qualified".

The following extract gives statements from two speakers from the two different modalities in this group who express their interest in learning about each other's approaches.

Focus Group Extract 11: Reflections on the group experience

DE2 *"It's really interesting for me, being in quite a, sort of, closed environment in the psychodynamic training, to hear, you know, what you've experienced." (PSY)*

DE4 *"Yeah, likewise. I often wish that we had the chance to have these more theoretical discussions in this group, because I find it equally enlightening the other way around". (HUM)*

In the same group, the observer used words such as "agreeing", "involved", "engaged" and "reflective" to describe the process and I remember enjoying the group the most of all the six. It seemed to be, in Bion's terms, a" work group". Grinberg wrote:" the workgroup that tolerates frustration allows the evolution of new ideas and these will not be deified, denied or evacuated their progress will not be obstructed" (Grinberg, 1993 p. 15).

In contrast to the above example, there were examples in most of the groups where the dynamic is one of disagreement. On these occasions, the observer has noted a participant's body language, that he or she may be looking away, looking down or sitting on the edge of the group. For example, she reported that a participant at one point in the discussion "doesn't want to make eye contact or be drawn in". However, this presumed withdrawal from engagement changed when one of the other humanistic practitioners spoke. In the same

group, the observer noted that one participant “challenges” an idea and another “questions”.

In another group, the observer pointed out that one speaker is” having to defend herself in discussion about personal information”. The discussion about the value of self-disclosure has been included in full in the Focus Group Extract 3 on pages 94 to 96 in Chapter 4 on the Thematic analysis. The observer then noted the provocative statement made by one participant that “clients are coming to her after not getting on with other counsellors/modalities”. This group had the most wide-ranging discussions which included overt rivalries and some rigidity in one particular practitioner’s views. At times, I noted they went off the subject and I remarked to them that I could have chosen any subject and they would have had an interesting and lively debate. I think the impact of their discussions illustrated the difficulties I could have at times within the organisation of holding the differences in mind. Although the observer remarked after the group that she had enjoyed it the most, she also noted that she felt tired and that during the group “I looked tired”. In this instance, two members of the group perhaps took on the “smoothing over” function. One concluding comment was:

> *“I think what was coming up for me is that it’s almost at times like a linguistic discussion. We work in different ways, but the commonality is certainly there. The language can be a bit of a barrier. There’s a lot of words, the psychodynamic modality, that are quite alien to me. That has been really quite a positive experience I think to find… to be able to start to explore that commonality. And really, for me, it’s not to get too hung up about what you call it – you call it one thing, I call it another thing. It’s the*

core of the work that you are doing, and you are not to let language or training becoming a barrier to that."

The political and cultural context of counselling and psychotherapy organisation

As described in Chapter 1, there has been a division over decades between the three tiers of national registration for counsellors and psychotherapists. Politically, there has been a hierarchical relationship between these three: The British Association of Counsellors and Psychotherapists; The United Kingdom Council for Psychotherapy; and the British Psychoanalytic Council. The processes which keep these associations apart are complex but the tendency towards exclusion of therapists of certain modalities creates a climate of elitism. This elitism arguably is founded on fact where exclusion from membership is based on for example how many times a person is seen per week. However, the climate where therapists from different modalities rarely meet and discuss the similarities and differences between them, has also resulted in phantasies, stereotypes and prejudices about each other.

I was aware that there was already a tendency to stereotype each other's modality in the existing forums within the organisation under study. The introduction of IAPT, improving access to psychological therapies, resulted in the setting up of schemes to train practitioners in cognitive behavioural therapy. Central government provided funding for specialist training at the local university for "low intensity workers", practitioners who would offer psychological help informed by cognitive behavioural therapy, and "high-intensity workers" who would offer cognitive behavioural therapy itself. This change in primary care provision resulted in a number of the counsellors within the low-cost scheme who had been working as GP counsellors having to reapply for their

jobs. The changes also involved regular session by session evaluations of the effectiveness of the help offered, for example by asking the person to complete various forms in an attempt to monitor outcomes. The culture of filling in forms for each session did not sit comfortably with the counsellors already working in primary care. In consequence, the low-cost scheme became the good, wholesome service where the recognition of the importance of the depth of work that could be so disrupted by this measurement could be sustained. Whilst on the other hand, Cognitive Behavioural Therapy and IAPT became the enemies. Lewis gave a vivid description of exactly this process whilst working as a student counselling psychologist within a department of psychological medicine at the time when IAPT was introduced. She wrote: “temporary relief is found by taking refuge in the collective membership of shared therapeutic orientation and fighting the “IAPT enemy” through derogatory and dismissive comments” (Lewis, 2012 p.26).

Over time, the organisation under study developed a closer working relationship with the local IAPT teams. The experience of meeting the practitioners as whole people rather than part objects coloured by phantasy reduced this dynamic. However, cognitive behavioural therapy tended to retain the manifestation of all that was alien. This process of splitting served to avoid chaos, conflict, doubt or muddle between practitioners’ views held within the organisation. Whittle describes a split that exists between psychology and psychoanalytic psychotherapy which in my view could be applied to many bodies of knowledge (Whittle, 1999).

In the organisation under study, the process of splitting (Halton,1994), can have a dual function. Firstly, the bad and threatening object can be projected out into the other theoretical orientation or modality. Secondly, any doubt or conflicting

thoughts and feelings can be guarded against to create an illusion of certainty and false confidence. The outside enemy might be at any one moment the" master discourse" of psychoanalysis as mentioned in my introductory chapter (Cooper & Lousada, 2010 p 35). Whilst on the other hand the introduction of IAPT services produced a different kind of threat, again with some foundation, because the overall emphasis was to "cure clients and get them back to work" (Lewis, 2012. p. 25).

I would argue that the use of focus groups in this study has made it possible for the participants/practitioners to think about their own theoretical choices and ways of working. In addition to being stimulated by other practitioners' ways of working, it has been possible to further encourage self-reflection. It then makes the reliance on the defence of splitting modalities or different ways of working into all good and all bad less prevalent. For example:

> *"As we sit here, I think I'm realising that I am working with it all the time, I think it's almost everything I do, is be listening out for and looking out for how that person is operating with me. And I suppose the difference comes with then what you do with it once you recognise it, and perhaps that's when I… my natural inclination is to not encourage more of it but to try and head it off into a new direction, a, kind of, more, I don't know, unique relationship between me and that person rather than to try and encourage that person to go more into that transference. Something doesn't feel right to me about doing that. So I think that's where I'm working".*

Unconscious Processes within the Organisation and Containment

The consulting service, the Tavistock Clinic Consulting to Institutions, has been working for some years with organisations and applying Bion's work with groups

and Klein's primitive unconscious dynamics to both public and private institutions (Obholzer & Roberts, 1994). More recently Armstrong has developed Obholzer's concept of the "primary task". He suggests that the term practice better describes the emotional enterprise of an organisation than the term primary task (Armstrong, 2005). Armstrong also advocates that the function of a leader is to make "present in the interplay with others, reflectively and cognitively, as well as emotionally, the what-ness, the is-ness of the organisational object" (Armstrong, 2005 p.128). He refers to the work of Alvarez and Pecotic who are both child analysts and who both consider that Kleinian authors have tended to emphasise both the defensive nature of institutions as well as their function of containing anxieties and psychic pain rather than the aspects of containing which can promote growth and development.

The concepts of transference and containment are both central to my clinical practice. Just as the likely transference to me as the director and researcher needed to be thought about throughout the research project, so containment has also needed to be considered as a key issue. I think that the original Kleinian view of containment as a defensive process to contain anxieties and psychic pain plus Armstrong's additional perspective of containment to promote growth and development both have relevance to this research (Bott Spillius et al 2011 p. 282) (Armstrong, 2005).

Containment facilitating development and change

The majority of participants in the focus groups reported enjoying having the chance to talk to together in this way. Each existing group has its own task when meeting ordinarily. The trustees keep an overview of the funds. The management team coordinates clinical issues. Each mentor group gives

practitioners the opportunity to talk about their clinical work and any problems arising. Following are two expressions of their enjoyment from two participants from different groups.

> *" Yeah exactly, it's revisiting these concepts actually and takes you back to your training in a way, and not to take them for granted and to revaluate it, and also actually it's lovely to hear everybody else's kind of, you know because we all have slightly different angle, and that's something we don't normally do in the mentoring group and actually I'd like more of it, if I'm honest, I'd like more of this kind of – 'cause I think we all could learn so much, well I'd certainly want to learn from everybody else".*

> *"… The very idea of having the opportunity to chew the cud on a couple of topics is… I find it enjoyable. It's enlightening, isn't it? It's really interesting to hear how other people do it and different thoughts and ways and ideas. I just find it really enjoyable."*

At the end of one focus group, it was suggested that the practitioners in the low -cost scheme could meet monthly to read academic papers. The practitioners were aware of the existing academic reading group and the appointed leader wanted to call theirs the "kids' group." This initiative was one of the first steps in changing how the low-cost scheme operated from a top-down leadership to an approach where practitioners would be encouraged to develop in a way they feel confident and competent. I conclude this section with Armstrong's description of the more creative function of containment.

> Yet I think that it is through bringing the practice interview – discerning it, questioning it, testing it, sorting out what is essential and what are

> accretions or perhaps defensive distortions – that one may be able to approach change more creatively: to approach it less in terms of the language of loss, the need to “give up something”, and more in terms of a language of adaptive development, “the finding something” (Armstrong, 2005 p.134).

Containment of anxiety

Menzies Lyth is renowned for her contributions to the understanding of defences to anxiety when working in a caring institution (Menzies Lyth, 1988). She points out that when nurses are caring for their patients who are ill and may die, how this picture mirrors the internal world and anxieties of an infant. “The infant fears for the effect of aggressive forces on the people he loves and on himself. He grieves and mourns over their suffering and experiences depression and despair about his inadequate ability to put right their wrongs” (Menzies Lyth,1988 p 47). In order to compensate for the times when we have felt helpless and unable to “cure” people, I think that the administrator and I were in danger of becoming omnipotent.

A member of the Management Team focus group brought up the relevance of the concept of containment to the dynamics of the organisation by asking the administrator how much she felt she contained distress of the work. It had already been a frequent topic of discussion both formally and informally that I, as the Director, had been managing the whole service. As the sole director at the time, with the one paid employee, the Administrator, I needed to reflect upon any unconscious projections and defences aroused by this kind of service. The following focus group extract highlights this process.

Focus Group Extract 12: Containment by Administrator and Clinical Director

DCM4 *D I was wondering how much you experience having to be the container when a client rings up and how you would see it from that point of view?*

D *Well Mary takes more information but I tend to not go in to anything but that doesn't always happen because I often don't get a chance, and people start pouring out because it doesn't matter who's answered the phone even if I say I'm non-clinical Mary L will speak to you later, they've already started. And in that situation obviously you don't just cut them off because that would be awful and so I suppose I just try and do you know I'm just trying to hold them until those particular people I know Mary's going to have to speak to, many of them I just take on and you know, I just tell Mary I've spoken to somebody and give a rough outline, and then she just says well ask J or ask L. She doesn't even speak to them but there are some where it's just an obvious. I don't know if that [answers your question]*

DCM4 *Yes, I suppose what I was wondering was what that experience of being, what's like for you to be, to having to contain [this anxiety over the phone?]*

D *Um. Sometimes you know it's worrying, it you know, can be upsetting, and I sort of, I feel anxious because I want Mary to talk to them sooner rather than later, or somebody, you know if Mary's away on holiday it will be somebody else is*

babysitting, and you know, in a short period of time you can feel a lot for somebody, can't you, in literally in three minutes, you can sort of be thinking oh my gosh that's awful, you know, …but I do generally try not to get to that point because that isn't my position.

DCM4 *Yeah, no, no.*

D *But sometimes it happens. It's quite rare.*

DCM2 *You might actually be containing more (DCM1 um) than you think you do because the mere meeting and answering of the phone and your voice, you know you provide…*

D *Well I mean perhaps because often they are very anxious, they've been referred to us and then it's making that call and you know I do, sometimes pick up that even if I don't hear the story at all, I do, you know they will often, people will often say to me oh I'm really pleased I've spoken to you and that sort of thing and you can infer from that, so hopefully...yeah.*

DCM2 *Um.*

Long pause

DCM1 *I was going to say I was intrigued by what you said because I suppose in a way …it's err a sort of an aspect of something going on for you or something going on for the place, something going on for the patient, but I suppose that sort of comment that you said, that in a way like being in in a session with somebody said I had to do some babysitting. And I think, what's that about?*

D *What because I used the term babysitting?*

DCM1 *Yes, somebody's else's babysitting when Mary wasn't there.*

D *That's probably not a term we use, I just used that [....in place?]*

DCM1 *[laughs] Exactly, I don't, let's not go any further, but that's the sort of [some] that somebody might say. (much louder)*

D *Yeah*

DCM1 *In the session about something, oh that sounds really interesting, what's that about?*

D *Babysitting the Clinical Director's role, isn't it?*

[all laugh]

D *Babysitting me 'cause Mary's [not here...]*

In this extract, D, the Administrator, is asked by one member of the group whether she feels she has to hold a lot of distress when dealing with phone calls. The questioner is thinking about the likelihood that D has to contain the initial anxiety which can be communicated when someone rings in for the first time to ask for help. She agrees that this can be the case but inadvertently uses the term babysitting which another participant picks up on. From my knowledge of this participant he was likely to be thinking of a parallel with Bion's ideas. This approach is congruent with the finding in the thematic analysis, that it was the psychodynamic group who referred to babies and infantile states. The Administrator appears to take the comments about babysitting as though the speaker thinks she needs babysitting and the observer comments at this point that she thinks D is feeling defensive. On the contrary, my understanding of the interchange was that the Management Team were aware of how much

the administrator contained the distress within the organisation especially when I, the clinical director, was away. Indeed, D goes on to describe how on one occasion, one of the practitioners came out of a session crying and distressed. D then describes how she listened to the practitioner and how the practitioner expressed her gratitude for the support received.

Research as stepping back from the service

I believe that once I had enrolled in undertaking the clinical doctorate, I had already begun to step away from my role as Clinical Director without being aware of this process. When I was required to undertake a small-scale research project, I chose to study various aspects of the low-cost organisation including the demographics of those people referred and some picture of the outcome of those therapies which have reached the two-year mark (Lister, 2014 unpublished). The poster presentation of this study hangs in the general office of the low-cost scheme and the findings were helpful when applying for grants. In the exchange within the Management Team referred to in Group Extract 10, the participants noted that unlike their experience of me in the academic reading group, my role as moderator puts me outside the group to hear what they have to say about the concepts.

When reflecting further on my dual roles as director and researcher I have referred to the work of Obholzer in the Tavistock series of publications “The unconscious at work” (Obholzer and Roberts, 1994). Obholzer’s work has provided me with a framework to examine further my role within the organisation under study and how becoming the researcher brought about change in the ways I experienced my role. I came to realise that I had been founder, leader and manager at the same time and that this system worked because those who joined the service invested me with power and authority.

