A STUDY OF MUTUAL INFLUENCE IN THE THERAPEUTIC RELATIONSHIP

Alison Mary Turner

BA(Psych) Macquarie
PGradDip(Psych) Macquarie
PGradDip(Coun) Inst. of Counselling
PGradDip(Grp.Fac.) Inst. of Counselling

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Abstract

Therapy is a mutual endeavour yet literature commonly portrays the process from the viewpoint of the therapist with minimal focus on client perspectives. The therapeutic relationship is considered central to healing, yet many questions remain about the interpersonal phenomenon that contributes to the healing process. Early research and literature has focused on the construct of the therapeutic alliance and the analytic concepts of transference and counter-transference. More recent research carries forward the focus on the alliance and relates it to treatment efficacy and outcome. To date there is a paucity of research focused on the mutual impact of therapists and clients within the context of a therapeutic relationship. This qualitative work explores the phenomenon of mutual influence in the therapeutic relationship by providing empirical accounts in the form of in depth interviews with therapists and their clients in a current therapeutic relationship. A phenomenological analysis revealed a number of interrelated themes with two overarching phenomena. Firstly relational boundaries contributed to the development of trust in all the relationships. This theme was explored in relation to previous therapy, choice of therapist, equality and agency, generosity of self and mutual trust. Secondly the personal aspects of the relationship between therapists and clients occupied the foreground of the therapeutic relationship over and above theory or model. The theme of a personal relationship was explored in relation to informed intuition, emotional relating and empathy, paradox, and the role of love in therapy. The findings point to the centrality of the bi-directional personal influence of both therapist and client on the quality of the therapeutic relationship. Therapist and client perspectives in context show the verity of the relationship between therapist and client as being more than, and different to, the construct of the therapeutic alliance. Findings are discussed in relation to the literature and recommendations are made for clinical practice and therapist's education. Future directions for research are identified.

Certification

I certify that the substance of this thesis has not already been submitted for any degree and is not currently being submitted for any other degree or qualification.

I certify that any help received in preparing this thesis and all sources used have been acknowledged in this thesis.

Alison Mary Turner

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Chapter 1

Introducing the Context

Mutuality is inevitable in the crucible of daily therapeutic work. The therapeutic situation provides a potential space for the mutually creative co-construction of meaning, the ferment of two minds meeting (Aron, 2007; Renik, 1993; Stolorow, 2001). This is an interpersonal pursuit involving the influence of one person on another, influence that can have a significant personal impact and where meaning emerges relationally in unexpected ways. Influence in the context of the therapeutic relationship can also present challenges. Just the word influence can conjure up notions of directives and coercion. Counsellors are educated not to exert undue influence on their clients by way of imposing their own agenda (Hill, Stahl, & Roffman, 2007; Witty, 2005). It is commonly viewed that the therapist's personal life and particular value set must be put aside in the service of the client. There are good reasons for this, most importantly because a therapist's expert status and knowledge are seen to create a power imbalance that must not be exploited (Bond, 2007; Pope & Vasquez, 2007; Spong, 2007). Mutual influence is therefore a powerful interpersonal force with the potential for healing and change, as well as harm.

The centrality of the therapeutic relationship to the healing process was first recognised by Freud (1910). While he acknowledged the mutual nature of the relationship, his emphasis was on analysing the distorted view of the client, or the transference and its potentially damaging impact on the therapist. Throughout the history of counselling and psychotherapy the importance of the therapeutic relationship has reverberated through time in terms of the inherent ambiguities that exist in the reality level or collaborative endeavour, versus the metaphorical or unconscious level. The quality of the relationship between a therapist and client is widely recognised as playing a significant role in the successful outcome of therapy across a range of models and approaches (Cooper, 2010; Hubble, Duncan & Miller, 2009; Norcross & Goldfried, 2005a). As such it is viewed as one of the common factors that accounts for positive change in therapy

(Asay & Lambert, 1999; Wampold, 2001; 2010). Despite this there is little consensus in the field regarding a unified definition of the therapeutic relationship, nor universal agreement in regard to its fundamental components (Gelso, 2009b; Hatcher, 2009; Horvath, 2009; Wampold, 2010). Research focusing on therapeutic change has attempted to differentiate therapist traits and effects (Levitt & Williams, 2010; Norcross, 2002; Skovholt & Jennings, 2004; Sprenkle & Blow, 2007) and client contributions (Binder, Holgersen, & Nielsen, 2009; Geller, Greenberg, & Watson, 2010; Klein & Elliott, 2006), serving to keep the debate alive yet unresolved.

An extensive body of literature and research has focused on the construct of the therapeutic alliance (Bedi, Davis, & Williams, 2005; Brossart, Willson, Patton, Kivlighan, & Multon, 1998; Castonguay, Constantino & Holtforth, 2006; Gelso, 2006; Hatcher & Barends, 2006). It is generally agreed that the alliance represents the collaborative elements of the relationship, particularly the ability to agree on and engage in the tasks of therapy (Castonguay, et al., 2006). As such alliance research covers the conscious and purposeful aspects of the therapy relationship, but does not extend to the more affective dimensions or personally historical elements that both therapists and clients bring to their current encounter. There is also very limited alliance research on the shape and quality of a productive therapeutic relationship over time.

Recent clinical advances have linked the therapeutic relationship to the attachment bond between therapist and client (Fonagy & Target, 2005; Schore, 2003; Wallin, 2007). These authors stress that it is real relationship experiences, as opposed to internally driven fantasies, that shape the developing person and forms their inner working model of self in relationship (Bowlby, 1977). Until recently attachment theory has been relegated to the domain of early development, and has received little attention from clinicians and researchers in terms of how it might inform clinical practice with adults. Therefore despite a long theoretical history attachment has made little impact to date on clinical theory and practice. As a theory predicated on

emotional development attachment theory has the potential to fill the gaps found in the alliance research on the personal and affective contributions brought to the relationship by the therapeutic dyad. Recent research has begun to explore the mutual effects of therapist and client attachment on the therapeutic relationship (Dinger, Strack, Sachsse, & Schauenburg, 2009). The mingling of therapist and client histories appears to make a difference, but quantitative measures prevented to make clear how attachment dynamics between therapist and client might impact on the therapeutic relationship. Other recent trends link attachment theory with neuroscience, presenting a brain based model of practice (Cozolino, 2006; Schore, 2003; Siegal, 2009) that acknowledges the joint verbal and nonverbal reciprocal interactions of therapist and client.

Mutual influence and reciprocity are mentioned frequently within counselling and psychotherapy literature. However the terms are stated as a given and rarely defined to expose the meaning for any particular author. Contemporary relational and inter- subjective perspectives within psychoanalysis (Aron, 1996; Mitchell, 1995; Slavin, 2010) have moved away from the relationship as an objective and unidirectional provision of treatment to encompass a recognition of the inclusion of the subjectivity and participation of the therapist. As such, these theorists join other post modern theorists (Brown, 2006; Jordan, 2001; Rogers, 1951; Yalom, 1980) of the view that the therapeutic relationship is a reciprocal encounter. Despite the growing acknowledgment from particular theorists that therapy is a mutual endeavour, it is less clear how this mutual process occurs and how it is experienced. This thesis attempts to shed light on those questions.

This chapter has touched on the main topic areas relating to the exploration of the phenomenon of mutual influence within the therapeutic relationship. Following is a description of the guiding question underpinning this study and an explanation of the significance of this qualitative project. I then position myself as the researcher in relation to this topic. Lastly I

clarify the use of the primary terms used throughout this dissertation, and provide an overview of the chapters to follow.

Guiding Research Question

In order to examine therapists and clients experiences of their relationship within therapy, the guiding question behind this research was: *How do therapists and their clients perceive and experience mutual influence and change within the therapeutic relationship?* This guiding question was explored from a holistic view of the relationship over time, rather than a particular chosen therapy event, session or arbitrary point in time. This included particular stories or salient points that otherwise may have been missed by focussing on the minutiae of a single session or a particular topic area. In the end the relationship was viewed as being bigger than the sum of its parts (Perls, 1969). A holistic view therefore allowed the participants the freedom to tell their story as they so chose, and to introduce particular topic areas, as well as the exploration of other sub questions and themes that arose from the stories.

Purpose of the Research

This qualitative project has the purpose of exploring mutual influence in the therapeutic relationship through engaging with the stories as told by therapist-client dyads to describe their experiences of working with each other. This endeavour aims to enhance and build onto existing theory and research and in turn, the ongoing clinical and training issues in the field around educating therapists in establishing and maintaining strong relationships with their clients (Boswell & Castonguay, 2007; Hill & Knox, 2009; Hill, Stahl, et al., 2007). A phenomenological case study approach was employed to uncover and explore the meanings and impact attributed to the phenomena by both therapists and clients engaged in a current therapeutic relationship.

This study attempts to gain a fuller understanding of what constitutes an effective therapeutic relationship, with the larger aim of benefiting clinical practice and training. The overarching question mentioned above underpins the study, and several sub questions complete the purpose of this investigation.

1. How do therapists and clients negotiate and manage mutual influence in the therapeutic relationship?
2. How does mutual influence shape an effective therapeutic relationship over time?
3. What is the differential impact of therapist and client on the success of the therapeutic relationship and the outcome of therapy?
4. What do therapists and clients think have been the main catalyst for positive change in their therapeutic work?
5. What were the similarities and differences between the particular dyads and their descriptions and perceptions of the therapeutic relationship?

Significance of the Research

Counselling and psychotherapy is still emerging as a legitimate treatment despite the fact therapy has been found to be more effective than many commonly used evidence based medical practices and is more enduring than medication (Wampold, 2001; 2010). The practice of therapy has been researched widely in terms of efficacy and outcome. The majority of this previous research has focussed on particular treatment modalities and interventions for specifically diagnosed problems. However there are few differences between the therapeutic outcomes as they apply to either various treatments or particular disorders (Wampold, 2001). “When the purported active ingredients are removed from established treatments the benefits remain” (Wampold, 2010, p. 111). Over time, the trend has moved towards a research focus on particular clinical populations and strict adherence to manualised forms of treatment (Goldfried &

Eubanks-Carter, 2004; Westen, Novotny, & Thompson-Brenner, 2004). A shift towards research on therapeutic process (L. E. Beutler, 2010; Blatt, Zuroff, Hawley, & Auerbach, 2010) rather than outcome, has yielded approaches that could potentially establish how certain processes within the therapeutic relationship can bring about change (Elliott, 2010; Hill & Knox, 2009). This includes client reports of helpful factors and important moments in therapy and acknowledges clients as credible witnesses to their own change. Recent interest in the concept of therapeutic presence (Geller, Greenberg & Watson, 2010; Tannen & Daniels, 2010) has found that clients perceptions of their therapists ability to be wholly present in sessions was related to a positive relationship and outcome. According to Wampold (2010) a fuller understanding of therapists skill in delivering treatment is critical.

Authors from the relational analytic perspective have produced some rich and compelling literature specifically focussed on inter-subjectivity (Aron, 2007; Cornell, 2007; Orbach, 2007). The relational perspective has emerged strongly over the last decade and holds the view that the client can only be conceptualised from within the relational matrix. Therefore this view relates closely to mutuality; however the relational literature relies heavily on anecdotal clinical material from the therapist perspective that is then linked back to psychoanalytic theoretical constructs. Therefore research is needed that informs main stream clinicians and practitioners working in a range of settings and models.

A gap remains, and is growing wider in Australia, between the findings of treatment and evidence based research and how this informs clinical practice. This dilemma has serious implications for policy and training. What also remains is a need for a more layered, finer grained and more clinically meaningful look at the therapeutic relationship (Gelso, 2009b; Horvath, 2009). According to Horvath there is a “pressing need for an overarching conceptual framework for the relationship in therapy” (Horvath, 2009, p.273).

According to McLeod (2003) research that is clinically meaningful must be based on accounts that reflect the extent to which clients have eliminated their presenting problem or improved their everyday functioning, so that any meaningful change can be of practical significance. The reality experienced by therapists and their clients in every day practice also needs to be free of the constraints of agency expectations and the limits of treatment plans. The general focus on outcome research (Barber, 2009; Westen, et al., 2004) seems to have confounded the question of what a successful relationship might mean to those involved regardless of outcome. There is a paucity of literature, especially research-based investigations focusing on the phenomena of the interpersonal qualities and dynamics in a successful therapeutic relationship from the perspective of both therapist and client in an existing relationship. This is possibly due to the delicate nature of gaining access to this private domain.

Research on the therapeutic relationship has considerable methodological and ethical difficulties due to the very nature of the work, the intimacy of the relationship, and the possible impact that any intrusion into that relationship may produce. An awareness of the sensitive ground on which I was potentially about to tread, lead to the quest for a research design that had the potential to accommodate and respect the needs and freedom of the participants.

Positioning the Self: The Researchers Relationship to the Research

The processes of a qualitative study are centred on the skills, personal characteristics and judgements of the researcher. “The person is the research tool” (Polkinghorne, 2006, p.75). As the research tool for this study my own ideas, motives, background and prior knowledge all contribute to the lens through which I viewed this project and its results. It seems only appropriate as the author of a work based on relational principles that I should position myself and the development of my ideas within an interpersonal context.

The usefulness and validity of the work that follows can only be understood as the product of a co-construction of meaning within its given context, just as my involvement in the field of psychology and counselling has developed and grown out of my particular life experiences. My interaction with the theories, the participants, their stories and the resulting text has impacted and influenced the way this project has been designed, researched and reported.

Professional and Personal Context

I have had many years of education in both psychology and counselling covering a broad range of areas within the field. My professional roles encompass private practice and the education sector. I hold an academic role where I am responsible for educating those who want to become clinical practitioners. In this role there is a constant question around how training can be geared towards developing and enhancing relationship skills and capacities, alongside academic knowledge. In particular facilitating what is known as *use of self* in the therapeutic relationship. It was the relationships I encountered in the process of my own professional development and training, rather than the particular courses I undertook that had such a profound impact on me. I have found that therapeutic relationships are not exclusive to the world of therapy, and I have had the very good fortune at different times in my life to experience the powerful and transformative effects that strong and committed relationships can bring.

The research question I have today germinated many years ago in the soil of my adoptive family and the many unanswered questions I had about the nature and quality of nurturing yet non biological relationships. Despite having two very devoted and reliable parents I felt at times like an alien in my family skin. What was that elusive bond that everybody else seemed to have and to which I was not privy? Society places great value on sharing blood ties so how can non-blood ties ever be as strong? As a child adoption felt like second best. Therefore I believe my choice of topic is no accident, nor is it a purely academic question. My interest in the personal

aspects of a helping relationship, are closely tied to my past relationships, both personal and professional, and how they have influenced me. My journey took me on a long and winding road through both my adoptive and birth family histories, where I heard many untold secrets and uncovered many lies, all underpinned by enormous grief. My adoptive mother carried the shameful secret of being placed in an orphanage, along with her three siblings, after her mother died when she was only eight. My birth mother had lived the ultimate adoption story "go back to your life as if this had never happened". Her secret had been safely locked away all those years, and remains so to this day.

During this search for identity, I became an accidental counsellor. The counsellor I approached to act as mediator for my search and possible reunion with my birth mother insisted I attend four counselling sessions in preparation for the decision. I dragged my indignant and belligerent self to those sessions. I did not need counselling. How dare he! But it was a means to an end. Some months after the reunion, the counsellor contacted me to ask if I could assist with a young thirteen year old boy who was having difficulties, and who refused to speak with anyone who was not adopted. I agreed and remember tearing up in the face of this young man's pain. I can still remember his words to me, "I can see that you understand". I remember thinking to myself this is terrible, I had better learn how to do this properly and the seeds for my career in psychology and counselling were sown. However the concept of mutuality would point to the impact of my own story and personal pain, as well as the obvious emotional identification, to make meaning of the shared empathy of that encounter.

During the search for my own history and identity I was often asked by people close to me "what are you looking for"? This often felt like a judgment, especially as I was not sure of the answer myself. Didn't I have a right to know? Of course there were all the rational answers. Who did I look like? Was there medical background I should know? What kind of people were they? What was the story behind my adoption? I was given the answers to those rational questions.

However it was not until ten years after I met my birth father that my unknown but very poignant answer came. It arrived when I least expected it about a week before my birth father died. I was visiting him in hospital, and his brother and family arrived while I was there. I felt immediately uncomfortable. They didn't know about me, and this would place him in a very stressful situation, on top of already having a "bad ticker". He was a Catholic Priest, and I was a big secret. My anxiety rose and I quickly made noises to leave, thinking to myself, what if they noticed that I looked like him? What if they guessed the truth?

As I stood up my birth father looked calmly into my eyes, held out his hand and said "why don't you stay a while." And there it was! Encompassed in a simple statement, but meaning so much more. My birth father seemed to know what was needed even when I didn't, although I recognised it immediately when it came. Even remembering those words now years later brings a sad yet wonderful feeling of contentment. Like balm to a primal wound. It makes me wonder how we ever really know what that elusive goal is for therapy and healing. It is such an overtly expected beginning to the therapy process.

Not surprisingly I am now a psychologist, with a particular interest in the underpinnings of therapeutic relationships. My own personal journey through the various relationships of adopted daughter, granddaughter, wife, mother, friend and colleague have kept me fascinated in the questions surrounding human attachments, and their quality, meaning, importance and impact on one's life. As I conducted this study my curiosity about human bonds remained stimulated, particularly in relation to the transfer, impact and influence of one mind on another. My experiences have taught me that personal adaptation, learning, development and growth happens in relationship with and to another. And, at times does not happen well. My belief and bias towards therapeutic relationships as the default for growth and well-being is obvious. How relationships facilitate or stifle this growth and change remains for me a fascinating question. The fact that this venture has both a personal and professional focus for me makes it almost a

necessary undertaking that will satisfy a long standing curiosity. What are the most important aspects of a successful therapeutic relationship for therapists and clients? How does mutual influence play a part in the process, and what does this mean for clinical practice?

Definition of Terms

The language used to describe different terms and concepts in the field of counselling and psychotherapy provides some convenient shorthand for discussing clinical work. However many familiar generic terms often hold different meanings within specific disciplines and models of counselling and psychotherapy, as well as having many and varied individual interpretations and manifestations amongst therapists. This study was designed to capture the meanings that participants put on their particular experiences without the constriction of looking through the lens of existing theoretical constructs, disciplines, models or typical understandings. Therefore the following terms will be referenced for this study.

Therapeutic Relationship

There is no consensus in the field as to a clear definition of the therapeutic relationship, or its constituent components. Much of the prior research has utilised the construct of the therapeutic alliance to explore how therapists and clients negotiate their relationship, in particular the goals and tasks of therapy. There is a general tendency in the literature to treat the concept of the therapeutic alliance and the therapeutic relationship as interchangeable, yet in the view of many authors they are not identical constructs (Gelso, 2009a; Horvath, 2009; Safran & Muran, 2006). The main distinction for this study is that the therapeutic relationship is not viewed as being synonymous to the therapeutic alliance. Therefore when mentioned the therapeutic relationship and alliance are seen as being separate and different constructs.

The therapeutic relationship can be viewed from both individual and connective standpoints (Aron, 1996; ; Barrett-Lennard, 2007). At a connective level the therapeutic relationship is an interactional system that emerges and develops to form a life of its own. In this view the therapeutic relationship system becomes an entity in itself where participants influence and are influenced in an interactive process. In an individual sense, the therapeutic relationship means that two people have an association and are causative players in its process. This view (Barrett-Lennard, 2007) holds that individuals are the bearers of consciousness and that relationships support, satisfy or frustrate individual needs and desires. This dual definition serves the purposes of this research.

Mutual Influence

Mutual influence for the purposes of this study is defined as the joint conscious and unconscious impact of one person on another. Especially when sharing a joint emotional field. An introduction to mutual influence is outlined in chapter 2.

The Therapeutic Alliance

The therapeutic alliance when referred to in this study pertains to the construct outlined by Bordin (1979). His conception of the alliance was a collaborative endeavour encompassing three key components: agreement on therapeutic goals, consensus and collaboration on therapeutic tasks, and the nature of the bond between therapist and client as it relates to collaboration of goals and tasks of therapy.

Boundaries

As explained previously, a conscious decision was made to avoid the use of existing theoretical jargon where possible. The term “boundaries” falls into the category of jargon.

Despite this the word boundary and its derivatives were retained because it was language introduced and used by participants to a significant degree. The word boundary is a well known short hand term in the profession meaning the limits placed on the relationship to keep it on a professional footing. For the purposes of this study the word boundary is used to describe how the participants engaged and related to one another on a mutual person to person basis. This way of looking at boundaries emerged from the stories and had significance for the participants. Therefore in this thesis boundaries are not referred to solely as a term of reference for the behaviour of therapists that is governed by a code of ethics.

Thesis Overview

This chapter has provided a synopsis of the context for this study. This includes a rationale for the significance of the research and its purpose, my position as the author and a definition of the particular terms used throughout. In Chapter 2 the relevant literature is reviewed and critiqued. Because there is limited research and literature on mutual influence I have included areas of study that relate closely and overlap with the current topic. Chapter 3 outlines the methodology chosen for this study and gives a detailed description of participant selection, data collection and analysis. Chapter 4 begins the presentation of the data by describing and interpreting how the seven relationships managed boundaries and the links between relational boundaries and trust. Chapter 5 presents six of the seven cases studied and focuses on representing how the personal aspects of the relationship and mutual influence interact. Chapter 6 brings together the findings and examines and critiques the themes in relation to the literature. This includes linking the themes in chapters 4 and 5, and outlining the similarities and differences between the different case studies. Chapter 7 outlines the contribution of this thesis to research and considers the implications and recommendations for clinical practice, education and policy. I have been privileged to be able to enter into the private vortex of seven therapeutic

relationships. The following chapters are my attempt to honour the raw material so generously given by the participants, while also making epistemological sense of the data from my own relationship with the participants and their personal accounts.

Chapter 2

Literature Review: Mutual Influence in the therapeutic Relationship

Introduction

Humans are born hard wired for relationships (Bowlby, 1965 ; Cozolino, 2006). The experienced power of satisfying and emotionally connected relationships forms the hub of one's sense of self (Fonagy, Gergely, Jurist & Target, 2004; Schore, 2003; Sroufe, 1996) and consequent resilience for the ups and downs of life (Cassidy & Mohr, 2001; Fonagy, et al., 2004). Mutuality in relationships encompasses the implicit and explicit ways that experience and learning crosses the gap from one mind to another (Siegal, 2009; Stern, 2004). Sometimes the developing self is lost in the translation of this mutual endeavour, resulting in ongoing difficulties with life, relationships or mental health. There are no shortages of psychological theories and models to explain how the process of human development and growth is fostered or thwarted and in turn how to rectify its deficits. Regardless of theories or models, central to the process of human change and transformation in therapy is a therapeutic human relationship (American Psychological Society, 2002; Barrett-Lennard, 2007; Cozolino, 2010; Schore, 2003; Slade, 1999).

The relationship in therapy between a therapist and client is now commonly viewed across diverse traditions and models of therapy as one of the vital contributors to healing and change for clients. Despite its significance, the essence of the therapeutic relationship has evaded theorists throughout its history, from Freud to postmodern perspectives. At this point in time the resurgence of interest in neuroscience has brought the debate full circle from Freud's early beginnings as a neurologist, returning to a focus on the brain and its role in clinical practice (Cozolino, 2006; Schore, 2003; Siegal, 2009). The evolution of the therapeutic relationship throughout the last one hundred and twenty years has taken many directions. In particular there

has been a renewed interest in attachment (Collins, 2007; Harris, 2004; Schore, 2003; Slade, 1999; Wallin, 2007) due to recent links with psychoanalysis (Fonagy, 2001; Schore, 2003; Wallin, 2007) and neuroscience (Cozolino, 2010; Decety, 2010; Lewis, Amini & Lannon, 2000; Siegal, 2009). Alongside these trends there has been a paradigm shift within contemporary psychoanalysis towards a relational approach that emphasises inter-subjectivity (Aron, 2007; Mills, 2005; Mitchell, 1995; Orbach, 2007). The concept of the therapeutic alliance which originated within psychoanalysis (Zetzel, 1956) faded into the background for a time and then remerged in the middle of the last decade, fired by renewed enthusiasm from American researchers and theorists (Castonguay, et al., 2006; Horvath, 2006; Safran & Muran, 2006). More recently, the notion of the real relationship (Greenson, 1971) has resurfaced (Gelso, 2009b) with new vitality, complete with new variables of interest and new psychometric measures.

This chapter introduces and critiques previous research and literature on mutual influence in the therapeutic relationship, plus topic areas that interrelate with mutual influence. I have included literature that is closely linked to the development and maintenance of good relationships in general, not only those in the therapeutic setting. Therefore relational themes that are both universally human and particular to therapy will be examined. This includes an analysis of the historic and current issues in the field pertaining to the therapeutic relationship, as well as identifying the gaps that exist at this point in time. An extensive search of the literature contained in multiple databases revealed that the Australian context has a paucity of offerings relevant to mutual influence in the therapeutic relationship, and therefore the majority of the literature examined has been gleaned from overseas authors and researchers.

What is Mutual Influence?

What is the meaning of mutuality or mutual influence? To begin, mutual influence is the product of two words that both have separate meanings in every day common sense terms.

According to Merriam Webster (2002) *mutual* means the parties unite by interchange in the same act; as a *mutual* covenant. The Australian Oxford Dictionary (2007) describes *mutual* as "something felt or done by each to the other" and *influence* as "action invisibly exercised" or "to exert influence on, or affect". While these definitions leave room for both conscious and unconscious affect and behaviour, they do not really address the level or meaning of mutuality within the therapeutic relationship, nor do they include any reference to whether mutuality or influence within a relationship is unidirectional, equal or something different again.

Mutuality in the therapeutic relationship is therefore an interpersonal phenomenon that impacts both people involved. There is the impact on the client and the therapist individually, but importantly there is also the impact on the dyad as a system or entity in its own right (Aron, 1996; Mitchell, 1995). Therefore the subtle and incremental dynamics and interactions between therapist and client include implicit and explicit forms of mutual influence that become part of the daily crucible of clinical work. At this point there are no empirical research studies that have focussed on this aspect of the therapeutic relationship over time, and very limited literature that focuses on mutual influence as a shared experience, from the perspective of both therapist and client.

An Early History of the Therapeutic Relationship

The significance of the therapeutic relationship was first articulated by Freud (1912). He believed the therapeutic relationship to be central in working through the client's neurotic attachment patterns with parents that had been displaced onto the therapist. This displacement was viewed as a distortion of reality. The therapist's role was one of observation and interpretation from a purposely uninvolved stance that did not contaminate the emergence of the displaced feelings and attitudes that Freud termed transference. The focus of therapy was on the client's intra-psychic life, with the therapist in the position of objective expert, influencing and

changing the patient through theoretical interpretations of the patient's content. Therefore the therapist was seen to be the one who was all knowing and the arbiter of the client's psychic realities or fantasies.

While working with and through the transference was seen as the sin qua non of psychoanalytic psychotherapy, Freud (1912) also acknowledged the vital importance of building rapport and *attaching* the patient to the person of the doctor. However while Freud viewed the consciously positive and friendly aspects of therapy as the necessary conduit for treatment, he also wrote about rapport and transference interchangeably. Therefore the more reasoned, rational and reality based aspects of the relationship were acknowledged as necessary to engage in successful treatment but were still treated as a form of transference that was subject to interpretation by the therapist. Over time there were various splits from Freudian theory and its focus on the unconscious, one of which developed the relationship as a more conscious pact.

The term therapeutic alliance was first introduced by Zetzel (1956) to describe the healthy part of the patient's ego that aligned with the therapist to engage in the tasks of therapy. The concept of the alliance was progressed to include the notion of therapist and client forming a personal bond (Greenson, 1971). The bond was seen as a reality based attachment utilised by the client to help manage and resolve the more neurotic attachments that co-existed alongside the reality based aspects of the bond. In this sense Greenson extended the bounds of the therapeutic relationship to include more rational and undistorted aspects of a *real* relationship.

It was Bordin (1979) who introduced the idea of the working alliance as a collaborative endeavour encompassing three pantheoretical components: agreement on therapeutic goals, consensus on therapeutic tasks, and a bond between therapist and client. The focus on bonds, task and goals as actively collaborative components of the therapeutic relationship were the distinguishing feature of Bordin's working alliance. He reformulated the concept as a more conscious part of the relationship that was both necessary to undertake the work, as well as being

therapeutic in and of itself. Luborsky (1976) expanded these ideas to include particular relational elements. He suggested the alliance developed in two phases. The first phase included the provision of a warm, supportive or *holding* relationship that was necessary for the work of therapy to take root and grow. The second phase included the client believing in and taking shared ownership of the work, plus having faith in the process. The alliance concept was heavily criticised from within psychoanalytic ranks (Safran & Muran, 2003) for conforming with the patient's desires, over valuing the role of consciousness and reality, and emphasising the human influence of the therapeutic relationship at the expense of finding the correct interpretation. The notion of the therapist as all knowing versus a working partnership remained a consistent tension throughout the history of the therapeutic relationship, particularly within psychoanalysis.

The seeds of the role of the therapeutic relationship as being curative in and of itself were first sown by Ferenczi (1932) He discerned that it was the unnatural, aloof and insincere stance of the classically oriented analyst that precipitated and repeated the patient's trauma. He challenged the prevailing focus on the patient remembering and gaining insight, and advocated a case for the centrality of experience within the relationship itself. Ferenczi (1932) had a strong conviction about the role of the person of the analyst as being vital to the process of therapy, and he championed the idea of the *real* over the *contrived*. In particular he emphasised that only a sincere relationship could be the basis for trust. Emotional accessibility and honesty were essential. In shades of the future for contemporary relational psychoanalysis, Ferenczi also maintained that transference and counter-transference involved mutual participation. He went further to suggest that analyst and patient heal each other through mutual analysis. This was highly controversial, however by his own admission, Ferenczi (1932) had a penchant for extremes and risk taking, and this tendency found him out of favour within mainstream psychoanalysis. His focus on the reciprocal processes that operated between analyst and patient were considered too radical. Ferenczi's thinking that healing could only result through deep

empathy and love, rather than evoking negative transferences or reactivating trauma, was definitely outside the mainstream for his time. There were however others who shared the idea of replicating maternal love and its deficits.

The British object relations theorists (Bion, 1962; Bowbly, 1965, 1980; Winnicott, 1965) separated from classical psychoanalytic theory by placing an emphasis on the developmental and systemic origins of psychopathology, particularly stemming from the early mother infant relationship and the human need for attachment. The therapeutic relationship gathered importance within object relations thinking, which focussed on what Winnicott (1965) famously named the *holding environment*. The notion of *holding* meant the therapist attending to, and staying with, the non verbal, emotional and regressed states of patients rather than interpreting the transference. This emotional *holding* (Winnicott, 1965) or *containment* (Bion, 1962) acted as a maternal metaphor that provided a *corrective emotional experience* for the client.

Self psychology (Kohut, 1971, 1981) was part of the object relations school but had a slightly different emphasis. Self psychology extended the parameters of mental health to include a less moralistic and pejorative view of narcissism, and gave increasing emphasis to the role of relationships over and above internal conflicts and biological drives. In particular Kohut placed great importance on empathy, both its failures in early relationships and its reparative role in the therapeutic relationship. By highlighting the role of empathy and its absence in traditional analytic therapy Kohut's theory of the self also pointed indirectly to the importance of the therapist's contribution to the transference. However Kohut's theory of careful empathic attunement and mirroring, whilst taking the relationship into account, was still predicated on the concept of transference. His theory focused on the idealising, mirroring and twinship transferences (Kohut, 1981) that he believed met the underlying human needs required to develop a solid sense of self.

The humanistic client centred tradition catapulted the relationship into the foreground. The work of Carl Rogers (1951, 1957) brought to the fore the notion that it was specific relationship conditions rather than techniques, that were responsible for effective therapy. Rogers proposed that the conditions of empathic understanding, congruence and unconditional positive regard provided by the therapist were, in and of themselves, necessary and sufficient to release the client's natural *actualising* and healing tendencies. Empathic understanding was the ability to perceive the feelings and experiences of the client and their meaning. Congruence was the matching of both inner experience and outer expression by the client, and unconditional positive regard was the total and unconditional acceptance of the client by the therapist. According to Rogers, personal change and growth happened in and through a caring and understanding relationship.

In the preceding decades an enormous body of research has verified that a good therapeutic relationship correlates with positive outcome, however it was also discovered that Rogers core conditions, while beneficial, were not considered *sufficient* for change (Horvath, 2000). Rogers (1957) view of the relationship was based on a particular *way of being,* and *regard* for the client. This included therapists treating the clients as equals and not unduly mystifying the process. Historically, Rogers provided not only the first theoretical argument for the therapeutic relationship as a healing force (Safran & Muran, 2003) he also exposed his theory to empirical scrutiny. However Roger's theory of therapist provided conditions is none-the-less therapist centric.

The therapeutic relationship developed from its inception over time to include intra-psychic, interpersonal and mutual concerns. However the apparent ambiguity between the reality based, or conscious aspects of the therapeutic relationship and the unconscious or transference related aspects, have reverberated through the historic developments of the therapeutic relationship and alliance since its origins with Freud. Object relations theorists despite having a

developmental focus, placed an important emphasis on being able to distinguish the psychological boundaries between self and other. The arrival of views that espoused a more relational or bi-directional process in therapy were not readily accepted. Contemporary views of the therapeutic relationship continue this debate. The state of the field was rich but very diverse, with no real unified voice regarding the therapeutic relationship or its future.

Comments on the Early History

My experience of reading the early literature raised more questions than answers about mutual influence and the therapeutic relationship in general. The field was rife with theoretical disagreements, professional splits and damaged relationships. Different schools of thought or heretic independent thinkers were strategically locked out, ostracised or condemned by classic theorists. For example it is difficult to make sense of conflicting statements and opinions about Freud as a therapist and a theorist. Bowlby's (1980) empirical research focused on real experiences and had positive ramifications for clinical work, yet was airbrushed from the psychoanalytic picture for decades. Ferenczi (1932), whose ideas and experiments set the agenda for most of the current debates within contemporary psychoanalysis (Aron, 1996), had his work suppressed for half a century by mainstream psychoanalysis. Rogers (1957) was often criticised as having a Pollyanna view of human nature, and being overly positive and simplistic yet today Rogers client centred theory underpins most contemporary approaches to therapy (Cooper & McLeod, 2007).