“Members who voluntarily join an organisation are by definition, sanctioning the system. By the act of joining, they are at least implicitly, delegating some of their personal authority to those in authority, and in doing so confirming the system” (Obholzer and Roberts, 1994 p. 40).

Within the organisation under study, I could therefore take up a place of omnipotence which I knew to be unreal. This form of leadership meant that I could keep the benign side of working within a voluntary organisation prominent as long as I acknowledged the shadow side of resentment about working for little or no pay. The Shadow side of the personality is seen by Jung to contain both positive and negative aspects but crucially to harbour unwanted aspects of the self (Marlan, 2010).

For me the greater learning experience has come from stepping away from this position of power and authority to become a student again. The training that the Tavistock Institute of Group Relations give on working in organisations is a “group experience” where one can experience taking on other less powerful roles within a large group. I think the experience of being a student has been such an experience where I have had to rely on the capability and reliability of other leaders.

The discussion in Focus Group Extract 12 on pages 161 to 163, highlights the role that the administrator has been taking within the organisation. It is my view, with hindsight, that undertaking this research made it possible for both D and myself to step back from our rather omnipotent positions within the organisation where we had been trying to accomplish all the practical tasks as well as endeavouring to contain the anxieties and irritations aroused by the work. Was it a coincidence then that D found a new job some months later? My reaction to D leaving required a good deal of self-reflection. After wrestling

with my initial feelings that I had been betrayed and abandoned by D, I began to appreciate that the organisation had been stuck in an effective but potentially dependent state.

I think that the actual process of undertaking the research was for me the first step in allowing the low-cost scheme, “my baby”, to become a separate entity. Since D’s departure, the organisation has had to undergo a period of loss and change. There has been a new Administrator who has brought change and development with her. In addition, a temporary Assistant Director has made many changes to the system of referral, assessment and interview procedure. At the time of writing, we have a Clinical Manager but no replacement for me as Director.

Chapter 6

Discussion

The impetus for this study came from an awareness that practitioners within the low-cost service of which I was Clinical Director had been trained in different theoretical modalities. The dilemma was how much to expect practitioners from different modalities to take on psychodynamic ways of working. The psychodynamic approach had previously been the favoured one of the organisation and had been encouraged by the management team. This research gave me the opportunity to examine how relevant key psychoanalytic tenets were to the whole team, and particularly to the humanistic practitioners within the service.

The research questions were aimed at ascertaining what differences and similarities in ways of working existed between the practitioners from the different theoretical modalities. These findings would help assess, at a local level, how difference was being managed at the time of the study, and how these differences should be managed in the future. In Chapter 1, I pointed out that a number of schisms and divisions have occurred in the past within the therapy communities such as the Institute of Psychoanalysis. The rationale for this study includes the need to accept that in the present day, therapists and counsellors have a wide variety of trainings to choose from and there is an increasing movement towards integrative trainings and an adoption into practice of more than one modality. Therefore, the situation where therapists from different modalities work alongside each other is likely to be a common one,

and these findings have implications for other such organisations and the counselling and therapy community at large.

In Chapter 2, I reviewed the studies and papers available at the time in this chosen area of research, the exploration of the differences between the two major therapies available in the low-cost service under study i.e. humanistic and psychodynamic. The papers reviewed varied in their approach and some did not have direct relevance to my research findings.

Firstly, Orlinsky's study concentrated on therapists' views of which factors contributed to their positive experience of development post qualification. These contributing factors included the choice to add another approach to their skills set such as couples therapy but not a switch to another modality or orientation (Orlinsky, 2005). Secondly, a number of studies set in different countries investigated the changes in trends of therapists' primary choice of modality. For example, Coscolla in Spain, Jacobsen in Denmark and Jaimes in Canada (Coscolla et al, 2006), (Jacobsen, 2012), (Jaimes et al, 2015).

In this chapter, I discuss the relevance of my findings in the light of the aim of the project, and seek to demonstrate the place of these findings within the existing research. I begin with a discussion of my choice of method and then place the findings in the context of the literature which is more closely relevant than the above studies. I have given particular attention to the difference found concerning self-disclosure and the meeting point about countertransference between the two modalities. I consider the thinking about personality traits and the choice of theoretical orientation, and make some comparison between my findings and Roth's Q-sort results (Roth, 2015). I conclude with my views about the pros and cons of the movement towards integration.

Method

In the context of the literature review in Chapter 2, this study is unusual in that apart from the papers from the Jungian/humanistic conference, it is the only study that compares the humanistic approach with just one other approach. My choice of method is also different from the studies reviewed in that, apart from Tuckett's study, (Tuckett et al, 2008), the other research projects do not use discussion groups. In addition, the focus groups that I ran had a different emphasis from the groups in Tuckett's study. In his groups, analysts would meet for a much longer time and the members of the group would respond to a clinical presentation. Tuckett had to create a structured approach to these groups whereas I was able to adopt a method of running focus groups which is a long-standing method that has been used extensively.

The employment of focus groups gave me the opportunity to collect findings in a focused and structured way. Although in this instance I have drawn from other observations of the organisation under study, taking on the role of the focus group moderator provided me with the structure to observe what was said from a more removed position from the organisation. One of the major advantages of focus groups in contrast to the use of surveys or individual interviews, which many of the reviewed studies employed, is that different ideas can be sparked off by group discussions and these ideas and discussions were the key foci of this study.

Lastly, my chosen method of analysis of the focus group discussions has not been replicated in any of the studies I reviewed. I chose a combination of thematic analysis and my particular approach to reflexivity. My approach to reflexivity was unusual as I included an interpretation of the unconscious processes within the organisation under study (Obholzer and Roberts, 1994).

Themes and literature reviewed: countertransference and self-disclosure

Two themes arising from the discussion of the concept transference that were identified in this study when undertaking the thematic analysis have also been addressed in two of the pieces of research which I reviewed in Chapter 2. These themes are countertransference and self-disclosure.

Countertransference

Spektor in 2015 compared practitioners' use of countertransference when working with psychotic patients and patients with the diagnosis of borderline personality disorder (Spektor, 2015). It was found that psychodynamic and humanistic practitioners were more likely to use their countertransference helpfully when working with psychotic patients in comparison with practitioners from the other modalities under study including the cognitive behavioural practitioners. However, psychodynamic practitioners were found to be more able than their humanistic counterparts in drawing from their countertransference experience when they worked with borderline patients. In my study I did not attempt to evaluate either the humanistic or psychodynamic practitioners' use of countertransference. There were, however, both explicit statements and descriptions of clinical work that implied the use of countertransference by practitioners from both modalities, in consequence, I have seen it as an area of overlap rather than difference. Following are two quotations from participants in my study. The first is a psychodynamic practitioner and the second is humanistic.

> "But I'm thinking of a particular client who I would sometimes get an incredibly sad sense of sadness which they would appear to be shutting off completely and then somehow in the session we actually get and at that point I realise I stopped feeling sad because they are owning the

feeling and they're able to own it. Um but that's, that's in some ways countertransference and they are projecting a feeling into you."

"Yes. I think it's something that's come out many times working with anxious clients, actually thinking more where I've worked with young people. I've worked with quite a lot of young people with anxiety issues, and, yes, you are becoming the anxious person and taking that out to supervision, and the supervisor, effectively, can give back that anxiety that's there. That's going back outside of that countertransference/ transference."

It could be argued that both speakers are talking about projective identification as described by many including Waska, (Waska, 1999), but that relationship between the two concepts is beyond the scope of this study.

Self-disclosure

Holmqvist's paper which I reviewed in Chapter 2, describes an investigation of the occurrence of self-disclosure among Swedish psychotherapists (Holmqvist, 2015). His particular interest is whether the development of relational psychoanalysis has changed the way psychodynamic and psychoanalytic psychotherapists deal with the issue of self-disclosure. His findings include the fact that CBT therapists reported that they disclosed both more about themselves and their training than psychodynamic therapists. The humanistic therapists in Holmqvist's study have been listed under "other therapies" and it is not clear what their attitude to self-disclosure was. When Holmqvist examined the findings that correlated with age difference, he found that the younger psychotherapists reported that they told their clients about their training to a

larger extent than the older psychotherapists. Also the younger psychotherapists talked more about their relationships and ways of handling feelings more often than the older psychotherapists (Holmqvist, 2015 p. 88). These distinctions could confirm Holmqvist's hypothesis that the move towards relational and intersubjective psychoanalysis has influenced the attitudes of younger psychotherapists.

It was clear from my study that there was a difference between modalities over self-disclosure, although the main discussion of this topic only occurred in one focus group. Part of this discussion has already been displayed in the Focus Group Extract 3 in Chapter 4. In this discussion, one humanistic participant showed some surprise at the psychodynamic participant's attitude to personal self-disclosure but other humanistic participants did not totally agree and stated that they were careful about what information they did disclose. At another point in the discussion, a criticism was levied by one humanistic practitioner at an unknown psychodynamic practitioner who refused to give details about their training.

Holmqvist's choice of study brings to notice how relevant this subject is to therapists and counsellors as a whole. In my view, disclosure of personal information has a different weighting from disclosure of professional information. I think it would be considered unethical not to share information about one's training. However, the disclosure of personal information can have a number of effects. It is thought by some practitioners that it can be helpful to share with a client when the therapist has experienced a similar life event. This is thought to be helpful in making the client feel less isolated with their experience. However, the therapist's experience could be very different from the client's and could get in the way of understanding the client's individual response to their experience.

In addition, some clients have described the inappropriate sharing of information by therapists which has led them to wonder who is the one who needs help.

In my study, the findings did not demonstrate a comprehensive difference between the modalities about self-disclosure. The inference was that practitioners from neither modality would disclose a large amount of personal information. There was, however, a distinction between the ways practitioners might handle questions about themselves. This distinction I think highlights a key difference between the modalities where the psychoanalytically based theory encourages a practitioner to restrain from giving too much away about themselves in order to invite their patients' phantasies about their therapist. In contrast, a humanistic practitioner would see it as a priority to preserve an authentic self and relationship with their clients.

Two prominent psychotherapists, Rowan and Jacobs, have devoted a book to discuss the interface between the humanistic and psychodynamic viewpoints particularly in relation to the therapist's use of self (Rowan & Jacobs, 2002). In chapter 6, "A dialogue: the authors discuss the therapist's use of self", they compare from their different theoretical positions what it means to be authentic with one's patient or client.

The following exchange of ideas puts into a nutshell how the absence of self-disclosure does not automatically mean that the therapist has not engaged their authentic self in the process.

> Rowan *"I found it hard to see how a psychoanalyst could be authentic. It seemed obvious to me that such people hid behind a role that made them quite impervious to any access by the client... One cannot read Searles, for example, without realising that his authenticity consists not*

only in his being in touch with his conscious reactions to clients, but also in his being ready to engage in a genuine dialogue with the client based on his awareness of his own countertransference..."

Jacobs *"What "authentic" may appear to mean. Which involves openness to the "real" self, which, in turn, probably means self-disclosure and even being more active. But" authentic" can also mean "true to oneself" and, if we recognise, as we surely must, that psychoanalysts are trying to be as true to themselves as much as any other therapist, is there any reason why the relatively silent analyst should be any the less authentic than the more expressive person centred therapist - just to take stereotypical extremes?"* (Rowan & Jacobs, 2002 p 123).

This kind of dialogue between two very experienced practitioners illustrates the kind of relationship that can exist between practitioners from different modalities. In many ways, this dialogue mirrors the quality of conversations that went on in the focus groups in the present study, where there was an openness to listening and learning about the other's point of view.

The risks of stereotyping and division

When such opportunities to talk about and to discuss theory and practice are not made possible, stereotyping can happen and factions can form. Larsson's study which I reviewed in Chapter 2, confirms this hypothesis as he found that therapists were more likely to make misjudgements about another therapy orientation than their own and to exaggerate the differences between their own and other orientations (Larsson et al, 2013). In Chapter 5, I described some observations of the organisation and the likely unconscious processes at work based on the work of amongst others Obholzer (Obholzer, 1998) and Armstrong

(Armstrong, 2005). I noted that in my view, stereotyping had been occurring within the low-cost service about outsiders. Due to the re-organisation of the National Health Service of primary care services, CBT practitioners had become the enemy.

Psychoanalytic institutes are also in danger of becoming the enemies and the outsiders, and they have been accused of isolating themselves in “ivory towers”. Cooper and Lousada have suggested that this alienation can be caused by psychoanalysis being seen as the superior method (Cooper & Lousada, 2010). Knox’s concern too is that, in the face of challenge from outcome research, psychoanalysts could retreat into “a position from which we do not really engage with the critics of and threats to our profession, but instead adopt an attitude of unquestioning certainty about our theory, training and clinical methods” (Knox, 2013 p 426).

Personality traits and choice of theoretical orientation

One way that employers in the business sector have sought to improve teamwork and to reduce conflict has been to employ personality inventories such as the Myers Briggs Type Indicator which places people in groupings of certain personality characteristics (Briggs & Myers, 1995). One aim of the use of personality testing is to choose a team that can work together. A number of the studies that I have reviewed in Chapter 2 have included an exploration of the different personality characteristics of the practitioners which might contribute or correlate with their choice of theoretical orientation. Boswell and colleagues looked at characteristics such as openness to feelings (Boswell et al 2009). Hopmann and colleagues compared practitioners’ attitude to spirituality between modalities (Hopmann et al 2011), Ogunfowora et al employed the HEXACO personality inventory to compare practitioners for such traits as

conscientiousness and agreeableness, and openness to experience (Ogunfowora et al, 2008). Winter et al administered a number of questionnaires to examine differences between certain modalities for philosophical beliefs and personal constructs. They argued that:" The findings would suggest that heated disputes between therapists may occur because any challenge to therapists' preferred theoretical orientation is likely to imply a challenge to their personal style and fundamental philosophical beliefs, or in personal construct theory terms their core constructs" (Winter et al, 2006 p. 327-8). This last approach appears to aim at understanding and perhaps reducing conflicts between therapists from different orientations.

All these studies involve comparisons between a number of modalities rather than the two examined in this study and the key differences found were very often between cognitive behavioural practitioners and the other modalities. However, Hopmann and colleagues found that there was a clear difference between the humanistic and other modalities in regard to the importance of spiritual/religious aspects to therapy. As mentioned in the previous chapter, this difference between the modalities in respect to spirituality did not feature in this study (Hopmann et al, 2011).

Looking at the characteristics of individual practitioners might be a way of understanding the differences between the characteristics of certain modalities with the intention of preventing stereotyping and the dismissal of other people's approaches. In the case of this study, a decision was made from the start not to explore individual differences between the practitioners in this low cost service, primarily because I believed that it would be unethical to interpret their participation in this way. I also think that the exploration of individual differences would need to include numerous factors such as the training

opportunities available, the theoretical orientation of one's therapist and personal history. Levine underlined the personal factors involved in the choice of theoretical orientation when he wrote:

> For each of us, there exists a deeply subjective side to the foundation on which these hypotheses, beliefs and ideas are constructed. This foundation predates professional training and rests upon highly personal and context -dependent-often fantastical-attempts from early childhood on to make sense out of the perplexing mysteries of how the world works (Levine, 2012 p 22).

Q-sort and modality choices

Roth's approach in the UK to investigating the differences between the three key psychotherapy modalities, psychodynamic, humanistic and cognitive behavioural therapy, has been to validate a standardised framework for competences for each orientation (Roth, 2015). Advised by experts, he compiled one hundred competences which were attributed equally between the three modalities and a generic category. Some of the findings from the present study are in step with Roth's competences. For example, the participants' agreement in this study over the important functions of supervision coincides with Roth's generic competence and the difference found between the practitioners of the two modalities in the low-cost service over self-disclosure mirrors one of Roth's humanistic competences.

> An ability to self-disclose and communicate experience of the client to the client, especially where this is relevant to the client's concerns and likely to facilitate rather than impede the client's therapeutic process (Roth, 2014).

Many of the other competences for the humanistic or psychodynamic modalities in Roth's study coincided with my findings. However, two competences designated solely as psychodynamic in Roth's work were found in this study to be meeting points arising from the discussions. These were the influence of the past on the present and the value of the countertransference.

The pros and cons of an integrative approach

A small number of reviewed studies addressed the issue of integration. Boswell referred to theoretical orientation choices for counselling psychologists in training in a northern American state (Boswell et al, 2009). They found that the highest single rating for theoretical orientation choice was psychodynamic but that the highest rating overall was for integrative. Then once the trainee had chosen their single orientation, their next preference was for a humanistic orientation.

Hickman also looked at trends in orientation choice in the United States but the sample was small and of "expert therapists" rather than students. He found that his participants had been influenced by all four orientations under study but only one held prominence for each participant. This choice of the prominent orientation was not the same for each therapist (Hickman et al 2009). There appears to be a greater trend towards an integrative approach in the United States and an argument for an integrative training for counsellors and psychotherapists. 79% of training directors in a study by Lampropoulos and Dixon believed that being trained in one therapeutic model was not sufficient (Lampropoulos & Dixon, 2009).

Levy and Anderson also looked at patterns of preferences for theoretical orientation choice for psychology students in Canada, finding that over twenty years there was a decrease in interest in the psychodynamic and an increase in

the choice of cognitive behavioural therapy. These authors were concerned too that these patterns showed that there had been a reduction in diversity within the training (Levy & Anderson, 2013).

However, Ronnestad and Skovholt have emphasised that it is in the post training period that a therapist or counsellor explores other possibilities, integrates new experience and develops a personal way of working (Ronnestad & Skovholt, 2003). Carlsson has added that finding a personal style involves freeing practitioners from training requirements (Carlsson et al, 2011).

It appears from previous studies that there is not a consensus on the usefulness of an integrative approach for training psychotherapists or counselling psychologists.

This ambiguity about the usefulness of an integrative approach mirrored my experience when undertaking the research and witnessing the various influences on the practitioners who identified themselves as humanistic. In particular, some of the participants had trained or were in training with one humanistic integrative training body. Yet another group of participants had trained or were in training with a separate humanistic integrative training body. The differences between the training institutions were very noticeable as some of the participants seemed to have been offered a training which did not come across as having a coherent whole. In contrast, the other training appeared to offer a more substantial foundation and an integration of theoretical ideas and clinical approaches.

As mentioned previously in Chapter 2, Hollanders distinguished between eclecticism and integration, where integration is" primarily theoretical in its development, blending elements together into a unified whole" (Hollanders, 2000 pp 32-3).

Courses which are orientated towards a humanistic approach have turned to the work of Khan, (Khan, 1996), and Mearns and Thorne, (Mearns & Thorne, 2000) for a synthesis of theoretical approaches, for example the University of the West of England's training for counselling psychologists (Appendix 14). Khan has described how in the United States, Kohut's self-psychology provided a meeting point for humanistic therapists with psychoanalysis. Khan added that the influence of feminism on psychoanalysis provided a further move away from what he described as a cool analytic relationship towards the warmer therapeutic relationship that the founders of humanistic therapy such as Rogers advocated. Khan suggested that Kohut's approach then allows for an incorporation of both an authentic relationship between therapist and client plus interpretation of transference experiences: "It has been repeatedly observed that Kohut represents a coming together of the humanistic and psychoanalytic traditions, and one major reason for this observation is his insistence that therapists express their humanity" (Khan, 1996 p 98-9).

It has therefore been possible to bring together aspects of the psychoanalytic tradition and humanistic tradition under what has been called a "relational model". The basic argument is that human psychological development is mediated by relationship. This action of bringing together psychoanalytic and humanistic thinking using the bridge of self psychology has been further strengthened by other developments and influences on in psychoanalytic thinking. Mitchell and Greenberg have been influential in showing how the theories of object relations have taken different two routes based on drive theory and a relational model (Mitchell, 1984), (Mitchell & Greenberg,1983). The research drawing from attachment theory too has emphasised the importance of early relational bonds showing how significant relational patterns

can be repeated and can affect cognitive as well as emotional development (Holmes, 2001). In addition, the interpersonal studies involving the close observation of interactions between infants and their mothers, initiated by Stern in 1980s, (Stern, 1985) and carried on by the Boston Change Process Study Group (BCPSG) which stress the primary role of early relationships have profoundly influenced the thinking of many psychoanalysts (BCPSG, 2007).

The focus of the present discussion is about the value of the integration of psychodynamic and humanistic thinking within a training for counselling or psychotherapy. It is, therefore, beyond the scope of this study to add a review of the psychoanalytic trainings for psychotherapists inevitably include a number of different theoretical viewpoints which may or may not concur. I am aware that I must be biased to a certain degree as I am looking at integrative training programmes from an outsider's point of view. However, this study has shown a sufficient number of differences between the psychodynamic and humanistic ways of working for me to recommend that it is preferable that a person leaving training has opted for one particular approach to be their primary approach rather than attempting to combine the two.

The differences that were noted from the focus group discussions have been summarised in more detail in Chapter 4. In essence, the key distinctions are that the psychodynamic participants referred to working with unconscious processes through transference and containment which involved limiting self-disclosure, drawing on theories of infant development and taking the lead at times as the expert. Whereas the humanistic practitioners placed most value on the authentic therapeutic relationship, seeing the therapeutic alliance as essential, self-disclosure as possible and their primary role as being to encourage a client to fulfil their potential.

I think this present study illustrates the value of practitioners being able to acknowledge the differences in approaches and the underlying differing understandings of the mind when working alongside each other, rather than attempting to integrate their approaches. It is through the dialectic and debate that we become aware of our own thoughts and identity. As Gordon put it, we can be grateful to our enemies as they teach us about ourselves (Gordon, 2005).

Chapter 7

Conclusions, implications and recommendations

The study

All 28 people who were working in a voluntary capacity as a therapist or counsellor or who had a non-clinical role within the low-cost service participated in six focus groups. The groups took place during the period from August to December 2014. This study shows a picture of the organisation at that time. In these focus groups, participants were asked to discuss whether three psychoanalytic concepts had meaning for them and were relevant to the way they worked. All but one participant contributed fully and many gave examples from their clinical work.

Research questions

- What do the therapists and counsellors working in a small organisation say about the three psychoanalytic concepts: the therapeutic alliance, transference and containment?
- How does what they say illustrate the differences, agreements and meeting points of their different modalities?

Through the thematic analysis of the conversations during focus groups, I have endeavoured to show the similarities, differences and meeting points between the practitioners of the two modalities, psychodynamic and humanistic. These findings have relevance to the future management of the service under study but also potentially to other counselling and therapy services and to the therapy community as a whole.

Summary of findings: what the participants differed over

There were clear differences in approaches for both modalities. There were also differences within modalities.

Therapeutic Alliance

I expected there to be agreement about the importance of the establishment of a therapeutic alliance for both modalities, but this assumption was dispelled by the fact that the psychodynamic participants brought into question of the place of transference. The discussions highlighted how both positive and negative experiences can cloud any sense of a "real" relationship between therapist and client.

Transference

This line of division over therapeutic alliance was evident in the discussion of transference where the humanistic participants emphasized the importance of a "real" and "authentic" relationship with the therapist and on the whole, did not aim to work with the transference experiences within the therapy.

It was perhaps not surprising that the psychodynamic participants talked of working with the transference whilst the humanistic speakers acknowledged learning about the concept, but often talked of being aware of this process rather than actively working with it within the therapy. Those participants who had trained on an integrative course appeared to be more confident about applying the concept of transference on occasions.

Containment

The participants agreed about the importance of containment over the practical necessities of setting the frame and boundaries, the place of emotional and psychological containment and the importance of supervision in containing the practitioner's responses. However, the dividing line in the instance of

containment was over working with unconscious processes and infantile states. This coincides with a similar dividing line when looking at the findings about transference. Psychodynamic concepts such as “inner world” and “alpha function” seemed unfamiliar to the humanistic participants who appeared to be more at ease with the idea that transference involves past relationships with key figures such as parents.

Power Dynamics

Although the initial topic of power dynamics emerged when a humanistic practitioner expressed her dislike of the term “patient” which had been used by one of the psychoanalytic practitioners within the service, the division between the modalities over whether the power within the relationship resides with the therapist or client was not clear cut. At either end of the spectrum there were differences between the two approaches as shown in the thematic analysis in Chapter 4. However, the discussions also showed meeting points where practitioners from both modalities would acknowledge the need for some expertise.

Reference to theory: barrier or bridge to communication and understanding

Participants from both modalities recognized that there was a difference between them in the language they used. However, there were differing opinions as to whether this mattered (as referred to on page 120). The analysis of the participants’ usage of theoretical language and reference to theoretical expertise showed a wide divide between the modalities. There were meeting points, but these reconfirmed the view that humanistic thinking has been influenced by psychodynamic and psychoanalytic thinking as the terms mutually referred to were psychodynamic of origin and the two theoretical experts were

from the psychoanalytic school. This may have been one reason why, as previously recounted in Chapter 5, the participants wanted to call a reading group that they decided to take up after the focus groups the “kids’ reading group”.

The therapy relationship

The further analysis of the themes arising from the discussions of the three concepts the therapeutic alliance, transference and containment led me to choose the final theme i.e. the therapists’ view of the therapy relationship. This theme, in my view, highlighted a major distinction between the participants’ modalities in the way they approached their clinical work. In short, the humanistic practitioners would concentrate on working in partnership with their client to empower their client to fulfill their potential. In contrast, psychodynamic practitioners would be focusing on what lies beneath the here and now of the relationship in the consulting room to discern echoes of past relationships and experiences within the client.

The process: how the participants differed

The members of the low-cost scheme participated readily in the focus groups. There was some incomprehension and an occasional rigidly held stance, but mostly the discussions seemed to create curiosity and interest. Many gave clinical examples.

I think the whole exercise demonstrated the importance of small group discussion where an attempt can be made to break down assumptions and stereotypes between the group members. Without any meetings, there is a risk that assumptions and stereotypes can dominate the dynamics of a working group. If meetings only take place in a large group setting, there is a risk that the primitive unconscious processes for survival could impede the capacity to

work together (Collie, 2005). The more that unconscious processes such as splitting can be identified, the less likely it is that they will have a destructive effect.

Strengths and weaknesses of the study: limitations and struggles with methodology

The study took place in the work setting of the participants and had immediate relevance to the organisation. There was one hundred percent participation. It was possible to use a template for myself as the moderator which could be replicated with each group. The use of an independent observer gave another angle on both what was said and how the issues were discussed.

If I personally had not undertaken research, the findings could have been different. Nevertheless, I think that this potential bias has been enhanced by my thorough knowledge and my day-to-day observations of the low-cost service. My training as a Jungian psychotherapist included psychoanalytic theory but not humanistic theory therefore my knowledge of the latter is not as extensive. However, as the study is aiming to explore how much the potential psychodynamic bias within the organisation can be addressed, I consider that this bias has been taken into sufficient consideration. My choice to use focus groups meant that I could opt to take an overtly non-directive role once the questions had been put to the group.

One advantage of using focus group discussions is that the extent of diversity and consensus among the participants can be noted as with my study (Morgan and Krueger, 1993). Morgan writes “This ability to observe the extent and nature of interviewees agreement and disagreement is a unique strength of focus groups” (Morgan, 1996 p. 139). Another advantage is that participants can query each other and explain their point of view. This process was

particularly noticeable in my study when participants from one modality were curious about the other modality's way of working as with Focus Group Extract 3 on pages 93-95. The third advantage was that I was able to observe the times when the thinking of a participant from one modality was influenced by or inclined towards a participant from the other modality, an occurrence which I termed a "meeting point".

The risk of bias in choice of themes when undertaking the thematic analysis could have been lessened if there had been a team of researchers working on the same project. It was therefore essential for me to share my thoughts and decisions following the analysis of the transcripts, coding, choice of candidate themes and the final adoption of themes with academic colleagues throughout the research. This was undertaken with supervisors, within formalized groups at the University and also with a peer group that met regularly. Braun and Clarke have compiled a check list of criteria for a good thematic analysis which I have applied to this study (Braun & Clarke, 2014 p 287).

The focus groups were made up of existing groups within the low-cost scheme. It was possible to compare statements from the different modalities across focus groups and across the hierarchal structure of the service. One drawback was that by using the existing groups, the mix of psychodynamic and humanistic practitioners turned out to be different in each group. Where there was a good mix of the two modalities, the discussions in my view showed up the similarities, differences and meeting points more clearly.

The choice of participants was based solely on who worked within the low-cost scheme. Therefore, the sample cannot be seen as a representative sample of the population of therapists and counsellors. The strengths of undertaking a qualitative methodology has made it possible to examine the interface between

the modalities in a detailed way. The close-up picture of the service offers other services the opportunity to see how recognizable dilemmas have been managed. Hence the findings from both the thematic analysis of the focus group discussions and the reflective observations of the service are transferable and relevant both to other voluntary organizations and to IAPT teams within the NHS.

Tussles with Methodology

My original choice of method, which I outlined in the research proposal in 2014, was discourse analysis and this was the method that I informed the trustees that I would be using. (Appendix 2). This was as a result of my concern, as stated in Chapter 1, that psychoanalysis has set itself up as the master discourse with the implication that other modalities are of lesser importance to the therapy community. I spent some time assessing the different approaches to this method and decided that it was inappropriate in view of my critical realist stance. If I had continued with a discourse analysis, I would have concentrated on how the ideas in the group discussions had been socially constructed and influenced by power relationships within the organisation and the therapy community as a whole. The ideas and opinions of the participants would then have been thought about in social constructionist terms. Their ideas would be seen to have been formed by the social context of the therapy community at large and shaped by the language of what Lacan termed the “University of discourse”. Lacan used this term when he referred to the followers of Freud as adhering to a body of knowledge that was being held up as indisputable (Lacan,1957/88 p 103).

At the start of the research, I included a Q-sort analysis for each participant in order to provide a second take on the differences between the modalities.