Alongside the rigorous and detailed attention to the development of particular theories, and the lively intellectual debates, therapist's personal lives bled into their work in poignant yet obvious ways. At times it was difficult to differentiate the personality from the theory. While it is beyond the brief and focus of this thesis to explore the personal histories of these seminal figures from the past, their theories and clinical work were illuminated and made sense of through the

details of their personal lives. It is evident that therapists developed and built their theoretical concepts through either, breaking away from, or adhering to, aspects of their own histories. This included searching for the gaps in their own early emotional experiences. The personal subjectivity that drove each theorist's particular interests, and the social and cultural context that spawned them, were fundamental to both their discoveries and their limitations.

Contemporary Views of Mutual Influence

Much of the literature that discusses mutual influence or reciprocity comes out of the growing relational movement (Aron, 1996; 2007; Mitchell, 1995; Orbach, 2007; Slavin, 2007; Slavin, 2010; Stolorow, 2002) that has been spawned from the mainstream psychoanalytic traditions within Britain and America. Within this view the therapeutic relationship is viewed as a mutual or inter-subjective process. However what this actually means in theory is quite varied between the different relational schools and theorists. While the paradigm debates are far from over within relational analysis, the notion of the therapeutic relationship as an inter-subjective system (Atwood & Stolorow, 1984; Eshel, 2010; Mitchell, 1995) to which both patient and therapist contribute has taken over from traditional Freudian theory. Although despite having a more relational and bi-directional view, the relational literature commonly portrays and explores the therapeutic relationship from the perspective of the therapist and through the existing psychoanalytic constructs of transference, counter-transference or projection.

Mutual influence does not have a specific or strong presence in the broader non-analytic literature. A range of authors tackle mutual influence from the stance of the power differential in the relationship (Spong, 2007; Witty, 2005), issues of self disclosure (Aron, 1996; Cornell, 2007; Renik, 1995), divergent needs (Slavin & Kriegman, 1998) co-analysis (Fiscalini, 2006), and expressions of care (Aron, 1996; Fosshage, 2007). However postmodern approaches to therapy have also adopted the terms and concepts within psychoanalysis, and continue to frame their

thinking through the lens of constructs such as transference and projection. However overlaps with mutual influence can be found in some contemporary views (Brown, 2006; Jordan, 2010) and those of recent trends in attachment and neuroscience as applied to psychotherapy (Cozolino, 2006; Schore, 2003; Siegal, 2009; Wallin, 2007).

Relational Analysis

Relational theory was developed in the 1980's (Greenberg, 1986; Greenberg & Mitchell, 1983) in an attempt to expand and encompass the full range of interpersonal functioning in therapy. This domain included external relationships, and internal and intra-psychic relationships, both real and imagined. Relational theorists as a whole are not a homogenous group and represent a diverse range of hair splitting perspectives. The distinct theoretical positions they hold never the less, share the underlying belief that the therapeutic encounter is co-constructed between two active participants. In particular this includes the importance of the therapist's subjectivity and the centrality of the relationship as an inter-subjective system (Aron, 1996; 2007; Fiscalini, 2006; Mitchell, 1995; Orbach, 2007). "Clinical phenomena ... cannot be understood apart from the inter-subjective contexts in which they take form. Patient and analyst together form an indissoluble psychological system, and it is this system that constitutes the empirical domain of psychoanalytic inquiry" (Atwood & Stolorow, 1984, p. 64). Despite the shift to a more systemic view of the therapeutic dyad, great pains were taken to reinforce that this system is asymmetrical and therefore does not operate in an equal way.

The majority of the authors who have aligned with relational theory use the analogy of the mother infant relationship to explain their rationale for the asymmetry of reciprocity within the therapeutic relationship. The maternal analogy highlights that while the mother and infant may impact and influence each other in their interactions, they do not necessarily influence each other in identical ways or with equal impact. The power differential between an adult and an infant is

obvious. Therefore transposing this analogy to mutuality within the therapy relationship implies a form of reciprocity and sharing that is qualitatively and quantitatively different for both therapist and client. However adult to infant interaction does not necessarily translate, even metaphorically, to adult to adult interaction, and not all therapists agree with the view that clients are more vulnerable than therapists (Lazarus, 1994; Williams, 2000; Zur, 2008). Aron (1996) differentiates mutuality from symmetry by exploring the variety of ways that mutuality manifests in analysis. He states that, "mutual transferences, mutual resistances, mutual regression, mutual generation of data, mutual enactments, mutual regulation" (Aron, 2007, p.98), and more, contribute to mutuality within the analysis. But, according to Aron, none of these manifestations implies a collapse into symmetry due to the fact that patient and analyst have separate roles and responsibilities. One of the contentious topics within this debate has been the issue of therapist self disclosure.

Mutual Influence and Self Disclosure

Self disclosure has become a much debated part of this analytic relational reform, and according to Cornell (2007) it is not about whether to say or withhold a piece of information, it is about being authentic. In the same vein (Renik, 1995) suggests that every decision not to intervene communicates something to the client. "In my view, to suggest that an analyst can minimise communication of his or her idiosyncratic psychology, emotional reactions, personal values, constructions of reality, and the like, is to advocate pursuit of an illusion" (Renik, 1995, p.468). Renik argues that analysts are always revealing themselves regardless and it is counterproductive to view deliberate self disclosure as something that *burdens* the therapy and necessitates *damage control.* In the end anonymity is a psychoanalytic strategy intended to unveil the patient's unconscious mental life, and as such is a posture that the analytic profession are reluctant to give up. However it is intriguing that in this paradigm, self disclosure is seen as

giving too much reality and therefore lessening the opportunity for fantasy or imagination to fuel the transference. If the coin is flipped, it could also be said that the mystique and authority of the therapist can be maintained more readily through a distant and more anonymous stance. This would seem to benefit the analyst. Interpretations or comments that are ambiguous and delivered without clarification can potentially pave the way for the analyst to be an un-challengeable authority with magical powers. However there are always two sides to an argument.

Watchel (1993) suggests that the protected position of the analyst, in being less known to the patient, allows the analyst to work in a state of lowered anxiety that serves the patient. This position enables the analyst to pursue themes with the patient without the threat of having to expose a personal vulnerability. According to Hoffman (1994) the position of asymmetry of self disclosure in the relationship enables the analyst to function at his or her best, and to be more understanding and tolerant. So the early concerns were that therapist self disclosure could be too gratifying to the client, or a form of acting out. As such it was seen to obscure the nature of the transference and restrict reactions and fantasies. However according to (Aron, 1996) the more current relational school of thought would say self disclosure concretises what ought to be left in symbolic form, and therefore closes rather than opens the space for clients to create for themselves what they need. The difficulty with both early and late concerns is that they are a contradiction in terms. If the current relational schools propose that the therapist and client mutually participate and co-create the relationship, then conjuring up symbolic unreality begins to look like transference in another guise.

More recent views attempt to assess the impact of the therapist's theory or model on levels of self-disclosure (Carew, 2009). Carew recommended that more client feedback was needed to understand the impact of therapist self-disclosure on the therapeutic relationship. Audet and Everall (2010), investigated the impact of therapists self-disclosure on the relationship and found it was both facilitating and hindering; however they cautioned against indiscriminate self-

disclosure. Therefore studies in general seem to circle back to the reality self-disclosure is in essence a clinical judgement in the moment, while theorists try to explain it through the lens of existing constructs within their tradition.

Aron (1996) lists some of the current struggles saying that self disclosure can close off a topic, distract the patient from an exclusive focus on themselves and assert the analysts authority. He asks questions along the lines of: Who should initiate the disclosure? Should it be thought through or spontaneous? Should the analyst share their thinking with the patient? Should disclosures only focus on in session immediate material or include details about the therapists outside life? In the end Aron errs on the side of *optimal asymmetry* which leaves the analyst free to choose whether to disclose or not. This relativist position leaves the door open for a range of responses to the dilemma. Aron was firm that he disagreed with Renik's (1995) proposal which he saw as an extreme reaction to standard technique and anonymity. However while stating that there was no right way to self disclose Aron (1996)said he was against the stance of analysts doing or saying whatever they pleased as long as it was analysed. There are not many answers in the previous position, and part of what complicates the issue, is that any current stance is yet again sifted through the net of existing analytic theory keeping things theory bound. Other relational theorists take a more liberal view.

Co-Participant Inquiry and Mutual Influence

Fiscalini (2006) advocates a style of relational analysis called Co-participant Inquiry that values the relationship as a personal encounter. He states that this form of inquiry calls for a more "natural, less stilted and reserved way of analytically interacting or relating" (Fiscalini, 2006, p.449).This variant of psychoanalysis sprang from the interpersonal school (Sullivan, 1954) and is considered to be at the radical end of the continuum. Fiscalini was influenced by the work of Ferenczi (1932), hence his more liberal views. The name co-participant was formulated

to emphasis the intrinsic mutuality and *psychic symmetry* of the therapeutic relationship (Fiscalini, 2006). Philosophically and in practice it collapses the asymmetry in the relationship that Aron (1996) states as being essential, and that Hoffman (1994) and Watchel (1993) suggest provide the optimal climate for the therapist, which in turn benefits the client.

Co-participatory inquiry (Fiscalini, 2006) extends the participant-observer model (Sullivan, 1954) and views mutuality as a phenomena where both therapist and client are treated as analytic equals and have the potential to be transformed, "thus patients are actively encouraged to take a pro-active role as analytic co-partners" (Fiscalini, 2006. p 442). In co-participant therapy the analyst is not seen as the expert or the arbiter of reality, however they are viewed as someone who has developed some wisdom about the human condition that may prove useful to those they work with and the process is seen as reciprocal. "The patient may prove insightful about the analysts difficulties and, accordingly, may contribute to his or her co-participatory partner's psychological development" (Fiscalini, 2006, p. 443). According to Aron (1996) a theory or technique that requires self disclosure is equally as limiting as one that puts an injunction on it.

An early study (Cappella, 1981), but one of the very few on mutual influence, investigates reciprocity through the interpersonal impact of expressive behaviour. This study found that mutual influence is a pervasive feature of social interactions across a wide variety of expressive behaviours. A particularly robust conclusion was what Capella calls the *disclosure-reciprocity effect,* where disclosure begets disclosure. While the study focussed on observable verbal and non-verbal behaviours of adult dyads, the matching and compensatory influences within the interactions, mapped onto the interactions and processes also found in attachment relationships (Cassidy, 2001; Crawford, Shaver, & Goldsmith, 2007). In light of this study, if symmetry of self disclosure was considered the norm in therapy, as espoused by the co-participant inquiry model, then it would imply a true collapse of current professional boundaries and reduce therapy to a dynamic similar to a social relationship. This would have implications for the professional

relationship, which has an intrinsic undercurrent that is often discussed in terms of the power differential between the authority and influence of the therapist versus the client's fragility and dependence.

Mutual Influence in Relation to Power and Autonomy

Witty (2005) placed great emphasis on the power of the therapist. She says that all therapies are a form of social influence. She argues for the helpfulness of the non-directive person centred approach, because it is her belief that it is impossible to avoid harm. Therefore the main aim of the therapist should be to minimise the level of harm. Witty believes that the non-directive approach gives clients *a kind of power*, because their reactions make some degree of difference to the therapist. Yet even in pure Rogerian therapy (1951), not all personal material offered by the client would receive qualitatively or quantitatively equal attention from the therapist. Also if it became evident that a client lacked essential information, it is unclear how Witty's (2005) view would reconcile giving the necessary information within a dictum of harm.

Spong (2007) explored counsellor's perspectives of influence. Counsellors took three distinct core positions on influence in therapy. 1. Counsellors should not influence. 2. Influence is inevitable, and 3. Counselling is influence. In essence the counsellors in this study viewed influence through the lens of power dynamics and differentials. This included a focus on the client's right to autonomy. This finding is not surprising, as it aligns with the power imbalance consistently thought to be inherent in the therapeutic relationship. However it is an argument that has begun to be countered (Lazarus, 1994; Zur, 2008) in that it can deny the realities of client's power, and places too much emphasis on exploitation and harm. What Spong (2007) sees as the powerful focus on client autonomy, also denies the counter argument that autonomy can be a form of abdicating responsibility. According to (Bond, 2004) an over reliance on informed consent and autonomy can disempower clients. "You were told, you agreed" (Bond, 2004, p.

80). As such there can be contamination of trust with self responsibility and compliance, rather than a relational response and a joint working through of the issues.

According to Spong (2007), the therapists in her study struggled with differences in understanding the lack of clarity of the word *influence* and its meaning. Of each core position mentioned above, one and three generated many quotes from the research, whereas core position two, influence as inevitable, only had three quite broad and vague examples from participants. Therefore it appears that position two is less understood by professional counsellors and psychotherapists. This highlights the notion of unconscious influence or hidden influence, versus deliberate influence a paradox, in that, influence is inevitable, yet deliberate influence is not acceptable; however it will occur regardless. According to Spong (2007) the legitimacy of influence within counselling can be seen as a necessary evil or an accepted good. Influence in relation to power is often discussed using the metaphor of the power imbalance of a parent and an infant; however in reality this metaphor does not translate easily to the realities of adult to adult therapy. This is clearly a contentious issue, and if the concept of inter-subjectivity is accurate then it is one that will require further clarification in clinical practice. The challenge of mutual influence and power leads to related sub issues that travel beyond model and rules.

Mutual Influence and Divergent Interests in Therapy

Slavin and Kreigman (1998) tackle mutual influence from the perspective of conflict within the therapeutic relationship deriving from diverging interests and needs. From their perspective, the identity and self interest of both therapist and patient underpin the continuing efforts at mutual influence within the therapeutic relationship, and are "likely only allowed to be used" (be influenced) by their analyst, when they experience the analyst as genuinely allied with their interests" (Slavin & Kriegman, 1998, p. 258). Inter-subjective disjunctions are viewed as being rooted in genuine conflicts of interest that generate continuing efforts of mutual influence.

They say we must be influenced and feel this influence, and it is the patients experience of the analyst changing in the face of the patients personal influence that impacts the patient to open themselves up to rework old conclusions. “They take us someplace that is obviously hard for us to go. But we go there and often change in the process, because having a relationship with them requires it” (Slavin & Kriegman, 1998, p. 281). Being open to the influence of the client is not usual in the psychoanalytic frame of working, especially from the classical stance of anonymity. However as poignant as this revelation is, it is not unusual for general therapists or non analysts to be guided by the client’s frame of reference (Jordan, 2010) or theory of change (Duncan & Miller, 2000). However the difference being, Slavin and Kriegman (1998) are talking about interpersonal emotional influence, as is Jordan, whereas Duncan and Miller are describing a strategic form of alliance.

Mutual Influence and Expressions of Care

A broader more controversial aspect of mutuality within relational analysis emerges from the gap identified by Aron (1996). He notes that while remaining mindful of the asymmetry and differences in roles, functions, power and responsibility between the therapist and the patient, there is a lack of emphasis in classical analysis placed on the importance of the “patients caring, reaching, penetrating, loving, healing or analysing the analyst” (Aron, 1996, p. 125). If as Aron postulates the analyst’s personal contributions are fundamental to the process of therapy and the analyst’s affective experience is a major component of the method, it is unlikely that analysts would want neurosis, pathology or transferential distortion to be viewed as mutual endeavours. However in the classical one person psychology model there was no danger of this, whereas in the two person perspective, the analysts own pathology becomes unavoidable. Returning to the gap noticed by Aron (1996), Fiscalini (2006) has since mentioned all these factors and more in relation to classical theory.

> "If a patients transference experience of curiosity about the analyst is seen only as expression of some endogenous dynamic, such as primal sexuality, hostility, or infantile dependence, then other possible unconscious motivations, such as loving care, fearful ingratiation, or compassionate helpfulness, interactionally linked to the analyst's countertransference [eg. His or her loneliness, exhibitionism, or desire for treatment] may be overlooked, and a truer, more complex interactional meaning of the patients transference may go unrecognized" (Fiscalini, 2006, p. 444).

This raises the question of how open or vulnerable does the therapist need to be in order to be therapeutic? According to Cornell the therapist's willingness to experience and inhabit their own vulnerability can deepen the therapeutic endeavour.

Mutual Influence and Vulnerability

Slavin (1998) discussed influence in terms of reciprocal vulnerability to being influenced, both in treatment and in supervision. He viewed analyst and patient as being susceptible to influence through their own, and each other's subjectivity in ways that neither one could predict or apprehend. Slavin states that clients come to therapy implicitly seeking to be influenced, yet at the same time are guarded and sceptical of the very influence they desire. He suggests that clients test the relationship until some *turning point* that enables them to fully believe the therapist can be trusted to provide the kind of influence that will be in their best interests. However further to this Slavin believes that it is the therapist being open to influence from the client that is central to how client change occurs. Therefore it is not only a nice relational thing for the analyst to be personally involved, it is a necessity. In essence the therapist would have to risk being in the vulnerable position of allowing the client to impact them. If this is unpacked further, it could also mean that the client cannot become more authentically themselves without being shaped in some way by the therapist's personality.

Synopsis of Mutual Influence in the Field

The skew towards relational analysis in this review of the literature means that current research and literature does not fully represent the perspective of the broader professions of counselling and psychotherapy in relation to mutual influence. Other empirical research on the relationship concentrates on investigations of treatment and outcome (Horvath, 2005; Hubble, Duncan & Miller, 2009; Safran & Muran, 2003; Wampold, 2001); however the need for a focus on relational factors within the therapeutic dyad are acknowledged as necessary for future research. The ongoing debates within the analytic relational literature show a wide variety of theoretical nuances around how to treat and manage mutual influence as a relational phenomenon. However the direction and consensus seem to be around greater technical freedom, the judicious use of self expression, including the sharing of experience or emotional reactions. This shift allows for more attention to authentic 'here and now' interactions rather than historical excavations of a clients past followed by therapist centric interpretations of the clients reality. Relational theorists are therefore arguing for a more interpersonal rather than intra-psychic focus where the therapeutic interaction becomes the focus rather than the unveiling of the clients unconscious.

An examination of the literature by relational theorists exposes a wealth of rich anecdotal examples from analytic therapists reflecting and theorising on their clinical case material in great detail. However the stories are told through the eyes and theories of the therapists. It is clear from the accounts in this body of literature that influence in therapy is not seen as a unidirectional process, quite the contrary. Yet the voice and view of the client is missing. For a discipline that holds the view of inter-subjectivity and bi-directionality at its centre, having the client or patient absent in the literature denies the espoused mutually interactive nature of the relationship.

Non-analytically trained therapists who have been working in the relational cultural, feminist, existential and humanistic traditions may wonder what is new about these discoveries within the psychoanalytic world. Allowing the relational analyst to become a more active and real contributor to the interpersonal dynamic, and acknowledging the value of 'here and now' interactions is merely bringing psychoanalysis more into line with other post modern disciplines and professions that espouse empowering the clients voice and that healing happens in connection with others (Brown, 2006; Jordan, 2010). Also as social and cultural mores have changed, the freedom of self expression, as seen through reality based television and the internet, means that analysis is no longer administering to a repressed society.

Yet the non-analytic mainstream professions of counselling and psychotherapy have not fully embraced the notion of inter-subjectivity. While being egalitarian and genuine in the here and now is more common place within post modern theories, the mutuality of the relationship as defined by the relational analysts has not been researched or explored anecdotally outside that discipline to any significant degree. Some of the themes drawn from the relational literature, point to areas that have a significant impact on the quality of the therapeutic relationship. Issues like power, autonomy, empathy, trust and vulnerability as a mutual enterprise are not usually seen in contemporary treatment plans. The treatment relationship is still viewed generally from a one way perspective despite the impact of inter-subjectivity over the last decade. The tension remains between the level of therapist involvement in the relationship, and where the boundary of that involvement gets drawn.

Mutual Influence in Therapy: Where is the Boundary?

The relational view emphasises the inevitability of a mutual and reciprocal two-way influence between patient and analyst, over the classical uni-directional view that preceded it. Yet mutuality as a principle, needs to be balanced by self regulation or autonomy (Mills, 2005).

However it was not clear from a reading of the relational literature what personal capacities facilitated self regulation. If mutuality is inevitable and irreducible, where is the psychological boundary of the self, and how does it operate in a given relationship? The idea of being able to hold onto one's own mind in the face of an intense interpersonal pull is an intriguing question. Are human minds so impenetrable that the self gets lost in every intimate discussion? There does not appear to be any literature on this topic, except to revert back to the Freudian concept of defences as self protection. The work of Wilfred Bion (1962) addresses living with internal and external emotional intensity by including comment on the phenomenon of being able to think under fire. Bion uses this war analogy because he was treating traumatised soldiers after World War II. But also because he was underlining the notion of being able to hold onto one's mind when under physical and emotional challenge or attack. The notion that therapists could be personally affected by their client has commonly been reported in terms of the psychological damage or vicarious trauma that could be experienced. Almost as if pathology can be caught like the flu. The positive aspects of being impacted by clients are less prevalent.

The fact that therapists could also experience personal growth, development and change through interactions with clients has been explored (Beitman, 1987; Kottler & Carlson, 2005; Kottler & Smart, 2006). This aspect of the relationship has been researched in relation to the personal transformational experiences of therapists as a result of being influenced and changed through their experiences with clients (Kottler & Carlson, 2005a). However the notion of co-analysis (Fiscalini, 2006) extends the bounds of normative treatment and is quite controversial. For mainstream therapists who are not analytically trained and are employed in a range of work settings and integrate a range of post-modern theories, the notion of co-analysis would be more than fanciful. How could one justify the cost of therapy? Who should be paying who? Is this what the client expects, wants or contracts for? The relationship in therapy is an emergent phenomenon (Safran & Muran, 2006) as is the agenda for therapy, therefore expectations, goals

and predicted contracts for the relationship and the work run counter to the process. Despite the tension between emergent and pragmatic properties necessary for a successful therapeutic relationship, the concrete focus of the therapeutic alliance on goals and tasks informs the pragmatics of engagement and contractual arrangements of most mainstream therapists operating within postmodern paradigms.

Contemporary Views of the Therapeutic Alliance

While most alliance theorists nowadays share the view that the therapeutic alliance is about collaboration between therapist and client in therapy, this joint work is seen as being accomplished through a focus on the goals and tasks of therapy rather than the interpersonal relationship. So while the working alliance relies on a bond between therapist and client, it is the active component of the relationship, as in the agreement on goals, and consensus and participation around tasks that has been fundamental to the alliance, and therefore the main locus of investigation for research.

The alliance has been the subject of a substantial body of research since its inception, and over time it has been found to be a consistent predictor of positive treatment outcome. (Castonguay, et al., 2006; Hatcher & Barends, 2006; Horvath, 2006). Alliance research brought the therapeutic relationship back into focus at a time when the person-centred tradition with its emphasis on the core facilitative conditions had become marginalised, and overtaken by the trend towards specific treatment approaches (Wampold, 2010). Within this trend cognitive behavioural therapy (CBT) has played the starring role and relationship factors took a back seat to specific techniques and treatment manuals. Gelso (2006), suggested this was because theories and constructs in *soft* psychology that were once *hot*, seemed to fade away because scholars lost interest after finding that the constructs were highly imperfect.

The therapeutic or working alliance now refers to a number of related constructs with no single accepted definition. It has been defined historically (Bordin, 1979; Greenson, 1971; Luborsky, 1976; Safran & Muran, 2006) in terms of the instrument developed to measure the particular alliance construct under question for a specific study. At present there are more than twenty four different alliance scales in use by researchers. These many and various measures "have relatively little impact on how we understand the alliance" and "render the empirical evidence less clinically meaningful" (Horvath & Bedi, 2002, p. 39). According to Hatcher & Barends (2006) the loss of a clear definition, has deprived research and clinical work, and impoverished the influence of research on theory. The literature consistently asks the question, "What is the alliance"? Each author has their own working definition of what the term alliance means, which mirrors what has happened in the research field at large where a variety of different measures have been used to assess the construct (Hatcher & Barends, 2006; Horvath, 2005). The persistence of independent measures tailor made for specific studies therefore continues to limit the overall clarity of definition and clinical relevance of current research findings.

In a recent paper provocatively titled "Has the therapeutic alliance outlived its usefulness" Safran and Muran (2006) state unequivocally that they do not believe there is any value in pursuing more research on the predictive validity of the therapeutic alliance, or related technical and relational factors. They add that attempts to refine the construct further or to develop new measures will be equally invaluable. They have run a critical eye over the alliance literature and find that, "to be frank the research evidence is modest, not overwhelming" (Safran & Muran, 2006, p. 290). Their ambivalence about the usefulness of the alliance concept does not extend to abandoning the idea altogether, but states the importance of a broader focus for research, on the role that relational factors play in the change process within therapy, with the critical task being

to continue to clarify how and in what way the relationship factors, separate to the alliance factors, play a central role in the change process.

Alliance or Relationship

Safran and Muran (2006) proposed a shift away from the alliance to the role that unconscious mutual influence and enactments play in the relationship. They also address the limitations of the alliance, particularly in terms of what it measures. For instance what looks like an alliance may in fact be subtle signs of compliance, deferring or withdrawing. Also much of the previous research on the alliance has focussed on individual therapist or client contributions rather than a contextual view. Safran and Muran (2006) advocate, "focusing our research efforts more broadly on understanding the role that relational factors play in the change process and keeping in mind the relational context in which all other aspects of the therapeutic process unfold" (p. 290).

This comment captures the current dilemma for researchers in terms of the therapeutic relationship. The relationship is known to be a vital ingredient of therapy and contributes to a positive outcome for clients, that finding is well proven, so what else can possibly be discovered that is not already known? However if the question was, what is it about the interpersonal aspects of the relationship that make it work? There is still no definitive answer. "Although the cumulative research convincingly shows that the therapy relationship is crucial to outcome, relatively little is known about how to create and sustain the relationship and about why the relationship works" (American Psychological Society, 2002, p. 6). However outcome research does not give the full story. Many researchers state that client contributions have been underestimated (Bohart, 2000; Cooper, 2010; Duncan, Hubble & Miller, 2009). The fact that relational factors are linked to outcomes does not give proof that the relationship caused the

outcome. According to Cooper (2010), it may be that clients who feel they are doing well in therapy then start to feel more positive about their therapists.

Horvath suggests (2006), a new conceptual framework is needed for assessing the alliance as a universal construct. The idea of a universal construct addresses the problem of developing a clearer definition of the pan-theoretical factors as they relate to the broader therapeutic relationship. He raises the question: "To what extent is the alliance intrapersonal versus interpersonal in nature, and how do relationship processes lead to change"? (Horvath, 2006, p. 260). This echoes the views of Safran and Muran (2006) and is therefore an important question for this study. However the literature remains confusing when the alliance and the relationship are used as if they are interchangeable. Horvath's quote implies that he views relational factors as part of, but separate to the alliance.

Different theoretical models emphasise different theory driven injunctions about the relationship, creating a difference between what is emphasised versus what is actually practiced. Meissner (2006a), who writes from a psychoanalytic perspective, asserts that the alliance exists in all treatments regardless of the extent to which it is explicitly conceptualised from a theoretical framework. He proposes a triadic construction from which the therapist and patient come to know each other: The working alliance; transference and; the real relationship. Meissner argues that one of the reasons for the conceptual fuzziness of the alliance is due to the overlap or blurring of distinctions between these three elements of the relationship. In an earlier article within the same year (2006b) he singles out empathy as the sine qua non of therapeutic work, and qualifies this with an emphasis on empathy as a two way street. The Division 29 Task Force (2002) also mention empathy as one of the demonstrably effective factors within the context of the therapeutic relationship.

The limitations of differing alliance measures are obviously a significant issue for research, and are beyond the scope and focus of this study. However Hatcher and Barends (2006)

conclude that the relationship is different to the alliance. “The relationship is a vastly encompassing concept that includes any and all motivations and activities of client and therapist, including hostility, seductiveness, humour, ingratiation, guilt and so forth” (p298). The alliance research literature was devoid of the more nuanced and intimate stance portrayed in the literature from within the relational school relating to mutual influence. Alliance research also isolates the variables in question in a way that depersonalises and de-contextualises the therapeutic couple, the process and the research. The relational school literature while rich in intimate detail remains based on analytic theory and is therefore less useful to mainstream therapists operating within different theoretical frameworks. In terms of mutuality, the alliance requires a joint mutual agreement and collaboration, however what is shared between therapist and client is limited to the actual work of therapy and the therapeutic contract for that work. Thus it is the alliance that is mutual, which is a comparatively narrow and limited use of the term mutuality. Trends that link attachment to the therapeutic relationship broaden the field.

Attachment Theory, Mutuality and the Therapeutic Relationship

The concept of attachment, one of the fundamental and essential needs of human existence, has struggled to be understood and accepted within the ranks of therapeutic practice (Karen, 1998). Attachment theory (Bowbly, 1969; Main, 1991) is an empirically grounded framework that has been rigorously researched in relation to early social and emotional development. The convergence between attachment research and theories of emotional development see the formation of emotional attachments to caregivers during the early years of life as establishing emotional dispositions that have far reaching consequences for the development of attentional strategies and regulation of affect in childhood and beyond (Bartholomew & Horowitz, 1991; Cassidy, 2001; Cassidy & Mohr, 2001; Fonagy, et al., 2004). While other significant relationships can influence learning and adaptation throughout the lifespan the intergenerational

transfer of patterns of relatedness and resulting emotional biases are well documented in the attachment literature (Bartholomew & Horowitz, 1991; Hazan & Shaver, 1987; 1993; Kobak, 1999). It remains one of the most prominent and influential approaches to research on close relationships and intimate pair bonds.

The term *inner working model* which is synonymous with Bowlby (1980) and attachment theory, is a concept built on research that showed the representational system of self in relation to others was created through real and repeated interactions with significant others. "Bowlby was, without a shadow of a doubt, the quintessential relational theorist" (Fonagy, 2001, p. 126). Internal working models of the self in relation to others have been widely researched in relation to the continuity of these working models into adult life (Bartholomew & Horowitz, 1991; Broussard & Cassidy, 2010; Holmes, 1999). There is a plethora of evidence from research during the last two decades that the organised beliefs and expectations belonging to one's inner working model persist over time and can become self perpetuating. According to Shaver and Hazen (1993) attachment styles are not simple mental structures, they are linked in a meaningful way to memories, emotions and behaviour patterns with primary care givers. "Many of the most intense emotions arise during the formation, maintenance, disruption and renewal of attachment relationships" (Bowbly, 1980, p. 40)

While attachment theory was predicated on the development of attachment styles or categories, it is beyond the scope of this study, and not relevant, to elaborate on the intricacies of those styles as they relate to infant development and behaviour. The saliency at this point in time is that early attachment relationships map onto a time of significant neurological development and wiring up of the brain through repeated real experiences (Cozolino, 2006; Schore, 2003; Sroufe, 1996). More importantly for this study, are the findings that attachment styles persist over time and are resistant to change (Diamond, Blatt, & Lichtenberg, 2003; Fonagy, 2001; Strahan, 1995). According to Fonagy (2001), ones inner working model is only open for review

and change through mentalising, or the capacity to self reflect and think about one's own thinking. If this is the case, and considering that attachment is a universal and cross cultural phenomenon, it would also stand to reason this would be the case for therapists as well as clients. It might be assumed that therapist education and training attends to the modification of past relational patterns, or enhancement of reflective capacity, because the literature does not address the development or deficits in the area of reflexivity from a focus on therapists. The limited amount of literature speaks about relational deficits in regard to clients, whereas therapists are imbued with more sophisticated psychological capacities, mentioned as a given.

According to Slade (1999) attachment patterns tell a story. The story reveals what early experiences of one's emotional life have been given attention and allowed into consciousness, either through avoidance, preoccupation or in the case of secure attachment, flexibility. The cohesiveness of the one's personal narrative (Bartholomew & Moretti, 2002; Fonagy et al, 2004; Main & Goldwyn, 1998; Siegal, 2009) is viewed as the royal road to assessing attachment security from the degree to which a person has made meaning or sense of their early experiences. These varied narrative capacities have a distinct impact on the therapeutic process (Siegal, 2009; Slade, 1999). Not remembering early experiences, clinging to rigid stories, overly positive stories that are backed up with negative experiences, being emotionally overwhelmed without a clear story, and not being able to find a story strong enough to hold traumatic content, are all examples of incoherent life stories. As mentioned the high predictive ability of attachment for continuity over time is well researched and proven. Therefore patterns of relating learned early in life remain dominant purely because of their experienced emotional and interpersonal power. As a result, those with insecure patterns of attachment are seen to have greater difficulty in managing the vicissitudes of life generally, and interpersonal relationships in particular (Fonagy & Target, 2005; Karen, 1998; Shaver & Mikulincer, 2002).

The literature on attachment theory as it relates to clinical practice is a small but steadily growing area spurred mainly by developments in the assessment of adult attachment (Bartholomew & Moretti, 2002; Fonogy & Target, 2005). The literature focuses on two main areas. The relationship between attachment and psychoanalysis (Fonagy, 2001; Harris, 2004; Holmes, 2010; Wallin, 2007) and the application of attachment research to the theory and practice of psychotherapy (Harris, 2004; Slade, 1999; Wallin, 2007). Authors in this area make it clear that attachment theory is not a clinical theory or model of practice. According to Slade (1999) attachment provides an understanding of the nature and dynamics of a relationship that can inform clinical thinking.