Thus, the members of the organisation were also asked to participate in a Q-sort exercise as championed by Roth to demonstrate therapists' competences (Roth, 2015). Please also see my information sheet for prospective participants in Appendix 4. At a later date, I concluded, after discussions with supervisors and colleagues, that the two methods Discourse Analysis and Q-sort were unlikely to be compatible, so, having asked for the practitioners' involvement, I completed the initial Q-sort gathering of data and plan to complete the analysis at a later date and as a separate study.

The exclusion of this part of the study was partly because the use of Q-sort is an essentially quantitative rather than qualitative method. However, I also found that the amount of data that was already available from the transcripts was more than sufficient to provide a rich thematic analysis and therefore, thematic analysis became my final choice of method.

In retrospect, I can see that the struggle with the choice of methodology was in part as a result of being a novice researcher. However, being a novice or a beginner in any setting has its strengths and weaknesses. Like some of my participants who are still in counselling or psychotherapy training, I have had considerable input from University staff and colleagues to help me learn and focus intensively on my research project. This early capacity for self-scrutiny can fade with experience which might then make choices of the methodology easier but also, like clinical work, make the researcher complacent about one's choice of method.

Impact on the low-cost service

Fordham, the developmental Jungian analyst who founded the Society of Analytical Psychology, conceptualized the psychological development of an infant as a process of de-integration and re-integration. Thus, the infant in a

state of change might appear to fall apart or disintegrate in order to take on new experience, but in Fordham's conception of infantile development a more constructive process of de-integration could be occurring.

> In comparing the self in childhood with the self in individuation we are also comparing the process of integration with another one for which I propose the term deintegration. This term is used for the *spontaneous* division of the self into parts – a manifest necessity if consciousness is ever to arise (Fordham, 1957 p 117).

Armstrong too, as I referred to in Chapter 5, suggests that containment can result in the facilitation and development of creativity and growth within an institution (Armstrong, 2005). In this vein, the impact on the group as a whole brought about change which was both positive and comfortable, but also disruptive and uncomfortable in the short term.

As I have previously described in Chapter 5, the research project had some immediate impact on the service at the time of the study. As a direct result of the focus groups, some of the participants who enjoyed the opportunity of discussing theory together set up their own academic reading group. It is also my view that the process of taking on the research both freed up me and the previous administrator to step back from our commitment to the service. The administrator left to take on a full-time post in the County Council in February 2015 and in July 2015 I began to hand over the role as Clinical Director which has finally been taken on by someone else in April 2016. These departures produced a period of uncertainty and discomfort along with fears of abandonment by trust practitioners. However, this has made way for a period of de-integration in Fordham's terms and has given the service the opportunity to change and develop.

Conclusions

- The teaching of a psychodynamic approach to the humanistic practitioners is not the solution in the low-cost service
- The application of psychodynamic ideas and understanding to individual practitioners of all modalities and the organization as a whole can be helpful.

The adoption of a psychodynamic approach

The underlying rational for the research was to address the dilemma of how much to expect practitioners from different modalities to take on psychodynamic ways of working. My overall conclusion from the findings is that it is not helpful to impose a psychodynamic approach on practitioners who are unfamiliar with this way of working and the theories of the mind and infant development which lie behind this approach. This conclusion has also been informed by the work of Roth and Fonagy who summarized outcome research in psychotherapy and found that the competence of the therapist is seen as a key factor in a successful outcome (Roth & Fonagy, 2005). Therefore, if a practitioner can only take on a way of working in a piecemeal way, they are unlikely to be confident or competent with the method.

The recognition of the possible danger of encouraging a practitioner to take on another way of working as opposed to being aware of differing ways of approaching the work, has implications both for the role of mentors and also for the selection of supervisors. So much of any training occurs from the experience of one's own analysis or therapy that the imposition of one way of working onto another in supervision seems impossible. For example, trying to communicate the depth of a regressed infantile transference to someone who

has been in therapy for forty sessions on a once a week basis rather than seven years of three or four times a week seems unfathomable.

The application of psychodynamic ideas

Many of the humanistic practitioners in the study knew about psychodynamic concepts but did not necessarily apply them to their work. In addition, the humanistic approaches to the power dynamics in the therapy relationship and self-disclosure meant that a psychodynamic approach would clash with theirs. However, a conclusion still is that offering a psychodynamic way of thinking could be enlightening both to an individual practitioner and in running the service. This was particularly so for the concept of containment where the reminder to reflect before acting can be such a helpful mantra.

Recommendations for the low-cost service

The recommendations for this low-cost service are the need to:

- Offer mentors the training and further opportunities to discuss the difficulties of running peer clinical discussion groups with practitioners from differing theoretical orientations.
- Recommend and match supervisors to practitioners by theoretical orientation where possible and/or to select supervisors who are sufficiently aware of the practitioner's orientation and flexible enough to value another's modality sufficiently.
- Organise training events for practitioners that match more accurately with their needs and interests.
- Continue to look out for the unconscious dynamics in operation within the organisation.

Conclusions for the wider therapy community

- The thinking about the three concepts therapeutic alliance, transference and containment is not static and warrants review.
- If an integrated approach is chosen, it is better adopted later in a practitioner's career.
- Theoretical language can be an obstacle to communication and understanding between the practitioners of different modalities.
- Discussions within groups of mixed modality provide valuable learning experiences.

The thinking about the three concepts warrants review

The discussion of each concept produced ideas and questions that are relevant to contemporary thinking in the psychoanalytic world and the therapy community at large in the following ways.

Therapeutic Alliance

The place of the therapeutic alliance was essential to the humanistic modality and not to the psychodynamic group. The second question raised about the therapeutic alliance was how much it describes the initial contract and how much it encompasses the therapeutic relationship as a whole. My conclusion is therefore that further debates in psychoanalytic settings and with mixed modalities about the therapeutic alliance could be stimulating and productive.

Transference

The discussions around the subject of transference raised questions which again I think are relevant to the psychoanalytic world and other modalities. I think the findings mirror debates outside this low-cost scheme over whether it is always essential to work with the transference. This difference was also noted between psychoanalysts' approaches in the international study of

psychoanalysts. In the same study, there was a similar debate too over whether therapists can offer their patient the opportunity to have a new and healing experience within their relationship or not (Tuckett, 2008).

Containment

The discussions around containment brought up aspects of the concept which again would benefit from a debate in a larger forum.

- What are the differences between Winnicott's concept of holding and Bion's concept of container/contained?
- Can the term containment have a broader meaning than Bion described?
- The observation of the unconscious processes in this kind of service with particular reference to containment can reduce destructive dynamics.

An integrated approach is better adopted later in a practitioner's career

Some of the studies that I have reviewed in Chapter 2 have focused on psychotherapists' choices of theoretical orientations in order to inform and improve training courses for psychology students (Levy et al, 2013), (Boswell et al, 2009), (Jaimes et al 2015). The findings from the studies varied but, in general, the trend was a move away from the choice of a psychodynamic approach to a cognitive behavioural one. In Boswell's study, he found that after students chose their primary orientation their second choice was integrative. He noted that trainees were being exposed to integration early on in their training and suggested that there needed to be a further investigation of the similarities and differences between seasoned integrative therapists and these trainees (Boswell et al, 2009 p. 309-10).

The present study highlights a number of issues about the value of an integrative approach. As mentioned in Chapter 7, some of the participants had trained or were in training with two local training institutions who offer integrative

approaches within a humanistic framework. These courses appeared to differ and one course seemed to offer a more coherent presentation of the integration of different approaches.

One trainee in my study did not contribute throughout the focus group that she was in and seemed to have been overwhelmed by the number of possible approaches open to her. Although there were many other possible factors contributing to her sense of being overwhelmed, I would advocate that it is preferable at this early stage of training to limit the number of approaches taught. At a later stage of training or when a particular training body requires greater complexity, then, as Levine writes “heterogeneity, contradiction, uncertainty, and complexity are inevitable” (Levine, 2012 p 25).

This study demonstrates how unhelpful it is to impose one approach onto another. Integrative trainings can be criticized for being too diverse and even shallow. To the other extreme, the preciousness of “schoolism” where alternative approaches seem threatening, can result in another form of rigidity and the concrete application of theory. Therapy and counselling training makes demands on the trainee to be able to critique the methods and approaches on offer. This critique needs to include an awareness of the different theories of mind underpinning certain approaches such as the study referred to in Chapter 4 undertaken by Parry, who compared Bion’s concept of containment with Winnicott’s concept of holding (Parry, 2011). Paradoxically, the trainee therapist or counsellor needs to begin clinical work believing that there are answers and later in their career gain enough confidence to tolerate a lack of certainty.

Theoretical language can be an obstacle to communication and understanding between practitioners from different modalities

Some participants in this study thought that the differences were only about language and that fundamentally therapists and counsellors operate in the same way. I do not think the findings reinforced this view. As previously mentioned in Chapter 4, Messer in his critique of articles aiming for a common language argued that the different terms arose from different ideologies and thereby compatibility would be impossible (Messer, 1987). These ideologies themselves have been inspired by different clinical experiences and different people with differing personal histories.

Discussions in groups of mixed modality can provide a valuable learning experience

The opportunity to discuss clinical work with people who have different approaches has the potential to both challenge and enrich clinical practice. These discussions can break down stereotypical views and assumptions about each other's ways of working. In this instance, the opportunity to observe the discussions closely, exposed the differences present which were sometimes contrary to my expectations, for example their views about the therapeutic alliance. Thus, first we need to be sure what the differences are before applying any measures to encompass them. I think that this method of using small group discussions to examine similarity and difference also has a wider implication for other areas of society such as politics, religion, culture and gender.

Kassan, who is an advocate for the importance of peer supervision groups particularly to obviate isolation for people working as private therapists, has surveyed a number of therapists to ascertain their views. He records two participants' differing views, one expressing the wish for more diversity and the

other wanting less diversity. In my view, these statements sum up the two extremes of too much diversity and the dangers of “schoolism” which are integral to my argument.

> I wish there were a more consistent group of people. It’s a wide spectrum of therapeutic orientations represented, and it makes them more confusion than for stimulating points of view.
>
> I sometimes worry that we all know each other so well now that were missing something. Also we all come from a similar theoretical orientation, and for out of five were trained at the same Institute. I sometimes worry that we’re missing someone with a very different point of view (Kassan, 2010 p.136).

Recommendations

In Appendix 15, I outline some actions for the dissemination of the findings and conclusions for this research both at a local level to the low-cost scheme and at a national or international level, via potential publications and conference papers.

The recommendations that I would make on a local level over the management of the differences between the modalities in the low-cost service are

- Training for mentors in facilitating groups of practitioners of mixed modalities.
- Matching of supervisors either from a similar theoretical orientation as the supervisee or with enough flexibility to value their approach.
- Choices for training events which better match the practitioners’ needs and interests, for example on managing endings in therapy.

In the wider forum, I would recommend

- A reappraisal of the three concepts and their relevance to contemporary clinical practice.
- Training counsellors or therapists might more confidently integrate methods and modalities later in their career. This suggestion has implications for trainings particularly where the synthesis of approaches in the planning produces less of a coherent approach.
- Regular meetings of small mixed modality discussion groups within organisations and across different institutions.
- The inclusion of the observation of unconscious processes within an organisation ideally by an independent observer.

Future research

- There is a need to identify all the small voluntary services that exist around UK, to find out their aims and to promote similar studies within their set ups.
- UK participation in the research on a larger scale in line with the work undertaken by Orlinsky and colleagues internationally on psychotherapists' and counsellors' views on what factors have positively and negatively contributed to their professional development (Orlinsky, 2005).

Appendix 1 Search details

Records of Systematic Searches on Ovid

Database: PsycINFO <1806 to February Week 1 2016>
Search Strategy:
---
1 exp Psychodynamic Psychotherapy/ (2734)
2 psychodynamic counselling.ti,ab. (58)
3 humanistic counselling.ti,ab. (13)
4 exp Humanistic Psychotherapy/ (2972)
5 humanistic psychoanalysis.ti,ab. (17)
6 psychodynamic psychoanalysis.ti,ab. (6)
7 psychodynamic psychotherap*.ti,ab. (2098)
8 humanistic psychotherap*.ti,ab. (167)
9 (humanistic adj3 psychotherap*).ti,ab. (279)
10 (psychodynamic adj3 psychotherap*).ti,ab. (2622)
11 1 or 2 or 6 or 7 or 10 (4035)
12 3 or 4 or 5 or 8 or 9 (3146)
13 11 and 12 (52)

Database: PsycINFO <1806 to February Week 1 2016>
Search Strategy:
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1 psychodynamic psychotherap*.ti,ab. (2098)
2 psychodynamic counselling.ti,ab. (58)
3 psychodynamic psychoanalysis.ti,ab. (6)
4 exp Psychodynamic Psychotherapy/ (2734)
5 humanistic psychotherap*.ti,ab. (167)
6 humanistic counselling.ti,ab. (13)
7 humanistic psychoanalysis.ti,ab. (17)
8 exp Humanistic Psychotherapy/ (2972)
9 humanistic.ti,ab. (6049)
10 psychodynamic.ti,ab. (15073)
11 psychodynamic therapy.ti,ab. (938)
12 humanistic therapy.ti,ab. (59)
13 (psychodynamic adj5 psychotherap*).ti,ab. (2865)
14 (humanistic adj5 psychotherap*).ti,ab. (371)
15 1 or 2 or 3 or 4 or 10 or 11 or 13 (15683)
16 5 or 6 or 7 or 8 or 9 or 12 or 14 (8685)
17 15 and 16 (431)
18 17 and 2006:2016.(sa_year). (190)

Database: PsycINFO <1806 to March Week 1 2016>
Search Strategy:
1 exp Psychotherapists/ (16309)
2 exp Group Discussion/ (3503)
3 1 and 2 (15)

Database: PsycINFO <1806 to March Week 1 2016>

Search Strategy:

1	"psychotherap* attitudes".m_titl.	17
2	exp Integrative Psychotherapy/ or exp Theoretical Orientation/	6654
3	exp Psychotherapist Attitudes/	1198
4	2 and 3	77

Appendix 2

Application to Trustees for their agreement to undertake research

A study of an Interface between psychoanalytic and other orientations of therapy in a low-cost scheme.

The Aim

This is a low-cost scheme which offers counselling and psychotherapy on a once a week basis for up to two years. Although the management team is psychoanalytic by training and bias, many of the practitioners who work for the scheme come from different theoretical trainings. The research plan is to find out the practitioners' views of the importance of three psychoanalytic tenets, namely the therapeutic alliance, transference and containment and their relevance to their practice.

Background

D is a voluntary organisation which was set up in the west country by a small group of like-minded counsellors and psychotherapists. It was registered as a charity in June 2005 and clients began to be seen in November that year. At that time many counsellors working within Primary Care were only able to offer a short term intervention. They considered that a number of people needed much longer-term help owing to the seriousness of their problems and the need for an unhurried approach. The stated mission of the Trust is to offer up to two years of therapy or counselling on a once a week basis to those people living within travelling distance of D who cannot afford a private fee.

The ethos of the Trust is psychoanalytic and all the mentors have a psychoanalytic bias. However, the practitioners come from a variety of theoretical backgrounds. When practitioners apply to D, they fill in an application form on which they are asked for their theoretical approach and to write about this approach in more detail. The kinds of approaches that have been recorded by our present practitioners are psychodynamic, psychoanalytic, humanistic, integrative, person-centred and psychosynthesis. The terms humanistic, integrative and person-centred overlap and can be a description of one practitioner's approach.

Rationale

Psychoanalytic therapists are now working in an era where psychoanalytic trainings receive far fewer enquiries and national schemes such as IAPT, the UK government scheme Improving Access to Psychological Therapies, promote methodologies other than psychoanalytic or psychodynamic because they are considered to be both more cost effective and verified by outcome research. In an organisation where the members of the management team are predominantly psychoanalytic but many of the practitioners have different trainings, what currently happens is a psychoanalytic influence from the top down with mentor input and training days. The option proposed is to study from the ground force up the nature of an interface between the theoretical approaches.

Methodology

Focus Groups

In order to get a picture of how the practitioners respond to certain psychoanalytic concepts, the major project is a qualitative study drawing from discussions in focus groups. Focus groups were first introduced in the 1940s when sociologists studied audience reactions to radio programmes. (Merton & Kendall, 1946). They have only relatively recently been adopted by psychologists for example Wilkinson's use of focus groups in health research. (Wilkinson, 1998).

The employment of a research assistant is planned. She will be present in the focus groups, will not participate in the discussions but will feedback her observations after each group. Her independent observations will contribute towards an attempt to achieve internal reliability.

Q-Sort questionnaire

As the researcher is also the clinical director, there is a need to minimise the possible bias. Therefore, a brief questionnaire based on the Q-Sort will be sent to each member of the Trust. (Roth, 2014 in press). Each recipient will be given a code rather than named. Their views will be compared with the opinions expressed in the focus groups by someone other than the director.

Field Log and reflexive supervision

The researcher will keep a field log of discussions that arise on a day to day basis which are pertinent to the study of the three psychoanalytic tenets. In addition, she will use her supervisor and learning set for reflexive supervision.

The procedure

A pilot group with colleagues outside the organisation will be set up first. The plan is to approach either D2 or a voluntary organisation similar to D such as S Counselling Centre, or a group formed of the current practitioners' supervisors. Within D, those participants invited will be members of existing groups: - the group of five trustees; the five members of the management team; and the members of four mentor groups without their mentors.

Each mentor group has been given a name using the initials of its leader and mentor. Mentor group M has one man and four women, mentor group G has one man and five women, mentor group E has one man and four women and mentor group J has one man and three women. At present the total number of participants from D are therefore 30 people.

Some changes of membership may occur before the research commences as periodically trust practitioners leave and new ones are taken on. It will be made clear in the written invitation that practitioners are not obliged to attend but it is hoped that they will be motivated to be involved. See the invitation letter below. If there is a problem with attendance, the group may be re-scheduled or past practitioners could be invited to form a group. There are 15 practitioners who have finished working at D.

Data Analysis

It is envisaged that the researcher will use Critical Discourse Analysis or CDA, which is a branch of Discourse Analysis, as a tool for analysing the material that arises from the focus groups. Each focus group will be asked to talk about the three psychoanalytic concepts of the therapeutic alliance, transference and containment. The findings will be initially coded and all the sentences including reference to these concepts will be extracted.

DA generally focuses on how ideas surface in a social setting and how language and the employment of particular terms can shape society's views. Potter, a key exponent of discourse analysis, writes "DA emphasizes the way versions of the world, of society, events and inner psychological worlds are produced in discourse". (Potter, 1997 p 146). DA draws from philosophers' thinking and in particular Michel Foucault whom Bryman attributes with the contribution that DA "was a term that denoted the way in which a particular set of linguistic categories relating to an object and the ways of depicting it, frame the way we comprehend the object" (Bryman, 2012 p 528). A second layer of analysis will then be made paying attention to how the group's ideas have surfaced in this social context.

Ethical Considerations

D is a voluntary organisation and a registered charity and so permission to proceed needs to be sought from the Trustees and the Exeter University Ethics Committee.

Service users or clients are not asked to participate in the study and therefore their consent is not necessary. Participants in the focus groups may refer to client work and they will be expected to maintain the usual rules of confidentiality by anonymising any reference to a person and withholding any recognisable details.

The practitioners are not employed by D but they have an unwritten contract as volunteers and written contracts where they have student placements. It is very unlikely that any concerns about a practitioner's clinical work would come to the moderator's notice via the focus groups which had not already been noticed in their mentor group. If this did happen, the normal procedure would apply i.e. the concern would be raised with the practitioner and, with his or her knowledge, the mentor would be informed to monitor future progress.

All tapes and transcripts will be coded and stored away from the D premises in a secure place. Any transcriber will be asked to sign a confidentiality agreement. All participants will be informed that a written thesis is expected and that their comments may be referred to anonymously in that report. If any of their comments are to be included in any publicised document their written permission will be sought beforehand.

Conclusions and dissemination plan

The study should enrich the work of the D and increase the practitioners' motivation and confidence. The findings are likely to indicate what further training would be necessary or helpful.

There is a gap in services between the primary care intervention via IAPT and the secondary mental health services for the more seriously depressed, mentally ill, or for those diagnosed with personality disorders. D has a role to play between primary and secondary mental health care. Planned evaluations and evidence from this study should improve this voluntary organisation's reputation locally.

Some other voluntary counselling and therapy organisations such as the W Counselling Centre provide their own psychodynamic training, but this study is likely to be relevant to other organisations who employ practitioners with a variety of approaches.

In a time when psychoanalytic practitioners are needing to re-appraise the relevance and applicability of their theory and practice, this research aims to make a contribution to the debate. The findings should inform where psychoanalytical tenets retain relevance and importance, and where other approaches overlap and differ. The publication of aspects of the analysis should be relevant to a cross section of psychotherapy and counselling journals. Finally, presentations at voluntary, statutory and training institutes would all be appropriate.

References

Bryman, A. (2012). Social research methods. Oxford University Press.

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Roth, A. (2014). Are competence frameworks fit for practice? Examining the validity of competence frameworks for CBT, psychodynamic and humanistic therapies. *Psychotherapy Research.*

Wilkinson, S. (1998). Focus groups in health research: exploring the meanings of health and illness. Journal of Health Psychology 3, 329-348

Invitation letter

Dear

D is a thriving organization and a large part of its richness is due to the number of practitioners from different trainings. As you may know there is a psychoanalytic bias in the management team's approach. I am undertaking research at Exeter University and would like to approach you as a valuable member of the team to hear your views about certain psychoanalytic concepts.

You are invited to meet with me in your existing mentor group on Monday…… at….. to discuss the three concepts: therapeutic alliance; transference and containment. The purpose of the discussion is to learn your views of the relevance and importance of these ideas and is not a means of assessing anyone's capabilities. Your mentor will have a chance to discuss these concepts separately in a management team and will not be present at our meeting. It will last approximately 1 ½ hours.

I need to tape the group discussion as I would not be able to rely on memory or note-taking. The content of the discussion will remain confidential and I will not use any quotations in further reports without the speaker's permission. Any references to client material will be within the confidentiality restrictions that you already apply in mentor groups. I would be very grateful if you would attend and participate in the discussion but you are not obliged to do so. Please let me know by returning the attached slip.

Best wishes

Mary Lister

Appendix 3
Letter of invitation

Dear

DTCP is a thriving organisation and a large part of its richness is due to the number of practitioners from different trainings. As you may know there is a psychoanalytic bias in the management team's approach. I am undertaking research at Exeter University and would like to approach you as a valuable member of the team to hear your views about certain psychoanalytic concepts.

You are invited to meet with me in your existing mentor group on …… at….. to discuss the three concepts: therapeutic alliance; transference and containment. The purpose of the discussion is to learn your views of the relevance and importance of these ideas and is not a means of assessing anyone's capabilities. Your mentor will have a chance to discuss these concepts separately in a management team and will not be present at our meeting. It will last approximately 1 ½ hours.

I will tape the group rather than write notes. My colleague, S. W, will be there to assist me and to give an additional account of the discussion. The contents will remain confidential and I will not use any quotations in further reports without the speaker's permission. Any references to client material will be within the confidentiality restrictions that you already apply in mentor groups. I would be very grateful if you would attend and participate in the discussion but you are not obliged to do so. Please let me know by returning the attached slip.

Best wishes

Mary Lister

Clinical Director

Appendix 4

Information sheet for clinical research project

Title

A study of an interface between psychoanalytic and other orientations of therapy in a low cost scheme**.**

Context of research

I am undertaking a clinical doctorate at Exeter University and this research proposal has been approved both by DTCP trustees and the university's ethics committee.

The Aim

As you know, the Dorchester Trust for Counselling and Psychotherapy is a low cost scheme which offers counselling and psychotherapy on a once a week basis for up to two years. Although the management team is predominantly psychoanalytic by training and orientation, many of the practitioners who work for the scheme come from different theoretical trainings. The research plan is to find out the DTCP practitioners' views of the importance of three psychoanalytic tenets, namely the therapeutic alliance, transference and containment and the relevance of these tenets to their practice.

Rationale

In an organisation where the hierarchy is predominantly psychoanalytic and many of the practitioners have had different trainings, what currently tends to happen is a psychoanalytic influence from the top down with mentor input and training days. The option proposed is to study from the ground force up the nature of this interface between the theoretical approaches at DTCP. The DTCP's personnel's experience, views and attitudes towards certain tenets of psychoanalytic theory will be recorded in focus groups.

Procedure

The intention is to hold these focus groups with the groups that already exist within DTCP i.e. the trustees, the management team and the mentor groups. It

is proposed to tape the discussion and my colleague, S. W, will be present to assist me and to give an additional account of the discussion. The contents will be anonymised and stored in a secure place away from DTCP's premises. Any references to client material should be anonymised in the usual way that clinical discussions occur within the DTCP.

There are no hidden agendas and no right or wrong answers. In order to allow for the possible bias caused by the Clinical Director being the researcher and moderator of the focus groups, each practitioner will also be asked to complete anonymously a Q-sort questionnaire. This will involve one meeting with our administrator, D T, to complete the questionnaire on a one to one basis. The Q-sort is a tool that has been adapted by Professor Roth, (Roth, 2014), at University College London to rate therapists' preferences for the various competences for the different therapy modalities.

Mary Lister 12.7.2014

Reference

Roth, A.D. (2014). Are competence frameworks fit for practice? Examining the validity of competence frameworks for CBT, psychodynamic and humanistic therapies. Psychotherapy Research 16 April pp1-13

Appendix 5

Moderator's prompt sheet

Welcome and introduction

As I said in my letter I am undertaking research at Exeter University and hope you feel free to have an open discussion about the topics I mentioned. You will be invited to a second stage individually to choose those competences that you consider central to your clinical practice where relevant.

My friend and colleague, Steve Walker, is present but not actively participate other than to introduce herself at the beginning as she is keep notes in order to retain a good account of what was discussed.

I am not looking for any right answers but maybe differing points of view. I am interested in what you all have to say. We will be on first name basis if that's ok.

Please try not to talk when someone else is talking as it would make it difficult to hear what people say.

The tape will be transcribed and anonymity preserved at all times.

Practical details

I envisage that we will meet for a maximum of 1 ½ hours. Please make yourself comfortable with refreshments and a trip to the toilet before we start. Please turn off your mobile phone if you do not mind.

Before we start on the main subject I thought it might be helpful if each trustee had a chance to say how long you have been a trustee and a little about your background.

The therapeutic alliance, transference and containment are the three topics I have chosen to ask you to discuss.

There are two questions for each topic and I envisage spending about 10 minutes on each question.

Does the term therapeutic alliance (transference / containment) have meaning for you? Does it make sense to you?

Do you use it in practice? Please include anonymised clinical examples if you like.

Appendix 6

Guidelines for the Assistant Moderator

1. Please arrive before start time to help set up the room and chat to people arriving.
2. I will start the recording but please keep an eye that both red lights are on.
3. The AM sits a little outside the circle, nearest the door. You might need to welcome late-comers but please do not participate in the group unless invited by the moderator.
4. I will start with a warm up question.
5. Your major role is to observe the discussion and to write as copious notes as possible. One tutor thinks that your observations are more important so not to worry so much re the details of what people say.
6. It can be helpful to note who says what with a name and the first couple words of the sentence. There will be names placed in front of each participant.
7. Please note body language, signs of agreement, frustration and concern etc.
8. Some people recommend a kind of structure on the page where different categories are put in separate parts of the page e.g. quotations, themes, impressions. You may have a system that works for you.
9. When the group is finished we will turn the recorder off. If it has failed we have a longer debrief!
10. We meet without the group afterwards to discuss impressions etc. We can record this also.
11. Please write up your notes. I will transcribe the recording in due course and then will be the first to comment on it for accuracy etc.
12. You will then be the first to review the transcript and to suggest additions, further observations etc.