Utilising the attachment framework of human functioning is seen to have the potential to change the way clinicians think about and respond to their clients (Eagle, 2003; Harris, 2004; Slade, 1999). Therefore attachment is viewed as a useful clinical tool for all stages of the process of therapy from initial assessment and relationship building and beyond. Attachment patterns function to evoke reactions in others (Dozier, Cue & Barnett, 1994; Parish & Eagle, 2003), and this also translates into the therapy room. Clients with insecure attachment styles bring their patterns of relating into the therapeutic relationship in very immediate ways. “Dismissing patients lock the therapist out, just as they were locked out by their attachment figures” (Slade, 1999, p. 588). According to Dozier, Lomax, Tyrrell & Lee, (2001) these kinds of patients often succeed in driving clinicians away, thus losing the help they need.

Harris (2004) emphasises the relevance of *proximity seeking* as a key instinct and motivational force towards self-preservation, that he views as being equivalent to the drives of *fight, flight or sex.* In that sense Harris postulates that when attachment is activated in therapy it is a drive towards a way of relating. Therefore individuals who display particular behaviours or attitudes such as fearful withdrawal, fear of rejection or engulfment, or compulsive care-giving are displaying learned patterns stemming from real experiences in relationships. The therapist’s

own attachment patterns were studied by Dozier et al (1994). They found that case manager's attachment style was relevant to how they intervened and responded to the emotional needs and demands of clients. In another study, the therapists own history bore heavily on his or her ability to relate and contain the emotional distress for the client in order to settle the *care taking system* (Heard, 2003). However, most of the research on attachment dynamics in therapy focuses on client attachment patterns and does not explore the dyadic effects. Attachment is in many ways a systemic theory, as such the therapist acts as a *secure base* for the client, by providing stable, consistent and reliable care. Through providing a secure base the therapist disconfirms the client's usual interpersonal and emotional strategies and expectations. But what about the therapist's valency towards emotional avoidance or pre-occupation, how does this impact on the relationship? Inter- subjective theorists would agree, this impact is *inevitable*, and therefore must be taken into account in a relational system.

The beginning research in this area also shows that the differing attachment styles of the client elicit different types of responses from therapists (Shapiro, Hardy, Aldridge, Davidson, Rowe & Reilly, 1999) and that therapist's level of experience is positively correlated to the strength of the working alliance and the development of intimacy. When clients were comfortable with intimacy, counsellor experience made no difference to the strength of the working alliance. However when clients were uncomfortable with intimacy therapist experience was significant.

The empirical reality of attachment theory means that it touches the most vulnerable aspects of human life and therapists are not exempt. In particular ones own early childhood experiences and ones parenting of the next generation. According to Richard Bowlby (2004) this is precisely why attachment has struggled for acceptance and why it almost ceased to exist for thirty years. People in general, including therapists, do not want to be confronted with their own relational shortcomings and attachment theory cuts close to the bone.

Attachment theory and psychoanalysis in their contemporary form both have the potential to merge and explain how both therapist and client bring emotional patterns of relating, distorted perceptions and consolidations of real experiences with others in previous interactions to the current therapeutic encounter. This includes where residues from the past can be displaced into the present therapeutic situation, but also more crucially, where those remnants can be re-experienced and reorganised in the present. According to Fonagy (2001) there is agreement between relational and attachment theorists that clients past history and memory reconstruction are unimportant to clinical work compared to the clients current experiences and ways of handling anxieties. This emphasis also encompasses an interest in observable behaviour, and a continual clarification and verification of the relational data one is eliciting.

According to Schore (2009), attachment theory is now the dominant theory of social and emotional development, with the demonstrated theoretical power of being able to shift between psychological and biological realms. Schore (2003) states that the *dyadic psychobiological system* of emotional communication and affect regulation, is the same system that mediates the essential processes that adaptively sustain all later intimate relationships. However how this system operates in the area of adult to adult relationship's, and in therapy, is still in its infancy.

Neuroscience and the Therapeutic Relationship

The emergence in the last decade of an intense interest in neuroscience and brain development and change within psychology is making a large impact on the field of theory and practice within therapy. Schore (2003) writes about the importance of therapeutic empathy, and the concept of interactive repair and inter-subjective resonance that he sees as underlying empathy. Schore views this form of relational attunement as being more of a right brain non-verbal state, where the therapeutic relationship is reliant on "non-conscious yet mutually reciprocal influences" (Schore, 2003, p. 279) much like an attachment relationship. Siegal (2009)

and Cozolino (2006) both focus on the *social brain* and the link between attachment, narrative and the capacity for *mindsight.* This current trend towards neuropsychology, privileges human relationships as the mutual learning ground for human development and therapeutic growth and change.

Neuroscience and attachment converge in regard to how our brains are wired up by experience in the context of significant primary relationships. Both approaches focus on how we are biologically linked and interwoven in a way that demonstrates that our brains emotionally regulate one another in relationships (Lewis et al., 2000; Schore, 2003; Siegal, 2009). This interactive contagion or transfer of emotion and stress occurs within intimate relationships seemingly automatically. This automatic, acting out of unconscious anxiety is a common observation in family therapy. When a child is referred for therapy as the identified patient in the context of family therapy, it is very often the case that the child is behaving in a way that expresses the unconscious or unexpressed feelings in the family system (Hoffman, 2002). While this is a gross condensation of a very complex theory it is a common example of the systemic roots of emotional distress.

Human development from the view of the neuroscience of human relationships (Cozolino, 2006; Siegal, 2009), shares that of Attachment Theory. “Our parents are the primary environment to which our young brains adapt, and their unconscious minds are our first reality” (Cozolino, 2006, p. 7). Interpersonal neurobiology focuses on the workings of the experience dependant human brain, and how attachment shapes the neural system, and in turn future relationships. While this is not a totally new idea, it gives evidence to theories that were conceived before such evidence was possible. The social construction of the brain and the role of attachment relationships are of primary interest to therapists who are attempting to understand their clients in the here and now of a new mutual relationship. This experience for therapists includes how working towards a deeper understanding with their clients has also changed them

in the process. “I have also experienced how working with my clients has also changed me, inspired me, and helped me to grow. It is the power of being with others that shapes our brains” (Cozolino, 2006, p. 9). These statements concur with Kottler and Carlson (2005a) who reported on the positive impact of meeting clients at a deep emotional level, and Lewis et al. (2000) who suggest that, “a relationship is a physiological process, as real and powerful as any pill or surgical procedure” (Lewis et al.,2000, p.81).

Schore (2003) has written elegantly and comprehensively on the integration of psychoanalysis, attachment and neurobiology. He gives convincing evidence for the dominance of the right hemisphere of the brain in the first three years of life, and for the central role of the right hemisphere in emotional and unconscious processing. The significance of Schore’s work for this study is the emphasis on the social nature and construction of the brain through relationships, particularly emotional unconscious processing. What Schore calls *interactive repair,* has implications for clinical practice and the concept of mutual influence. However while there has been a significant amount of literature in this area devoted to early human development there has been less emphasis on researching the nature of mutuality involved in the therapeutic relationship. So despite these new advances in scientific evidence, neuroscience as it relates to therapy is in the main observational and atheoretical. Schore considers himself to be essentially a theoretician who has integrated data from a wide range of different fields into a synthesis.

At this point in time there has been some clinical research linking Schore’s (2003) work and attachment to couple therapy (Clulow, 2007). The link with individual therapy is convincing and compelling but remains at the level of theory in regard to the therapeutic relationship. It is an exciting new field for clinicians; however when sitting with another human being it becomes less clear why it is helpful to know which parts of the brain may be activated, or involved in emotional processing. Emotion and its cousin empathy appear to be the thread that binds the divergent areas of theory and research together.

The Role of Emotion and Self Reflection in Mutual Influence

The therapeutic relationship is an emotionally demanding one for both therapist and client. The regulation of emotion is seen as one of the primary functions within therapy and therefore being able to read the emotional cues of others is a vital task for the therapist. The human capacities required to identify, monitor and self regulate emotions have been put forward as emotional intelligence (Goleman, 1995). The key emotional skills include the ability to know which emotion one is feeling and why, and realising the links between what one thinks, feels, does and says. Consistent with this thinking is the central postulate from differential emotions theory (Izard, 1984) and other emotion theorists (Bagby & Taylor, 1999; Greenberg & Paivio, 1997) that see the emotion system and emotional processes as primary in human behaviour. "Emotions are the guiding structures of our lives, especially in our relations with others" (Greenberg & Paivio, 1997, p. 14)

Several researchers and theorists have claimed that all difficulties of living can be attributed to problems with emotion regulation (Lane, 2008; Taylor, Bagby & Parker, 1997). Damasio (1994) demonstrated convincingly that without emotion, people have a deficit in the ability to be actively motivated and goal directed. Emotion regulation and its failures, as found in alexithymia (Bagby & Taylor, 1999; Krystal, 1988) has a major influence on mental and physical health, and the ability to engage in the self reflective capacities required to make optimal use of therapy. This research suggests that most medical and psychiatric illnesses (as differentiated from diseases) can be reconceptualised as disorders of affect regulation.

Therefore emotion theorists believe that accessing emotion in therapy is a key aspect of transformation and lasting change (Fosha, 2001; Greenberg & Pavio, 1997). Greenberg & Pavio (1997) view accessing primary emotional responses as leading to a deeper knowing than reasoning alone, and this process requires a complexity and subtlety of empathic response that goes beyond specific learned skills or attitudes of responding. The ability to self-reflect and to

think about one's own thinking is a critical developmental task in the interpersonal domain and is seen as the inverse of defensive exclusion (Fosha, 2001). The self reflective function is the capacity to conceive the wishes and intentions of others as different from one's own (Fonagy et al., 2004), and to have a mind of one's own and to hold the other in mind (Fonagy et al., 2004; Slade, 1999). This reciprocal process is synonymous with personal intimacy and requires a mutual empathic connection.

Mutual Empathy

Empathy as a human capacity is defined by Hoffman as the "cognitive awareness of another person's internal states (thoughts, feelings, perceptions, intentions) and the vicarious affective response to another person" (Hoffman, 1984, p. 103). Kohut described it as "the capacity to think and feel oneself into the inner life of another person" (Kohut, 1984, p. 82). Research on the facilitative conditions in therapy found empathy was the variable most predictive of being an effective or ineffective therapist (Lafferty, Beutler & Crago, 1989). However theorists have commonly discussed empathy as a capacity or skill used by the therapist rather than a mutual endeavour. Trop and Stolorow (1999) state that from within an inter-subjective framework empathy is a mode of investigation. As such their stance echoes Kohut (1981), who saw empathy as a heuristic tool for gathering data. However Kohut also saw empathy as a form of affective responsiveness. He differentiated the two as *experience near* and *experience distant* methods of gathering and interpreting data. Trop and Stolorow (1999) go further to say that when empathy is equated with the ideal of optimal responsiveness it is seen to be at the heart of the therapeutic process. As such it becomes a necessary requirement; however it can also exacerbate the therapist's countertransference by possibly triggering their own childhood histories.

Jordan (1999; 2000) says that emotional connection is established through empathic responsiveness, in that there is a palpable sense that one emotionally touches and influences the other person. “In mutual empathy one gets to experience oneself as affecting and being affected by another “(Jordan, 1999, p. 343). For example if a therapist tears up while the client expresses deep sadness, the client can see they have had an impact on the therapist. According to Jordon in mutual empathy it is acknowledged that both people involved are affected and that both gain value from the interaction. Therefore Jordan sees the process of mutual empathy as the main vehicle for change.

According to most authors emotional self awareness and the capacity to empathise is learned developmentally, and the ability to empathise accurately is an advanced cognitive skill based on the knowledge one has of one’s own inner emotional experience. It stands to reason therefore that the development of affect regulation will vary from person to person, and therefore the capacity for empathy will also be relative to the individual and their level of emotional development. This point is particularly important in light of the clinical observations (Goleman, 1995; Greenberg & Pavio, 1997; Krystal, 1988; Lane, 2008) that highly intelligent individuals can be deceptively unsophisticated in their awareness of their own emotional reactions or those of others. Therefore empathy plays a central and crucial role in the process of therapy to facilitate the formation of connections between emotions and cognitions.

According to Tangney (1991) the perspective taking component of *mature empathy* requires the ability to make a clear differentiation between self and other, an ability that must remain robust in the face of intense empathic affective arousal. An important distinction here is the difference between other oriented empathy and self oriented personal distress where one’s own needs become foreground and the other gets lost. This difference has been referred to by Hodges and Wegner (1997) as either automatic empathy, as in emotional contagion or identification, versus controlled empathy that can be consciously and intentionally produced. The

development of controlled or mature empathy has been linked positively to social and moral development (Mendez & Shapira, 2009; Tangney, 1991). Empathy is therefore not just a learned skill or a basic human capacity and is uniquely different in each person according to their personal development. In the case of therapists this also includes education and training. Empathy as a human capacity enables one to feel for another and facilitates relationships being rebuilt when they have been disconnected or damaged hence it has been reported as a vital aspect of the therapeutic relationship (American Psychological Society, 2002; Greenberg, Watson & Bohart, 2001; Jordan, 2000; Myers & White, 2010).

Emotional responsiveness and connection through empathy is a key element in therapy; however so is the differentiation of oneself within this relational process. Yet referring back to the literature, inter subjectivity is seen as inevitable and the right brain processing of emotion is shown to be automatic and rapid. According to Stern (2002) we are forced to resonate with the minds of those around us, therefore inter-subjectivity is not just a capacity it is part of the human condition."We are not the sole owners of our minds, and our minds are not independent or separate. The borders of the self are permeable and we grow up in a soup of other people's intentions, feelings, thoughts and desires that construct our mind and brain." (Stern, 2002, Conference recording). While this comment speaks to early development, the prospect of how this plays out in adult relationships is an ongoing question. There is an inherent contradiction between the inevitability of inter-subjectivity and the concept of individual psychological differentiation. According to Mills (2005) inter-subjectivity cannot cancel out intra-psychic reality or individual lived experience. Therefore, how much does a person's individuality become subordinated to the relational matrix? The relationship in therapy is obviously much more than a simple conscious negotiation of tasks and goals.

The Real Relationship

Gelso's (2009a) research on the *real* relationship attempts to access the more transference free perceptions of clients in order to get at the real elements of the relationship. Gelso views the real elements operating silently in the relationship, in that they are not the explicit focus of the work. He views the *real* relationship as consisting of two elements: realism and genuiness. Realism means if the therapist does not perceive the client in a way that fits with the clients own perception then the relationship would not feel real. Genuiness reflects the ability of each person in the relationship to be oneself as opposed to "phony or inauthentic".

Gelso (2009a) has begun to develop a theory, and measure, for the *real* relationship, but it is noted that Gelso and those who commented on his paper (Hatcher, 2009; Horvath, 2009) all agree that "it is time to move beyond a highly global concept of the therapeutic relationship and beyond the view that the therapeutic relationship is equivalent to the working alliance" (Gelso, 2009a, p. 282). Gelso's psychometric measure is called the Real Relationship Inventory (RRI), and it was developed to capture both therapist perspectives (RRI-T) and client perspectives (RRI-C) on the real relationship. The difficulty with yet another psychometric measure is that much like the common factors model, it will perpetuate the separation of differentiated variables or concepts that in reality overlap considerably and are clearly ambiguous. These concepts then become discussed and researched as if they are mutually exclusive. According to Hatcher (2009) in his review of Gelso's scales, it is unclear what is actually being measured by the RRI and how it then relates to the theoretical constructs that make up the scale. This reverts back to and could possibly repeat the measurement difficulties found in the alliance research.

The Therapeutic Relationship and the Common Factors

The therapeutic relationship has also been identified and quantified in research on the common factors that contribute to positive outcomes in therapy (Asay & Lambert; Chwalisz,

2001; Rosenzweig, 1936) which puts forward the case that all models of therapy are equally effective in relation to outcome. Asay and Lambert's (1999) extensive meta-analysis of empirical studies of outcome research, arrived at a four factor model related to common elements in therapy. The outcome variance allocated to each factor is: Client/Extra-therapeutic factors 40%, Relationship factors 30%, Model/Techniques factors 15% and Placebo, Hope and Expectancy factors 15%. The common factors debate has made a significant contribution to therapy outcome research. However the relationship factors are based on the client centred conditions of empathy, warmth, acceptance and congruence. These are all therapist centric factors rather than reciprocal factors, and are based on efficacy of treatment and outcome rather than process or experience. The common factor categories also raise the questions, where exactly does the expectancy or hope within a relationship reside? Is it with the therapist, the client, or both? How discrete are these variables, versus how much overlap do they have when looked at holistically? The research on the common factors was initially a reaction against the medical model in therapy, and the majority of the research results have been gleaned through the cumulative findings of meta-analysis, and in some cases meta-analysis of meta-analysis (Wampold, 2001). While it is shown that there is little to no difference in outcome between the models and techniques used in therapy, the research emphasis on particular treatments continues. A holistic look at the relationship factors could add information to the elements within the common factors that apply to the relationship.

Conclusion

The focus of this review of the literature has been to outline the historical and current theoretical status and research base relating to mutual influence in the therapeutic relationship. The particular focus on mutual influence has necessarily eliminated a range of studies that concentrate on treatment and outcome. While outcome studies might share the underpinning

philosophy that acknowledges mutual influence as a co-created relationship, this review has given a broad sweep of research that treats this phenomenon as a given and relied on literature and research that specifically addresses the phenomena as much as possible.

The literature from the relational analytic school (Aron, 2007; Mitchell, 1995) addresses mutual influence, as defined in this study, more directly and in great detail compared to other approaches. The emerging relation school of thought therefore provides the richest source of information to date. The constraint found in the relational analytic literature is the propensity to continue viewing mutual influence through the lens of existing analytic constructs thereby limiting a fresh perspective. Other grand theories such as Rogers (1951) person centred approach, mention equality and place it at the centre of the relationship, but do not address how mutual influence operates. The concept of the therapeutic alliance (Bordin, 1979; Hatcher & Barends, 2006; Horvath, 2006) has been studied extensively and currently research is not producing new insights to inform practice. As suggested by Safran and Muran (2006) the alliance may have outlived its usefulness. The alliance and the relationship have been used synonymously however it is becoming more evident that the relationship factors in therapy constitute more than forming a bond to collaborate on tasks and goals (Gelso, 2009b; Horvath, 2005; Safran & Muran, 2006).

The rise of a more relational view that encompasses a bi-directional influence has progressed significantly over the last decade. However a tension remains when considering the role of reality versus unconscious processing, in particular the consistent focus across disciplines on transference and countertransference and the variety of manifestations of definition. Self disclosure, both deliberate and implicit adds to the debate and raises the question about the place for personal transparency on the part of the therapist. There is a wide range of dissent regarding how much of the therapists material should enter the therapeutic space and what are the optimal conditions in which therapist and client operate (Fiscalini, 2006; Renik, 1995; Watchel, 1993).

Related issues such as personal power and autonomy, divergent and competing interests, and expressions of care, all combine to create areas where there are considerable gaps in our understanding of the mutual aspects of co-creation. Considering the bi-directional nature believed to be operating in the therapeutic relationship around all these issues, the voice of the client is conspicuously missing from the literature.

Attachment and neuroscience (Bowbly, 1965; Cozolino, 2010) converge to provide theoretical information and research about human development and close relationships both in general and in therapy. These disciplines add significant weight to the emerging evidence of the power and enduring effects of real experience, especially affect laden experience, in human development and change. Emotional regulation, awareness and empathy are key factors in *interactive repair* (Schore, 2003). These factors are universal to all relationships not only therapy. Therefore therapist's emotional styles and levels of awareness are significant. However emotional awareness has been discussed as though it exists in equal measure in all therapists, yet emotional maturity and robustness according to the tenants of attachment and neuroscience is a unique and variable human capacity. Therefore there seems no guarantee that therapists have all received optimal personal development or education to develop or enhance these functions.

The fact that the therapeutic relationship is a mutual endeavour and both therapist and client bring their entire beings to the process means that giving substance and context to the current debates is timely. Through studying therapists and client dyads, some flesh can be added to the bones of theories and concepts that at present remain in abstract form. The following chapter outlines the philosophies and methodology chosen to explore and understand the context and meanings of mutual influence in the therapeutic relationship as perceived by therapists and clients.

Chapter 3

Research Methodology

Introduction

This chapter provides details of the background, method and design for this study, and is presented in two sections. The first section gives a brief overview of the evolution of the problem that underpins the study. This is followed by a discussion of the rationale for the theoretical framework used to guide the study and to examine mutual influence in the therapeutic relationship. The second section provides a detailed description of the research design which includes participant selection, oral data collection in the form of interviews, data analysis and ethical considerations.

Section 1: Evolution of the Problem

The experience of mutual influence in the therapeutic relationship from the perspective of the therapeutic dyad of client and therapist has not been a major focal point within research circles, despite the fact it is often taken as a 'given' that influence must occur for change to take place. As such the dynamics of mutual influence in therapy are not well understood. The literature investigating mutual influence is scant and springs mostly from anecdotal clinical accounts of inter-subjectivity within the contemporary relational analytic school of thought. Alternative paradigms such as attachment and neuroscience are emerging as important and relevant bridges to understanding mutual and reciprocal influences in the therapeutic relationship; however there is little research as yet.

The therapeutic relationship in general has been extensively researched from a quantitative framework with different variables of interest being separated and examined for their discrete contribution (Hubble, et al 2009; Norcross, 2002; Safran & Muran, 2006; Wampold, 2009). The

majority of this research has been investigated and presented in relation to the concept of the alliance (defined in chapter 1) as it relates to therapeutic models of treatment and treatment outcomes (Duncan & Hubble, 2005; Wampold, 2001; 2010). However there is a paucity of research that examines how the therapeutic relationship, as defined in chapter 1, is experienced within its context from the perspective of therapists' and clients'.

In the last decade a large exploration into therapeutic relationships by the APA Division 29 Task Force (2002) encouraged researchers to "avoid a therapist-centric view of the therapy relationship and to study both patients and therapists contributions to the relationship" (p. 6). The task force added that "although cumulative research convincingly shows that the therapeutic relationship is crucial to outcome, relatively little is known about how to create and sustain the relationship, and about why the relationship works. These are vital questions for future research" (American Psychological Society, 2002). This also raises the question about what is known about the shape of a productive relationship over time. Therefore examining how therapists and their clients view the therapeutic relationship and the experience of mutual influence may give some insight into these questions.

At this point in time the trend towards evidence based treatments means that research is necessary that can produce clinically meaningful results and shed light on what is most relevant for practice and education. According to Hatcher and Barends (2006) the concept of the alliance has lost a clear definition, depriving research and clinical work, and impoverishing the influence of research on theory. This begs the question, is the therapeutic relationship adequately described and understood for both theory and practice using the existing construct of the alliance. The importance of understanding the fundamental aspects of a successful relationship and how clients view and experience that relationship has become a more urgent concern as the trend towards managed care and evidence based treatments increases.

Treatment based studies have missed the significance of relationship factors and run counter to the growing body of evidence that all models of therapy are equally effective in relation to outcome (Asay & Lambert, 1999; Cooper & McLeod, 2007; Hubble, Duncan & Miller, 2009). The literature consistently reports that the relationship is important but the lack of understanding over how and why means therapists' continue to view the relationship through the lens of their favourite theories. The discrepancy between theoretical concepts of the relationship within different models of therapy and clinical practice mean that at present there is no consensus on what constitutes an effective therapeutic relationship. As a result counsellor and psychotherapy education and training in Australia holds a diverse view of what is necessary for prospective therapists to learn in order to engage in effective clinical practice.

This brief background information points to the necessity of understanding the internal dynamics of a successful relationship. The phenomena of mutual influence within therapeutic domain, lends itself to this purpose. This sits alongside the recommendations of many voices in the field for more qualitative inquiries into relational dynamics and questions around what, why and how the relationship works. These dilemmas have prompted the current exploration into the core of the therapeutic domain and the reciprocal process at its heart. The guiding question for this study has been how do therapists and their clients perceive and experience mutual influence and change within the therapeutic relationship? To achieve this aim a qualitative method was chosen to elicit the deeper underlying meanings of experience for therapists and clients in a therapeutic relationship.

Rationale for the methodology

A qualitative methodology, using phenomenological inquiry as the method of investigation has been chosen for two main reasons. One is the view that research within the field of counselling and psychotherapy needs to be congruent with methods more closely related to

clinical practice (Morrow, 2007; Polkinghorne, 2005; Ponterotto, 2005; Silverstein, Auerbach & Levant, 2006). The primary purpose of qualitatively generated knowledge is to describe and make sense of human experience as it is lived and manifested in awareness (Dahlberg, Dahlberg, & Nystrom, 2008; Finlay, 2009; McLeod, 2003; Polkinghorne, 2005). Phenomenology is particularly suited to counselling research that focuses on the facilitation and investigation of experience from first person accounts and the lived experience of the participants. This paradigm has a commitment to the use of human expression as the primary data source. Therefore the area and topic under study determined the decisions about which method was employed. To successfully capture and elucidate the human phenomena of the interactions within the therapeutic relationship this study required what Polkinghorn (2005) calls *languaged data*. Secondly this study attempted to build on previous extensive quantitative research on the therapeutic alliance. The alliance is considered to be qualitatively different to the therapeutic relationship (Horvath, 2009) and as such requires an approach that does not focus solely on the tasks and goals of therapy. Understanding the role that relational elements and processes play in therapy, and the context in which they unfold, calls for a mode of inquiry that goes beyond isolated variables of interest. It is therefore timely to move away from known constructs towards a more holistic exploration of the relationship that includes the impact of mutual influence. To date there is a paucity of research on the different forms and nature of mutuality involved in the therapeutic relationship.

For the purposes of this study the participant's experiences of mutual influence within the relationship, as well as the context for those experiences could not be gained through further quantitative analysis. The rationale for this study is therefore grounded in the philosophy of science that informs qualitative paradigms. The primary purpose of such an inquiry is to describe and clarify human experience as it is, "Lived, felt, undergone, made sense of and accomplished." (Polkinghorne, 2005, p.138).

It was necessary to use a methodology that was congruent with the area of study, and one which would draw out the everyday realities of working in a therapeutic relationship. The counselling session in itself is a piece of qualitative research, and the counselling process has always been the preferred method for eliciting and understanding the issues and dilemmas brought by the client. The processes and results of qualitative research are formed and shaped from the data, in a similar fashion to the counselling process, rather than being preconceived and tested. Therefore qualitative methods that involve interacting with participants expressions of their lived experience was the most congruent way to understand the complexities of this human phenomena. The most important concern was the parsimony between the therapeutic relationship as the phenomena being studied, and the method used to glean further understanding of the phenomena through meaningful accounts (Morrow, 2007; Rizq & Target, 2008). My aim was to gain a richer in-depth understanding of mutual influence in the therapeutic relationship and its implications for meaningful clinical practice.

Qualitative research as bricolage

It has only been within the last decade that the concept of bricolage has been openly accepted as an overt practice within therapy research. Before then, according to McLeod (2000), researchers in the field of therapy were covert bricoleurs who downplayed this aspect of their work and presented their studies as conforming to the requirements of a particular method. "There is an appreciation that doing good qualitative research is never just a matter of applying a pre-defined method to a clear–cut question. It is acknowledged that to be an effective qualitative researcher requires common sense, imagination, flexibility and determination to do whatever needs to be done, or can be done, to find meaning in the research material" (McLeod, 2000, p.4).

Bricolage is a construction that emerges from the activity of the bricoleur rather than being completely planned in advance (Denzin & Lincoln, & Lincoln, 2000; Kincheloe, 2005; McLeod,

2003). Denzin and Lincoln use the French meaning of the word bricoleur, being *handyman/woman,* or someone who utilises whatever tools are at hand to get the job done. The notion of drawing on the many traditions located within qualitative approaches has grown out of the post-positivist and constructivist paradigms and is consistent with the methodological flexibility that is common within these paradigms (McLeod, 2003; Morrow, 2007) The bricoleur therefore holds a creative tension between resourcefulness and conformity. This kind of inquiry is predicated on the mindset of *not knowing* often used by therapists. This stance generates useful questions based on the need to understand a phenomenon more fully, rather than aiming to prove a predetermined hypothesis or looking for definitive answers. "The rigour of research intensifies at the same time the boundaries of knowledge are stretched" (Kincheloe, 2005).

Using a combination of phenomenology and case study methodologies was necessary to gain new insights and uncover new perspectives on the phenomena of mutual influence in a therapeutic relationship. Subjects are often removed from the contexts, relationships, processes and connections that shape them (Kincheloe, 2005). This research study was designed to honour the ontological sensitivity of the context of the participants, and to retain the locus of the research which was the therapeutic relationship. This focus could be maintained through utilising a combination of phenomenology and case study approaches.

Phenomenology

Phenomenology encompasses both a philosophical movement and a range of research approaches. When applied to research, phenomenology is the study of phenomena, particularly the nature and meanings of that phenomenon. Pure phenomenological approaches have historically sought to describe rather than explain, however over time, theorists have expanded and moved towards going beyond mere descriptions, to elaborating and interpreting the data (Brocki & Wearden, 2006; Lester, 1999; Wertz, 2005). Hermeneutic approaches (Dahlberg, et

al., 2008; Smith, 2004) also highlight the role of the researcher in *imaginatively varying* the concrete examples given by participants to bring into relief particular essential features in the data.

Phenomenological inquiry therefore lends itself to the detailed exploration of human experience. Epistemologically, phenomenological approaches are based in a paradigm of placing value on personal knowledge and subjectivity, and emphasising the importance of personal perspective and interpretation. As such, a phenomenological approach can be a powerful way of understanding subjective experience and challenging conventional wisdom and assumptions (Kendler, 2005; Larkin, Watts, & Clifton, 2006; Rizq & Target, 2008).

Phenomenology was chosen for this study as way of remaining open and flexible while exploring therapists and clients experiences of being in a therapeutic relationship with each other. The dual aim being to leave the space open for the participants to express their particular views about the relationship with as little structure or intrusion as possible. Also to understand, the central experience of the participants and engage in a new way with their perceptions. I was conscious that I needed to listen to participants experiences *freshly* in order to allow news of difference to emerge from the interviews. I also needed to remain mindful that my position was one of researcher, not therapist, and that my existing knowledge base could interfere in the process, or more hopefully, free me to become surprised. I chose a methodology that allowed me, as the researcher to remain visible in the frame as a keen co-participant and observer, and therefore a subjective actor in the process. This paradigm was a good fit with contemporary views of research and with who I am as a researcher embedded in the research. Phenomenological inquiry allows for an interpretive dimension that enables findings to be used to inform practice and also to support or challenge existing theory.

The relational approach to phenomenological research (Finlay, 2009) advocates the research relationship as an interactional encounter in which both parties are actively involved.

Therefore what emerges is a dynamic co-created relational process to which both researcher and participant contribute. I have not used this variation of phenomenological research as the main lens for the study, but I drew from its underpinning philosophy of transparency at times in regard to how I used myself as the research tool to interpret and imbue meaning through my analysis of the text. My aim for the interview process was to set myself aside and go with the participant's agenda.

"If there is a general principle involved it is that of minimum structure and maximum depth" (Lester, 1999, p.2). This more free flowing view of ideas also suited my intention not to intrude too much on the direction the interviews would take, while also being able to use my experience as a psychologist and counsellor to flesh out the topics raised by each participant if appropriate. I aspired to remain as open as possible regarding the topic, despite my previous knowledge. This stance, mentioned earlier, of *not knowing* is very similar to the concept of *bracketing* which in phenomenological research means to suspend previous assumptions in order to be open to new phenomena as it appears. Bracketing is often misunderstood as an effort to be objective and unbiased (Polkinghorne, 2006). As the researcher bracketing meant remaining cognisant of my beliefs and prior knowledge and reflecting on those to the best of my ability so they did not get in the way of acknowledging new information. "In unstructured or open ended interviews, the researcher will invite the informant to discuss a broad topic or theme, with the emphasis on recording the free flowing meanings that the interviewee is able to articulate" (McLeod, 2003, p.74).

My main task was to facilitate the exploration of what the phenomenon meant to the participants. In line with McLeod (2003) the principles of person-centred counselling provided the basis for gathering participant's accounts. I endeavoured to establish an interview climate of respect, empathy, congruence and acceptance, where participants were comfortable to engage in the interview process in an authentic manner. The principles and values set down by (Kvale,

1996) were followed as much as possible. The core principle being, to explore and understand the *life-world* of the participant as it is lived, whilst remaining open to unexpected phenomena. This included, being able to identify central themes and their particular meaning for the participants. An important aspect of this type of process is that the participant, or the researcher, might change their perspective or belief during, or as a result of, the process. As such my intention was to strive to remain mindful of the relational dynamics between myself and the participants, without allowing my experience to preoccupy the foreground. Through employing an unstructured style coupled with a capacity for self reflection, I attempted to facilitate the interview process so that the primary voice that emerged from the data belonged to the participants. However in the end, to summarise Polkinghorne (2006), the processes still involve the skills and character of the researcher, and the analysis of the data are a result of the researcher's personal judgements.

Case study

The case study has a long history in both therapy and research. As a research approach case studies do not represent a specific philosophical paradigm. Case studies can be utilised in qualitative, quantitative and mixed methods approaches to data collection and analysis, and are therefore a flexible tool for in depth research with a limited number of participants (McLeod, 2003; Moon & Trepper, & Trepper, 1996; Yin, 2003). Different types of case studies depict the particular purpose of a study. Stake (1995; 2005) distinguishes between three different types of case studies; *intrinsic, instrumental* and *collective*. These types correspond to what Moon and Trepper (1996) refer to as *descriptive, discovery oriented* and *explanatory-oriented* approaches. Intrinsic and descriptive case studies are undertaken because the researcher is purely interested in a particular case. Alternatively, an instrumental case study seeks information and understanding of a broader issue beyond an individual case or to remap a generalisation. The discovery-oriented

approach usually requires a comparison of several cases. Similarly Stake (2005) identifies the collective case study as including a broader range of cases for the purpose of gaining a better understanding of a phenomenon or to assist theorising. This also maps on to Moon and Trepper's (1996) exploration-oriented approach which focuses on developing an explanation for how or why a phenomena occurs.

A case study approach is flexible; however the unit of analysis and the approach to analysis remain important issues. In the present study the main unit of analysis was the therapeutic relationship, but also includes the therapist and client as individuals in that system. Case study research can feature single or multiple cases and does not require a minimum number of cases to be viable (Yin, 2003). This approach strives for a holistic understanding and the researcher's task is to work with the situation that is presented. Case studies are an interpretive and inductive form of research that explores the detail and meaning of experience as well as acknowledging multiple realities. As such this method investigates phenomena in its real life context and provides in depth, rich and real data (Stake, 2005; Yin, 2003). The seven cases investigated for this study covers the potential within the discovery and collective method of case study analysis for an in depth exploration of the experience of the therapeutic relationship. Seven cases also accounts for the provision of a range of cases to explore the nature of the phenomenon as it is experienced by the participants in order to assist with tentative theory building (Stake, 2005).

Case study data can be analysed in several ways: within case analysis, cross case analysis or comparisons of cases within the literature (Moon & Trepper, & Trepper, 1996). I drew broadly on each of these forms of analysis to search for patterns of meaning (Yin, 2003) and to build an explanation of the phenomena within and across the relationships. For the purpose of this study I have employed a phenomenological inquiry as the primary mode of investigation,

combined with the case study approach to explore and understand more fully the real life experience of the fourteen participants within the seven therapeutic relationships portrayed.

Section Two: Research Design

The research design is comprised of several components that relate to the phenomena under study. These components will be detailed in the following section to make the thinking and the rationale behind this research as transparent as possible.

Selection of participants

Access to participants was restricted due to the sensitive nature of this topic, and the ethical concerns of intruding upon, or causing harm to an existing therapeutic relationship. Care was taken to ensure that participants remained free to choose whether they would participate therefore no participant was contacted until they had returned a letter of consent agreeing I could contact them by phone. This was a two-pronged process, once the therapist had agreed to participate they approached the client, and then the client contacted me. While this process enabled participants to retain the freedom and autonomy regarding whether to take part in this study, it was a lengthy procedure and reduced the expected participant numbers slightly. I had originally anticipated 16-20 interviews or 8-10 dyads. Two other therapists agreed to take part however their clients did not make contact with me which precluded their participation. In the end it was not possible to wait for these last two therapists to find a client for the study. Due to the two pronged recruitment process, which are detailed later in this chapter, it proved to be a very lengthy process to recruit participants. However, the interviews to that point had gleaned a rich source of material that gave a complex picture of the therapeutic relationship as it was experienced. In reflection, I realised that my anxiety regarding numbers came from my

quantitative past. Whereas, in a qualitative study the sufficiency of the data rather than numbers should drive the selection process (Morrow, 2007; Polkinghorne, 2005; Ponterotto, 2005).

The goal of qualitative research is to enrich and expand the understanding of an experience; therefore selection entailed finding professional exemplars of the therapeutic relationship. A purposive selection of therapists was employed in order to provide what Patton (2002) calls *information rich cases* for study. In line with the ethics condition for recruiting therapists I contacted the Counselling and Psychotherapy Association of NSW (CAPA). I spoke with the current President of CAPA at that time and asked if I could have some recommendations for therapist participants for this study, in particular those that were considered in the eyes of the association as having excellent capacities for relationship skills. The name and contact information for one therapist was provided, I wrote to that therapist inviting her to participate and she accepted the invitation. From that first contact snowball sampling was used to contact further therapists, except for one instance when opportunistic sampling was utilised. In that instance one therapist offered to participate after hearing about the research.

Therapist selection

To be eligible to participate in the study therapists were required to belong to an accredited professional body in the field of counselling, psychotherapy, social work, psychology or psychiatry, and currently practicing. Once therapists had been identified, the selection process aimed at providing a cross section of therapists who came from different training backgrounds, worked from different models and had different levels of experience, as well as a mix of those working in private practice and agency settings. It proved difficult to stay with this ideal selection process with some therapists stating time constraints due to busy workloads and others stating they did not want to involve a client. However the goal of selection was mostly achieved

except in the area of workplace. All but one therapist worked in private practice. Table1 provides a summary of therapist demographics and work practices.

Table 1. Therapist demographics

Therapist Age and Gender, Mode of Working, Level of Experience and Nature of Practice

Therapist	Age	Gender	Discipline	Model	Yrs/Exp	Workplace	Clients/Wk
1. Anne	59	F	Counselling Social Work Psychotherapy	Multimodal Attachment Narrative Family Systems	Up to 10 yrs	Private Practice	10-15
2. Leo	74	M	Counselling Psychology	Psychodynamic Psychoanalytic	20yrs & over	Private Practice	10-15
3. Giselle	49	F	Counselling Psychotherapy Psychology	Process Oriented Psychology	20yrs & over	Private Practice & Agency	8-20
4. Thomas	44	M	Psychotherapy	Gestalt Relational Psychodynamic	Up to 20	Private Practice	17-20
5. Sarah	51	F	Psychotherapy	Gestalt	Up to 20	Private Practice	20
6. Graham	73	M	Psychology	Eclectic Person Centred	20yrs & over	Private Practice	4-8
7. Will	60	M	Psychotherapy Counselling	Psychodynamic Family Systems Person Centred	20yrs & over	Private Practice	10-12

Client selection

There were no criteria set for the client selection. It remained the choice of the therapist to decide which client, or clients, they invited to take part. This was due to the ethical considerations pertaining to the privacy of potential client participants. Therapists were asked to nominate a client who, in their clinical judgment, was not unduly vulnerable in terms of their life situation and particular issues. The main aim being, to interview therapists and their respective clients who were interested in talking about their particular experience of mutual influence within the therapeutic relationship, and who could provide the most salient information possible for the purpose of the study.

Table 2: Client demographics

Client Age, Gender and Therapy Attendance

Client	Age	Gender	Approx. Sessions	Frequency	Years in Therapy
1. Chloe	28	F	72	Weekly	1 ½ Yrs
2. Paul	42	M	25	Fortnightly-Monthly	1 Yr
3. Jim	45	M	200	Weekly	4 Yrs
4. Bella	42	F	325	Weekly	6 ½ Yrs
5. Lily	30	F	215	Weekly	4 ½ Yrs
6. Peter	53	M	20	As needed	2 Yrs
7. Eve	60	F	52	Fortnightly	2 Yrs

Recruitment of participants

Recruitment was a two-pronged process, due to the sensitive and ethical nature of involvement in the study. It was important for all participants to remain free to decide whether they wished to take part, and the process set up was to protect the autonomy of the participants, particularly the clients. Therapists were contacted first and once they had made a decision to participate, they were responsible for choosing and contacting a current client. The procedure that allowed the greatest autonomy was utilised and is described in detail below.

Recruitment of Therapists

Therapists were initially contacted through a letter of invitation (Appendix 1). If the identified therapist wished to participate they contacted me. Seven therapists made contact by phone, one chose to email but gave permission for me to ring them. During that phone contact I explained in detail what involvement in the study would entail, and answered any questions or concerns. A full set of research documentation was then sent to the therapist. There were two sets of information, one explaining the therapist's participation (Appendices 2, 3, 4) and a second set of information explaining the client's involvement. This included a draft cover letter to the client from the therapist introducing the study (Appendix 5), an invitation on behalf of the researcher, asking the client if they wished to participate (Appendix 6) and an initial client consent form (Appendix 7) that gave permission for me to contact the client by phone.

Therapist's who responded to the invitation to participate, gave varied reasons for their decision. Some said they owed it to the profession to further research in the field, others thought participating was a way of giving something back to the profession. Some also said they understood and empathised with the difficulties of finding participants for research having undergone recent study themselves. Two of therapist participants had some minimal contact with

me primarily through professional organisations and committees. All therapists expressed their interest in the topic and also wanted to contribute to the field.

Recruitment of clients

In order to preserve privacy, prospective clients were approached in the first instance by their therapist via letter. A sample Cover letter was provided to therapists for use or amendment as required (Appendix 5). Included with the letter was a preliminary consent form (Appendix 7) to be posted back to the researcher, therefore allowing me to contact client participants by phone.

Once clients had returned the initial consent form, I phoned them to discuss involvement in the study and answer any questions. Several of the clients phoned me rather than returning the consent form. During that first phone conversation I described the study and what their involvement would entail. After this conversation if the clients wanted to proceed they were posted or emailed out the relevant documentation for their participation. A client information sheet (Appendix 8), a client demographic sheet (Appendix 9), and a consent form to take part in the study proper (Appendix 10). Most often the interview appointment was made with the client during the first phone call. When it was clear that the relevant clients were willing to participate, I then rang their therapist to arrange an interview time.

The recruiting process allowed for the possibility of a client not responding to the therapist's invitation. If there was no response from a particular therapist's client, the process was that the therapist would be asked to select another client and so on, until a consent form was received from a client indicating their willingness to be contacted. All of the seven client participants responded positively to the invitation.

In actual practice none of the therapists used the letter provided to invite their client to take part. All therapists asked their client personally and directly. I had no control over that process when it happened. Some clients contacted me directly by phone, and it was apparent that their

therapist had given them my number, rather than use the more longhand process of the letter. When I inquired about this, the answers from therapist participants were all very similar. They felt that a letter would seem odd to their clients, and as such would be at odds with the relationship they had built with their client over time. Some were worried about the impact on their clients of receiving such a letter, and what their clients may make of that, versus being able to discuss it face to face. In essence, the distance that using the cover letter would have provided was in direct conflict with what all the therapists thought was in the best interests of their clients and their relationship with those clients.

In view of this, the research process and protocols were discussed with all clients before their interview. Each one assured me they were participating of their own free will. Some said they thought the study sounded very important for therapy research, and they had benefited from therapy, therefore they felt they had something to contribute. Others thought it might prove to be a useful tool to facilitate a discussion with their therapist about the journey they had shared. When I asked if they would have preferred to be approached face to face or by letter, every client said that they would have been quite mystified or confused if they had received a letter.

Oral data collection

One of the core assumptions of a qualitative study is that the investigation occurs in interaction with participants and their context, and the reporting of results is presented in the everyday language of participants. This form of oral data collection in qualitative studies is defined as a product of the interaction between participant and researcher, "and are not identical to the experience they are describing" (Polkinghorne, 2005, p.138). The thoughts and ideas expressed by participants are therefore seen as indirect evidence. For this study exploration of participant's experience of their therapeutic relationships were conducted using face-to-face

interviews. The term *data* for the purposes of this study is taken to mean participants oral and textual accounts of experience.

Interview protocol and outcome

The interviews took place at the time and place designated by the participants. All therapist interviews took place at their private practice or agency rooms. All client interviews took place at their choice of venue. Usually this was a room at my practice or a room at their therapist's practice. One client chose her workplace where there was a private space. For another client a room at a colleague's agency was organised because it was convenient to where he lived. The main rationale for the choice of venue was the client's comfort with the arrangement. All interviews ranged from one to two hours. Two half hour follow up phone interviews took place with two of the therapists at my request.

Interviews were recorded on a small Sony digital recorder, 10cm by 3cm placed between myself and the participants. Therefore there were no obtrusive pieces of equipment and the participants did not have to wear microphones. This assisted in allowing the interview process to be more relaxed and conversational. All but one of the therapists contacted me after their next therapy session with their client following the research interview. The consensus was that the interview process had contributed greatly to their next session. The process had facilitated a fruitful discussion about their work with each other, and highlighted important themes that were followed up together.

Several clients commented at the end of their interview that they were going back to their therapist with thoughts and ideas that had come to them during the interview. For the majority, the interview process had the effect of permitting participants to observe their relationship and reflect on it, much like a supervision session. I offered all participants the opportunity to receive

a copy of the interview transcript for review and comment. None of the participants took up this offer.

Interview process

Each interview began with some brief social conversation to help the participants relax and settle in. Each participant was asked if they had read the information sheet, and clients were reminded that they were not expected to discuss the issue that brought them to therapy. I asked all participants before we started if there was anything else they wanted to know about me before we began. Some clients wanted to know if I was a therapist myself, and one client wanted to know what model of therapy I used.

I began each interview by stating that I was interested in the therapeutic relationship and how that was experienced by different people. Then I asked the question: "What has been your experience of this therapeutic relationship?" This question was chosen so that participants could start wherever they wished and with whatever aspect of the relationship that first sprang to mind. In this way the participants were in charge of the interview topic and the nature of the material they introduced. I participated in the interview by allowing the participants to tell the story of their relationship and by using open-ended questions or empathic reflections to invite them to expand on their comments. I was cognisant of not intruding into an area that I sensed was going beyond where the participant may have intended, therefore not labouring a point if it was not made clear, or did not make sense after a reasonable amount of exploration.

The interview process was unstructured and free flowing in line with a phenomenological approach. By inviting the participants to lead and engage in a broad way with the topic I was able to enter into each interview afresh without any prior assumptions contaminating the foreground of the interview. "In unstructured or open ended interviews, the researcher will invite the informant to discuss a broad topic or theme, with the emphasis being on recording the

spontaneous free flowing meanings that the interviewee is able to articulate. The task of the researcher is to define or delineate the phenomena to be studied, and then to facilitate the exploration by the participant of what this phenomenon means to him or her" (McLeod, 2003, p.74).

In summary the practical and conceptual skills necessary for the process of a qualitative interview are closely related to those required by therapists (Morrow, 2007; Polkinghorne, 2005; Silverstein, et al.) The concept of the interview as a co-construction of meaning is similar to the theory of inter-subjectivity in psychotherapy where the relationship is considered to be a mutual endeavour (Aron, 1996; Etherington, 2007; Finlay, 2009). Importantly the interview experience was viewed as being a potentially rare and enriching experience for participants (Etherington, 2007; Kvale, 1996).

In line with Kvale's (1996) principles all participants expressed that the interview had been a positive experience and for some had produced new insights into how they viewed the relationship with their therapist, or was a timely reminder to them of the amount of progress they had made during therapy. All but one dyad reported having a session focussed on their respective interviews after the interviews had been conducted. I was not privy to how much information from the interviews was shared between them. All participants were agreeable to be contacted again after the interview for follow up if necessary.

Rationale for text analysis

I began this study with the initial view that I would use grounded theory to assist with analysing the data. I soon realised that grounded theory did not fit the study or the researcher. My background in psychology and my previous thesis were grounded in quantitative methods. I was looking forward to a change to qualitative work and grounded theory seemed like it was trying to accommodate the ideals of the positivist tradition. The focus was all about the

methodology, and the correct steps and rules that must be taken in order to prove reliability and validity of results, regardless of the person who was employing the method. I became quite stuck and ambivalent regarding how to go about analysing the interview material. In trying to code the texts I felt compelled to mechanically divide and separate the text, which de-contextualised the data to the point of losing its meaning.

A thorough reading of the literature on grounded theory confirmed my view. Although, I was tempted by Charmaz's (2003) compelling argument that portrayed constructivist grounded theory as the method for taking qualitative research into the 21st Century. Constructivism assumes the relativism of multiple social realities, recognises the mutual creation of knowledge by the viewer and the viewed, and aims towards interpretive understanding of participant's meanings. However this interbreeding between grounded theory and phenomenology only convinced me more to turn to a methodology that incorporated the inter-subjectivity of the participant and the researcher.

I was encouraged by Polkinghorne's (2006) synopsis of the development of qualitative research and his agenda for the second generation of qualitative studies. He proposed, "a negative correlation between the quality of findings in a qualitative study and the researchers obedience to the rules of method (Polkinghorne, 2006, p.74)." He suggested more sensitivity to the *study's gestalt* and a departure from using a set of procedures, towards using virtue ethics to exercise care in the production of a study and make responsible judgements. This philosophy means that the personal skills, proficiencies and character of the researcher are primary as the instrument producing increased understanding of the phenomenon. Patton (2002) concurs that the quality of the results of a qualitative study does not depend on the strict adherence to a sequence of steps or the application of a particular methodological technique.

The best phenomenology according to Dahlberg (2008) highlights the complexity, ambiguity and ambivalence of participants' experiences. Phenomenological research is

characterised by its capacity to present the paradoxes and integrate opposites demonstrating holism. This parallels closely with the therapy session and the real world dilemma of moving away from theory at times to acknowledge the variety and uniqueness of the client's particular problem of living and what it may mean. "The achievement of desired outcomes in the human realm differs from achieving results in the physical realm" (Polkinghorne, 2006, p.73).

In keeping with the image of the bricoleur, the analysis of the interview material included a combination of phenomenology and case study. As the researcher I decided that these methodological theories related to the data, and I could resonate with them to begin to make sense of, and bring together, the participant's experiences and stories of their relationship.

Analysis of interviews

All interviews were recorded digitally and transferred as voice files to a computer. The voice files were transcribed in detail with careful attention to accuracy, this meant the audio file was replayed several times whilst transcribing. This process assisted me to *dwell* in the interview material, and to become mindful of the tone and nuances present in each interview. The voice files also enabled fast access to the interviews when writing so that I could double check material for content, tone and prosody of the material.

The transcripts were initially imported into NVivo for coding, but this was abandoned in favour of a manual approach that relied on the person of the researcher once I decided to discard grounded theory and any attempt to categorise the data. However NVivo was very useful in terms of managing large amounts of text and accessing them quickly, so not all was lost in that exercise.

I wanted the integrity of the data to be retained and to achieve this I analysed and presented the data by preserving the context of the relationship they shared. This meant a detailed examination of the seven dyadic relationships as they related to one another. A narrative of the

relationship was then formed out of the two accounts. The aim of this analysis at the point of writing has been to recognise and explore the identified narrative themes in as much detail as possible. However I recognise that the depth and breadth of alternative interpretations have not been exhausted in this current thesis. Participant's quotes have been included verbatim with no stylistic or grammatical editing. For audit purposes the interview transcripts are available if necessary.

Quality and trustworthiness

I have chosen to use the terms quality and trustworthiness (Morrow, 2005) instead of the common quantitative terms of validity and reliability because they have a specific and different meanings within the positivist tradition. Morrow (2005) argued for the limited usefulness of using parallel criteria with a paradigm that has very different underlying assumptions. How bias and the promise and limitations of subjectivity are managed within any study is vital. "All research is subject to researcher bias; qualitative and quantitative perspectives have their own ways of approaching subjectivity" (Morrow, 2005, p.254). In this study I have attempted to make my subjectivity as transparent as possible.

Morrow conducted an extensive review of the constructs and criteria for quality and trustworthiness in qualitative research (Morrow, 2005) and gave some recommendations for conducting and writing a qualitative study. While she prescribed guidelines rather any definite conclusions, she was very clear that the criteria for trustworthiness should be closely tied to the paradigmatic underpinnings of the discipline in which the study is conducted. That *dependability* can be established through an audit trail. An audit trail details research activities and processes, as well as influences on the data collection and analysis. In the end the integrity of the results are embedded in the data and any reader of the research should be able to confirm the adequacy of the findings in the reading of the material. Qualitative researchers are influenced by a range of

theoretical approaches, however all perspectives hold in common the view that knowledge is not received or discovered, but to varying degrees constructed.

"In qualitative research there is no single correct way to interpret data. Rather, different researchers might emerge with different interpretations of the same data set. However each interpretation must be supported by the data, thus the requirement of transparency. Each interpretation must make sense to other observers, and it must tell a coherent story" (Silverstein, et al., 2006, p.353).

Qualitative research is a personal activity, and the *languaged data* is also personal, social and cultural, rather than objective and impersonal. Social and psychological research therefore requires that language is examined within its context and in the light of its parameters and constraints. This involves understanding the context in which the research participants are situated as well as the context of the researcher. Therefore it is the researcher's responsibility to present their findings as fully and faithfully as possible.

Elliott, Fischer and Rennie (1999) identified *publishability* guidelines pertinent to qualitative research, including; owning one's perspective; situating the sample; grounding in examples; credibility checks; coherence and general versus specific research tasks and resonating with readers. There is no real consensus regarding the most rigorous criteria, techniques or steps to employ. Due to the personal and interactional nature of most qualitative research and its reliance on the skills and personal judgments of the researcher the capacity of reflexivity (Morrow, 2007) or self-reflection has become a well accepted activity by most perspectives as way of managing ones subjectivity during the research process.

Reflexivity

Reflexivity is defined as "self awareness and agency within that self awareness" (Rennie, 2004, p.183). The gold standard for quality and trustworthiness in qualitative research has

become the activity of the researcher making their implicit assumptions and biases overt. In phenomenology this is termed bracketing. It is similar to the capacity the therapist employs in therapy in order to truly hear the unique presentation of each client. However therapists and researchers remain human and fallible and therefore susceptible to what Denzin and Lincoln (2000) describe as the *crisis of representation.* In particular whose reality is represented in a piece of research? This *crisis* is particularly important when the researcher is an *insider* in relation to the phenomena under study. "Investigators always believe something about the phenomena in question"(Morrow, 2005, p.254). According to McLeod (2003) researchers own personal experiences are not always a source of bias. The researcher's purposeful use of feelings and reactions can also be a rich source of insight and data. This parallels the use of self in therapy. However importantly it is the continual monitoring of the self (Silverstein, et al., 2006), for how the researchers values and biases may be influencing the process that is the vital. In this sense the researcher becomes an involved and active participant in the research.

Some other reflexive strategies include keeping a self reflective journal of experiences and reactions about the research process to bring any underlying assumptions into the foreground (Polkinghorne, 2005). Also consulting with a research team, debriefing with peers (Hill, Knox, Thompson, Williams, Hess & Ladany, 2005; Morrow, 2005), or enlisting a *community of practice* made up of knowledgeable colleagues to act as the devils advocates and engage in critical discussion. This last strategy is a similar process to clinical supervision where accountability for ones work is closely scrutinised. According to Polkinghorne (2006), trustworthiness is a status given by the reader in response to being convinced that the researcher has made responsible judgements and exercised care in the production of the study.

The notion of axiology or care has been elucidated more recently to include not only the researchers value system but also their moral judgments (Haverkamp, Ponterotto, & Morrow, 2005; Norris, 2005; Ponterotto, 2005) According to Ponterotto (2005) the researcher should

acknowledge describe and bracket their values rather than attempt to eliminate them. Norris (2005) proposes that basic epistemic virtues should act as the prerequisite for any judgments made by the researcher including, honesty, integrity, caution, openness to criticism, and willingness to give up cherished beliefs in the face of conflicting evidence. Brinkmanne and Kvale (2005) content that objectivity is a moral concept before it is a methodological concept. Their meaning of objectivity is being open to seeing the others as they really are. "One fails to be objective and ethical in this sense if one does not allow ... human beings, to frustrate one's investigations" (Brinkmann & Kvale, 2005 p.170). Therefore ethically competent qualitative researchers master the art of *thick description*. In thickening the description the context is preserved and deepened and the researcher can portray the narrative truth rather than trying to find an absolute truth. As the research tool for this study, the reliability depends on my value judgements and the responsible use of my particular skills and capacities to guide the process of intellectual and critical self- reflection. I am responsible for the presentation and any claims made from the data.

After reading the literature I decided not to employ the commonly used activity of participant verification. Participants were offered the opportunity to check their interview transcript, as a form of face validity, however as mentioned this offer was not taken up by any of the participants. Because the data has been presented in the form of case studies of relationships I could not ethically show the other half of each dyad the information provided by the other. Confidentiality would have been breached, and in line with (Giorgi, 2008), whether each half of the dyad agreed with my portrayal of their relationship is not the same as validating the findings. To privilege the individual participant's perspectives of their particular relationship as the main focus of the findings would only serve to subordinate the phenomena under study. For the purposes of this study I have undertaken to keep a reflective journal and I have utilised the process of a *community of practice* by asking colleagues to read sections of the study. I have also

utilised my three person supervision team who bring clinical, academic and research knowledge and expertise to engage in critical reflection.

Ethical considerations

The interviews with client participants in particular needed to be undertaken with respect for each client's unique perspective on their therapy experience and particular relationship with their therapist. This would usually be a very private endeavour and can contain intimate and sensitive material about the personal lives of the participants. Potentially information they may not have disclosed to anyone else other than their therapist. Therefore it was important that my relationship with the client participants was non intrusive, respectful and sensitive in relation to the information they might choose to share. It was stated clearly in the information for clients (Appendix 8) that they were not expected to disclose the issue that brought them to therapy or the content of their sessions. This was repeated verbally at the start of each interview. However the possibility was always there for a participant to slip across the boundary between a research interview and a therapy interview. This occurred with only one participant, where I had to be mindful of holding that boundary while remaining sensitive and respectful to his present need. In this way I attempted to assist this participant to monitor his reactions to the interview process, and to ensure ongoing consent. The particular client was asked if he would like to have a break, or if he would prefer to discontinue the interview, and he made it clear that he wanted to continue.

Therefore it was critical when beginning the recruiting process, that the first contact with the client participants was approached with prudent consideration for their autonomy and freedom of choice throughout the process. It was also crucial that therapist participants were responded to with respect for their position and expertise. All participants were laying out and exposing their work for scrutiny, and the interviews were sometimes touching on personal areas

that went beyond the research topic, model or techniques involved in their work. I was struck by the altruism and generosity of all the participants. They were very open and generous with their time and the telling of their stories. As stated previously participant verification was not utilised for both theoretical and ethical reasons. This will be an ongoing concern regarding further publishing of the material, where particular accounts of sensitive material will necessarily have to be omitted.

Ethics approval

Ethics approval was granted through the University of New England's Human Research Ethics Committee (HREC), approval number HEO4/155. There were four conditions placed on the study.

(i) The Researchers are to provide the project information to the counsellors and the counsellors can then contact the researchers to agree to participate.

(ii) The Information Sheet for the Counsellors is to include a statement indicating that counsellors are not to nominate vulnerable clients for participation in this research i.e. someone nearing the end of their counselling program would be more appropriate etc.

(iii) If the first three clients come back after participation and say that they now need another counsellor as the initial relationship has been damaged, the researchers are to discontinue the research.

(iv) The researchers are to ensure that clients who would find it difficult to obtain a replacement counsellor (in the event that the counselling relationship is damaged as a result of this research) i.e. where there are lack of options such as remote areas or those clients that may be in a low socio economic situation and unable to afford a new counsellor, are not included in the study.

Conditions one and two were adhered to throughout the research process. However despite the statement to therapists requesting them not to nominate overly vulnerable clients, there was one client who I deemed to fall into this category. This was not foreseeable until the interview process was underway. The interview with this client was difficult, however it was managed with sensitivity and respect, and during the debriefing the client reported it had been a positive experience. Conditions three and four did not arise.

Conclusion

The methodology utilised for this study was designed to investigate the phenomenon of mutual influence in the therapeutic relationship. Phenomenology and case study approaches were chosen to achieve this task as they provided the most parsimonious and ethical pathways (Etherington, 2007) to enter such a private and sensitive area. Keeping the relationships within their context was an important part of the decision making. As such, the analysis attempts to retain the narrative truth and reliability of the data. Previous literature shows a paucity of offerings that explore the relationship from the perspective of the therapeutic couple. Existing studies in this area mainly spring from quantitative philosophies of science and do not provide an in depth look at the phenomena. In the following two chapters, the data is presented and explored through two overarching themes. Chapter 4 follows the theme of relational boundaries as they pertain to the development of trust. Then Chapter 5 unpacks the personal aspects of mutual influence within the narratives of six of the seven therapeutic relationships.

Chapter 4

Interpersonal Influence: a Matter of Trust

Introduction

An exploration of mutual influence necessarily begins by unpacking the stories of both therapist and client to capture their experience and understanding of what their particular relational journey has meant to them. This chapter begins the set of narratives that illuminates each relationship in terms of how it came about and how each dyad mutually contributed to its development over time. The major theme running through each set of narratives relates to how the relational boundaries for each dyad, while quite different, were intertwined with trust. Therapists and clients told the story of their relationship independently of each other, however when pieced together they provide a rich and detailed insight into the mutual interplay of thinking and feeling underpinning the dynamics of the relationship, in particular the negotiation of interpersonal boundaries.

The word boundary is the colloquial term used in therapy for the limits placed on a professional relationship where the care of the client is paramount, and do no harm is the absolute bottom line (Pope & Keith-Spiegel, 2008). The term boundaries also denote a construct that acts as a metaphor to contain the often invisible constraints that therapists and clients experience in the crucible of their relationship and their work with each other. Commonly these constraints provide a predictable and safe set of role expectations to optimise the work, and are governed through professional codes of practice. Personal subjectivity and mutual influence are not topics commonly linked to boundaries in the literature.

While there is fundamental agreement in the field of therapy that boundaries are a vital component of both the structure and process of therapy, there does not appear to be any consensus on a clear definition of boundaries, or what constitutes adaptive and useful boundary

shifts, except to acknowledge they must be in the service of the client. The exception to this would be sexual contact with a client, which is always considered a violation of boundaries. My focus for the purpose of this study relates only to non-sexual boundary adjustments, their particular meaning for the two people in the therapeutic relationship and their link to trust. There has been a paucity of research on how the dynamics of the relationship influences therapists to change their usual frame of working when faced with the daily complexities of boundary decisions. How therapists actually manage boundaries in every day practice and what this means to clients is obscure in the literature.

This chapter focuses on the accounts given by the various therapist-client dyads in relation to how boundaries were negotiated, or not, at different stages of their relationship. The accounts provide an indication of the impact of those decisions on the nature and trajectory of the particular relationships over time. All seven therapeutic relationships tell diverse stories of their particular relational boundaries, how these were tested, manoeuvred and reciprocally managed. Each relationship will be presented in relation to the three major themes that emerged in relation to mutuality and the development of trust.

Testing Trust; Availability and Responsiveness

Trust is a given in therapy, an essential ingredient for the viability of the relationship and a clichéd term used generically nowadays within therapy. Tests of trustworthiness happen on a daily basis both in and out of therapy. A brief exchange of words, a few questions, a feeling, an astute observation, and trust begins to take shape, or not. While the main thrust of this chapter relates to interactions between therapist and client, the accounts from clients show that even before therapy begins the therapeutic relationship is alive in their minds and imaginations. These imaginings highlight the importance for clients in finding the "right" person to talk to and in whom to place their trust. All of the clients in this study had experienced therapy previous to

their current therapy relationship and had exercised their power of veto by sacking their therapist and continuing the search for the "right person," and "someone they could trust." The search for trustworthiness became more salient through the reciprocal interactions of mutual availability and responsiveness.

Graham and Peter

Peter has been meeting with his therapist Graham for two years. According to Peter their relationship began in an "accidental" way. Peter had been attending his local Church and observing Graham who was the Minister, and also a Psychologist. Peter observed Graham in his role as minister and formed an impression of Graham as "ordinary, reasonable, and up front, not fundamentalist." These were all qualities that helped Peter make his decision to go ahead and risk talking to Graham. Peter had thought carefully before approaching Graham with his personal difficulty. For Peter, beginning to place trust in Graham was mixed with some ambivalence about him being the right person to help and a wondering if Graham would be able to move "beyond the box," which for Peter meant outside a religious framework.

> I attended the church and he was the minister. He seemed, he seemed quite okay, I didn't even know that he was a psychologist, and he seemed fairly um, fairly ordinary, and reasonable, not, not, not fundamentalist. Ah, an okay person, not because of any technical skills, but up front. And then, um, yeah, I decided to say, okay, talk to him about it [his difficulty], and that's the first thing. I think perhaps the second thing is perhaps I approach it I suppose from a view that, on a particular value set, should I say, I got a lot of mixed things because in terms of Graham, he's got his religious beliefs. So does that affect his counselling ability about being able to move beyond the box, okay? In my case, I wanted him to do it within the box, but on the other hand, there's also this realisation that perhaps working within the box might not be the best way to approach it, but nonetheless that was a

possibility. I thought maybe he would, he might move beyond the box if he needed to. (Peter)

Peter had clearly considered his choice from all angles. He wanted to ensure that Graham would be capable of being flexible if it proved that working "beyond the box" was "the best way." Peter is also Chinese and there were possible cultural taboos, implied through his words, around sharing private information outside the family. Family injunctions would place even more importance on this decision. This was coupled with the risk of being viewed differently and possibly judged.

That um because, those two roles, yeah, minister, confidant, counsellor, is um, if you are in the minister and congregation-type role there's this reverence and perhaps this thing about embarrassment, I mean both parts. What if he said something which went beyond, you know, my perception of him? What if I told him something that he would then look on me from a different perspective because of that religious perspective, so there was a risk there (Peter).

For Peter the other side of risking his image was the added risk of possibly having his perception of Graham changed. It is evident from Peter's level of thinking that he was apprehensive about his decision. For Graham the decision was also an awkward one, because he had announced to the congregation when he started in the parish that he would not be available in the capacity of counsellor.

I made a clear statement to the Parish that I was there as the rector and not as the counsellor, and therefore I would not be seeing people of the parish ... in this instance, I was there in a different role and I didn't want boundary violations. (Graham)

Peter was unaware of Graham's statement to the Parish when he approached him to talk about his marriage difficulty. Graham suggested some referrals and Peter "baulked at the idea" and told Graham that he would prefer to talk with him. Graham changed his mind and decided to see Peter, and his tentative language in retelling and describing the conversation showed the discomfort of the decision for him.

> I said well, you know, I had made a decision, not to, um, but, it may be easier, um, if that's what, you know, your choice. Then we establish it as a, a sort of, a counselling relationship, and um, as much as possible, that's where it stays. (Graham)

Graham was concerned about setting a precedent for something he could not offer to everyone. In the end Graham responded to the need he saw in Peter and the difficult first step he had taken.

> I think I was fairly easily persuaded, because I just saw his need and realised that um, that probably for him, making that first step was, as it is for so many people, it's a difficult step to take. And therefore if I sort of said well you know, you should go and see somebody else now that you've disclosed all this to me, then that can easily be taken as a sort of form of rejection. (Graham)

Graham's perception of the impact for Peter was accurate according to Peter's account.

> I suggested it, and in my case I said things which perhaps, which might be a risk to my image, but it didn't matter, because there is an element of trust so once he said yes, it was within that paradigm. (Peter)

Graham also mentioned that he thought Peter had tested him out, through listening to his sermons, and as a result would have been aware he was "inclusive and accepting of people, where they are and who they are." Peter might have suffered what the Chinese call a "loss of

face," if he risked exposing his life difficulty to Graham only to end up being referred to someone else. There were also other risks for Peter. What if Graham "went beyond" his perception of him and disappointed him, or as he alluded, judged him? The imagined relationship was already actively alive in Peter's mind pre-therapy, and highlighted the importance and risk in this decision for him. Added to this was the personal courage it took to reveal himself, given the risks as he perceived them.