July 2014

Appendix 7

Trial of category choice using N-Vivo based on process and content

Process - Agreement or disagreement
Partial agreement
Full agreement
Blunt disagreement
Covert disagreement
Implied disagreement
Polite disagreement

Positioning - Development of ideas
New idea
Next speaker stays on own agenda
Idea is questioned
Silence and no development
Idea is taken forward

Psychological themes
Reflections about the process
Humour
Expressed emotion
Defensive

Themes in content
Mentor group
Language
Overlap
Supervision
Training
Therapeutic alliance
Transference
Containment
Unclear statement

Therapeutic alliance
Therapeutic alliance or therapeutic relationship
Negative transference and therapeutic alliance
Context

Transference
Child
Personal disclosure
Countertransference
Transference is everywhere

Containment
Reference to baby
Frame
Holding
Bion

Appendix 8

Table 4 – Therapeutic Alliance

Theme	Psychodynamic	Meeting point	Humanistic
Comfort/ Discomfort	**DT4** Um and 'I'm not sure if I'm going to get on with you', and I think that's, that's really good, 'cause if you don't feel comfortable actually if there's a discomfort around and I can work with it you know and so I'm not convinced about anyway that you need to feel comfortable. And the other aspect of it is that, um, there is there is some value in heightened anxiety and you know, it sort of brings more to the surface.	→ → → → → → **DT2** But I just it reminded me of the comfort thing, of when I first sort of did my training, and obviously you have to go into psychoanalysis yourself and you're given the name of one or two people you know to go and see, and I went to see one person who was a very, very, Kleinian analyst, and shown into her consulting room and she made a gesture, you know, so there were several chairs in there, and I sat in a particular chair because I had pulled a muscle in my back, and she immediately made some kind of.eh interpretation- **DT3** Right. **DT2** - about why I had sat in this upright chair, you know, was this to do with control, and I thought and I.... [out-breath] sort of thought about it a bit and I said well actually no, I pulled muscle in my back and this is actually the most	**DT3** you are offering that information to the client so they can make an informed decision, you know, actually informing them that actually the process works better if you feel really comfortable with the therapist that you're working with and it's important that they're allowed to .....feel that and decide that for themselves and that actually if this isn't feeling good for you then what other options are available **DG4** Yes, yes it does. I think it's very important. I think it's fundamental to my work. Um, when starting with a new client it's really important for me to build a rapport to build trust to build the relationship because I don't think anyone is going to be, um, opening up to me unless you know they feel they can trust me and they feel they can feel

Theme	Psychodynamic	Meeting point	Humanistic
		comfortable chair for me to sit in. But then when I found the analyst that I eventually worked with, um, after the first session with her I came away with the impression that she was wearing slippers, and I thought, oh I like that! [laughs] You see what I mean? **PSY**	comfortable talking about really difficult issues. So for me it's vital. It's the most important thing. **DM1** And secondly, I think it's how relaxed the work is and how… I hesitate to use the word 'comfortable', because comfortable can be misconstrued, but there is real warmth, I think, there between us.
Positive transference	**DCM1** I think it is very hard, isn't it, um, sometimes to differentiate I suppose between what is um transference or positive transference or negative transference, and what is therapeutic alliance or treatment alliance, or I think it is sometimes referred to as sort of the real relationship .... um that goes on. **DM5** Yes. I suppose I'd think of slightly in terms of a positive transference that you use to do the work with. So yes, I'd bring the word transference into the…		**DCM3** Well I'll pitch in first and say the way it is meaningful to me is that when it isn't there it feels as if it matters but… **DE3** I think establishing that therapeutic alliance is, if I'm understanding it correctly, is essential, but it can take varying… client-to-client, it just takes a bit more time depending on who you are seeing and establishing it with. That is an underpinning essential component, isn't it? **DM3** It describes, for me, how the underlying bedrock

Theme	Psychodynamic	Meeting point	Humanistic
			of my work with the client is based on a good therapeutic alliance.
Negative transference	**DE2** And you can have negative transference in just the same way. But if you are securely held enough and the frame is solid enough then the person trusts enough. **DT4** I personally wouldn't say that. I mean the one thing I would like to pick up on then you see is, that I think, let's just take the gender issue. I think there are some really good examples where someone comes to see me as a man and says 'I have come to see you because I don't think I get on with men very well'.		**DE4** Yes, I suppose my response to that would be being allied doesn't mean necessarily that you are involved. But, for me, you are setting out some kind of relationship which says you are allies but that there is space for those allies to tussle, argue, feel angry, whatever, but there's room for everything within that alliance.
Contract and boundaries		**DCM2** I think I agree with **DCM4**'s description but also think it is perhaps is to do with the contract as well, which creates a safe containing environment for hopefully that to happen. so um, so I think I include, when I think about therapeutic alliance um a commitment in quite a concrete	**DG2** The alliance is something that is not just – it's formed and then it needs to be maintained...sometimes some people call it a contract, I call it a client agreement, which I write and I give them a copy in the first session and ask them to read through that then we – you know it's

Theme	Psychodynamic	Meeting point	Humanistic
		way in terms of, maybe you meant this as well actually, but in terms of time and boundaries, all of those – the more practical things but perhaps that just goes without saying. **PSY**	something that you can – where you also agree, I don't know, the holidays, about payment, holidays or not, or what is – and it's something you can always refer back to isn't it? It's something that you've agreed and therefore – **DJ2** Well, the alliance for me, the key to it is the relationship. It starts off with clear boundaries and contracting, involving the client in how they see the process, what previous experiences they've had and how their wishes are taken into account. So they are involved right at the start. They would be re-contracting after six or so sessions. So it's a continuous process of judging how the thing is going, getting the feedback from the client and making sure that they feel that things are focused on what they particularly want, part of it.
Context of the work		→ → → → → **DCM1** I was thinking about the	**DE3** I think establishing that therapeutic alliance

Theme	Psychodynamic	Meeting point	Humanistic
		difference I might think about it here and I might think about it in NHS work, but I think in brief work perhaps where...you know where there tends to be err perhaps more of an agenda in terms of agreed aims and things you are working towards, which I think establishes the idea of the treatment alliance and working towards achieving the stated aims and objectives in the process, perhaps a bit differently than doing longer term open ended type of work...I think it's something about perhaps in brief or NHS work ...needing to be more active I suppose um in the way that I might work. Trying to as you say I would take perhaps some responsibility of it more responsibility ...the way for ...that engagement rather than sort of maybe thinking about it in terms of somebody's defences or resistance or ambivalence or whatever, um **PSY**	is, if I'm understanding it correctly, is essential, but it can take varying… client-to-client, it just takes a bit more time depending on who you are seeing and establishing it with. That is an underpinning essential component, isn't it?

Theme	Psychodynamic	Meeting point	Humanistic
Alliance with Organisation	DCM2 Potential for splitting really	← ← ← ← ← ← **DCM3** Yeah....so I was just thinking how much there's an issue of people having a sort of alliance with the organisation either as well as or...yeah...as well as with the individual counsellor, 'cause you know when people say I want to change the counsellor but stay within the system, that's quite a confusing thing as to whether that's about ..having a,.saying I'm still committed to the idea (DCM1 um) but I just don't like them. But perhaps that counts as therapeutic alliance, I don't know. Do you see what I mean? Attached. **HUM** **DCM4** Well it sounds as if they haven't made a therapeutic alliance with the person they don't want to see. **PSY**	
"Working alliance" or relationship	**DG5** I think the word 'working' is quite important. You have to work at it. The client works at it, you	**DG2** I think it might mean slightly different things, because we're talking about psychodynamic	**DG3** See when I see that and sort of as part of – ok – that's sort of a part of the alliance in a way but, the

Theme	Psychodynamic	Meeting point	Humanistic
	facilitate the client but they do a lot of the work themselves to empower themselves, take responsibility for themselves, so I think that's quite important. **DE2** are we talking about an analytic pact, or are we talking about a relationship, a more, sort of, human relationship, which comes later with Balint and all of those people? Because Freud talked about an analytic pact, oh, way back, 1920. For him it was about money, the room, attendance, how long does it last. So simply the essence of what we would call, I would call, the frame –	concepts, but I'm not convinced... I think we use you know therapeutic alliance no matter what the orientation…. I think you can come from a humanistic perspective and you will still build therapeutic alliances. So I don't think it necessarily has to be limited to working in a psychodynamic way **HUM** **DE2** So you have an alliance at the level of your interaction with the client and then it moves with the client as the client gets further into the work. Does anyone find that? **PSY**	alliance seems to be much more the relationship, it doesn't... **DG1** It's quite muddied isn't it? ……, I think that there's two different things, the working alliance and the contact. That's what it feels like to me. Quite different. **DJ1** then once you've got that then the process is effective. But I'm not… I suppose I'm just not likely to be convinced that without a therapeutic relationship you can get to the kind of stuff, generally speaking, that people come to see us for. The role play you have just described, to me, there's got to be some level of therapeutic alliance. **DE4** Yes, I think, certainly. But then, to me, that sounds like the whole… that feels like the whole thing rather than just the therapeutic alliance, which seems to be, kind of, talked of as something

Theme	Psychodynamic	Meeting point	Humanistic
			separate. But I completely agree with you. And I think you also… You touched on something that I think about it. I think the therapeutic alliance, especially initially, is also to do with the frame, at least at the beginning. So the second part of that – do I use it? Then yes, I do. I certainly use the setting of the frame as thoughtfully thinking that that's a way into a therapeutic alliance.

Appendix 9

Table 5 - Transference

Theme	Psychodynamic	Meeting points	Humanistic
Past to present - Actual people	**DT4** Whereas it should mean in the strict sense in which it was originally used, that we are relating in a manner that is similar, if not identical to the relationship that took place previously at some point in the past with key figures or is currently taking place with key figures outside the session. **DCM1** I suppose in terms of a person's past relationships but whereby they are tending to relate to you as though you were that person from their past,	← ← ← ← ← ← ← DG3 So in the present now that past is still operating and I think that links in with transference because your early relationships have formed the way you see, you relate to people generally, and so often it comes up in the hour that you really can't get away from the past, it's with you now, as you, that's what I've found...sort of concepts which I think I use a lot. **HUM**	**DE3** This is the time where you can offer a different relationship. Maybe that's from a person-centred kind of… This is the point where you can either, if you don't acknowledge the transference, you go down the same line and you repeat that pattern, or this is the point where you get to offer something different to your client and change that relationship? I am somebody different and we have got potential to do something different here.
2. Disclosure/ blank screen	**DM5** I think there's more to it, something about the training of keeping yourself a blank screen. I suppose I have to manage that blank screen all the time by being a blank screen but, sort of, not making it punitive.		**DE1** Do you feel that in order to do that then you'd have to be more of a blank screen, that you couldn't be, sort of, you couldn't be in the relationship?
3. Repetition of relationship	**DCM4** I'm thinking of situations where you may be	← ← ← ← ← ← ← **DE4** While I might see that as an	**DE3** This is the time where you can offer a different

or a new experience	working with someone and finding that whatever you say seems to be experienced as abusive. And that however you make a comment it seems to be abusive, however affirming or caring or whatever you may be trying to do in helping them understand, you're experienced as abusive which is their lifetime's experience of people	incredible aim to have this relationship that's different from any other, I think it's happening all the time, that the way they behave in therapy or counselling is similar to the way they behave in the relationship. **HUM**	relationship. Maybe that's from a person-centred kind of… This is the point where you can either, if you don't acknowledge the transference, you go down the same line and you repeat that pattern, or this is the point where you get to offer something different to your client and change that relationship? I am somebody different and we have got potential to do something different here.
4. Actively working with or being aware	**DT2** It allows me as a therapist to through the relationship with the client to understand what their projections are on to me which gives me some insight into their unconscious processes or previous experience, and then I'm able to work with that, to understand them, to interpret – to make a kind of transference interpretation, to allow them to see what they're projecting into me, which is, you know, nothing to do with me.	**DG2** I suppose the first thing that springs to my mind about transference is because unlike the therapeutic alliance it is a psychodynamic concept and so it's, I think other orientations are aware of it and acknowledge it but I think it's only with the psychodynamic sort of orientation that therapists tend to interpret the transference and bring it to the client's attention. And I think that's the big difference so it's not that it's not acknowledged in other orientations. Yes, I'm very aware of it, and yes I do	**DM4** Transference is something that I am aware of, I'm mindful of. But I don't necessarily actively use. **DG3** It was included in our training but not in the same, well my impression is, not in the same way as in psychodynamic. I use it more just being aware of possible transference and what it might be rather than actually using it.

	DG5 I think also when to give an interpretation, I'm psychodynamically trained, the judgement when to offer an interpretation, whether the internal structures are strong enough to work with that.	sometimes either interpret or at least encourage an interpretation of it or, and it would be very difficult for me not to because it makes itself felt so easily, doesn't it? **HUM**	
5. Counter-transference	**DE2** I find it tricky to separate the transference from the countertransferenc e at times. I struggle with that. **DCM2** But noticing it within one's own practice, I find it difficult to separate it from counter-transference actually, I think I'm looking at my counter-transference in order to inform transference	**DT4** I had a student many years ago who did a piece of research into whether therapists used transference interpretation or not, and what he found was they don't actually use transference interpretations very much. They used countertransferenc e, their own countertransferenc e experiences a lot, but they don't actually make this transference explicit very much. **PSY**	**DE1** But also I think, especially the training that I'm doing, it's all about countertransferenc e as well. So it's hard to just talk about transference, because especially at my training they are very into all this intersubjective systems theory. So countertransferenc e, it can't be separated so easily.
6. Internal world (objects)	**DCM1** What is transferred or what is projected into the therapist might be I parts of the person themselves. An internal object relationship so it's about not just that you might be somebody else from the past but you might be actually at times a part of them that they are		

	transferring and projecting **DG5** To do with the internal world, what they've taken in from their childhood. And sometimes you can be the good mother or the good father and sometimes the bad father the bad mother and how that informs your work as well and how to put to make an interpretation and when to make an interpretation, for the client to understand more about their internal world and their relationships.		

Appendix 10

Table 6 - Containment

Theme	Psychodynamic	Meeting points	Humanistic
The frame	**DT4** Contracting is actually providing a containment, but then there are interesting examples about what happens when the client actually wants to break the contract in some way by actually asking for an additional session, or telephoning you.	**DE4** I think I'm learning as I go along that those initial boundaries and that aspect of containing a relationship, I'm realising how important that is and how important it is for me to feel confident about all those kind of arrangements and setting them out. **HUM**	**DG3** To help create an environment which is safe and in which the relationship can develop and the work can take place, but... and so the sort of importance of keeping boundaries in place and not you know breaking them
Holding and Containment	**DCM1** I think there's lots of similarity between Winnicott's ideas and Bion's ideas of holding and containment, but I think there are some differences as well. For me the containment is about all those internal processes about how minds actually develop and form, how we learn to think, and that stuff about dreaming and alpha function that's all about containment container/contained, when I think about it.	**DM4** But is containment the same as holding a client? **HUM** **DE1**That reminds me a bit of what Winnicott said about, you know, there's the mother and baby, and that's the, you know, the mother can contain. **HUM**	**DM4** It's for me, it's holding on the client in a safe space which has got the most potential for growth. So, it's being able to safely hold that client, wherever that client goes.

Theme	Psychodynamic	Meeting points	Humanistic
Endings of a Session or therapy			**DM2 or** because it's got a two-year framework that's been set up, then it's very comfortable and very relaxed, and that's what happens. But could it be that that actually slows them down and sort of makes them feel like it's all right. We'll get around to it eventually in the end. And, therefore, kind of extend it along. **DJ3** Another aspect of containment is actually endings, and planning for that so that to some extent some of the emotion can be expressed during the therapy rather than out of the door into the cold and then all kinds of emotion coming up
Supervision	**DM1** How much I draw on supervision sometimes when I'm really wrestling with something I think, how that really helps me to contain the work as well in that there is a place to be able to - not	**DG2** That's why we have supervision, that's one function, another function of supervision, to help me to contain something that the client can't contain. **HUM**	**DM5** I think that is something that's come up many times working with anxious clients, actually thinking, "Well, if I work with young people, work with quite lot of young people with anxiety issues." And you

Theme	Psychodynamic	Meeting points	Humanistic
	only can I think about it on my own in my own sort of processing of things. But it can be then thought about somewhere else.		come with the anxious person and taking it to supervision.
Containment of emotions	**DCM4** There was a period where they really just needed their sessions to help them contain their grief and anxiety and then containment and being there to listen was the most important thing.		**DCM3** I'm thinking of something occurring at the college when they are angry, and the feeling that you are not allowed to show it to your parents, they've got enough on their plates and they can't cope with it, so that would be part of the containment then to sort of survive and enable them to be cross within the sessions and it still be ok.
Containment of risk	**DG5** I also have a client who is suicidal and has made several attempts, and it's being able to contain that for me to bear her and also to bear myself in all this. To be contained, to be a container and at times I find it very hard. And yet I do the best I can do		**DJ3**There is a sense of betrayal when they discover that you put boundaries on phone calls, the subjects that they can talk to you outside of therapy. They go to see a GP if they are feeling suicidal, not you. So it's containing it that way through boundaries.