Anne and Chloe

Chloe has been seeing her therapist, Anne, for approximately two years. When Chloe who is nearly 30, decided that she needed to "sort out" some long-standing issues in her life, she approached therapy already carrying multiple baggage from previous therapy encounters. Chloe described being caught in a medical system where she felt "unheard, disrespected, bad", and "treated like a number rather than a person." When describing her dissatisfaction and lack of trust in previous practitioners Chloe repeated several times, I "was given this diagnosis." It turned out the diagnosis was Borderline Personality Disorder. This label was added to the growing list given to Chloe during adolescence, along with "chronic depressive and schizophrenic," when she was admitted to hospital for what she termed "addictions."

> All the other therapists, psychologists and psychiatrists at the hospitals and stuff, it was all very much hierarchical, from their point of view. It was a medical point of view. They couldn't really diagnose me. I wasn't getting the help that I needed, um cause I'm not a trusting person as such, and having a different doctor walk in every other day, and I'd be just like well, who are you, what do you want? And they'd ask me questions and I'd say well, there's my case notes read them, you know. And then I'd be like oh! I can't be bothered to talk to you anyway cause I'm not going to see you again anyway, and I'm not going to be dissected on a table every time someone else comes into the room ... as much

> as I want your help it's still pretty painful to be here and it's not for me to help you, so please don't make me feel like I'm some monster. (Chloe)

Chloe still wanted help, despite her negative experiences, so trust was going to be vital, along with respect and, at the very least, a therapist who showed an interest in understanding her. Chloe had been seeing another therapist just before finding Anne, and alluded to the fact she was still struggling with "addictions" at that time. "I used to miss my appointments sometimes, and then I'd phone and say I'm really sorry, and then I'd get really bad again. But then she would say, just, ok that won't work for me and she'd walk away." Chloe was cognisant of her part in the consequence of her previous therapist walking away. However she became desperate and decided to try therapy again at her boyfriend's suggestion when their relationship hit rocky ground. Chloe found Anne through her boyfriend's best friend, who was seeing Anne himself. Despite making the free choice to attend therapy she still felt "very dubious." The thought of feeling "pressured and awkward" and it being "pretty painful" remained fresh in her mind.

> Certainly when you come to a professional, you are feeling all those things already ... and you don't want to have those feelings enhanced really, and it's obviously not meant, but it's, I think they [therapists] forget the subtleties. Yeah and [therapists could] just think well you know, I could end up in this position very easily. (Chloe)

Forgetting what Chloe calls the "subtleties" highlights the possible details that therapists might take for granted, or become desensitised to, while immersed in daily practice with an eye on managing a busy schedule and watching the finances. Therapists in private practice do not welcome missed appointments, however a therapist "walking away" could mean the last chance of assistance for someone who does not have the wherewithal to persevere and seek alternatives. As well as the practical strain on a busy practice, there is also the issue of theoretical and professional attitudes towards addressing recalcitrant behaviour. Clients like Chloe can stretch

the boundaries and, in turn, the therapist's patience to breaking point. However, one of the factors that convinced Chloe she was going to be able to trust Anne was that Anne responded differently than her previous therapists when she missed appointments.

> So I'd think ok, so she's not angry, so I can go back and see her again, and I'm not made to feel like I was irresponsible, or I was being selfish, because I already knew all that [we both laugh] ... Yeah and I was just like oh! Okay! Maybe I'll go today cause she hasn't changed. (Chloe)

Anne did not tighten the boundary around Chloe's transgressions either pragmatically or emotionally, which allowed Chloe to feel it was safe enough to return. This would fly in the face of a range of theoretical explanations and behavioural responses to perceived "irresponsible" client behaviour, especially from a client with "that diagnosis." It is quite poignant to note that Chloe was aware of the negative aspects and impact of her behaviour. Anne explained that her non-punitive responsiveness to Chloe came from a personal reaction that sprang from her own experience of therapy, and therefore a subjective conviction of what was needed. "It was so important to me to know that no matter how revolting I felt, I was *never* [italics added] going to be rejected, to me that's the core of attachment, working with attachment." Anne's identification with Chloe and her situation enabled her to make herself available, as well as providing an accepting haven for Chloe. Anne's generosity of self allowed Chloe to begin to trust in her and in turn utilise the therapeutic space.

Will and Eve

A combination of first impressions and wanting a male therapist drew Eve towards her therapist, Will, approximately two years ago. Eve is a social worker and she had attended a family therapy course at a university where Will was one of the presenters. Eve said Will's name

kept “cropping up around the traps” so when she decided to go to therapy Will’s name came to mind again. However as with other clients there was usually more to the decision.

> Because of, I guess being in that course and meeting people and understanding ah, the model of work, um, I trusted, I think I trusted that um he would be ah a good therapist for me. Yes, I think all of those factors came in ... and I think it was respect, you know, so I think also that link. (Eve)

This imagined relationship was also alive in the mind of Eve before therapy had begun. Eve appears to have based her choice squarely on someone she already had a sense of, and whose way of working she had glimpsed by virtue of the course she had attended. It was also significant for Eve that she was able to talk with someone she held in respect. There were also other concerns. “For me it’s important that the relationship is not one of, “I’m the expert and you’re the supplicant”. For me it’s important that in a way we’re meeting, um, on an equal level.” These pre-therapy impressions, expectations and imaginings all contributed to the trajectory of the therapy. The decision was even more important due to previous negative therapy experiences. Will recounted hearing about Eve’s previous encounter with therapy.

> She had seen one woman therapist for a few sessions, and she had arrived late. She told me the story, so I was obviously meant to take notice of it [we both chuckle]. She phoned and said, “I’m really running late”, and the woman said, well, come anyway, and when Eve arrived 20 minutes late this therapist said, “You’re showing your anger against me in a passive manner, you’re angry with me and this is how you’re showing me”. So Eve had not gone back after that [chuckles]. To me that was an example of a too early challenge. (Will)

Will’s interpretation of Eve’s lateness was “her reluctance to tackle the uncomfortable things” and therefore narrowing the amount of time in the sessions. Will said in the beginning

Eve had complained about the cost of therapy and the frequency, and opted for fortnightly sessions. This possible avoidance was a hint of a future theme in the relationship.

Thomas and Bella

Bella has been in therapy with Thomas for just over six years. She began her relationship with Thomas in a fairly straightforward way compared to some of the other dyads, by approaching a reputable counselling organisation where she knew a contact. Bella had already been to three previous therapists. The first one she had seen when she was "only" eighteen, and she found that experience "horrifying."

> I had no understanding of what really was going on, or being confronted with things, I guess too early. Later, there were two other people that I really hadn't felt comfortable, just hadn't felt comfortable with, and yeah, and I guess I felt a bit analysed. One person had reams of notes about me on their desk, it was horrifying 'what's she written about me' just horrifying. (Bella)

Despite three previous attempts Bella persevered with her search and spoke to her contact at the agency. She already had some necessary criteria in mind. She wanted a male therapist, who was in a similar age group as herself, and safety. "That safety and trust was the most important thing for me." The contact recommended Thomas. However the lead up to the start of this relationship did not go smoothly, and was described by Thomas as "insulting" to Bella. He said the agency administration managed to "stuff up" Bella's appointment time. The appointment was rescheduled and then, "they did it a second time."

> Now I'm assuming there's a client I will never see. She schedules, she books, she comes a third time, I go out to reception, I say, say "Hi, I'm very, very sorry for what's been happening to you", and she says "that's not a problem". It's all there should we say, it's

> insulting, see it's all there, there's an awful lot there and we've reflected on it over the years how much was there ... she'll just fit in to whatever is asked of her. (Thomas)

At least it was not Thomas who "stuffed up" the appointments, but Bella's tolerance spoke volumes to him. Bella's background was one of being overlooked by others, especially the significant male figures in her life. In her mind, it was only a matter of time before any man would tire of her and lose interest. The therapeutic relationship with Thomas began with what was a familiar theme from Bella's life, and except for Bella's valency towards tolerance and compliance the relationship was almost over before it began. The preconceived relationship as it is conceptualised by clients takes many shapes, and as with Bella can unwittingly be played out in an uncanny fashion.

Giselle and Jim

Jim and his therapist Giselle have been in a therapeutic relationship for four years. Jim met Giselle when he began to train in Process Oriented Psychology (POP), and he had attended several workshops where Giselle was one of the trainers. According to Jim meeting Giselle ahead of time and also having her recommended by other POP trainers was important to him in terms of being able to trust.

> I actually drove with her and her partner and some other process work people up to [names the town]. So I actually met her before I engaged in the therapeutic relationship with her. Yeah, so I had some experience of her before we started doing therapy together. It was really important actually. Ah, having a sense of someone and engaging in that relationship to that level of trust is pretty, it's a big one. You come across people who are just like "no I don't think so". I wouldn't engage with them. Listening to what they say and looking at how they are and, [long pause] you know that's pretty key for me, and how I feel when I'm

> around someone is what I trust. What it feels like in my body when I'm around that person is pretty up there, so if someone also comes with a recommendation that's pretty good. (Jim)

Having some knowledge or experience of a potential therapist was 'key" for Jim. He said it was also about the model of therapy, because he had tried several therapists from other modalities before "hitting on" Giselle, and found they were not a good fit for him. "Like I've sat with CBT therapists and totally wrecked their world." Jim became quite determined in pursuing his choice of therapist. Giselle had obviously made a strong impression on Jim; however it took quite a bit of time, energy and ingenuity for Jim to finally convince Giselle to take him on as a client. Giselle's preconceived imaginings of a relationship with Jim were anything but positive.

> He kept pursuing me over months and he'd write me emails. He got my email probably from this community training event …He met me at a workshop, … Jim was new to this group and I was not at all impressed by him I thought he was a very unsavoury character. (Giselle)

These initial reactions are usually private, but Giselle was quite transparent about the strength of her first impressions, and why she was not too interested in taking Jim on as a client. "I thought, oh, he's kind of an unpleasant character, he's got a weird beard, he's a bit overweight and he's, he's not sensitive in the ways that would matter to me in being very close to someone." These comments are very honest, and might shock those who hold dear the Rogerian concept of unconditional positive regard and the accompanying attitude of being non-judgemental. However these first uncensored and personal opinions were formed before any approach had been made by Jim for therapy, and they have obviously stayed with Giselle over time.

> He seemed to really take to me, and it's, it's nice, but I wasn't interested and he asked me, would I start to work with him therapeutically. He wanted free, not free necessarily, he

> wanted to negotiate a lower price, but since I had no interest in working with him anyhow, I definitely had no interest in negotiating special deals. (Giselle)

Jim kept on "pursuing" the possibility of therapy with Giselle over several months despite her lack of interest and negative response. Jim had gleaned other information about Giselle through the training events they had attended together, including the fact that she lived on acreage. Eventually Jim suggested to Giselle that he could help clear her land in return for his therapy.

> The bizarre thing was, he was one hundred percent correct, and that was a little wake-up moment. He persevered long enough and made enough suggestions, and he actually hit on a suggestion I did need. So I talked to my partner and she said, yeah, so that's when we started with this trade, that he did some labour, some work on my property, and he put in so many hours to equal an hour of my therapy work. (Giselle)

The interesting point raised by Giselle's decision, is her open acceptance of getting her own practical needs met in the arrangement, rather than basing the decision on a more one-way benevolence solely in the service of the client. This was something she needed also. Despite Jims apparently lengthy pursuit of Giselle to provide therapy, when I asked him how he negotiated their arrangement his answer was very brief. With a slight laugh, he said, "I asked." When I asked if Giselle had been open to that arrangement, he answered, again briefly, "it took a little while, but it eventually worked out." The meaning he put on the length of time it took was, "Oh well, me overcoming shame and valuing what it is I do, and what it is I can do, and her consulting with her partner."

The fact that Jim does not mention that he pursued Giselle over a long period of time, and rather states it as "taking a little while," could be a simple glossing over of the detail, or a slightly self-protective stance of not wanting to admit that Giselle had originally said no several

times to his requests for therapy. The continuing theme of needing to feel on a more equal level was also apparent. Jim mentioned several previous therapists, who he had "terminated," because they practiced in what he called "the pathology model." Giselle and Jim's different narratives about the beginning of the relationship were also mirrored in the different role expectations that each of them had about how the relationship would work in practice. This only became apparent once therapy had begun in earnest.

Sarah and Lily

Lily was referred to her therapist Sarah by a friend who teaches and studies with Sarah. Lily has been seeing Sarah twice a week for four and a half years, and has followed her through four geographical moves within a major city. As with other clients Lily used a trusted source of referral as well as having a belief that a "holistic" form of therapy would be the most beneficial for her.

> The girl that referred me is a good friend of mine and she is a therapist now, and ah, she had told me all about Gestalt and that's why I think Sarah and I are working. Cause, I really believe as well it is about body and mind, that it's all connected. (Lily)

Lily had been to two other therapists, and now in hindsight was convinced that "you have to find the right person." However back then Lily had not found the right person after two attempts and was not really keen to continue. "I was so bad that it was that, or who knows what else, I just thought you know I had to do something." According to Lily therapy with Sarah was "just an absolute difference." The difference was one of style, as Lily found her previous therapists very nice; however she left the sessions feeling "like I'd talked about it, you know, kind of like a relief, but nothing else." Despite two failed attempts Lily felt desperate that she "had to do something." Like the other clients in the study Lily had her own idea about what she

needed. ‘‘My last Psychologist would just um, ah let me talk, but I could ramble on about other things, see Sarah won’t let me go off.” Lily had a good sense of the kind of person she needed in a therapist to bring about change. Despite this and her sense of desperation “to do something,” she had a real reluctance and ambivalence about the process of therapy. This attitude was a sign of things to come for the relationship. Sarah remembers Lily presenting as quite helpless yet not wanting help, “there’s this dilemma that constantly goes on.” She did not agree with the diagnosis of depression given by a psychiatrist; however she experienced Lily as having “no real connection with herself or me.” According to Sarah, Lily was a silent client and this was the beginning of a “huge journey.”

Paul & Leo

Paul has been seeing his therapist Leo for approximately one year. The relationship began through a referral from Paul’s best friend Stephen. Like the other clients, Paul preferred to have the recommendation of a trusted friend rather than choose from the phone book. This was due to the fact that he had previous counselling that he found a waste of time. “The lady I used to see over there, she’s, she was very nice but I don’t, I didn’t end up telling her anything. I sort of don't know why I went to counselling, you know.”

Paul offered the reason things did not go well as being his fault. However it sounded as if he did not feel able to open up to the therapist. It is understandable that this time round someone his friend knew and recommended was an attractive option. The tricky aspect to this referral is that Paul’s best friend is Leo’s nephew. In his role as best friend Paul is invited to most of Stephen’s family events and Leo is also in attendance. They have spent Christmas dinner together and family birthdays, amongst other events.

> One of my best friends is Leo's nephew ... so Stephen just said go and see Leo he's easy to talk to, and if he's, he'll tell you if he's not the right person. And I've seen him for the last year or so, but now only sort of maybe once, twice a month. (Paul)

Paul seemed to be aware this was not your everyday situation, however again the recommendation of a trusted source and the beginning imaginings of the relationship start to take shape. Contact outside the therapy office is usually condoned only in relation to how it serves the treatment, and clients are often unaware of professional standards. However this arrangement suited Paul, and is not unusual in rural settings where these kinds of situations are unavoidable. Leo appears to have held a firm boundary around his interactions with Paul within the social settings and Paul had no fears about his privacy or confidentiality in relation to the overlap.

> Yeah, and then you see him on, like I had Christmas with my friend Stephen, and Leo, Leo and Pat [Leos wife] were there so, so you see him on Christmas day and stuff like that and he's, he's so lovely you know he's just lovely. I'm sure it [the social situation] would be weird with, with certain people, but not with Leo, no. (Paul)

Paul was comfortable with the arrangement and held Leo up as someone above the average pack. Leo is a psychologist in his seventies, and he had come from a religious background and training where this kind of insider 'pastoral care' would not be unusual. Leo said that Paul had been through a relationship break up, which "followed a prior split-up in a previous relationship and the whole thing had been hugely distressing." Leo made a brief mention "he's a friend of a nephew of mine," but did not make further comment on the social aspect of their relationship. His attitude and open disclosure of the referral and nature of the relationship indicated there was no discord in the arrangement from his perspective.

Finding the Boundaries: Manoeuvring Towards Trust

Coping with uncertainty and personal difference is an ongoing challenge in regard to the development of trust in any relationship. The previous accounts show that the majority of clients sought to gain a recommendation that would provide not only the "right" therapist, but also a form of control or predictability amidst the fear of uncertainty and potential change. Despite the need for certainty and a sense of agency, the emergent life of the new relationship had an influence of its own, distinct from the individual personalities.

Will and Eve

When Eve approached Will for therapy she had already imagined that Will would be a good therapist for her. Both Will and Eve introduced the topic of boundaries within the first few minutes of their respective interviews, and with no direct question to prompt the topic.

> Another thing that's easy is boundaries because she knows, because she's a social worker anyway, she knows about those things, so quite often she'll make some remark about the garden, or our house repairs, or something as she comes in, because our, our room is, it's a little studio down the back, like everybody has in the mountains ... some clients, you know, would kind of misuse that, or ... obviously try to turn it into a social relationship, that has not arisen. No, it hasn't arisen um except one time I lent her a book and then thought afterwards, I probably shouldn't have lent her that book. (Will)

Whereas Eve's first comment was:

> Probably um for me personally the thing that is um very valuable about our, our therapeutic relationship is um, the boundaries. The boundaries are so clear and so set, and so inviolate, and that's um, that's a safety factor, that's a very good thing that they are there. (Eve)

These early comments from both Will and Eve show that the notion of boundaries remains forefront in their minds and signifies something meaningful in the emergence and development of their relationship as Eve's words indicate. Eve talks about the boundaries as she sees them existing, but with the implicit meaning that Will has put them in place. They "are so set, and so inviolate ... they are there." Whereas Will mentions them as something he has not had to worry about because he thinks that Eve "knows about those things." Both think the other is responsible for operating in a bounded way. When I asked Eve how she knew the boundaries were there, and how Will showed her they were there, she raised the topic of "the book."

> I mean [sighs], I know it from the way that I'll push Will a little bit, around that you know. Because I love books, and of course we sit in an environment that is wall to wall books, so I've managed to borrow *one* [strong emphasis and laughing] in two years [continues laughing], and that was really wonderful, and that was very um, that was also, I mean Will, Will would say that maybe that was a, a, a very mild boundary violation ... and he'll laugh and he says well you know, I shouldn't have done that. (Eve)

The significance of seemingly small things can take on a greater meaning once the context is known. Despite Will's concern that he "shouldn't have done that," Eve found loaning the book a positive experience. Her "pushing" had influenced Will to deviate from the norm and this act was meaningful for her.

> Because I need to do certain things to feel really comfortable in the relationship, and that is um, getting to know the other person a little bit as well you know. So even though our getting to know, is not going into his private life, it is about um books that we've both read, or you know little, little social things. (Eve)

The little social things, like a short discussion about the garden, or Will's house repairs were enough to satisfy Eve's need for "certain things." Within this context the loaning of the

book symbolised Will allowing her to get to know him, which was important for Eve, not just in terms of feeling comfortable in the relationship, it meant they were on a more "equal level." Eve's comment that she has managed to borrow only one book in two years is also telling. It shows the boundaries did not collapse around this area and slip into a continuing pattern, or an overly social interaction. On the contrary her words indicate the degree of difficulty in borrowing that "one" and only "wonderful" book. It could also be speculated that this boundary shift while positive and meaningful, was also significant in that Will was seen by Eve to remain firm in his resolve that it was not going to be repeated despite her "pushing." He could let her know him without going too far. The symbolism was powerful.

Will consistently came back to the issue of *the book* [italics added] throughout his interview it was a conspicuous and constant reference point alluding to something bigger. Despite saying in the beginning the boundaries had been "easy" Will appeared conscious of the importance of maintaining clear and firm boundaries with Eve. The metaphor of intrusion that loaning *that book* might represent did not escape him, and was a salient theme in the relationship.

Graham and Peter

Peter trusted "the substance" of the man he saw in Graham which contributed to his belief Graham was the right person to be his therapist. His view of Graham before their therapy relationship began allowed him to feel more confident that he would not be wasting time with the wrong person. He thought that if he selected a therapist himself there would be less risk of a "mismatch."

> I mean I think part of the reason why this has happened is because I, I sort of know him um reasonably well before the thing started. I mean, just as a congregation member, just watching him, and so you saw what the substance is like. But if I were to go in cold, and

> use the APS or something like that, I think it's highly possible they'd be eliminated in the pre-selection, and also to see him in a role, a non-counselling role, non-psychologist role. (Peter)

According to Peter his prior relationship with Graham was not an issue, and once Graham had said yes to seeing him there was "an element of trust." The main risk was exposing himself to someone who knew him in another context, which is quite different to seeing someone where there "is no prior connection." Peter speculated that there must be a "dynamic in how he [Graham] does that [manages two roles]." Peter trusted Graham to work between the two roles of minister and psychologist. Peter chose Graham because he thought he was a wise person who would have come across similar life situations in his role as minister. However he also thought: "Ultimately whether someone stayed or didn't stay, was whether we had this relationship going. So I say even if you choose on spec, it doesn't mean it's going to work out." Part of Peter's concern was about the skill level of the person he chose. He commented several times on the fact that the "clinical skills have to be better than the client's." Peter's sub-text points to self reliance requiring someone who is not only knowledgeable and wise, but someone who could "go beyond the barriers" of his own limitations, and extend his own knowledge base.

> Because um what happens is that if there's a mismatch, um that person can just, it doesn't work because you just won't be able to go beyond the barriers. And, yeah, so you have to be fairly, pretty good, I mean, good relative to the client. (Peter)

Peter's self-reliance might get in the way of him trusting Graham's ability to help him. Peter said he did not necessarily want Graham to tell him what to do in his current crisis, but he wanted Graham to confirm that he was on the right path. There is a subtle distinction between the two points of difference. Peter's need for confirmation manifested when he felt quite anxious

about his decision making and would approach Graham outside of therapy time. He had commented earlier:

> On a couple of occasions when it was in a new relationship, in the beginning, I might see him outside of the church, and I want to talk to him about it, and he didn't want to talk about it, about my situation. So um he wanted to talk about other things, so that was okay. I mean, um, ah, and, or even if it wasn't ok if there are pressing things, I'd say I want to ask you this, give me three minutes, or a couple of minutes or that type of stuff, you know ... There are situations where he has been reluctant on more than, and I've not completely pulled back, but at least if I needed something very short, I'd sort of say 'this, this, can, what do you think?' (Peter)

Peter's words indicate he did not realise that approaching ones therapist in an impromptu fashion was out of the usual bounds of the therapy relationship. The fact that Peter says it happened when the relationship was new indicates it has ceased. Graham appears to have modelled the message rather than tackled it through direct discussion. However there were times when Graham succumbed to the pressure of Peter's anxiety about "pressing things" that he found difficult to contain.

> He would tell me, yeah. He would tell me, but not um, ah, mm, not in that sort of relaxed setting type of counselling type session, you know? It would be like perhaps, yeah, more off the cuff. But, you know, that's what I want so, but not to be processed by me, counselling on the run, you know [laughs]. (Peter)

Most commonly in the paradigm of therapy clients are assisted to come to their own solutions rather than given direct advice. But that's what Peter wanted. Graham did not bring this up in his interview so his thoughts about this are not known. However during the course of the interview he did mention some out of session contact where Peter had made a point of

introducing him to his parents. Graham appeared to be familiar and comfortable with the duality of his roles as minister and psychologist.

> I'd forgotten really all about it. I met his parents. They came to a service for the Messiah, and I met them, I mean he, he purposely took me up to introduce me to his parents. And the thought crossed my mind um, ah with his father in the state that he's in [dying of cancer], now should I be the priest here and offer to go and visit his parents, um, and I haven't done so, I thought hmmm. Ah, now that I'm not at [names church], that's different but, but whether I, you know, just, whether that would be something which would be, I mean I haven't even asked Peter about it, but it just struck me. (Graham)

The concept of wearing two hats and having two separate roles is familiar to Graham. As a minister he is used to the role of administering pastoral care to his congregation, and as a psychologist he continues the role of carer in a different capacity. It does raise the question about early training in different disciplines and which discipline supersedes the other in a given situation and how that is thought through. As Graham discussed the topic of "which hat to wear he commented, I don't find it an issue, but other people might." Yet Graham's previous comment suggests an internal questioning about whether visiting Peter's parents would be a blurring or conflict of roles.

> But I know, I know that in this role, he cannot be a friend, and it would defeat the purpose, I think you need that line, that boundary. Because if you become too close, yeah, he comes too close to me, he's going to, so I still need him to say, 'hey!' (Peter)

Peter is expressing that he needs Graham to set the boundaries, to "say hey!" The previous examples highlight the complexity of decision making once a line has been crossed. For Graham it was "do I go further and meet the family"? "Am I priest or therapist at this moment in time"? Graham managed to wear the two hats successfully without jeopardising the therapeutic

relationship with Peter. The element of trust that Peter mentioned was present when he and Graham began working together, and was germinated in the context of what Peter called knowing "what the substance (of the man) is like" and being able to see Graham in a "non-counselling role." Peter's perception of Graham's "substance" and trustworthiness proved to be accurate and the trust deepened to include interdependence on Graham and his "knowledge."

Anne and Chloe

Anne and Chloe managed to engage despite Chloe's negative history with other therapists. Anne mentioned that one of her strengths was the ability to make strong connections. She thought her capacity for connection saw her through the "rough patches" when she "wasn't so good," meaning the times when she was not operating or conceptualising at her best. Anne had a realistic and humble attitude towards her own human failings when they were present, but Chloe related well to Anne's calm style.

> The way in which Anne does it um, she does, it's just a discussion ... The tone of her voice is settling, and um her demeanour, um cause I find a lot of doctors when I went to the other hospital, they sit there, they sit back, they cross their arms, they've got their legs crossed, and I'm just like well you know, if you're that interested should I leave now. I appreciate that they're busy, and I sort of stop and think oh well! I know they see a lot of people and this and that, but then I stop and think, hang on a minute, they're here to help me, they shouldn't make me feel like I'm obliged in any way, cause I find that quite pressurising. (Chloe)

The meeting point of Anne and Chloe's relationship found a balance that was far removed from the rigid boundaries Chloe had come up against previously. Chloe's comment about the tone of Anne's voice and her demeanour verses the body language of crossed arms and legs

shows how big an impact the prosodic aspects of the relationship played in "settling" her down. The non-verbal interpersonal communication spoke volumes about how this dyadic system needed to manage the more intuitive and affect laden aspects of their relationship. Anne had the ability to tune in and read Chloe reasonably well, and the emotional muscle to tolerate the occasions of intensity. "For me it was about really going with who she was, and how vulnerable she is. In the past she's been very reactive and not just on one occasion, and I know that she's one that internalises."

Anne holds Chloe in mind in a way that shows the 'we' of the relationship developing. The meaning Chloe attributes to Anne's intentions and behaviour and the way she links those signs to trust is significant for the success of the relationship. Again Chloe juxtaposes her thoughts about Anne against her past experiences.

> I used to find it quite [pause], quite disconcerting particularly when I was in hospital then again it was a case of the therapists would just sit there, whereas with Anne the tone becomes gentler and I know she's still interested, cause she'll, it's a case of its more personal cause, she always puts her notebook down if I'm upset [laughing gently]. So I know she's there, but at the same time it's giving me my space that I need, this is why I'm here. (Chloe)

Chloe mentions the tone of Anne's voice again and her reading of Anne's gestures of putting her notebook down. These seemingly small observations combined to help Chloe learn to trust Anne. Chloe admitted that her behaviour early in the relationship was a bit of a "trust test." Learning to trust was a challenge for Chloe but one that she became convinced had to happen.

> When I decided that I was going to come and do the therapy properly, and after all the trust test so to speak, I was like um, I decided in my head that if anything's going to change I have to break the cycle, and in order to do that I have to learn to trust. (Chloe)

Chloe had made up her mind to trust, so there was a position of readiness. However, manoeuvring towards trust happened through Chloe observing Anne's behaviour and attitudes and then gradually taking another step forward. If Anne had not been the right person it is unlikely even Chloe's readiness to trust would have overridden that state, as her history attests. Anne said she paid attention to the child within the young woman and to the trauma she had suffered that resulted in her turning to drugs and alcohol. One of the important background themes for Anne was her personal experience with her own therapist, and the feeling that "no matter what" she was "never going to be rejected." The other theme was Anne's previous training and background in welfare. Within that context Anne would step out of what she called "the strict client, therapist role" and she would sometimes meet ex-clients for coffee. These aspects of Anne's background infused into how she conceptualised and worked in the relationship and the role of therapist.

Anne also had her own previous negative therapy encounter. She told the story of seeing a therapist who worked from a psychoanalytic approach, and how over time she became "more and more distressed." She began to think this was the purpose of the approach. After a while she mustered the "courage" to ask her therapist to meet a personal need.

> It took a lot of courage, I was terrified, and I said 'I just wondered if, if, if,' and I spoke like this [used her voice tentatively] 'when I say hello, to you and how are you, is there a way you could actually say something back to me,' and um she just looked at me. That was my answer. (Anne)

Anne then rang her therapist to say she would not be coming again, and the therapist told her she needed to come more often, at least three times a week. When Anne said she could not afford that, the therapist said, "I'm sure you'll find the money".

> Now *that was detached* [italics added], and then, when I rang up to say to her I was definitely cancelling out, I'd been seeing her for almost a year, she said to me, 'I don't think it's a good idea for you to stop the sessions.' I said to her, 'no I think I need something more dynamic,' and she nearly came down the phone at me. She said 'I think you're far too fragile for that.'" (Anne)

Personal experiences of being infantilised and pathologised influenced Anne to allow her own clients more agency and freedom when necessary. As with the clients in this study Anne persevered until she found someone she could trust.

> The therapist I ended up with was warm, and I trusted him, and that was the first step, for me to maintain that trust and be able tell him everything, all those revolting things about the past. I could also regulate when I saw him that's the other part, so I always let my clients work out the best regulation of their timing ... I don't tell them when they've got to come ... their work hours change from one week to the next, or you know, they're not always able to come at that strict time. (Anne)

So much of Anne's personal experience has a parallel with Chloe's. The influence of Anne's previous therapists, both positive and negative, along with her welfare training had an impact on her current decision-making and how she managed the boundaries in her relationship with Chloe. Anne resonated with Chloe, and Chloe was able to finally trust in someone who felt some compassion for her, rather than reacting with irritation and anger. While using personal experience as a guide might not always benefit the client, in this case it proved otherwise. What some therapists might view as abusive, disrespectful, or pathology driven, Anne viewed as a form of communication. It was her understanding of Chloe's distress and self-protectiveness that differentiated Anne from Chloe's other therapists and enabled her to risk trusting in another person.

Thomas and Bella

Thomas and Bella's six-year relationship began when Thomas was working at an agency. Since that time Thomas moved to a home office, then opened a large practice in a prominent suburb of a major city. Bella has moved with him. In this long standing relationship it was how the personal bled into the professional that prompted Thomas to move "outside his normal behaviour." When Thomas and Bella worked together there was a particular interpersonal dynamic that lead Thomas to self-disclose more than he would usually.

> One of the curious things about Bella is that she is exquisitely sensitive to my health. Um, which is curious, because it doesn't appear to be any part of her history in any fundamental or acute way. Um, and we've talked about it a lot and actually I do, I'm, I'm inclined to put
>
> a lot of it down to the fact that she picked up without necessarily knowing it, that I had chronic fatigue in the early years that we were meeting. (Thomas)

Bella also brought up this topic, mentioning how she would worry about Thomas getting ill to the point of having a constant focus on his health. "Me checking out him straight away, to see where I think he is, you know, is he, if he's looking well. Oh! [laughing] worrying about his health all the time." After working on this together, Bella and Thomas put her concern down to a fear of "abandonment" due to her history of the significant men in her life always leaving. However the theme continued despite the insight related to her past, and the evidence that Thomas was not leaving.

> He hasn't ever um, yeah, he hasn't ever dropped me, or you know, or got up and left or terminated, and so then I developed this thing that he's going to die on me. He'll get sick and that's how he's going to leave me, so yeah, this thing of watching his health all the

> time. Oh! You coughed, or you look pale today. Do you need a tissue, yeah, you're tired, whatever, yeah. (Bella)

As time progressed, the theme of "checking" and "scanning" Thomas's health grew stronger, with the added worry that he would cancel their next session due to illness.

> It's only later in the piece that we began to realise that she would often think, "Thomas might call today and cancel the session". I mean she'd think that virtually every, every session we had, um, and she'd scan my, when we met we'd look at how she'd scan my health, *bang* [italics added]**,** before I even, yeah *so* [italics added] quickly. She's phenomenally quick at it. (Thomas)

According to Thomas Bella's instantaneous capacity was "elliptic". The hypotheses and interpretation of relating Bella's worries to fears of abandonment fits well and makes sense within her historical context. Therefore the obvious link with a transference reaction that Thomas will find some way of leaving her also makes sense. However at that point in time Thomas had not related this dynamic in their relationship to the fact Bella may have sensed the reality that he was truly ill. It had not occurred to him that someone might pick up on his chronic fatigue "in the client room." He felt that unless someone knew him outside of therapy they would not be able to tell. Thomas eventually came to the realisation that Bella "picked up on it" and as a result he ended up disclosing to Bella that he was suffering from chronic fatigue. According to Thomas, " it would be an opportunity to discuss what the hell had been going on between us, and I thought that I'd deprived her of that by withholding." Thomas mentioned another highly significant personal life event that had happened while he was seeing Bella.