Appendix 11

Table 7 - Power dynamics in the therapy relationship

Sub-themes	Psychodynamic	Meeting points	Humanistic
"Patient" or "client"		→ → → → → → → **DM5** But I agree about this patient thing, everybody says 'patient' and I don't like it, but I find myself doing it just because everybody is talking… And there is a power relationship, but I don't understand that. I don't understand why we have to use that word. Because I suppose, for me, how you hold the power is really important. And, as you say, the power is a two-way thing. **PSY**	**DM4** But working humanistically, it's very much an equal partnership, and we work with clients. And within the mentor group, DCM1, from a psychodynamic background, talks about patients and the, sort of, difference in power balance.
The Expert	**DE2** I just felt absolutely desolate. I thought I can't do anything for this woman, you know, I'm useless. And I didn't get it at all at the time that that's exactly what she was projecting onto me, and it wasn't until afterwards in supervision that, actually, that's how she feels – desolate and there's nobody	← ← ← ← ← ← **DJ1** I sometimes struggle with person-centred, because when you look at some of the original Rogers stuff, and he was talking about the client is the expert in the room, absolutely; the client is the expert in the room. However, that can be very tricky, because clients come to see us because they believe, I believe	**DM4** That's something that we've commented on, I think, many times, and I would not be comfortable me being seen as the expert. It's very much that the word 'client' is their own expert.

Sub-themes	Psychodynamic	Meeting points	Humanistic
	can help her. And that's what she wanted you to have, so you have done something for her.	they come to see us because we have a level of expertise and they want to make use of our expertise. **HUM**	
Balance of power		→ → → → → → **DCM3** Sort of equals in an endeavour? [But a shared task] **PSY**	**DJ1** So when I work with my clients, one of the things that I take a great deal of care about is the power in that relationship, so where does it sit? And that can be fundamentally important for me in terms of how what expectation that client gets of me. **DT1** I think clients contain and answer they don't know sometimes to questions, and in fact they do know and they decide either there or later to tell you, or they don't think you're going to handle it today.
Therapist or client/patient led	**DT2** You say to somebody I'm offering you say six sessions to see if we can work together, so that's the same thing and basically you make transference	→ → → → → → DM1 There's something really key, though, isn't there, in that, and especially very early on in the forming of therapeutic alliance about building trust, because it's	**DT1** The research suggests it's the client's assessment of the alliance that matters, not what the therapist thinks. If it is all going well, if the client thinks it is

Sub-themes	Psychodynamic	Meeting points	Humanistic
	interpretations, you see how they've reacted to the first session, whether they come back with any thoughts about it, any dreams, any material and in that way you, you're working out whether you can work with them.	strikes me that actually if something occurs and there is not trust in that relationship, it then can't be thought about and worked through properly in any sense. And even practising psychodynamically, I'd go where the client goes with that. **PSY**	going well then something useful will happen. **DJ2** It's a continuous process of judging how the thing is going, getting the feedback from the client and making sure that they feel that things are focused on what they particularly want. **DM3** as a humanistic therapist, I'm led by my client, I presume, they ultimately know what's best for them.

Appendix 12

Table 8 - Theoretical Language

Word	Psychodynamic	Meeting points	Humanistic
Blank screen	Blank screen		
Working alliance		Working alliance	
Boundaries		Boundaries	
Counter-transference	Counter-transference	Counter-transference	
Free child			Free child
Ego-states			Ego-states
Complementary transactions			Complementary transactions
Empathic	Empathic	Empathic	Empathic
Personality adaptations			Personality adaptations
Resistances	Resistances	← ← ← ← ← ← **DJ3** One of the resistances to it, if you want to call it a resistance. **HUM**	
Potency			Potency
Unconscious	**DM5** I suppose then psychodynamic counselling; we tend to think of unconscious communication maybe more than in other ways.		**DM3** I'm very aware of the unconscious; I'll bring it into the room. There's unconscious, subconscious and conscious. And it's all there. It's all the somatic response in my body and inviting clients to note what's going on for them.
Dynamic	**DM5** Maybe the supervision kind of contains the dynamic more so.		**DM3** What do you mean by 'dynamic'?

Word	Psychodynamic	Meeting points	Humanistic
	The dynamic could run away with itself.		
Congruently			Congruently
Narcissistic	Narcissistic		
Projective identification	Projective identification		
Reflexive			Reflexive
Drama triangle			Drama triangle
Self-parenting			Self-parenting
Projection	**DM5** They'll project on to you what they are actually feeling. And it's quite difficult sometimes to actually tell, I find, who is feeling what.		
Denial	**DM5** They'll deny it, but if you are feeling it and you know that it's not really yours then you'll wonder who is actually feeling it.	**DM2** Then they'll deny it as well. If it's at that level. HUM	
Self-actualised		→ → → → → → **DM1** We all have that common thread of wanting to help others to self-actualise, to grow, whatever phrase that we want… **PSY**	Self-actualised
Envelope	**DT4** Well there's the French who used to use the word [envelope]...which is so enveloping as well isn't it?		

Word	Psychodynamic	Meeting points	Humanistic
Defences	**DM1** I think today; I would talk about the defences		**DM3** I know what you mean. But it's not a word that we would use
Discounts			**DM3** We're looking at discounts, really, more than defences.
Racket			**Racket**
Avoidance	Avoidance	Avoidance	**DM4** I think we might talk about avoidance.
Dissociation	Dissociation	Dissociation	**DM3** Do you mean things like disassociation, or something? She says trying to think of words.
Internal world	**DG5** for the client to understand more about their internal world and their relationships.		
Interpretation	**DG5** I think also when to give an interpretation, I'm psychodynamicall y trained, the judgement when to offer an interpretation, whether the internal structures are strong enough to work with that.		**DG2** I think very often I prefer it when the client makes that connection themselves, you can guide them towards that.
Ego strength	Ego strength	**DG2** Ego strength **HUM**	
Rupture			**DG4** You could damage a therapeutic relationship with or rupture it - is that the word you use? Rupture it with a

Word	Psychodynamic	Meeting points	Humanistic
			wrong or an untimely interpretation
Reparation	**DG5** Also it's part of being, of reparation, I mean you didn't leave.		
Invitation			**DJ2** That was some sort of invitation from him? Did you sense that as an invitation from him?
Core conditions			**DE4** Something in me from the humanistic background says the idea is to give this person something they have never had before, sort of, back to Rogers in providing the core conditions,
Repetition	Repetition	← ← ← ← ← ← **DE1** The repetition… It's not an entirely, consistent repetition; there will be some gradual, shift in a layer in the repetition, maybe even encouraging it into that, sort of, different experience. **HUM**	
Attuned		→ → → → → → **DCM2** The most important thing is being attuned	

Word	Psychodynamic	Meeting points	Humanistic
		though, attuned to the client PSY	
Reverie	**DM5** and Bion talks about reverie		
Alpha function	**DCM1** The idea again of alpha function,		
Positive Regard			**DG3** So what would a person-centred, what's the core? Would they call it the core values? **DG2** Conditions, they are like empathy, and positive regard.
Normative, Formative and Restorative			**DM3** I'm a transactional analyst with my counselling practice. I'm a supervisor, and I'm very much into Inskipp and Proctor's 'Normative, Formative and Restorative', which I also use to inform my work with my clients.

Appendix 13

Table 9 - Reference to theoretical experts

Reference	Psychodynamic	Meeting point	Humanistic
Inskipp & Proctor			**DM3** I'm very much into Inskipp and Proctor's 'Normative, Formative and Restorative', which I also use to inform my work with my clients.
Carl Rogers		**DJ1** So Rogers pure, kind of, person-centred, which is you are just there to hold the room and to hold whatever they bring, just the very concept of it I struggle with sometimes (HUM)	**Carl Rogers**
Balint	**DE2** That's what was going through my mind, actually, because are we talking about an analytic pact, or are we talking about a relationship, a more, sort of, human relationship, which comes later with Balint and all of those people?		
Sigmund Freud	**DE2** Freud talked about an analytic pact, oh, way back, 1920. For him it was about		

Reference	Psychodynamic	Meeting point	Humanistic
	money, the room, attendance, how long does it last. So simply the essence of what we would call, I would call, the frame –		
Petruska Clarkson			**DE1** Maybe we are, sort of, in some ways more interested in the relationship and the alliance is just part of that. I suppose it's a long while since I looked at it, but I think it's Clarkson - and I can't pronounce her first name - and she has that thing where, I think there's five stages of the therapeutic relationship, and the alliance is the first one, and then it's about transference and countertransference, and then there's, I think, the reparative stage. Then there's the, sort of, I think it's like the person to person. I think it's transpersonal.
Tavistock Clinic	**DT4** I think that's the way in which I learnt in the beginning, was the Tavistock model. … create as much anxiety as you can, and then in the anxiety the transference will come out and		

Reference	Psychodynamic	Meeting point	Humanistic
	so on. I mean that was certainly the Tavistock group model.		
Melanie Klein **Hannah Segal**	**DCM4** I can't think if it was a Klein or Segal wrote a paper on the transference to the total situation and where it really feels as though what gets acted out in the,… within the related – the therapeutic encounter, or therapeutic room, is somehow a repeat which transfers back to the individual's emotional lifetime experience and relationships, and that can be so in the definition of transference in particular in how they relate to their therapist,		
Wilfred Bion	**DCM1** In Bion's model of the mind, that's what the mind is really about I suppose in terms of being able to managing affects and anxieties, um you know, and give them some sense of meaning really, um so they're not having to be um acted out acted on evacuated		

Reference	Psychodynamic	Meeting point	Humanistic
Donald Winnicott	Winnicott	**DM2** There's no boxes. I mean, I think something that I really like, the Winnicott thing, you know.	Winnicott
Patrick Casement (Michael Jacobs)	**DM5** I think Patrick Casement gives a really good example. He says like some of his clients come with feelings that are too much (.) for them to handle. And that was when I first understood it.		**DE1** I think it's Michael Jacobs's book, that Presenting Past where... or it might be Patrick Casement. I might have got this confused, where he talks about a client that came with some sort of live bullets, and that he thought he might shoot his wife.
Karen Maroda			**DE1** I'm just reading this really interesting thing on Karen Maroda, The Power of Countertransference.

Appendix 14

The Core Theoretical and Philosophical Model

Towards a Relational Model of Counselling Psychology

Unattributed. Text Provided for Psychology Counselling students at the University of the West of England

The core approach of the programme is humanistic and integrative, with a central focus on the therapeutic relationship. The relational model which is developed through the programme rests both on empirical evidence of the importance of relationship variables in therapeutic change[1] [2] and on the convergence of approaches to theory, practice and inquiry within humanistic and psychodynamic traditions. Michael Kahn's book "Between Therapist and Client: The New Relationship"[3] is a central text in tracing aspects of this convergence. Kahn provides a history of the use of the relationship in person centred and psychoanalytic traditions. He describes a synthesis of the two approaches in the work of Merton Gill and Heinz Kohut producing "a middle way that combines the advantages of warm engagement with the advantages of working actively with the relationship itself''.[4]

This paper traces the core structure of the relational model used on the programme with the integration of ideas and practice from the person centred approach and from key figures within the relational approach in psychoanalysis. From the clear conceptual core provided by Kahn, the model is then expanded to embrace compatible concepts

[1] Sexton, T. & Whiston, S. (1994)..The Status of the Counseling Relationship: An Empirical Review, Theoretical Implications and Research Directions. *The Counseling Psychologist, 22* (1), 6-78.

[2] Norcross, J.C. (Ed.) (2002). *Psychotherapy Relationships that Work*. New York: Oxford University Press.

[3] Khan, M. (1991). *Between Therapist and Client.* New York:W.H. Freeman & Co.
[4] Ibid, pp. 14-15.

and techniques from within the humanistic and psychodynamic traditions, and from approaches which have emphasised the social, historical and political context of difference and inequality. The paper then considers the relational perspective on psychological development, including the development of pathological processes, and the role of the therapeutic relationship in enabling change and growth. A compatible process model of supervision is presented. At this point the paper considers some of the issues and difficulties involved in both theoretical and technical integration, the limits of the model presented and the value placed on enabling students to develop their own critical perspective on the dilemmas of integration and on the relational model itself. Finally, the secondary training model of CBT is considered in the context of the primary relational model.

The programme begins with work at theoretical and experiential levels on establishing the relationship qualities and values identified by Rogers[5] [6] as central to the person centred approach. More recent developments in this approach are mapped, including the work of Mearns and Thorne on configurations of the self[7],[8] and of Mearns and Cooper on working at relational depth.[9] These developments emphasise multiple experiences and representations of the self, working with fragile and dissociated process[10] and the intersubjective nature of the therapeutic encounter in ways which converge with the relational tradition in psychoanalysis and with the broader philosophical developments of postmodernism and social constructionism. David Rennie has provided a philosophical look at these developments within the person centred tradition and within counselling psychology.[11]

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[5] Rogers, C.R. (1958). The Characteristics of a Helping Relationship. *Personnel and Guidance Journal, 37*, 6-16.
[6] Gillon, E. (ed) (2007). *Person-Centred Counselling Psychology.* London: Sage.
[7] Mearns, D. & Thorne, B. (2000). *Person-Centred Therapy Today.* London: Sage.
[8] Mearns, D. & Thorne, B. (2007). *Person-Centred Counselling in Action* (3rd edn). London: Sage.
[9] Mearns, D. & Cooper, M. (2005). *Working at Relational Depth in Counselling and Psychotherapy*. London: Sage.
[10] Sommerbeck, L. (2003). *The Client-Centred Therapist in Psychiatric Contexts.* Ross-on-Wye: PCCS Books.
[11] Rennie, D. (2003). *Counselling Psychology and Philosophy*. Paper presented at BPS Division of Counselling Psychology Annual Conference, Stratford on Avon.

From this person centred base, we follow Kahn's integration of the psychoanalytic framework for understanding, and working with immediacy in, transference and counter transference relationships. The conditions described by Gill[12] for the therapeutic re-experiencing of earlier (and other current) relationships, are similar to and consistent with those described by Rogers. Kohut[13] contributes a developmental model of interpersonal needs to the evolving picture of the "new relationship". In this integration, the relationship dramas which are transferred into the counselling relationship can be re-experienced, explored and understood with the counsellor providing a non-defensive, accepting, empathic and congruent response.