> The other thing that she has lived through which I have not shared with her, that she might have picked up on is that, which is very dramatic history, is that I lost my wife, my first

> wife died in 2001, which would have been, one or two years into our time together. (Thomas)

Thomas continued working during that time in his life and found work to be a welcome distraction.

> I felt absolutely fine working during that time, as long as I kept an eye on it, I appeared to have an adaptive capacity to disassociate, and to therefore actually in many respects, have a break from, and be genuinely available for the client and that was actually healthy for myself, that was supportive for me. (Thomas)

Considering Bella's capacity to hone in on Thomas's chronic fatigue I found myself being curious about the relationship between Bella's focus on death, her worry Thomas might die and his personal circumstances. Bella may also have picked up on Thomas's grief. The personal history Bella brought to therapy and Thomas's personal life issues dovetailed in ways that could have been attributed to either person's context. The person-to-person transfer of emotion (Schore, 2003) meant that Bella was possibly sensing Thomas's inner world.

> But maybe she picked up on it. However, what has happened in subsequent years is that Bella has found herself drawn to working um, ah, through (names an organisation) with people who have HIV, and ah, as well as having a friend who has recently died of cancer, as well as knowing another fellow, who appears to be in the process of dying, right now, um, so she has moved very intimately through a process of death and relationship in ways that have touched my world, um, but not in ways that I was prepared to share. (Thomas)

Thomas was clear that his attitude to self disclosure was purely in the service of the client and in this case his wife's death was one story that he thought Bella would not be able to put aside in order to focus on her own concerns. Thomas openly talked about having an "avoidant

style." He was referring to the concept of avoidant attachment. In adults this is manifested through the avoidance of feelings of hurt, sadness, personal distress or neediness through a distraction or focus on other things, often work. Therefore his comment came from an awareness of what he could or could not manage in terms of emotional intimacy. However he was candid about having his needs for intimacy met through being a therapist.

> She and I are both avoidant in style, and so for myself as an avoidant therapist, it would seem clear to me that one of the places where I have been able to learn to fully engage with someone very wholeheartedly has been in the therapeutic arena. Um and that attends to some need in myself, which I'm aware of, and I think it's okay if you're aware of it, if you're not aware of it then it might be a problem. (Thomas)

Therapist self-awareness and appropriately held boundaries in this case did not prevent personal information leaking through. The boundaries of the self were somehow permeable (Stern, 2004) when it came to the exchange of physical and emotional information. Thomas and Bella's relationship touched very real issues in Thomas's life. Thomas waited a long time before he disclosed his illness to Bella, and this piece of reality put the content of their sessions into perspective. Attributing Bella's focus on illness solely to her psychological functioning meant that a vital part of the relational information was missing. Thomas showed some vulnerability in sharing his personal information with Bella; however it proved to enable Bella to take her focus off his mystery illness and also to trust in his ongoing commitment to her.

Giselle and Jim

Manoeuvring towards a trusting relationship does not only resonate for the client. When Giselle and Jim's arrangement began of trading manual labour for therapy, Giselle was operating

from a home office on her property. The expectations for how the limits of the relationship would operate took Giselle by surprise.

> From the time it began onwards, recurringly, I had to work with becoming better at boundaries, you know, he wanted to move in, well he liked to be our best friend. He would have liked to be an uncle to my kids and, and sometimes, I might be having my lunch actually in my house, he'd be in my kitchen literally. (Giselle)

Jim and Giselle encountered some unexpected differences in how the boundaries would work in practice. This situation reminded me of the Gestalt concept of "therapy as a safe emergency" (Bowman, 2005), however the phrase is meant to pertain to the client's experiential emergency. This was Giselle's emergency, and Jim became her trainer.

> At one point in time, he wanted to come in and put his milk in my fridge and have his lunch at my place [spoken in a surprised yet indignant tone], this is going back years, so I got trained by Jim to be very clear and firm about where the boundary is, where he was welcome to come, and where he was not, there was no entry [spoken adamantly]. (Giselle)

For Giselle to trust Jim in this relationship, his unbounded behaviour needed containing. Jim seemed oblivious to the fact that a professional relationship required a more formal set of limits. The initial working contract was either unclear to Jim or not being heeded. The former seems to be the case because Giselle stated that in her model of work dual roles and crossing boundaries was a "normal thing."

> My training is in process oriented psychology, and in process oriented psychology, it's a specialty of that training, that paradigm, that it works a lot with dual roles and what would typically be called crossing boundaries. We frequently work with that kind of situation so we, in my own training system, my own paradigm, the fact is that within most systems,

> you end up crossing lots of boundaries. That's quite a normal thing. He was drawn to me because that is my training. That, I'm certain of, I think he was also drawn to me because I'm particularly open, even within my training, my nature, my style, it's probably more warm and open than most other trainers of my own paradigm. (Giselle)

Giselle's style may have given Jim the impression that she was more accepting and open than was the case. Jim did not mention this aspect of their work together to the same extent or in the same way as Giselle. He commented about how much he enjoyed working on the property and the importance of what he called a "flat level hierarchy." Jim did not want to be pathologised and treated with a top down approach and the trade meant he took pride in his contribution and it felt like an even playing field for him.

> I'd go and do work on her property in exchange for therapy with her, and so I put a lot of energy into the property that she shares with her partner, and her children, and her partners children, and, so I imagine that's had some influence, and, and so, yeah what I notice is that we have a friendship apart from, (pause) so pathology model say relationship outside of therapeutic relationship bad thing, process work says relationship outside of therapeutic relationship enhances therapeutic relationship. So I walk away having a sense that I've got a connection with a friend, and it's a flat level hierarchy, a flat level system. Pathology model would say, I'm therapist I know more than you do, my word is law and whatever you do couldn't possibly be right if I say it's not right. (Jim)

Like other clients there is a search for the "right" person and the right model. Because Jim had voted with his feet and "terminated" several therapists, theory might suggest resistance or pathology. The detail shows that Jim has an inner wisdom that relates to his sense of what will and will not work for him. These thoughts appear to spring from the healthy aspects of Jim's

personality, the part of him that wants to grow. He seems to know that certain experiences will only exacerbate his problems.

> Yeah like, stuff like when I'm carrying shame around and I imagine I've done wrong and, and also being impacted upon by pathologising models, and so then I sat back and thought well, ok, pathology models don't work for me. (Jim)

Jim's behaviour would be viewed through the lens of particular theories as a diagnosable personality disorder. At the very least it is evident he lacked social and emotional maturity, and his behaviour had evoked strong reactions in Giselle. However Jim's choice of therapist and his long pursuit paid off. Not only did he gain a relationship with someone who was willing to stick with him through his intrusive behaviour, Giselle credits him for helping her grow.

> He's trained me up about being much firmer and clearer boundaries, cause nobody else ever pushed those boundaries. Nobody else ever tried to overstep some of those. So I never had to get so firm, and I would even credit that it's an area I'm glad to have grown in, and I needed to grow in, so he's been quite helpful in that regard. (Giselle)

Giselle's patience was truly tested, but despite the struggle she has embraced the new learning. Jim's reference to a "connection with a friend" shows that Giselle's underlying and private feelings have not interfered with the relationship or the joint work of therapy. In fact they made it more real. Despite the draining quality of the work, Giselle remained nurturing throughout the process.

> But it was always a bit difficult, it's always been hard to sort of say, and we had, we had, not fights, fights isn't the right word, I would have to work out myself how to present the latest boundary and he would usually have, or often have, a problem about it, and, you know, it would take a lot of effort, and a lot of time talking about it, and sometimes I'd just

> be bored with the whole thing and think, it's that simple, you know, I'm your therapist, you come for the hour and you get out of here. Never did I say that, ever, never would I. But he's always needed a huge amount of very mothering, nourishing, and loving care around those issues. (Giselle)

The process of the relationship took a great deal of emotional energy and Giselle had to stretch herself emotionally to cope. About a year into the therapy Giselle took a job in a city counselling agency. She retained her private practice on the outskirts of town, but she moved Jim with her to the agency setting.

> That was part of moving him to my work here I got tired of having to pull the boundaries firmer, so always having an issue. And I thought, you know what, having him come here where the boundaries are more in place, here in the organisation, it's much clearer boundaries. Doors, waiting room, he doesn't even get in this part of the building. (Giselle)

Jim commented that after the move things were different. He did not elaborate on how the change was introduced to him, or why it happened, other than to say, "my time frames changed." Therefore he may not have been aware of the reasons. Jim's main comment about the move was the fact that he missed going to the property. "Yeah I lost a bit of that freedom, which I feel some sadness around, and I lost the connection to the property". Jim said that people "freak out" at the agency if he does "hard core anger work," whereas he used to be able to do that out at the property. Jim also pays for his sessions now, the agency has a sliding scale for people on a pension, so he gets a reduced rate, but he said it was manageable for him. Manoeuvring towards trust has been a difficult process in this relationship, more so for Giselle than Jim. She articulated the ambivalence and contrast of what they achieved together through perseverance.

> It's a funny thing to say, but there's quite a deep trust there. Now I also know I can't trust Jim a bar in certain situations, he'll step over the limit in a second, so that also being so, we still have quite a deep trust there, it's an odd thing. (Giselle)

Giselle remains aware of the valency John has to slip across a line in an automatic and mindless way, yet at the same time she seems to be saying that there is a reciprocal trust between them in terms of how they relate to one another. This *safe emergency* turned into a safe adventure for this relationship.

Sarah and Lily

For Sarah and Lily the management of relational boundaries was contained within the therapeutic hour and related to personal shifts around how much psychological intrusion Lily could tolerate. In her previous therapy Lily had experienced a benevolent counsellor, and had been left with the feeling that nothing was happening. Despite not liking being "pushed too far," Lily was aware that getting nowhere was not a good outcome either. Sarah was able to provide enough balance between empathy and challenge for Lily to tolerate the "difficult questions" and the psychological intensity of the intimate emotional field.

> She never pushed, but she was able to gradually, slowly push me forward without being too hard, so I could, I didn't like it at first, do you know what I mean, just a little nudge here and there, I'd really have to think hard. But actually that's how maybe I've influenced her, she, well, in terms of our relationship she knows when she's pushed too far. (Lily)

Lily noticed that she was able to make an impact on the way Sarah worked which was quite empowering. Lily was a very silent client at the beginning of therapy, therefore Sarah's ability to read and adapt to the unarticulated aspects of this relationship took constant vigilance. They were both working blind to begin with, just going on intuition. However Lily's comment that Sarah

knows “when she’s pushed too far” implies that Sarah’s nudges and having to “really think hard” makes the process quite emotionally demanding and reaches the limits of Lily’s tolerance. Lily was understandably self-focussed and struggling to maintain engagement so taking Sarah into account was beyond her capacity at that time. Therefore news of Sarah outside of therapy was too much information also.

> I don’t know. It just seems to work better that way. When I first started seeing her, I probably did, I was a bit curious, I think. Um and actually I think it’s been harder because I keep meeting more and more people that she works with outside, because of my friend, because they travel in the same circles. So I’m hearing things that I think, hm, that’s my therapist I don’t want to know that. Um, you know, I was actually at her house once where she has an office as well, and I had to go to the toilet, and I think her son was off school, and I was just so awkward and uncomfortable. (Lily)

Lily was happy not to know, or be confronted with Sarah’s private life, and Sarah picked up on this fact as part of their work together. “She was somebody I stayed extremely bounded with, um quite naturally. I was just percepting of it. I worked with her for a very long time, but stayed very um, instinctively, not guarded, but instinctively bounded with her.” These instinctively bounded dynamics were communicated at a non-verbal level rather than overtly discussed. And despite Lily finally finding someone she could stick with and trust she had no desire to be closer to Sarah than the professional relationship allowed. “She’s a stranger, but not really a stranger. I know the part of her that I really need to know, you know, the caring, the caring part. Yeah, it’s good. I think it’s good for me anyway.” Sarah’s reasoning behind her instinct was that she suspected that Lily had some aspects of borderline personality disorder, plus she was aware that Lily did not feel normal.

> She didn't feel like the rest of humanity. She didn't feel like she could ever have a partner or family, and she was so deeply depressed about that, that um, I was always very cautious about not exposing her to me in that respect. Um, [sighing], maybe wrongly [said with a questioning inflection], um, but she was somebody who I stayed extremely bounded with. (Sarah)

Sarah feared that her normality might be demoralising for Lily. Interestingly Sarah, who was 51 at the time of the interview, mentioned that she had been married for the first time four years ago and was raising a step son, but had no biological children. At some level she understood the space that Lily inhabited. Sarah had not disclosed her personal circumstances to Lily and in the retelling she raised the question mark of whether a personal disclosure could have helped. It was clear from Lily's attitude when discussing the personal aspects of their relationship that she found Sarah's style a good fit for her. Lily added that her attitude to personal boundaries, and of not needing to know, had been instilled through Sarah's modelling. "I think that's a lot of her influence as well, she's not, she doesn't really share a lot. Every now and then, but she doesn't, it's not really, only when it's necessary." Sarah's account matched Lily's in that she thought there was *no point* to personal self-disclosure unless it is "going to be of use to the client." Sarah added that she was "naturally a very private person" and she thought that aspect of herself, "probably comes through" when she is working in therapy "with the volume turned right up."

> On an interpersonal like local and moment by moment level I think that I have a lot of awareness around how much of myself I want to disclose. Um, and I think that I'm very much guided by my comfort level on that. Um and I tend to under disclose rather than over disclose. Um, I'm not a discloser per say. If I do disclose it will only be in a relationship that I've had for a very long time, or in a relationship where, um, we're coming to the end of therapy. (Sarah)

Sarah is clear and firm on her attitude to disclosure. Her reasoning has the underpinnings of theory but also highlights her subjectivity has the strongest influence on her level of disclosure. Her "comfort level" guides her decision-making which is also part of her personal identity and preference as a "private person." Sarah spoke strongly in regard to contact between sessions.

> If I have a client who looks like they might need to have contact with me between sessions Ill set a time, and I'll set that time aside for us to have a 10 minute conversation. If there is somebody who is suicidal and really in crisis I will say I'm available, but not after 8pm because I can't, I'm not a crisis centre. (Sarah)

Sarah had firm rules about her availability and Lily would save her distress for the appointment day. Lily said she had found it harder to reach out to Sarah than to family and friends when she was distressed. However she has felt more able to do this as the relationship developed.

> I never used to call her if I'm really upset, so I feel funny about that, it's like, well, it will have to be on the appointment day, 'cause, so then I thought maybe the boundaries are a bit too um fuzzy, but now I've started calling. (Lily)

Lily was aware of the both the implicit and explicit injunctions on contact because was studying social work. It is an interesting phenomenon that contact between sessions has become acceptable to Lily after four years of therapy rather than at the beginning when more support might be needed. The contact Lily is talking about is not excessive, but the firm boundaries set in place for this relationship have loosened as the relationship has developed and changed. Sarah thought that while therapists were in a "highly influential position," this did not mean they held all the power in the relationship. She thought that in general, clients at the higher end of "pathology" were often much more "oriented" and "practiced at taking power than she was."

Sarah expressed that she is cautious around who she takes on as a client in case she is, "taking on somebody's son, sister, or best friend, and if I do decide to do something like that it is with great discussion with both parties." On a structural level Sarah used "the frame" of same room and time to deliver the message of clear boundaries, as well as using her own behaviour as a model to show, "what is and isn't ok therapeutically and professionally." She also felt very strongly about varying the frame. "I'd never say well lets go for coffee, or let's do this or let's do that instead of having it in the room." Lily was equally measured in her apprehension to contact Sarah. This could have been due to Lily's reticence and compliance in regard to Sarah's stance around contact, or Lily's own reluctance to lean on or be a burden to Sarah. Regardless this "frame" consciously suited both therapist and client. In Lily's view a caring "stranger, but not really a stranger."

Paul and Leo

The boundaries in the relationship between Leo and Paul extended further into each other's personal lives than any of the other therapy couples. Paul almost felt like a part of the family.

> With him and myself it's because I sort of feel like a connection, and feel like, like he's, I mean he's my friend Stephen's Uncle Leo but I don't call him Uncle Leo to his face, but I always think of him as Uncle Leo [he laughs loudly]. So it's more of a sort of, um not a fatherly figure but more a sort of uncle like figure I suppose and, and someone that you
>
> listen to and, and tells you these little anecdotes and they, they stick in your mind. (Paul)

Paul had recently been present at an award ceremony where Leo received recognition for his contribution to the counselling field. Paul thought that attending family functions and events made no difference to his therapeutic relationship with Leo.

> I went to that dinner at [the venue] when he was awarded the [names the award]. Yeah, I went to that one so, and, and also you know Christmas and stuff. So I guess, I don't necessarily think that, that makes a difference. (Paul)

Whether this was a case of not knowing the norms, versus disagreeing with the norms was not made clear. However Paul had mentioned earlier that his arrangement was not *the usual* which indicates he was aware this situation was different. Leo did not seem at all phased about being the therapist for his nephew's best friend and wove it into the conversation as if it was the norm rather than the exception. He was much more interested in discussing his views of Paul and the therapy and whether Paul would stay the distance and get to the harder work. Leo viewed Paul as quite fragile and was very sensitive to the fact that he needed male support. It was also evident that he viewed the relationship more as counselling than psychotherapy.

> He's like many clients that, I think, we see in - in that interface between counselling and psychotherapy where there's a huge presenting issue in their lives and when that gets a little bit solved, you know, you don't know whether they're going to say goodbye or whether they're going to explore a bit further, or whether the other distress is going to come up. (Leo)

According to Leo, Paul is "mega polite and well brought up." Leo saw him as very affable and was conscious that Paul looked up to him. "He's got that huge politeness thing. He's one of these guys that's a little bit, in terms of the relationship, he takes me a bit too seriously, I think." Leo did his counselling training whilst still in his religious order and undertook some in-house counselling within the order, so this present relationship would not feel unfamiliar. Leo was a senior practitioner in the field and held top positions in industry organisations and was held in high regard in the field. Paul was aware of Leo's stature in the industry and it was obvious he held Leo in high esteem. I was conscious as I listened to the story of this relationship, of the

background scene of professional codes of practice. Leo and Paul's arrangement would not survive the scrutiny of an ethics board under the present Australian codes of professional conduct. However there was a palpable professional distance between Leo and Paul despite the overlap in social contact.

When I asked Leo how he thought Paul viewed him he said he was not sure but thought maybe like "a wise uncle or something." Leo answered questions about his own experience with apparent awkwardness and appeared uncomfortable having the focus on him and talking personally. He answered the majority of questions by focussing on Paul rather than himself. He was especially humble in regard to espousing any expertise or status. However the nature of this relationship enabled Paul to connect and open up to Leo in a way he had not felt able to do with his previous therapist and according to Paul the mutual trust in the therapeutic relationship was not harmed by social contact.

Reciprocal Risk and Trust

The particular relationship entities emerged and formed very differently. In the beginning the boundary manoeuvres occurred before either person had any real detailed knowledge of each other. Even at the very start some clients had influenced their prospective therapist to change his or her usual pattern of intake practice, however in hindsight these were never the less reciprocal adjustments. The adjustments continued as both the therapists and clients organised their relationship into a working partnership. The interplay between therapist and client emerged from their particular twosome, but also showed evidence for the individuality of each person within that twosome. The decision making for therapists did not rely on any pre-destined code or decision-making model it came from a need within the relationship for either party. For clients it was a real testing of the relationship for signs that their therapist could be trusted. Those signs were both overt and covert, including body language, tone of voice, manner, perceived

substance, wisdom, demeanour, responsiveness, self-disclosure, generosity of self, and respect. Later in the relationships, the beginning themes for each dyad morphed into a different form with yet a deeper meaning.

Graham and Peter

The relationship between Graham and Peter, like some of the others, included having extra knowledge and information about Graham and his family than would usually be the case. Peter knows Graham's wife because she works in the parish and has been privy to meeting Graham's adult children when they have had involvement in the parish.

> He sees me in that role, so he sees me in a totality in a sense. I think too, um, and I hadn't thought about it til now, that, because my wife and I are involved, we also modelled a relationship that, that, yeah people saw, and Peter would have seen. (Graham)

One of the main questions Peter was grappling with in therapy was, "how can I be a good father and how could I be a good husband?" Graham's comment made sense in the light of his intimate knowledge of Peter's quest. While Peter may have also chosen Graham because he modelled the kind of relationships that Peter was keen to learn about, Peter also realised the limits of the therapeutic relationship.

> It's not exactly clean, it's not clear-cut, but it's like this is a moving boundary, you know, it's like an ebb and flow, this relationship is not clear cut. I also know about that boundary, and he also knows about that too. (Peter)

Peter had complete trust in Graham to move with the boundaries of their relationship "like an ebb and flow" whilst also holding his confidentiality and trust. According to Graham holding boundaries too rigidly prevents real involvement and care.

> There's nothing unethical, but it's outside the norms of usual practice, um which has been a fairly consistent message in that there is something about rigid boundaries that prevents involvement or care, because it keeps it so professional. And that's not who I am. I mean I'm still professional. But you know, sometimes you, you're sort of a, um, you know, just, well, it just feels that it's right to do that. (Graham)

As with Leo, Graham is in his seventies and has a religious background and training that preceded his psychology and counselling education. The boundaries for those two therapists were based more on a sense of pastoral care and compassion rather than professional standards. Graham like Leo seemed to manage to hold the relationship firmly amidst the overlap with other roles. It was certainly what Peter asked for and wanted, so in that sense was client centred. "I think that ability to be, for me is the need to be able to move across, ah without, without hesitation. Of course I think for most counsellors, they have to move through that barrier." The reciprocity in this relationship was about shifting styles to meet each other in the middle. In Graham's words, how they met shaped the relationship. Peter being a parishioner meant an added complication for Graham, however the wearing of "two hats" is familiar territory for Graham in his role as Rector.

> I think he's bright, you know, he's a fun person, ah, yeah I enjoy his company, um, but, you know, it's a company that, in the relationship I make sure that you know, I keep the boundaries with some of these things. So that in, in sort of social events at the church when I was there, you know, that didn't matter and he would just be a parishioner. And as far as I'm aware, nobody else, and I have never disclosed that I've seen him professionally at all. Well I mean it's, it's something which I've been I 'spose, in a sense used to, you know. (Graham)

The trust in this relationship meant a risk for both Graham and Peter. Peter's cultural heritage meant he might have suffered a loss of face, or as he put it some *embarrassment*. Graham might have encountered problems if other parishioners found out. On a person-to-person level they relaxed the barriers but found an inter-subjective meeting point that contained the needs of the relationship despite their overlapping roles. The professional aspect was not a concern for Graham; however any change from the usual can produce a problem for the therapist from within the profession if things do not go well. In this case mutual trust and respect prevailed.

Anne and Chloe

Chloe had never had a therapeutic relationship where she was respected let alone considered equal. Anne commented that her way of working was to provide what she called a "flattened hierarchy."

> I work very much from that too, constantly thinking I'm not the expert, um we work as a team on these issues. If I can help you with these issues that's good, but I'm doing myself out of a job constantly, that's my goal. The other part of my goal is that I'm no better than you. I might be a therapist and you might be a client but I tell you what, we're two people together, two human beings. (Anne)

Chloe's sentiments echoed Anne's in their separate interviews.

> Yeah, so [therapists need] to stay in touch with what people might be feeling, just to come across more humane. I think it's to have mutual respect and um to maintain mutual respect, and that um encourages them that they're still a human being in their own right. Cause you just lose yourself so much when you're in that position. (Chloe)

Being in "that position," and the memories of her past therapy continue to pervade Chloe's narrative of her current therapy. However, the feeling of respect is mutual and Chloe is keen to work hard in her therapy with Anne, not just for herself, but for Anne as well. Anne has faith in Chloe, and Chloe has risen to the challenge. For someone with Chloe's history it is quite a show of trust to begin to risk letting down her familiar and well practiced guard of rebellion to please Anne. Equally, it is a show of mutual respect and support when Anne maintains the role of a "secure base" for Chloe when she slips backwards and "goes on binges." Anne operates under the premise of secure attachment, where she is providing a stable and consistent relationship "no matter what." Again it is Anne's personal therapy that acts as the template for her way of being with Chloe, and she is critical of the direction that counselling and psychotherapy is taking that is diverging from what she knows worked for her, including the changing role expectations for therapists.

> I guess a sense of reality about themselves as a human being, rather than only seeing themselves in that particular role. I mean the over professionalisation of therapist's roles, is, [long pause] there's a coldness to it sometimes, and there's a power imbalance ... and again like the therapist I worked with, I never felt like I was less than him. I was never made to feel like that, and there's actually I suppose a spiritual connection with that, so whatever you want to name it. (Anne)

Anne was reluctant to go with what she viewed as the current negative professional trend. In the end she uses her own judgment and preference for a more human and egalitarian stance. Anne's welfare background also informs her stance and she keeps in touch with certain clients at times in a "mentoring role once they have finished therapy."

> Thank God for my welfare background, it tests the limits a bit (laughing) is that ah when my clients leave ... we used to meet for coffee and support, now in the strict client therapist

> role you don't do that, however in the role that I had set myself and was engaging in it wasn't about cutting off at that point. (Anne)

Chloe occasionally brings Anne a coffee and a muffin if she arrives early and Anne accepts them happily as Chloe's way of letting her know she can also operate well in some areas of life.

> I see that as a way of trying to say to you I'm normal, please don't only see me as, I might be like this, but I'm also really capable and intelligent which are exactly the things I want her to recognise in herself anyway and I remember myself feeling that way with my therapist years ago. I wanted him to know I'm not always like this. I don't only come here and burst into tears and become a big mess, I'm competent in other areas. (Anne)

I would add it is also a positive sign that Chloe has come out of her previous wounded narcissistic space to show care for Anne. If Anne had any concerns about her level of professionalism they were lost on Chloe who felt she was on an equal level with Anne and there was certainly no sense of a power imbalance. The feeling she had of being "pressurised" with earlier therapists had disappeared in her relationship and work with Anne. "The way in which she approaches subjects, or she makes a statement, because she's allowing it to be rhetorical because it's not abrupt and it's not patronising, it's literally an open invitation." Despite the fact that this relationship is working well and Chloe is effecting change and making progress, Anne still felt a hidden pressure and had moments of concern over her style of therapy. One had to be a certain way to prove one was professional and she worried she was not living up to the ideal notion of what a professional therapist should be like.

> If I can be real in the sessions as much as possible I actually feel ok about that now, I used to get worried that maybe I'm doing this all wrong, because I'm not doing it professionally, and there's this kind of idealised element. (Anne)

Her perception that other therapists might behave more *professionally*, or that there was an ideal way to respond to Chloe's situation or behaviour soon dissolved when things began to work. Anne's flexible and tolerant approach to relational boundaries was again heavily influenced by her own therapist. She credits him with helping her gain; "an understanding that you **can** get close, it's not a crime to really, to be able to be yourself in the session you don't have to pull back into this detached space."

Chloe's boundaries for relatedness have changed as a result of her relationship with Anne. She attends weekly and arrives on time for her sessions. Chloe has found her moral compass and acts responsibly and respectfully towards Anne. That is quite a change from the Chloe other therapists could not tolerate because she would not co-operate or constantly miss appointments. Their lack of relatedness and theoretical distance contributed to making her worse. Anne took a risk taking Chloe on, and Chloe risked yet another rejection. This therapeutic couple risked engagement with each other and now have a mutually trusting partnership.

Will and Eve

Returning to the relationship between Will and Eve the theme introduced by the loaning of the book continues. The loosening of the boundary around loaning a book that was a work of fiction, rather than a self-help book, had left Will feeling uncomfortable and concerned that he had crossed a line.

> I'm really aware of that because I like the sound of my own voice, I like teaching, so I'm easily seduced to, you know, giving a little rave about something to clients, just as if I was lecturing, and I like reading and music and stuff,... I know my vulnerability to such (chuckles) things and I try and mind that, but that's why I felt bad about lending Eve the book. (Will)

In Will's perception, loaning the book was succumbing to a weakness that emanated from a need in him, and he "felt bad" for that reason. Yet when Eve discussed her modus operandi for relating with Will she wanted "something else" in order to make it easier to relate to him. "We've tried, I've tried, and I do the, I know that the way I operate is to, to establish something else, um that makes it um, easier for me to sort of um, relate, relate to him." Will operated on the premise that "giving a little rave" about something not related to the therapy was unwarranted. Will recognised that the "something else" Eve tried to establish in order to relate to him was beyond his usual comfort zone within therapy and mapped onto his valency and love of teaching. Both were aware of the reciprocal dance around boundaries.

> It's slightly a kind of (pause) maybe seductive is too strong a word, but what I've felt I'm being seduced into sometimes is a friendship and so I will go along with it up to a point and then I will stop it, you know, like I'll think no, but back to you, why do you think this book has had this sort of impact on you ... Like she wants to talk about a book or something, like I know it's really not my place to utter lots of opinions of my own on *that book* [italics added] ... I know when I'm indulging myself. (Will)

Will's thoughts raise questions that are common for therapists. How much of me can enter into this conversation, and what are my motives for stepping further in or out? In this instance Will came to the conclusion that his motives were self indulgent.

> I think part of me wanted her to like [the author], so I lent her a book by [authors name], and there was a particular story that I thought she'd connect with, which she did, she did connect with, and really liked. You know, I thought afterwards you didn't really need to do that. It was not necessary. (Will)

Will was self-aware and reflective about his decision. His attribution shows that he knows this part of himself well. However he does not give much credit to the notion that this might have

been a useful decision for Eve. Eve "connected" strongly with the story in the book, and the arts and literature can be very creatively used in relation to the human condition. What was so bad about this decision? "Well [sighing] my therapist wouldn't do it [laughing], and would tick me off solidly, if I was being supervised. And I haven't told her I did it because I'm scared, I'll be ticked off, right!" Part of Will's concern about loaning the book relates to thinking he has done the wrong thing, versus a more relational view of what would be helpful or not helpful to Eve. However there was another relational element to Wills disquiet that he had not mentioned.

> Now this may touch on an area that we may need to come back to or, you know, like, go into more at a later point, um, [long pause] I think [pause, sighs]. I mean I like her and she likes me, so that, that helps as well .... I sometimes have, I have sometimes had a question mark about whether she might have like warmer feelings for me than that, now that doesn't usually happen with my clients, and I don't put out any sexual vibes, I know I don't. (Will)

Eve could have easily developed warmer feelings for Will with or without any "sexual vibes" being "put out." However for Will loaning the book represented an undertone of reciprocation. While Will continued to ruminate about the loaning of the book and its consequences, Eve was certain in her mind that Will's "good boundaries" were the main contributor to him being so "therapeutic" for her.

> Oh look I think it is um, that he has such a very clear, [pause] it's the boundaries, it's always the boundaries, that's what makes him therapeutic, you know. I think um, I will push, you know, and I could ah, if I had the wrong therapist it would be a disaster. Yes, if that therapist didn't have those very, very good boundaries, yes. (Eve)

Eve's words spell out the potential for disaster. Will's discomfort with the possibility of an attraction and his struggle to grasp the essence of what was happening between them kept the underlying issue at a superficial level.

> She would say this herself, she's a bit sexualised in her behaviour, not heavily, but there's a bit of the coy and the flirt and, stuff. Now, she doesn't, ah [sighs] what's the word, I mean she certainly doesn't flirt with me, but there's ah [sighs], I don't know, there's a bit of that, you know, the compliant female kind of stereotype, a bit of the, I'll tell you what you want to hear. I'll be nice for you. (Will)

The underlying theme of attraction had not been explored in depth. Will was surprised during a recent session that he remembered clearly, where he said Eve had cried and told him, " 'The reason I feel safe coming here is because I know there are boundaries and you do keep to them, and you don't cross them,' which surprised me because we hadn't really talked about that." Will then related this to a very early session in the therapy where he had intuitively picked up the hint of a possible attraction. "And I wondered if that was what she was, it was that sort of thing that she was referring to, that she had thrown out a little bit of a hook or something and I hadn't taken it." In the session that Will was recalling, Eve had hinted to Will that he was the sort of man she could be interested in having a relationship with if he was available. According to Will "it was not said that plainly or clearly, but there was some kind of hint, it was implicit or something and I had felt uncomfortable."

This is a sensitive area to work with in therapy, and although it was discussed at a superficial level, Will said he did not feel equipped to explore "the erotic transference stuff." His rationale for that was that he had not had the training. "Compared with somebody that had, had analysis five times a week and, you know, really done all of that." Therefore he felt unprepared, but with the benefit of hindsight he said that he probably did not feel as comfortable as he could have under the circumstances. The dance of attraction was played out regardless of the fact it was not examined in any great depth within the therapeutic relationship. Eve used the metaphor of "coming to life" through "a process of awakening" to describe the internal change she has

undergone. This internal change has meant finding her "passion" and becoming "intensely excited about life."

> There is a profound change because I think um, more than anything I feel as though I've come to life. Yes, yes ... I felt as though you know ah these issues had been so burdensome that it was like um, being asleep, it was like I'd eaten the poison apple and I was just asleep, and ah [starting to laugh as she talks] then Will would have to be Prince Charming [she laughs], except there's no kisses. So it's a process of awakening I guess, and uh, you know I've come to a point where I'm so intensely excited about life [said with passion] it's, it's wonderful you know. (Eve)

This was prefaced again later in the interview when Eve came back to the topic and spoke about how Will had ignited her passion for all things literary. It seems the underlying fire in the relationship was the catalyst for the external changes, and the unexpressed passion within the relationship has been sublimated into an excitement about life and a love of literature. Even the author of the book that Will had lent Eve was an author that Eve had been unable to "enjoy or get into in the past. I said okay, I'm going to try her again, and I absolutely loved it, and now I've fallen into her books with a passion." Whatever the underlying dynamic, Eve's external life had changed dramatically and the language she was using to describe those changes is that usually reserved for the topic of erotic love. Even though Eve knew there could be "no kisses." "So from moving from being in a position where I felt I had absolutely no passion for anything, to being very passionate about life is just wonderful." When Eve discussed her new-found passion for life her voice was full of enthusiasm. Will has played a large part in that awakening and *the book* was ever present for him as a symbol of seduction.

> Well I think it's been very important. I think it's *very* [italics added] important that, that, I've not been exploitive in any way. Um, that's why I, so I sort of, that's why, I know it

> sounds like an exaggeration, but I'm worried a bit about things like things like the book, lending the book, just because you know, like maybe in a kind of a very mild way, that was a bit seductive too, and that was a bit, um, given what's happened. I didn't want to encourage her to think about me that way. Um, so I think the boundaries have been important. (Will)

Even Wills language about the book indicates the sexual undertones. Both Will and Eve have emphasised the importance of holding the relational boundaries firm, so it is tempting to interpret the lack of overt discussion regarding potential sexual feelings or acting out as being more than a concern over a lack of training or experience in this area. Sexual feelings were a salient aspect of their relationship, and as such the avoidance of the topic appears to be a mutual effort between Will's feelings of discomfort and Eve's belief that "he's holding those boundaries." Eve made the connection herself as she was trying to get across to me the importance and meaning of their relational boundaries.

> I mean it's ah, because my issue is with boundaries you see. Boundary violation is the issue, and so I know that um he's holding those boundaries. He won't allow me, ah [quick sigh] not even allow, that's [pause and sighs], [she begins to laugh aloud heartily]. We did, we did talk a lot. No we didn't talk a lot, we talked a little, um, about transference, and I'm, I'm very obsessed about somebody at the moment and I was saying to Will, now I don't know whether this is because I can't be obsessed about you such as it is [laughs from the gut]. (Eve)

The seduction was only successful in the form of loaning a book, which makes sense of the symbolism of that act for the relationship. The concern and worry about giving the wrong message has stayed with Will throughout the relationship. Eve's insight about her current obsession, offered with humour, seems to move closer to her truth.

Lily and Sarah

Unlike some of the other therapeutic relationships Sarah and Lily had a formalised arrangement. The only variation to this was that Sarah worked from a home office when they began their relationship, which added a more personal element to the initial context that Lily had found "uncomfortable." Sarah's strict adherence to structure had contributed to the safety for Lily and allowed her to come out of the silence and begin to feel. She no longer absented through dissociation. The other positive change that Lily announced was around personal values.

> I even ah, I actually noticed some of my morals and values have changed. And I don't, I mean that could be a combination of things, over four and a half years, but yeah, definitely. I actually enjoy doing the correct thing instead of resenting it. It feels good to know that inside I am a good person. I actually want to be like that. It's just a change that's hard to explain. I guess I felt for a long time that I was, not bad, but not acceptable unless I was a certain way. (Lily)

The values that have been espoused through Sarah's modelling have made a significant impact on Lily. Lily felt fully accepted by Sarah and as a result saw herself in the eyes of another in a positive way. The fact that Sarah remained "very bounded" with Lily was her intuition that Lily needed that stance, as well as a strategy for herself in case the borderline personality tendencies she saw in Lily emerged between them. However this did not happen. Sarah was the firmest therapist in the study when it came to relational boundaries; however her attitude to boundaries changed when she digressed to discuss training.

> As a trainer I tend to disclose more of myself than I would as therapist, um both professionally and personally, cause in gestalt you do quite a lot of residential group work. Um and so I'm her [an ex-client] group facilitator as well as her theory and skills facilitator, and it's actually been an interesting one because she's learning in hindsight. I

mean this is a very particular case but she'll sort of say so oh, that's why you did what you did. (Sarah)

Training in Australia usually has the same requirements as therapy around dual relationships and power imbalances, so this is quite a different attitude to the stance taken with Lily. Sarah took a developmental view as well as a personality view when making decisions around where to hold the frame in a particular relationship. Her relationship with Lily did not take many risks in regard to shifting boundaries or exposing herself as a person the way she has described as a trainer. However the risk was taken to enter unchartered territory together that was emotionally and psychologically challenging for both of them. The relational boundaries were manifested through being able to meet and touch each other in a very difficult personal space which enabled mutual trust and influence to develop and take shape.

Thomas and Bella

Thomas and Bella also had a more traditional and formal relationship around boundaries than some of the other dyads. This was partly due to an early experience during Thomas's training as a psychotherapist that made him particularly "vigilant" about how he treated boundaries. He recounted giving his phone number (home number I assume) to a "severely borderline patient" that he was seeing three times a week, "and off we went into the tried and true disaster that leads to." Thomas said he ended up being quite shaken by the experience. His supervisor's input left him with "theoretical misunderstandings," he then "lost" his "way very badly" and the therapy was a "complete disaster."

Thomas's disaster story was a precursor to a story about a time he thought he had "absolutely crossed a boundary" with Bella. He spoke candidly but with the air and tone of someone telling a huge secret. When Bella attended his home office early in their relationship they would often end up talking about pets because Thomas had cats which Bella came to know

and grow fond of when she visited the house. Pets became part of their usual conversation and Bella helped Thomas to develop a "fondness for dogs" through her stories of her childhood dog who played an important role in her life. Linked to their theme of talking about pets was another enduring theme where Bella constantly apologised to Thomas if something good happened to her. "So she'll apologise to me for the fact she getting school holidays and she going to get 4 weeks off and I'm working so hard." Thomas and his second wife had recently bought a puppy and on this particular day at the end of the session Thomas decided to share this with Bella. "I said, have a look at this, and I've shown her on my phone, a little video clip of Bridie." I commented to Thomas that he sounded very tentative and furtive about telling this and he said;

> Firstly I knew that she would melt for Bridie, cause she's a beautiful dog, for dog lovers, so I knew she appreciate that, but I wanted to make the point and I did make the point, look you have your holiday and I have my Bridie, and were all ok. I'd be troubled if I'd just shown it with no thinking behind it, there was something behind it and at the same time it was also just a "Thomas why don't you show Bella, and Bella would like it, and we have this history of talking about pets ... It is crossing a boundary, and it's not how I generally behave. I have not told any other client I have a dog. (Thomas)

After these comments Thomas joked about not reporting him to the ethics committee and making sure his name was de-identified in this thesis. The little things that mean so much to clients very often worry therapists. As Thomas expressed, "so few of us are really doing it the way we present it." Whereas Bella's view of the level of trust between them shows that this relationship had a reciprocity and level of relating that was not inappropriate, exploitative or harmful.

> It's been such a healing experience and I, yeah there are times when I look back especially at the beginning and I think I don't know what I would've done, because I was very, I was

> yeah, very down when I first went to him and, um yeah, and I'd think oh my goodness, I'm so lucky that, you know that I found him, and that it was a good match. (Bella)

The relational boundaries in Thomas and Bella's long relationship had penetrated each other's personal boundaries enough to resonate with current life issues for Thomas that were meaningful for the therapeutic relationship. In the end the reality of Thomas's self-disclosure made more sense than the interpretations plucked from Bella's history. Despite Thomas's worry about the phone video clip, those small glimpses of his life and gestures of generosity have added to, rather than taken from the quality of this therapeutic relationship.

Giselle and Jim

Giselle and Jim's have journeyed through some very difficult moments in their relationship, and according to Giselle it's "never been easy." Before therapy began Giselle had commented that from a social context:

> I definitely didn't like him. He wasn't the type of person I would be drawn towards ... but from the moment in time that I said yes, then whether I liked him or not seems totally irrelevant. It's not on that level anymore. When I didn't like him, that was on the level of a person in my social sphere. (Giselle)

The training context in which Jim met Giselle continues, so they come into contact with each other through their connection with the organisation where they met. Giselle now treats her contact with Jim within that context differently.

> He's my client, and I now have a therapeutic responsibility to him, and that affects everything. It affects how I relate in those email groups to sort of take care of him a tiny bit. It's not a social setting for him and I, it's not for me, let's say for me, it's never a social setting with him. So I put effort into warmly welcoming him and I will always warmly

> welcome him to any setting because we're always in a therapeutic setting, does that make sense? And the other thing is I've grown to respect him. (Giselle)

Giselle emphasised the distinction between feelings in a social setting versus feelings in a therapeutic setting. Her attitude was that once the therapeutic relationship had begun, everything changed and she no longer had permission to only do that (feel dislike). The therapeutic relationship demanded something more complex, but it also facilitated the growth of positive feelings and an attitude of respect. She "bent over backwards" and put "effort" into an attitude of acceptance and partial accommodation of Jim's tendency to always want more than the therapeutic relationship allows. "He often wants to be my friend, and I'm not particularly into that. But I don't mind relating as if we were friends now and then."

Jim did not talk about the relationship in as much depth as Giselle, so it is difficult to give his perspective in as much detail. However he constantly referred to the way Giselle had his best interests at heart. The way she "encouraged" him, and her emphasis on the "positives," and ways he could best look after himself. Jim made no negative remarks about the relationship, except for a brief comment about how he lets Giselle know if he's not happy with the direction and outcome of a session. This is discussed further within Chapter 5. However my impression of Giselle was that she welcomed the opportunity to discuss the difficult issues she has been managing in her relationship with Jim. I asked Giselle what the relationship was like down the track once they had manoeuvred through the initial roadblocks.

> It's never been easy. Well, not in the way easy means to most people. But it's been a good relationship because, a couple of reasons, one, I've grown. John's given me the gift of pushing me in just about every, wherever an opening is, he'll push. So given that I've a tendency to be very open, that's my strength, I'm very open, I'm very sensitive, and all these things, but my strength is not the boundaries, you know, 'that's the limit'. He's helped me grow in that area, which is not, my strength, so that's a blessing, that's good.

> The other thing is I've grown to respect him. I respect him in the area where I respect him. I, he's still a goof ball. But one of the things that turned me off from the beginning, in a social scene, would turn me off indefinitely but I think that's irrelevant. (Giselle)

Giselle holds quite diverse thoughts and feelings about John. At one end of the continuum is an honest awareness that she disliked John and that he was not someone she would "be drawn towards" as a friend. At the other end of the spectrum Giselle shows a genuine admiration and respect for John alongside the things about him that "turn" her "off indefinitely." John is less aware of the difficulties that Giselle has encountered within their relationship. His perception of the relationship as positive and supportive was consistent throughout the interview. In particular he found Giselle's positive focus a great help and comfort and he indicated a deep trust in her to have his best interests at heart. "I would clearly say Giselle's gentleness, and her sensitivity, and her focus on what's good for me, that win's out every time."

Jim's trust in Giselle has enabled him to take on board what Giselle called "hard information." This "hard information" has mostly been a response to "not respecting boundaries," and has been necessary when the issue has come up in the relationship. "I use our relationship now and then, not most of the time, but now and then, I use our relationship as the learning spot." Giselle recounted an example of when Jim's behaviour ignited a part of her personal history. "He touched me a couple of times, I just felt so uncomfortable with it, it was very real." Giselle disclosed that she had been raped as a young girl, so her reaction to Jim touching her was intense. According to Giselle while not being overtly sexual, "the touching had a bit of a wanting more."

> So then when John touched me, it was just gross. From my personal history, my … my body sense was revulsion, it was disgusting. I just, my body sense was like, fuck off, get out of my space, you gross creepy little, which was my initial experience of him when I

> said I wasn't, didn't like him much ... when I sat in this room and my body went like, ugh fuck you, you know, I've been raped, nobody touches me like that. (Giselle)

Again, Giselle's reactions remained private and she thought through how to tackle the situation with Jim. Like a lot of the other bits of "hard information" that Giselle had to deliver she worked on herself first, prepared herself, and brought it up during their next session. This boundary was more testing than the others and required Giselle to muster all her courage to deliver the latest limit. Her uncensored and private reactions were the catalyst for the work.

> As his therapist, not for a millisecond did any part of me think I would be handling it in that way. You know, working with John is a constant working with myself, working with my own abuse, you never get away from it. (Giselle)

Giselle acknowledged her personal weakness with boundaries. The notion that having a weakness in this area may mean she would be more likely to unwittingly act out a theme in her own life with a client came to fruition with Jim. His propensity to operate in a boundary-less way made him the ideal "trainer" for Giselle. Like some of the other therapy couples the way their personal valencies dovetailed together acted like a form of unconscious attraction.

> He was a particularly good trainer cause he crosses the boundaries so, so much more than the average person. So you wouldn't see my weakness around boundaries in a normal situation, you know. I'm well brought up, well behaved! (Giselle)

This therapeutic relationship could have slid down the metaphorical *slippery slope* several times. Not only did this relationship not loosen the boundaries further and slide downwards it tightened the relational boundaries more firmly. The initial influence was mutual but Giselle's individual emotional courage and strength stopped them sliding down the hill. Relational boundaries were significantly changed as a result of Giselle's many and constant efforts to "bend

over backwards" in order to help Jim learn about boundaries. However it is evident that Giselle has also gained from this encounter. While Jim has shown a change in his management of personal boundaries in outside relationships, it was Giselle who was taken by surprise and "trained by Jim" in an area that she "didn't know" was her weakness. In a relational sense this has been a truly reciprocal arrangement based on mutual trust and respect.

Paul and Leo

A therapeutic relationship that has social contact is more usual in rural communities where it is unavoidable, whereas Leo and Paul are based in a major Australian city. The boundaries between personal and private information and family information can be very complicated to navigate. However in Paul's mind it made no difference, he felt more comfortable with Leo because of the close family connection.

> Because I think I trust his motives, he's a good man in terms of, he's there to help me. And I think he's a lot smarter about understanding things that than I am. And I guess that's, I mean that's his job, but I guess if he wasn't a good counsellor then you might, I don't know. (Paul)

Paul commented that if he had not received the recommendation to Leo from his friend he would probably not have attempted therapy again. The fact that Leo is his friend's uncle is what makes this relationship work for him. "It just works very well, I feel it has helped me more than the person I saw who I didn't know." From both accounts it appears that the relationship has retained a bounded form despite the social contact. Other than Paul's friend, others in the family do not know that Leo is Paul's therapist. Leo's past training infuses his current attitude and behaviour within his role as a psychologist. However he carries out the overlapping roles with a strict respect for the person he is responsible for helping. "I would trust him with my life,

because when I am in the family situation, except for Stephen no-one would ever know. He is completely trustworthy and very good at keeping information to himself." It was difficult to understand the rational for decision making from Leo's perspective because of his tendency to avoid answering from his own experience and slipping into talking about Paul. However when asked for his thoughts on the therapeutic relationship he answered:

> I think the therapeutic relationship is a, is a human being to human being relationship in the first place, so that it's a relationship of, you know, as far as possible, respect and equality. It's based on respect and equality and, you know, we're two human beings dealing with some difficulties. (Leo)

The theme of respect and equality is also strong in other dyads, but has been expressed mostly from client's perspectives rather than therapists. The respect is returned by Paul to Leo along with other accolades and the shared contact outside the therapy hour has not detracted from the work of therapy or Paul's progress. "I have gained more insight through Leo's ability to really understand me. He is so intuitive and he is always very professional." Paul thinks a lot of Leo, and Leo had mentioned that he thought Paul "took him a bit too seriously," alluding to a possible idealised transference. Leo worked in an indirect way using humour and stories to engage Paul, adding to the uncle like feel Paul had for him. Paul made mention of his father in the context of thinking about how easily he related to Leo in comparison. "I could never talk to my father so I can't relate to Leo as a father figure because he's so different. So easy to talk to and I feel very comfortable with him." Leo's non-threatening and indirect style allowed Paul to connect with him. Does a young man looking up to a wiser older man and recognising and respecting his depth of knowledge have to be idealised transference? Even Freud said "sometimes a cigar is just a cigar". The extra personal knowledge that Paul holds about Leo means that Paul would be privy to the esteem in which others hold Leo. All these factors may

play a part in Paul's perception of Leo, but they are not related to the aspects of Paul's history that would elicit transference.

> Because you - yeah, because you think not, I was going to say it's almost like you're lucky, or I was going to say it's an honour to spend that time with him, because it, you know, he's such a smart guy. Someone you can respect and you're sort of almost lucky that you have that, that he's [trails off]. (Paul)

It could be speculate that Paul feels honoured to have the interest and attention of an older man, when this was a deficit in his development with his own father, and therefore a positive transference. Feeling "lucky" to have Leo may also be based on the reality of the context. It would have assisted to have some personal information from Leo to gain a sense of his contribution. However it was difficult to get Leo to talk about himself. In the course of our-two hour interview, he would have given no more than three answers that went even close to being personal. Questions aimed at his experience were answered by turning the focus on Paul and the therapy. He seemed quite uncomfortable focussing on himself when asked a question that needed a more personal answer. For example when asked how he thought Paul might view him, he was very brief. "Oh, I don't know. Probably as a wise father, something like that, a wise uncle or something." I found myself wondering if Leo's very private nature might act as a form of anonymity and neutrality in the therapeutic setting and therefore facilitate the emergence of a positive transference despite the amount of transparency about his private life and family.

Despite Leo's reticence to speak about himself, it was evident he had a calm and engaging personality, and a containing presence. He was the oldest therapist in the study, and his very private manner made it difficult to see the man inside the therapist. Maybe this is why having social contact outside therapy had not hindered the work. Leo was there for Paul and that was where the focus stayed. However the relational boundaries were fully engaged, and firmly held

in this mutually respectful relationship where the professional boundaries extended beyond the usual formal limits.

Conclusion

The theme of relational boundaries emerged unexpectedly out of the fourteen narratives and unfolded as part of the unstructured interview process. At first this theme appeared peripheral to the focus of the study; however the manoeuvring of boundaries, especially at the beginning phase of the different relationships, symbolised whether trust was going to be possible. This was particularly salient for clients who had experienced previous negative therapy relationships. Therefore when this theme emerged from the data, it not only highlighted the underlying dynamics of the particular couple relationship, but also the interpersonal and mutual negotiation of agency, influence and trust.

On closer examination the dyadic boundary interactions were significant for the initial engagement in the relationship and beyond and obviously held importance in the minds and memories of both client and therapist over time. The therapeutic relationship had already begun in the minds of the clients, before therapy had started. The imagined person, their particular personal qualities, and their potential trustworthiness, amongst other criteria, were mapped out by the expectations of the client and how they came to make their choice of therapist. Relational boundary adjustments and their perceived meaning within the different therapeutic relationships influenced and facilitated the mutual development of trust.

Each dyad raised the topic of boundaries (although not always named as such), independently in their separate interviews without prompting. The meanings were personally salient and viewed by all participants as playing a significant part in their relationship and why it was successful. In several of the relationships the boundaries were tested from the very start, as both therapist and client navigated the intake process, and negotiated where to set the frame for

their particular relationship and their work together. For other dyads the boundaries were about subtle and personal aspects of their relationship over time. However for each dyad, the implicit and explicit interactions around boundaries held specific and unique symbolic power and meaning within their particular relationship.

Previous negative experiences with other therapists did not deter clients from attempting therapy again. However previous experiences did impact on client's choice of therapist and how they went about finding a therapist. A consistent theme for all clients was choosing the right person for them. Generosity of self and level of responsiveness characterised all therapists, some of who stretched themselves to accommodate unorthodox requests and difficult situations and behaviour. The relational boundary adjustments did not disintegrate into a harmful relationship. The level of trust in the relationship was deepened through the mutual responsiveness of being impacted and influenced by each other and adjusting to that impact within the context of the relationship. Each relationship eventually found their level, but the boundaries were never completely set. They moved on a continuum according to the particular couple, their context and the stage of development of their relationship. Therapists varied in the way they practiced the management of boundaries whether they were structural or personal. In general therapists relied on their subjective response and judgment towards the client and their situation rather than being guided by professional codes. Thereby for some taking a risk and placing trust in their client. Being open to the influence of the client was a significant element of all the relationships investigated. Trust was based on a relational dance where the shifting boundaries were symbolic of trustworthiness. Reciprocal relational risk rather than a focus on autonomy facilitated a safe and trusting connection.

The following chapter continues with the presentation of the data and concentrates on the overarching theme of the personal aspects of the therapeutic relationship that operate in parallel and aside from the central work of the therapy. The relationship between Leo and Paul did not

allow for an in depth exploration of the personal aspects of the relationship, therefore the narratives of six of the seven dyads will be utilised to explore the mutual influence within the personal relationship.

Chapter 5

The Personal Relationship: Beyond the Purpose and Goals of Therapy

Introduction

The notion of a therapist and client having a personal aspect to their relationship is controversial. To earmark personal aspects of the therapeutic relationship that are not explicit or specific to the purpose of therapy has attracted more interest in the post-modern therapy world as it has become more acceptable, in some schools, for the person of the therapist to be acknowledged within the relationship. The parallel can be seen in qualitative research also, where the subjectivity of the researcher is now becoming more accepted as a vital part of the process and the findings.

The personal aspects of the therapy relationship have usually been considered as global theoretical and empirical variables that hover somewhere in the background of the professional relationship and the treatment. Sometimes the personal aspect is mentioned in the context of theoretical constructs such as transference and counter-transference and then related to the therapist's use of self within that context. However, the accounts of both therapists and their clients in this study saw the personal aspect between them as being very much part of the foreground of their relationship. This foreground was based on a personal level of experiencing each other as people more than through the lens of existing theoretical constructs. The personal foreground was also apparent in the previous chapter regarding boundaries, where the clients in particular wanted evidence that the therapist was worthy of being trusted, and the "right one" with whom to risk talking.

Therapists spoke of this foreground relationship in terms of their personal feelings and attitudes about their client, both positive and negative. This also encompassed the impact of being confronted by things that were either difficult to work with, or had never been encountered

before with any other client. Therefore when a client presented with particular difficulties, or behaviour that challenged a therapist's existing knowledge and experience, therapists relied on their basic human capacities and intuition. This has been written about in recent literature on the concept of mind-sight, as how we access the wisdom of the body to make wise decisions rather than just logical decisions (Siegal, 2009). Six of the seven therapists in the study commented on having to rely on their intuition or gut reactions as opposed to a model. Theoretical orientation was mentioned rarely or in a peripheral way in the context of discussing the relationship.

Clients spoke of the personal aspect of the relationship in terms of their feelings about their therapist, both positive and negative, and their more private expectations and inferences about the nature or state of the relationship. The majority of clients held a view of their therapist as being competent, sincere and genuine, yet also human and fallible. Techniques and theoretical interventions were discussed by clients as secondary considerations, and in some cases unwelcome and irrelevant intrusions on the relationship.

I want to emphasise that while I was asking participants to talk about their relationship in isolation to the issue they were working on in therapy, I was not viewing the personal aspects of the relationship as discrete categories, or mutually exclusive to the clinical work. Therefore the clinical issue and work, when referred to by the participants, is included throughout these accounts as an inseparable component of the narratives. This chapter focuses on the therapeutic relationship beyond the immediate goals of treatment. The following six therapeutic relationships bring to life the personal aspects and mutual influence within each relationship as reflected on and perceived by both therapist and client.

Six Therapeutic Relationships

Graham & Peter: Personal Wisdom

Graham and Peter were introduced in chapter 4. Their respective and independent interviews mapped onto the same themes within the relationship. "Personal wisdom" was a salient beginning topic for both of them. Graham often relied on his gut feeling, "I always say, if in doubt go with your gut, and so that's where I end up, you know, and what often happens then is well "how did you know to say that"? Well I don't know." What Graham expressed goes beyond theory or model towards a more personal well of knowledge that he puts down to wisdom. This inner wisdom or felt sense came automatically and unconsciously and emerged from Grahams lived experience. "This might sound smug, there's a degree of wisdom about, just simply because I've lived life long enough." Graham did not strike me as the smug type. His demeanour and manner were quite the opposite. However it does fit with the notion of feelings as primary knower's, with the result of right brain unconscious and automatic processing at a rapid rate (Schore, 2003). Graham's answers show he did somehow *know* what to say, and it was accurate for Peter. Peter's sentiments expressed independently of Graham also mentioned the getting of wisdom.

> I was only essentially after one thing, wisdom. I wanted someone who was wise, who was experienced, that ah (short pause), psychologist or not psychologist. Yes, I wanted someone that would give me, from an experiential point of view, from their life experience. (Peter)

Peter said that he "didn't worry too much about labels, counsellor, psychiatrist, psychologist, you know, witch doctor [laughing]." The main thing was that he got what he needed. Peter challenged Graham to work "outside the box" in more ways than just the religious

perspective mentioned in the previous chapter. Peter said he wanted direct advice and feedback, "someone to sock it to me." He wanted a wise view "because, there's blind spots in one's life," but he also wanted to process it himself, so he was happy for Graham to really speak his mind. However, Peter stated "that didn't mean I was going to accept it." In counselling sessions Peter would tell Graham, "look, you know Graham, be directive, you are the counsellor, do your thing." He said he understood the paradigm of counselling where the client comes to their own solution, but he did not want to just process his stuff (be introspective) he wanted to let Graham know that it was important for him to make a shift. "I was quite happy for him to be able to ... probably important for him to be able to shift, ah in styles, yeah, relationship styles, rather than one way."

Peter was able to express his particular needs for therapy that went beyond the usual theoretical underpinnings for the work, which foster focussing on the client's inner world and facilitating them to self reflect. Not that asking for direction or advice is a new request from a client in therapy. Peter stated clearly that despite the paradigm philosophy of counselling he wanted something different. It was evident from the very beginning that Peter wanted something back from Graham. Definitely something "wise," and certainly something "personal" that came from Graham's "life experience." Advice in therapy is usually frowned upon because it is seen to foster dependency on the therapist and prevent personal insight, growth and maturity. There is also the trap of idealisation of the therapist, and it is a long fall from grace off such a high pedestal. But, Peter was not under any illusions as to Graham's human and more fallible side.

> It's like, you know, you go to any health provider, service provider, you've got good days and bad days on both sides, so the good days you will be able to read it, bad days you don't, but he didn't, he wasn't, ah, but that's not very often, but I get a good sense of him, and I'm sure he's a got a reasonable, a similar sense of my states. (Peter)

Peter obviously likes Graham and has a level of tolerance for Graham's "bad days," or when he is not able to "read it." He also expresses a "good sense" and a "sure" judgement that Graham has a "similar sense" of his states. The previous quote shows that Peter has a realistic view of Graham as a person, there does not appear to be any form of imbuing guru like qualities into him, or having unrealistic expectations. On a "bad day" Graham obviously did not hit the mark for Peter, who was not perturbed by it. His "good sense" of Graham infers he is confident and realistic about what he expects from the relationship. Bad days will happen "on both sides." Peter's also "sure" of the reciprocity between them of being able to "sense" each other's "states" (of mind). Implicit in this "good sense" is an attitude of trust.

Peter's inferences about Graham and the state of the relationship were not discussed directly with Graham. These private feelings based on Peters observations and reactions to Graham were the building blocks of the relationship and underpin not only Peter's judgements about Graham, but give a particular texture to the whole relationship and how they operated as a partnership. For example Peter's way of letting Graham know if he had missed the mark was to "just ride with it." If he sensed that Graham was not relaxed or focussed he would not say anything about it to Graham, but would "revisit that at another time." He persevered with Graham's human side because at other times he was not afraid to confront Graham about his style.

Peter and Graham have had an ongoing tussle over Graham being non-directive versus directive. The relationship was strong enough to withstand these tussles. The process of therapy was able to tolerate more turbulence due to the solid underpinnings that shaped their relationship back at the beginning. It did not seem to matter whether their respective perceptions about the process of therapy matched or not, nor did it impact negatively on the therapeutic relationship. For example Peter thought that therapy was "not a neutral experience, nobody's neutral!" In other words Peter is convinced that Graham must have an opinion. Whereas Graham said, "I'm

not there to tell him what to do." Graham qualified this with a concern that Peter "tends to be fairly action oriented, sometimes to his own detriment." It would have been useful to know if Graham and Peter discussed this tendency together in therapy, or if this was also a private attitude, but regardless it had an impact on Grahams input. The lack of falling into advice giving seemed more about Graham's attitude to Peter than about a reliance on the restraints of a theory or model. Despite Graham's reticence Peter continued to push Graham to be more up front and directive.

> I give him permission, so I said be directive with me. I say don't worry. One because I might not do what you say but I want you to be directive, and then okay you can switch back to that [non-directive style]. (Peter)

I asked Peter, if this was a cultural difference or a Peter difference? He answered, "just a Peter difference. Yes, cause [laughing] after a while this thing about processing, there's nothing for me to process." Peter is saying that without input from another there is nothing there, he is empty. Peter explained that he was not after answers or solutions. He said he would only have the thoughts and feelings about something once he got Grahams perspective. "I can be introspective, but there's got to be something to be introspective about." Peters need for something, from Graham, and how he will deal with the information when it comes, was saying that he needed the two-way interaction to give him food for thought. Being embedded in the two-way dialogue of a relationship rather than remaining introspectively individual also fits with Chinese cultural values. Peters message to Graham was, "don't worry [about giving your opinion or advice] because I might not do what you say." Peter said the main thing for him was that "I want more I can think about." Therefore what Peter wanted and needed from Graham was not necessarily going to be swallowed and digested whole he wanted more to chew on. This was Peter's way of being in relationship, and how he preferred to make decisions, but was not an indication that he did not know his own mind or would be likely to be led blindly along by

Grahams thoughts or opinions. Peter's need for direction was not lost on Graham because it was also part of the supportive contract they had set up together. "He came to sort of validate some of the decisions he was making and get my observations on them and comments back ah about what he might do." Graham had been the minister of a Chinese Church in a major city for a time, and he said that gave him an added "awareness of the Chinese culture."

> I respect his culture, and I do understand it I think reasonably well ... having said that though, from my knowledge of Asian cultures, they, they do almost expect help and advice in that manner, because culturally that's how it works, so it's counter to counselling, but not counter to culture. (Graham)

Peter had ruled out culture as having any bearing on his need for direction, yet it would be difficult for any of us to tease out our embedded cultural beliefs or attitudes from our personalities easily. The interrelationship between Peter's personality and his culture may therefore be one of his own blind spots as this comment suggests. "I suppose the Western model about going inside, inside and trying to find this stuff, I think it's nothing there. I hadn't thought of it, I can't think of it." The personal aspect of the relationship between Graham and Peter meant that straddling the differences between them became foreground. This foreground was manifested by Graham compromising at times and working "counter to counselling" in the service of their relationship. "I'm not there to tell him what to do, but [I might say] look, if you make this choice then this is likely to happen, or that choice, then this consequence ah might be forthcoming." However there appeared to be times when working "counter to culture" was attempted despite Grahams understanding of the cultural expectation of "help and advice."

> Well, um, I mean he would often ask me you know, what I, you know, what I think, I said well "Peter does it really matter what I think? It's really what *you* [italics added] think and what the consequences will be for you". So I think he's, he's lived in Australian society for

> long enough, so whilst the traditional sort of Asian culture would expect you to tell them what to do, I sort of, you know, you're a big boy now, you can work it out for yourself. (Graham)

So despite Peters insistence on giving permission for Graham to be directive, there remained a mutual push and pull in the relationship that attempted to straddle their different perspectives. Graham resisted the pull towards giving his opinion or advice and persisted with his own interest in wanting Peter to explore and process his own thoughts and feelings about his situation. At the same time Peter remained constant in his wish that Graham would "shift relationship styles" and "be directive." Peter equated the difference in perspective and style as different ways of being honest. "You have this soft honesty which is convoluted, and then there's this direct honesty." The constant holding of this dual tension in the relationship was ever-present.

> He'll say often, I thought of you on Saturday [re what Graham might think about a situation], and I'll say well, yeah, I respect you, and really what I think is one thing, but it's more important to help you understand what it is you think, but perhaps more importantly what it is you feel about it all. (Graham)

The dance of mutuality for Graham and Peter involved the question of who could influence whom, and how significantly, but underneath the tussle was an attitude of trust and honesty. While Peter sees "direct honesty" as the expression of an opinion, and the more indirect comments as a form of soft honesty, he none-the-less trusts Graham to be honest with him even if it comes in a "convoluted" form.

> See, trust is a, ah, I trust him to be that [honest]. I think he is that, but there are many ways of saying things. You know like, um, if say someone says Peter, um, 'you know, have you considered this? It might be interesting, yeah?' Or trust is, 'why are you so stupid, why

> don't you just do that? It's so obvious, I can see it. I'm telling you I'm being frank with you.'" (Peter)

Trust and honesty obviously have several different meanings for Peter. However Graham commented that "sometimes I'm reluctant to be honest about it, you know. I would say, 'I'm not sure about that'". However in trying to facilitate Peter coming to his own insights, Graham said he would "probably be fairly transparent" about what he was doing.

> I wouldn't necessarily keep my thoughts to myself, because sometimes he might, he might be telling me something, and there seems to be a lack of congruence, um, because what I'm feeling and experiencing from what he's saying seems to be different. So then I would say well I don't know what's happening for you at this minute, but you know, I'm feeling such and such. (Graham)

Graham held the emotional tone or felt sense of their interactions. This is what Siegal (2009) and Schore (2003) have described as sharing the emotional contents of each other's minds, which is a right-brain to right-brain transfer of affect. However generally Graham and Peter kept the overt processing of their therapeutic relationship during sessions at the reality level, despite Graham saying, "I think there's probably, you know, maybe an idealised transference." Graham's hypothesis that an "idealised transference" was operating had not been talked about, or explored overtly within the therapeutic relationship. This may have been because their relationship was based on Peter having a significant amount of personal knowledge about Graham from the start. Graham stated that in his sermons he would often talk about his own issues or experiences. Graham also felt that "just simply the age difference" between himself and Peter meant that he was "almost like a father figure for him perhaps." The concept of re-parenting or transference relating to a father figure comes from a theoretical base, yet Peter clearly did not view Graham in that light. "Maybe age is not that important. I don't see him as a

father figure. I don't know, maybe I need more analysis [laughing]. Who knows I don't think so, maybe it is, but I never thought about it as that."