The use of the relationship as the central integrative concept provides students with access to a wealth of related theory and experience. The work of Rogers and later person centred therapists is closely connected to the broad spectrum of humanistic and existential approaches. In particular, developments within the traditions of gestalt therapy[14], transactional analysis[15] and existentialism[16] all provide additional perspectives on, and approaches to working with the relationship. Within psychoanalysis, Greenberg and Mitchell[17] have identified a division into two broad perspectives of drive theory and the relational model. The relational model within psychoanalysis includes British object relations theory, interpersonal psychoanalysis and self psychology[18]. It is closely connected to the feminist traditions of Jean Baker Miller and the Stone Center in the USA and Susie Orbach and colleagues at the

[12] Gill, M.M. (1982). *Analysis of Transference* (vol.1). New York: International Universities Press.
[13] Kohut, H. (1984). *How does analysis cure?* Chicago: University of Chicago Press.
[14] Hycner, R. & Jacobs, L. (1995). *The Healing Relationship in Gestalt Therapy*. New York: Gestalt Journal Press.
[15] Tudor, K. (1999). I'm OK, You're OK – and They're OK: Therapeutic Relatonships in Transactional Analysis. In Feltham, C. (Ed.) *Understanding the Counselling Relationship*. London: Sage.
[16] Spinelli, E. (2007). *Practising Existential Psychotherapy; The Relational World.* London: Sage.
[17] Greenberg, J.R. & Mitchell, S.A. (1983) *Object Relations in Psychoanalytic Theory.* Harvard University Press.

[18] DeYoung P.A. (2003). *Relational Psychotherapy*. Hove: Brunner-Routledge.

Women's Therapy Centre in the UK.[19],[20]

The concepts of relationship and relatedness are seen to embrace the location of the individual in broader patterns of socio-historical organisation. Thus, issues of social inequality mediated through race, gender, class, sexual orientation, disability, age or other difference are central to the approach. The model presented here is consistent with and encompasses the emphasis on relationship processes in feminist[21], trans-cultural[22] and systemic approaches[23].

The relational model embraces a wealth of psychological theory and research on human development. The basic argument is that human psychological development is mediated by relationship. The earliest psychological structures develop from the earliest relational structures, and are then subject to repetition, reinforcement or change in the person's development and growth through the lifespan. The pattern of an individual's development will depend on their experience of relationships, including the therapeutic relationship. It is possible then to integrate the relatively simple psychodynamic description of this process provided by Rogers in terms of the introjection of conditions of worth with more complex models provided by Kohut[24], Mitchell[25], Klein[26], Winnicott[27], Berne[28], Horney[29], Schutz[30] and many others. The

[19] Miller, J.B. & Stiver, I.P. (1997). *The Healing Connection*. Boston: Beacon.
[20] Orbach, S. (2006). *Democratising Psychoanalysis*. Paper presented at "Relationl Thinking" conference at UWE, Bristol.
[21] Chaplin, J. (1999). *Feminist Counselling in Action(2nd. ed).* London: Sage.
[22] Eleftheriadou, Z. (2003) Cross-cultural Counselling Psychology. In Woolfe, R; Dryden, W. & Strawbridge, S. (eds) *Handbook of Counselling Psychology (2nd. edn).* London: Sage, 500-517.
[23] Street, E. (2003). Counselling Psychology and Naturally Occuring Systems (Families and Couples). In Woolfe, R.;Dryden, W. & Strawbrideg, S. (eds) *Handbook of Counselling Psychology.* London: Sage, 419-441.
[24] Kohut, H. (1971). *The analysis of the self.* New York: International Universities Press.
[25] Mitchell, S.A. (2000). *Relationality: From attachment to intersubjectivity.* Hillsdale,NJ: Analytic Press.
[26] Klein, M. (1984). *Narrative of a Child Analysis.* New York: Free Press.
[27] Winnicott, D.W, (1958) *Collected Papers.* London: Tavistock.
[28] Berne, E. (1973) *Transactional Analysis in Psychotherapy; A Systematic Individual and Social Psychiatry.* New York: Ballantine Books.
[29] Horney, K. (1999) *The Neurotic Personality of Our Time.* London: Routledge.
[30] Schutz, W. (1966) *The Interpersonal Underworld.* Palo Alto,CA: Science and Behavior Books.

development of attachment theory by Bowlby[31], Ainsworth[32] and others provides an important empirically-supported framework for understanding the impact of early relationship experiences on later patterns of development and is a highly valuable resource in counselling psychology formulation, practice and research. The work of Stern in observing the active role of infants in early interactions is a further important contribution to the development of awareness of the intersubjective nature of formative relationships. In his recent writing, Stern has transferred his approach of minutely observing and analysing mother-infant interactions to looking at brief moments of contact in the therapeutic relationship.[33] Recent developments in neuroscience appear to support the strong psychological evidence for the importance of early relational experience by linking this to brain development and by providing descriptions in neurophysiological terms of the reparative potential of the therapeutic relationship.[34] [35]

The same relational processes which underlie normal development can also account for the development of pathological processes. Psychological problems develop from pathological relationships. The absence of good enough physical and psychological holding and the presence of conditional, inauthentic or abusive responses leads the individual to develop defensive survival strategies. Once established, these strategies become self-perpetuating and self-fulfilling. Experiences which are inconsistent with the self-system are subceived and either distorted or blocked from awareness. Emotional experiences are sought which recreate and reinforce earlier developmental experiences and decisions. The maintenance of this defensive/survival system uses considerable energy and leaves the individual depleted and distanced from authentic engagement.

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[31] Bowlby, J. (1988). *A Secure Base: Parent-Child attachment and healthy human development.* New York: Basic Books.
[32] Ainsworth, M. (1978). *Patterns of Attachment: A psychological study of the strange situation.* Hillsdale,NJ: Lawrence Erlbaum.
[33] Stern, D. (2004). *The Present Moment in Psychotherapy and Everyday Life*. New York: Norton.
[34] Cozolino, L.J. (2002). *The Neuroscience of Psychotherapy.* New York: Norton.

[35] Gerhardt, S. (2004). *Why Love Matters.* London: Routledge.

It is integral to this model that the presenting issues which have developed in relationship can be changed by the therapeutic experience of relationship, including centrally the relationship between counselling psychologist and client. Clarkson[36] describes five modes of relationship, which can each contribute to the therapeutic process. These modes are the I-You, transpersonal, transferential, reparative/developmentally needed and working alliance relationships. The "I-You" relationship of warmth, acceptance, non-defensiveness, empathy and genuineness provides a safe space in which the client can progressively allow an openness to experience. Rogers describes how this intimate contact in the working relationship between counsellor and client can sometimes have a transpersonal quality in which "profound growth and healing energy are present".[37] It also provides the context necessary for the client to re- experience, express, explore, understand and change transference and counter-transference processes. This good enough holding and non-defensive response can also provide a reparative and developmentally needed experience of appropriate parenting. This does not mean that the counsellor attempts to satisfy the needs of the client, but rather that they provide a relationship within which these can be experienced and accepted. The necessary container for these intra and interpersonal dynamics is the development of a working alliance in which there is an Adult to Adult understanding of and commitment to a therapeutic contract.

Clarkson[38] and Prochaska and Norcross[39] both identify the therapeutic relationship as a trans-theoretical concept used in all major approaches. They analyse the different roles and modes of the therapeutic relationship and advocate the intentional use of the relationship to provide the most effective therapeutic context and process. Holmes,

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[36] Clarkson, P. (1990). A Multiplicity of Therapeutic Relationships, *British Journal of Psychotherapy*. 7 (2), 148-163.

[37] Rogers, C.R (1990). A Client-centred/Person-centred Approach to Therapy. In Kirshenbaum, H. & Henderson, V.L. (Eds.) *The Carl Rogers Reader.* London: Constable, p. 137.

[38] Clarkson, P. *Op Cit.*

[39] Proschaska, J.O. & Norcross, J.C. (2006). *Systems of Psychotherapy; A Trans-theoretical Analysis*(6th edn). Belmont: Wadsworth.

Paul and Pelham[40] [41] provide a similar analysis of the relational origins of disturbance and of the significance of the experience of the therapeutic relationship.

The relational model presented here is complemented by the process model of supervision presented by Hawkins and Shohet.[42] This is the core model used in the supervision groups on the course. It provides nine different points of potential focus within a relational matrix and relates these to a developmental framework. The explicit selection of appropriate focus in supervision also models the process of selecting interventions in counselling, in relation to the development of the client and the relationship. Several theoretical models provide an understanding of individual differences in terms of relational concepts (e.g. Kohut[43], Schutz[44], Horney[45], Berne[46], Bowlby[47]) and guide assessment and selection of therapeutic response. Clarkson advocates the intentional use of different relationship modalities in response to a complex of factors which might be assessed within the process model. An awareness of developmental psychology and of developmental processes within relationships provides students with an important context for assessment and selection of intervention.

The relational model presented here includes both theoretical and technical integration. The technical integration begins with an emphasis on the development of core relationship qualities of empathy, unconditional positive regard and congruence. These qualities are then augmented with counselling skills of attending, listening, reflecting, using questions, being concrete and specific, challenging and confronting, immediacy

[40] Holmes, P., Paul, S. & Pelham, G. (1996, August). A Relational Model of Counselling. *Counselling*, 229-231.
[41] Paul, S. & Pelham, G. (2000). A Relational Approach to Therapy. In Palmer, S. & Woolfe, R. (Eds.) *Integrative and Eclectic Counselling and Psychotherapy*. London: Sage, chapter 6, 110-126.

[42] Hawkins, P. & Shohet, R. (2006). *Supervision in the Helping Professions* (3rd edn). Buckingham: Open University Press.
[43] Kohut, H. (1971). *Op Cit.*
[44] Schutz, W. (1966). *Op Cit.*
[45] Horney, K. (1999). *Op Cit.*
[46] Berbe, E. (1973). *Op Cit.*
[47] Bowlby, J, (1988). *Op Cit.*

and self disclosure. These qualities and skills facilitate both the development of the relationship and client self exploration. Students are encouraged to work with experience of the transference and counter-transference relationships in an immediate and non-defensive manner and to make use of the psychodynamic triangles of insight and conflict.[48] A range of concepts and interventions from related humanistic and psychodynamic approaches are also introduced as consistent with this model. Attention to the therapeutic frame is emphasised as a key aspect of the client's experience and the therapeutic process.[49] Students are encouraged to develop formulations from a relational perspective to inform their therapeutic aims and choice of interventions. Supervision groups enable students to apply the core model to their practice. Personal development groups and the requirement for personal therapy are intended to ensure that relational processes are explored at depth and that integration is grounded in personal awareness.

The relational model provides a coherent framework, which underpins the programme. However, it is not presented as an all-encompassing truth that is to be received uncritically. It is acknowledged that both theory and technique are located in the histories of different philosophies, value systems and epistemologies. It would be naive to claim that these differences can be resolved into a single new consensus, since they represent well-rooted and incompatible world views. The approach developed on this programme, therefore, has more limited ambitions. It promotes a synthesis of ideas and techniques where this is consistent with an essentially humanistic approach to the counselling relationship and a dialectical/intersubjective approach to developing knowledge, understanding and practice.

There are both apparent and real discrepancies between theory and practice in all models of counselling psychology. These can arise from the limitations of theory and research within an approach or within the whole profession, as well as from the various

[48] Jacobs, M. (2005). *The Presenting Past* (3rd edn). Buckingham: Open University Press.
ray, A. (1994). *An introduction to the therapeutic frame*. London: Routledge.

limitations of practitioners. In an integrative model there are also conflicts derived from the different theoretical and practical traditions which are brought together[50]. On the programme, we seek both to develop a coherent model of theory and practice and also to encourage a critical perspective in students. The potential merits of conflicting perspectives from both humanistic and psychodynamic traditions are presented for students to discuss and evaluate. One example of this would be a contrast between the emphasis on a flexible responsiveness to the circumstances and needs of clients in person centred work[51] and the value placed on a rigid therapeutic frame in psychodynamic work.[52] This provides valuable contrasts in language, perspective and process, and encourages students to develop their own understandings in the context of paradox and critical questioning. Students are also introduced to the cultural and historical contexts of developments in counselling psychology, to the development of more culture sensitive approaches, to critiques of counselling psychology and to criticism of the relational approach. The core model is presented as a coherent whole which allows flexible and creative responses to the dilemmas of practice. At the same time we value conflict and criticism as also providing a creative source of learning.

The second therapeutic model which is taught on the programme is cognitive behaviour therapy. This is presented as a separate model with it own complex history and conceptual and technical framework. However, as part of the presentation of CBT, the role of the relationship is examined and areas of convergence between CBT and the relational model are considered. Recent developments in mindfulness-based cognitive therapy[53] and in schema based therapy[54] are included, as are other works

[50] c.f. Wheeler, S. & McLeod, J. (1995, November). Person-centred and Psychodynamic Counselling: A dialogue. *Counselling*, 283-287.
[51] Mearns, D. (2003). *Developing Person-Centred Counselling*(2nd edn). London: Sage.
[52] Warburton, K. (1999). Establishing a therapeutic frame. In Lees, J. (Ed.) *Clinical Counselling in Context.* London: Routledge.
[53] Segal, Z., Williams, J.M.G., & Teasdale, J.D. (2002). *Mindfulness-based Cognitive Therapy for Depression.* New York: Guilford Press.
[54] Corrie, S. (2002). The role of the therapeutic relationship in promoting psychological change: A cognitive-behavioural perspective. *Counselling Psychology review,* 17 (2), 23-31.

stressing the use of the relationship in CBT[55], [56] and the integration of cognitive behavioural work with TA and psychodynamic approaches in Cognitive Analytic Therapy.[57]

[55] Safran, J. & Segal, Z. (1996). *Interpersonal Process in Cognitive Therapy*. Northvale, NJ:Aronson.
[56] Sanders, D. & Wills, F. (1999). The Therapeutic Relationship in Cognitive Therapy. In Feltham, C. (Ed.) *Understanding the Counselling Relationship.* London: Sage, chapter 6, pp 120-138
[57] Ryle, A. (1990). *Cognitive-analytic therapy*.. Chichester: Wiley.

Appendix 15

Dissemination Plan

1. To make the findings available in a full and/or in a summarized form for each group within the low cost service. I plan to offer all the participants the opportunity to discuss these findings by setting up three possible meetings.
2. To recommend and apply for funding for the training of mentors in the facilitation of groups for practitioners with mixed modalities.
3. To make recommendations for the choice of training events.
4. To make recommendations of the matching practitioners with supervisors.
5. The findings should be relevant for other similar voluntary organisations and it will be important to network and discuss the issues raised.
6. The findings should be relevant nationally and I intend to publicize the findings of this project through the medium of the British Psychoanalytic Council because the current chair, as I referred to in my Introduction, has expressed such a strong wish that the various associations should meet and talk. (Morgan, 2015).
7. A summary of the research could be offered to journals or conferences either in the UK or internationally such as via the Society for Psychotherapy Research Collaborative Research Network which was set up by Orlinsky and colleagues. (Orlinsky, 2005 pp 209-13).
8. A discussion of the methods used in this research, the thematic analysis of focus group discussions to look at differences, similarities and meeting

points, potentially has significance for a wider audience where there is concern about stereotyping and conflict.

9. There are a number of journal articles that could be fashioned from this thesis. The following topics could make a contribution to the field of therapy:
    - the current thinking about all three psychoanalytic concepts.
    - the difference in how psychodynamic practitioners see the therapy relationship from the humanistic thinkers.
    - how much theoretical language is an obstacle to recognizing that there is an approach in common.
    - the unconscious life of a voluntary service.

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