Often clients can recognise and make the connection with a similar theme or belief from their past they might be repeating with their therapist. However, Peter was genuinely bemused by the idea, and it did not fit with his view of Graham at all. Graham commented on how much he enjoyed Peter's personality saying, "he's got a sparkling sense of humour, that I respond to." Peter's humour was something that Graham looked forward to encountering in their sessions. "I mean his jocularity [is something] I can bounce back on and so we can have fun." Peter mentioned this aspect of the relationship from his perspective as a "friendly banter." Peter gave examples of how he would challenge Graham if they saw a point differently. Peter said that Graham might say, "yes, of course, but I am the counsellor." Peter laughs with gusto as he recalls this and adds that he might reply with a comment like, "how do you know?" Peter continued to laugh out loud as he recited his recollections of the "banter" between himself and Graham. The congruence between Peters strong positive emotional expression in parallel with his memories gave weight to the accuracy of his felt experience. Going up against Graham or "rattling him" was a positive and "fun" experience for both Graham and Peter and was a regular part of their repertoire. "I also know how to stir him so to speak, [laughing loudly as he speaks]. It's sort of also rattling him, but that's more like, for me, it's like a form of banter."

It could be interpreted theoretically that "rattling" Graham was an indirect or unconscious form of rebellion and Peter obviously enjoyed doing the "rattling." From what I could gather the "banter" was not explored or processed within the relationship for its meaning, however whatever it symbolised, it was fairly polite and reciprocally enjoyed. The banter could also be a positive way of dealing with negative feelings between them without damaging the connection, or simply a form of play, which has a vital and symbolic role in therapy.

Peter's descriptions separate the clinical relationship from the more personal aspects of the relationship. Peter used the term "ordinary" to describe Graham in the last chapter. The word ordinary did not minimise the regard in which Peter held Graham, it was meant as a positive way of describing someone approachable and comfortable to be with. Peter describes it thus. "So you have this connection, ordinariness, which is the connection and then you have these good clinical skills." Being ordinary was the platform that provided the "connection" not the "clinical skills," which Peter saw as separate. Peter thought of Graham as a combination of "professional, mentor and friend." Yet he qualified this comment with, "but I know that in this role, he cannot be a friend, and it would defeat the purpose, I think you need that line." "That line" was drawn even though this relationship has meant that Peter knows more about Graham's personal life than would usually be the case. Despite this extra information Peter viewed Graham through the lens of his professional roles. There was no indication from Peter of the idealisation mentioned by Graham. In fact Peter's view of Graham was much more realistic than Graham perceived.

> I don't worship him or anything like that, he's alright, I mean he's got this particular, I mean I think he straddles those many roles, one is his minister role, and then there's this professional psychology role, and then I think there's another Graham which I'm not familiar. (Peter)

The difference in perception between reality and fantasy is often portrayed through theoretical constructs such as transference or projective identification. Many of the older grand theories would say that transference and counter-transference are always present and that all subjective reactions and behaviours can be explained using those constructs. Graham's view was that Peter had an idealised transference, yet when Peter talked about Graham he expressed a more layered and complex view of Graham that encompassed several different roles and dimensions. However despite knowing that the role of friend "would defeat the purpose," Peter mentioned that he thought of Graham as a friend and he engaged in friendly behaviour.

> It's interesting because he always brings a cup of coffee with him, for me and for him, um and so you know, it's almost like a ritual that's happened, and [chuckles] I thought well when we go to the city [move rooms], it'll be interesting to find out what happens, but the coffee still arrived. (Graham)

The fact that this ritual, plus underlying attitudes that exist in the relationship have been noticed but not unpacked, explored and analysed in terms of their particular meaning, does not take away from the quality of this relationship. Peter also talks about the fact that he will at times challenge Graham, however this is rare because of the way he views Graham's intentions. Stern (Stern, 2002) discusses this manner of unspoken interaction as being a part of the inter-subjective nature of a relationship where "you know, that I know, that you know" (Stern, 2002). Therefore Graham's intentions and authority are viewed in a positive light, however still not necessarily through the lens of an idealised transference or displacement. Peter's earlier comments portray his capacity to hold an ambivalent view of Graham that encompass a fairly realistic and balanced attitude towards Grahams attributes, skills and motivations.

> A lot of the stuff is about, well, go and think about it, and try this, so it's always phrased in the, try, and I see it as that, so um, you know, maybe if someone sees it as commands, you know that's disagreeable. I see it as opinion, perspective, suggestion. (Peter)

At the beginning of the interview Graham talked about his own gut reactions in his work with Peter. Later in his interview, when reflecting on Peter's thinking or behaviour, Graham was more inclined to interpret through the lens of theory. It was when Graham used the theoretical concepts of idealised transference and the notion mentioned earlier of being a father figure, that the fit between his own view, and Peters view was less parsimonious. While it is likely that Peter, like most of us, is not completely un-conflicted about issues of authority, there is not much evidence in this relationship that working with the father figure transference would yield much

benefit. However, the "rattling" and "banter," were an example of *here and now* interactions that energised the relationship in a way that a there and then analysis of the past could not. The foundations of this particular relationship, based in part on unexpressed feelings, inferences, attitudes and judgements about each other, allowed for a lively yet emotionally secure relationship.

Peter expressed that what was most helpful to him, was knowing that, "over a period of time the pain will be less, that in the end, that's your crisis, you feel this, this impending doom and there's no way out, so that's the ability to say okay, it's going to abate." Peter came across as a fairly pragmatic person who wanted to find solutions to a personal problem, yet interestingly what Peter found most helpful about therapy in the end was not related to the solution. Peter's situation was that he was deciding whether to stay in his marriage until his daughter finished school. His wife was in a long time affair with his best friend, and they lived very separate lives under a shared roof. Peter had not told his extended family this news and he wanted to know if he "should stay," and if he did how he could "fulfil this role." He found it to be "just too hard" and wondered if he was "doing the right thing." He hoped that Graham could help him clarify if he was "on the right path." His main question to himself was.

> How can I be a good father, and how could I be a good husband, and how could I um live a whole life, quality life so to speak, not be in a longing, a yearning type thing. So those were the issues. (Peter)

Peter's need for "direction and reassurance" that he was "doing the right thing" were driven by the pressing emotional need to relieve his distressing feelings of "longing and yearning." He had originally hoped to repair his marriage. His relationship with Graham has managed to ease his internal distress. This positive emotional outcome was not hampered by the fact Peter's main focus was on his behaviour rather than introspection. According to Graham, he and Peter discussed a broad range of topics that might have been difficult to address within

Peter's culture. Especially around the topic of what Graham called his "sexual expression," given his circumstances and living arrangements. Peter also expressed that at times he felt he was expecting too much of Graham, and "getting too close or something," but he did not bring it up with Graham. These times happened when Peter had things "pressing on his mind" and therefore needed more contact than the formal therapeutic relationship could offer.

> Hmm we don't talk about this, it's not really spoken about but, it is a dynamic ... I think he understands, yeah, he understands, yeah it's implied, yeah but it's as strong as discussing it, because sometimes there's things that are unsaid that are more profound than things that are said. (Peter)

The implied understanding reinforces the intuitive "good sense" Peter has of Graham, and that he believes is reciprocated by Graham. There was a fair amount of information in the relationship that was intuited and kept covert, but it did not detract from the relationship or Peter's progress. Seeing a professional was new to Peter, and he said that if he had not accidentally come across Graham he might not have seen anyone. He would have processed it himself or with friends, even though his friend's advice was, "totally off the beam." Peter expressed that his connection to Graham was not because of "the role we have [as therapist and client]" it was more "because we've done things together."

> I'm attached to the person because of the connection the person had with me. Am I going to have attachments? Yes. Is it because he's the therapist? No. Or the influence he has on my life, yeah, just as these other friends of mine, have had an influence on my life, we've been through stuff together, it's in that sense. (Peter)

Despite being somewhat dismissive of the therapist role as being any different to a friend's role, it was the joint sharing apart from the role that he valued. In the end he put the outcome of therapy down to "the person" of the therapist not the therapy. "It's the person with their

processes, not the process itself, you must always have the person in this way, cause this person is the means. They are the one that does the magic, no, not the process." Despite Peters insistence on wanting Graham to be more directive, and possibly not having the therapeutic process he wanted. The committed presence of Graham over the past two years has created the means and the "magic" to make life bearable. Peter did have a problem to solve when he entered therapy. Whether to stay in his marriage or not? And if so, was it the right thing to do to live a good life? However when I asked Peter, what he thought had helped the most, it had to do with how his feelings had shifted and the implication that as a result of this shift different issues had emerged. The original situation itself had moved to the background.

> Being able to move out of um, the sense of despair, hopelessness, or a deep low, to be able now to ah, to see that ah yeah, it's bearable, you know, it's bearable, it's ah, it's ah, maybe it's got to other issues. (Peter)

The management of Peter's emotions and feelings of despair were paramount to the work, not merely finding a solution to whether Peter should stay or go. Making things "bearable" was a shared task. Peter said that Grahams main influence over time had "given me hope that things will be better ... that thing about hanging on." Graham also expressed that he had sensed in Peter, his "pain, and his sense of lostness and 'how am I going to cope?' Graham felt that Peter was, just feeling a lost soul completely. He therefore thought it was very important to be responsive and "available when the need has arisen." Graham said that, "rather than say well I can't see you for two weeks, usually I was able to respond within a couple of days." Graham's level of responsiveness came from his compassion for Peter and his situation, and therefore a commitment to be available to support a "lost soul."

> I think the most important skill that a person has, is listening at the two levels, not the head level in terms of hearing, but the third level, or the third ear you know, sort of listening with the heart. (Graham)

The heart level was not really mentioned by Peter in those terms, but the outcome of being able to move out of his despair and hopelessness is none the less poignant. Peter joked about the way he used therapy, on a 'call when you need to' basis rather than regular weekly sessions. "Yeah, this is irregular but it's still therapy, I mean, it's quite a long-term therapy for chronic distress and debilitation [fades off laughing]." Graham said with great sincerity that he really enjoyed Peter's company, and this attitude would no doubt come across to Peter. A relationship where Peter was enjoyed and supported is a far cry from his family reality. Apart from his marriage failing, he is the main support person in his extended family. His father is dying of cancer, and he has two siblings, one has a developmental delay and the other has schizophrenia. According to Graham "the good thing about the experience [of therapy] is that he's got himself out of the knot that he was in, so it's unravelled a bit, and, and he probably feels, well has felt freer to make choices."

Peter reflects on his decision and says, "yeah, I think that looking back, I made the right choice." Peter said the relationship with Graham was what gave him "hope that things will be better," and a large part of that was, "that thing about hanging on," and "staying the course," especially during "those spiky periods." This sustaining and reliable relationship helped Peter to hang on but was by no means completely smooth or regular. It would not fit the criteria for a Medicare treatment plan in Australia. Peter's words sum it up best, "it's like this is a moving boundary, you know, it's like an ebb and flow, this relationship is not clear-cut."

Sarah and Lily: The Power of Presence

The personal aspects of the four and a half year relationship between Sarah and her client Lily also defied theory in that intuition played a major role. However unlike Graham and Peter, the personal aspects were manifested within the frame of the therapeutic work. Sarah began by saying, "we have had a relationship for about four and a half years now, and it's been a very powerful relationship, very thought provoking, I'm very aware of the impact that her relationship with me has had on me." Lily began by commenting on how she experienced Sarah, saying she was "just wonderful, and a pain in the arse [laughing]." Lily's ambivalence with the process of therapy described in chapter 4 continued to be a dominant theme. "I would get very angry because I didn't want to talk about these things. So I wasn't very open in the beginning." Lily began to laugh as she recalled an early session. "One session in the very beginning of the first year, I didn't speak at all the whole time [still chuckling] we just sat there in silence."

Sarah confirmed the first two years of her therapeutic relationship with Lily were "really difficult." A lot of the time she "felt very deadened" by Lily and just "wanted to go to sleep" in the sessions. "I would come out of those sessions and really not be capable of functioning for a few hours afterwards, not all the time but quite often." Sarah said Lily would also get "fluttery eyes" and want to go to sleep during sessions, which she thought this was Lily's means of escape. There was certainly a powerful somatic force at work that meant the interconnection between Sarah and Lily was a mystery unfolding.

> When I first met her, um she was very dissociative, she would often sit in the session not saying a word, um she would forget from sentence to sentence what had been said to her, or even what she was saying, and so it was extremely difficult to connect with her for a very long time, she had a lot of suppression of emotion, repression I'd say actually, and it probably took about two years I reckon before we were able to hold a conversation that went for longer than about two or three minutes. (Sarah)

What Sarah called the repression of emotion, Lily interpreted as being "stubborn" adding "I've just been too difficult sometimes." Despite the "deadness" and "stubbornness" something kept this "difficult" relationship connected and operational. The mutual effect seems to be the joint psychological holding of something that was very heavy and not easily thought about, let alone spoken about. In the end Sarah relied on just remaining "present" to Lily.

> I didn't get a lot out of supervision around her, because she's, you know, in the end I just thought well nobody's getting her, so I'll just carry on, on my own. Nobody was getting her probably because I wasn't getting her, so I couldn't actually convey what it was like to work with her particularly, beyond saying I feel deadened. Um, and so I just had to, I think lean on being in the room and present. (Sarah)

Sarah intuitively joined Lily in a non-verbal but very mutual way that showed she was truly with her, a sustaining and functioning presence in the silence. Sarah's way of staying with Lily through this process was not an objective or observational stance it was an interpenetrating experience that Sarah felt both psychologically and physically.

> It was extremely powerful. I didn't overwork to try and make a connection, just being present in the room I felt was enough at that time. She was unable to explore what was happening for her, so it took a lot of me reflecting back to her what was being, what was happening. Interestingly, the influence that had on me at that time was that I felt very confident that I was doing the right thing, just by being in that space with her, it was really, really weird, there was some kind of energy around, yep this is right, just be here, just be that present other. (Sarah)

Sarah fell back on her intuition during difficult times and it felt "right." Lily did not elaborate on this part of the relationship as much as Sarah so it is difficult to compare perspectives. However Lily thought she was "too difficult," confirming that the therapy was not

a smooth process. In fact Lily was often reluctant to attend. “I get very frustrated with her, and often I don’t want to go, but I just tell her I don’t want to be here.” Lily put her reluctance down to being extremely anxious. “Because, I want to get better, and I want it to work, and I do feel that it is working.” However her anxiety worked against her determined efforts to “get better.” This also relates to another part of the interview where I commented to Lily that going to therapy twice a week was a “pretty big commitment,” to which Lily responded. “Ah it doesn’t feel like that, cause otherwise I’m not doing anything about that, and I’m just going to stay the same.” It is apparent Lily was motivated to change despite her presentation in therapy as “difficult,” or what theory would describe as resistant. Commonly this kind of presentation is written off as contraindicated for therapy in the majority of theoretical orientations and models.

Lily and Sarah described similar scenarios about their silent sessions, however the extent and time frame were vastly different. Lily recounts a short non-specific time frame of “when I first came in,” whereas Sarah specifies “two years.” Lily mentioned only one session where she did not speak at all, whereas Sarah’s recollection is that there were many sessions like this over the course of those two years. It would make sense that Lily’s tendency to forget during sessions has impacted on her memory and therefore her ability to accurately recall the facts. Silence and forgetting in therapy can be interpreted through a variety of theoretical lenses, and attributed different meanings. Sarah attributed Lily’s silence to dissociation, whereas Lily named it as extreme anxiety. Both may be accurate names for the same phenomena; however the importance of the relationship as a holding environment in this context was paramount.

> When I first came in I’d just forget. I’d be talking like this and I’d go, what was I talking about, I’ve no idea. And I could sit there and think for ages and just not remember, just block it right out, comes out in conversation, just that anxious, just want to leave the room, hide in the corner, and that, it just doesn’t happen now, you know, none of that. (Lily)

The context of this relationship highlights how the client can dictate the pace and nature of the therapy, regardless of the theoretical knowledge or accuracy of the therapist. I doubt Sarah consciously wanted to wait two years and endure quite so many constipated, unfinished and deadening conversations. Whether Lily's "anxiety" was an emotional defence or deficit, it was never-the-less very debilitating and Lily was desperate not to "stay the same."

Sarah used her personal reactions and intuition to guide her through the process of how to connect and stay with Lily under extremely difficult conditions. Lily mentioned she needed to be pushed and that was one of the main reasons the therapy was working. "She asks really difficult questions and that's what I needed." Yet anger was ever present in the relationship from the beginning, especially if Sarah "pushed too far." In the early days of the relationship Lily's anxiety was so high the only thing that helped her stay with the process was the breathing that Sarah had taught her.

> We learned very early on, how far I could go. In terms of our relationship, she knows when she's pushed too far. I'd have an anxiety attack (laughs) and go ah! and she'd go, okay, we've gone too far, no that's alright I'll step back. (Lily)

Sarah and Lily managed to slowly adapt to each other. Lily "didn't like it at first" because she would "really have to think hard." Not wanting to think too hard, whilst at the same time being desperate to change, meant she was caught in a bind with herself that needed a particular relationship to safely unravel. Permission to express anger became an important part of untangling Lily's ambivalence. "She would say "I welcome your anger". Ever since she said that "I welcome your anger" it kind of just made me think, well, right, everything is welcome in this room." It wasn't just the overt permission given by Sarah to express anger that was significant for Lily. She also sensed that her anger was not going to be taken personally by Sarah. "It's very easy to say it, cause I just know that she knows that it has nothing to do with her, really, that it's just being directed at her."

This mutual influence was not related to working with transference. However I wondered out loud if directing her anger at Sarah might feel awkward at times, to which Lily very energetically and emphatically said, “no not at all. I just say I am really angry with you right now. She says, “Ooh! tell me why, this is very interesting” and she wants to know.” Lily’s thoughts and feelings, while generated from within, could only be made sense of in the here and now context of the joint reality of this therapeutic couple. Lily’s reactions and responses cannot be divorced from Sarah’s participation. Sarah’s emotional involvement was an immediate feature of the dynamic that emerged between them.

Lily added, “I think that’s what I like, I don’t worry about how she perceives me.” Having the angry part of her fully received and accepted by Sarah was the catalyst for deeper change. This was a new experience for Lily who now credits that her personality has changed for the better. “I even ah, I actually noticed some of my morals and values have changed.” I regret not having this comment fleshed out further. Change had also emerged for Sarah. She reflected on the journey she and Lily had been on together and concluded that she was also gaining something from their relationship, and that it might be related to a present issue she was “grappling with.”

> I, struggle to let in the fact that I might have an impact on my clients ... I tend not to imagine that anybody would consider me to be important to them, or that I, and yet intellectually I know that’s not the case, so I think that is part of the habit, so I must, I imagine organise the relationship with the client around that characteristic that I have as well. How I don’t know, I can’t go any further with that, but that’s something that I’m grappling with at the moment as a therapist. (Sarah)

Sarah’s personal questioning was too new for her to make more of at that point, however how she “organised” her relationship with Lily “around that characteristic” is an intriguing question considering the relational literature posits the therapist’s subjectivity is a vital part of

the shared dynamic and a major contributor to the process. Sarah also seems to be saying that her personal issue was somehow embedded in the work and contributed to shaping the relationship. There is hesitancy in Sarah to claim any credit for Lily's progress. Although the change Sarah has witnessed in Lily bears evidence that this did not happen in a vacuum, or solely because of external events beyond the therapy room. Sarah's linking of her "current issue" to her work with Lily says that she at least wishes to be considered an important part of the process.

> I think if I reflect over the journey that we've both come on together, I feel very proud of my part in that, in the sense, I mean I, I can't, I mean for week after week after week, she would sit without talking, or would be slumped like this (physically slumps down). You know, we wouldn't get two seconds into a conversation without her saying I don't know what you just said, can you remind me of what you just said? So the fact that we can now have an hour's conversation, I *have* [italics added] to take some credit for. Both of us have worked really, really hard for that to happen. (Sarah)

Sarah's struggle to "take credit" for her role in Lily's progress was embedded in the underlying philosophy of counselling and psychotherapy where the therapist facilitates the client coming to their own insights or solutions. However in the crucible of her relationship with Lily, Sarah has gained the dawning realisation of her importance and the significance of her role in Lily's personal growth and change. For Sarah the personal aspects of this relationship came down to her human presence, use of self and feelings of fondness for Lily.

> We've had this amazing journey together. She's in my heart you know, there's no technique, there's nothing, um, there's a, there's a genuineness to our fondness for each other, you know, but the therapy is still very effective with that as well, yeah. (Sarah)

Lily articulated her sentiments about Sarah thus. “I think she is amazing, and I just think she has a real natural ability um, as a therapist ... it’s been wonderful.” Lily had been searching for a while to find someone who could understand her and her needs.

> I think that’s what I wanted for so long. That was a huge issue for me when I first came, which is not now, because of the whole personality thing as well, was just to be understood. Now I just don’t have that need as much, probably because I understand me better now. (Lily)

According to Sarah, Lily has developed the capacity to be “very self-reflective,” and she now has a more “immediate awareness” in the moment “when she withdraws, so the dissociation doesn’t really occur.” Lily said she “used to think she was going crazy,” so to be able to say whatever she wanted “to someone who’s listening” and have her feelings “validated” was a vital part of the process. The emergence of the capacity to feel and to become more comfortable with the expression of strong feelings has vitalised and energised Lily.

> Oh the energy! That changed too. I used to have no energy. I couldn’t even get out sometimes... I used to feel like I was carrying weights on my feet and just trying to get to Uni, it was horrible. (Lily)

Learning to feel has been the catalyst for many of the changes in Lily’s life, but for Sarah it was a different story. “When she first started to get angry with me, it was quite frightening actually.” Sarah worried that Lily might harm herself because at that time according to Sarah, Lily was “very unstable, very depressed and everything got turned back on herself.” Sarah’s concern came from her experience of not feeling fully and emotionally connected with Lily. “I didn’t experience her as having a strong enough connection with me, even though she could express anger.”

Sarah and Lily both described having "really working hard." According to Lily one of the most healing things about Sarah was "being pushed to really explore my feelings and what's going on." Being challenged and "pushed" was the only way healing was going to happen because of Lily's tendency to "pretend it doesn't happen. I'm a hider, in the dark." Lily's tendency to hide from feeling anything became a desire to feel. "There were like lots of feelings, like if I get angry and cry, I don't have to cry, but as long as I can feel." According to Sarah, Lily's newfound robust emotional life has enabled her to utilise their relationship more effectively.

> Now we have a very open relationship around what I would describe as a dialogical relationship in which there is a lot of discussion around the mutual influence on each other, even openly within our relationship. (Sarah)

In this context Lily's initial resistance or reluctance can be seen as a form of personal communication rather than being oppositional. Sarah was able to respond to that personal communication and Lily's emotional life is now accessible and welcome, and the relationship was the main vehicle of that emotional change. They attempted sand play at one stage and Lily "just could not do it." After that aborted attempt they did not utilise any practical activities or techniques. According to Lily, "those sorts of things didn't really do anything for me, and it is about the talking." Sarah said the conversation between them these days is "very present oriented, it's very immediate, it's very here and now focused." The mutual influence is more evident at these times.

Lily and Sarah had a consistent theme around self-responsibility running through their relationship where the mutuality between them was played out. There was an ongoing dynamic around Lily wanting to be psychologically and emotionally rescued. Sarah would name the rescue attempts and turn those moments into a process conversation. Lily said, "I wanted her um to come rescue me, and she always says no." According to Lily, Sarah would say, "I want to, but

I'm not going to" [laughing]. So it was as if she was thinking it out loud." Even now after four years the theme is still present at times and Sarah has on occasion succumbed to the temptation. However these days Lily picks her up for the transgression. As Lily put it, "she used to not let me do that [allow someone to rescue her], now I don't let me do that." This theme expanded to other areas of the relationship.

> That's where she really has rubbed off on me and this is something that we have been constantly working on for four years, is for me to take control of the session. I do, I take all the control of where it's going and what's happening. (Lily)

Thinking back to the silent sessions I speculate that Lily controlled the relationship very successfully, only in a different way. Lily and Sarah have passed the baton for control many times in four years. Lily tried to describe how these days the rescue theme has manifested itself again at an emotional nonverbal level. While these words are a somewhat awkward and unclear articulation, it is an attempt by Lily to describe something tangible.

> I've caught it because of how I feel. I can't even describe it, then all of a sudden I feel something, and she says something, and I think oh, you just saved me, and she goes, oh, I did too. (Lily)

Lily appears to be describing how she is able to function at an intuitive level, and pick up the emotional communication between them, despite their dialogue. The theme of Sarah as the strong rescuer has also impacted the way Lily presents in therapy. Sarah said Lily leaves her stronger part behind when she enters the therapy room, and she reflected on what part she played in that dynamic.

> She comes in here and presents to me this depressed self, or I can't cope self, yet she'll tell me stories about how well she copes outside, and what she does and how high functioning

> she is, and how she's you know, studying at a very high level and getting good marks and stuff, and yet that's not the side that's presented to me. (Sarah)

This dilemma has become part of their recent work together. Lily told Sarah that if she were to show her more independent and competent self, then Sarah might turn her back on her. Sarah reflected on how she had also "selected" to focus on what was in the room rather than the part that was left outside the door.

> There's a part of me that, goes along with that, that selects to, because that's the dynamic that grows between us, and it's only rarely do I say, what about the stronger part, or what about this? So I guess we've co-created a situation that organises our relationship around her helplessness as opposed to her resilience and strength. Um, and thinking about it now, um I leave that part of her out as well, to a certain extent. (Sarah)

The interview proved to be a catalyst for Sarah to reflect on how her personality might have played into the part that Lily presented in order for that *co-creation* to occur. Sarah's offered her thoughts spontaneously.

> It is fascinating, I'm just thinking of how has that influenced me or where does that come from in me (long pause)? I don't know if this makes any sense but I mean I've always been an incredibly strong independent person, I don't abhor dependence, but I attract people who, will lean on my strength, and maybe that's the part of me that comes out with her. Um, that feels very familiar to me, to be able to do that so I mean I don't, I don't know, I mean just talking to you now that could be part of what goes on for us as well. (Sarah)

Sarah was very open about her contributions to the relationship. The "incredibly strong" part of Sarah was there for Lily to "lean on" however the question that emerges is how might that part of Sarah unwittingly interfere or hold back Lily's quest for independence. Sarah has

been Lily's advocate and cheer squad, and as such has no conscious vested interest in holding her back. However Sarah's capacity for self-awareness allows her to reflect on her part in this dynamic. Sarah also commented on the sense of reciprocity within the relationship.

> Um, am I of use to this person, or are they of use to me in some way as a client, because I think that comes into it, um, and how we're organising our relationship to support that tension, and both get out of it what we need, and both give to each other what we need to give. (Sarah)

Sarah is certainly thinking about the aspect of how they fit together and use each other as a couple. The notion of the client being of use to the therapist and the therapist getting what she needs goes beyond the premise of the therapeutic relationship where the sole purpose is to serve the client, apart from the financial arrangement. However the personal impact of therapist and client on each other cannot be known in advance. It can only emerge from the work together. Sarah kept speculating out loud.

> Is there a transference? Is there a projection? Is there a, are we being organised in some way to respond? Or, and there's a part of us in that too, about how we do respond. So the tension is very strongly there um [pause], you know it's interesting, with her [Lily] um, [long pause], in Gestalt there's this notion of "I-It" and "I"-"Thou", and um, [long pause], "I"-"It" is when we look at somebody, or are in a relationship with somebody as a means to an end, um and that's very valid, and "I"-"Thou" is when we have a heart connection or there's a moment of meeting and there's that healing through meeting, and I ground myself very much in the "I"-"Thou" relational perspective, and I think that that plays into what we're talking about here. (Sarah)

Sarah's speculation about how she responds subjectively and the tension involved in Lily's healing had an intangible aspect to it. Lily has come a long way, but commented that she had

been “slipping back into the negative voices” lately and “back into no energy.” When this has happened in the past Lily said she would get “very overwhelmed” and feel it was “impossible to change.” She would then get very negative about therapy saying, “it’s easy just to forget where I’ve come and think nothing’s changed.” However going through the history of her relationship with Sarah during the interview process gave Lily a meta-view of her progress.

> She has given me, for me, it’s sitting there going, oh, she hasn’t given me anything, I’ve been going here four and a half years, what have I got out of it? Now I can see it, like there’s heaps, there’s heaps of little strategies and things that I just automatically use now, like I’ve just incorporated them without realising it you know. (Lily)

Lily gives Sarah due credit for some of the things she has managed to achieve as a result of therapy. “I wouldn’t have done half the things I’ve done, I’ve just finished my degree, I wouldn’t have done that.” Lily’s negative feelings about her lack of progress in therapy would no doubt have bled into the therapeutic relationship and neatly dovetailed with Sarah’s issue of whether she is “important” to Lily. What they will make of it I will never know, but it does seem relevant to the relationship dynamic and certainly was a subtle but prominent theme in the interviews.

> I know I am kind of, this keeps coming up for me at the moment, it’s really weird. Intellectually I know how important I am to her, I have a deep affection for her, but connecting those two in terms of my, that’s my affection for her, and intellectually I know from her, I’m important, um, can I feel that importance, do I embody that importance, probably not. (Sarah)

It is difficult to know whether Sarah might be picking up on some of Lily’s negativity at an unconscious level, or whether her feelings are discretely her own. Lily was very positive in her overt comments about Sarah. “Well she’s good! I call her super Sarah.” However I’m not sure if

Lily has voiced her positive feelings to Sarah as much as she has her angry reactions. The words "super Sarah," carry with them the ongoing theme of Sarah as the strong one and Lily's ongoing struggle to untangle and own that part of herself within the relationship.

Sarah thought that mutuality was also important in relation to care. She expressed that the point in therapy when "clients begin to realise that we care about them, um, and I think that's a really important point." Sarah felt it was important that therapists also remained open to being cared for, although "not in an intrusive way." Having, "an openness to caring and being cared for, I think that has to be a two way street." Sarah did not elaborate on how she opened herself to being cared for by Lily. It sounded vulnerable and counter to her persona as the strong one, but according to Sarah she and Lily have touched each other, metaphorically speaking, and had their vulnerable moments, and those moments of "heart connection" brought healing. Sarah has also learned from Lily how to appreciate the significance of providing human support through using herself in the relationship.

> Certainly with her um, (pause) yes, um, yes I think it's given me a much finer appreciation, of the importance, ah (pause) of supporting a client, being able to use the relationship, um if that makes sense. And opening myself up to what I would describe as the relational needs of the client. (Sarah)

Lily was able to utilise the relationship despite her "dissociative" and "silent" beginning with Sarah and Sarah feels there is a "very strong bond, a very strong connection" between them. "We trust each other implicitly to say whatever we want to each other." As a result of this relationship Sarah has allowed herself to acknowledge that she has had an important impact on Lily's life trajectory. "I can let it in, because I can actually see the fruits of the relationship."

> She's taught me a lot about the experience that I have around dissociation, when to sit back and when to just nudge forward, so there's a fine tuning I guess of how far in and out I

> move and I think the experience, it's a subjective phenomenon, it's not a, (pause) you know, I don't know that we can always say, I don't know that we can always pinpoint what our clients have done to change us, but I feel changed by her. (Sarah)

As I finish writing about Sarah and Lily's relationship I think of the word *desideratum*, "Something desired that is essential" (Merriam-Webster, 2003). It seems they have both desired and gained without either knowing what that desire was. Sarah's earlier words now ring true. "And both get out of it what we need, and both give to each other what we need to give."

Will and Eve: A Process of Awakening

The personal aspects of the therapeutic relationship between Will and his client Eve were manifested through what Eve named as "one of the most genuine relationships, I could think of myself as being involved in, you know." While the word genuine has become a generic term within the field of counselling, for Eve it had a specificity of meaning that did not apply to outside relationships.

> Everything is open, everything is on the table, you know, to be discussed. Whereas I think in relationships with other people, there's a certain amount that is on the table, but a certain amount that you do hold back, as well, so that's why I think it's, it's um, a very real relationship, genuine in that sense. (Eve)

Putting things "on the table to be looked at was very scary in some way" for Eve. It meant being exposed to another in a way that was not usual in other relationships and even at this point in the relationship was not easy. "I'm smiling right now because I'm thinking of some of the really difficult things that are just coming up and thinking oh, now I wondered whether I'll really tell Will about this." Despite saying "everything is on the table," personal disclosure and the consequent vulnerability it brings are still uncomfortable for Eve. For her this deeper exposure,

even in a trusting and genuine relationship has taken a long while. “We’re starting to explore at a much deeper level, you know, and it’s taken a long, well it’s taken two years.”

Will’s style played a part in the pace of therapy. “I’m overly patient, and overly kind of slow, and I probably have been too slow to challenge.” However Will has embarked on his own therapy, twice a week and credits his own therapeutic relationship with “definitely propelling me in the direction of more challenge earlier, but I still err on the side of caution, with that.” Will said his therapist “got sick of respecting my defences after a while” and what was making his therapy work was “being forced to acknowledge the painful feelings, and the angry feelings, she has just made me.” Will has therefore become more challenging towards Eve as result. This parallel experience of being in his own therapeutic relationship has given Will another string to his therapeutic bow, but he has not given up his cautiousness.

> With somebody like Eve, um, it’s sometimes got to be my, see my strength as a therapist is that I, I’m very, you know, like I do make it safe for people, and I’m very gentle and accepting, and I’m good at empathy, and they do feel that I understand them, and that I care. My weakness is that I don’t challenge enough, or that I let them go on for too long without challenging them, so that’s what I’m now trying to do is sort of be more aware of when, okay, look I could challenge a bit more here, and of course if it’s, you know, like if they just run away a million miles an hour, then I’m not going to see them destroyed. (Will)

Will was aware of his tendencies, and his default position remained a more empathic and accepting stance. Will was aware of the parallel tendency of Eve’s to avoid the work of therapy. “She’d say oh this is good, but then she was still just as stuck in that she wouldn’t really tackle the uncomfortable things.” Will’s “patience” and “lack of challenge” could also have been his own reluctance to enter painful territory; after all, his therapist had to “force” him. When revisiting his own therapy experience of being challenged, he stated:

> I hate it when she's doing it, like I really don't like it, and I get quite upset and several times I've, you know, like gone away and thought I don't want to go, I don't want to come back, you know, but I, I know I will come back. But I can see that those, those times have been the things that I've um learned the most from, as they have changed me in my other relationships. But, you know, just letting in painful things. (Will)

The parallel process with Will's own attitude and progress regarding his personal therapy is significant. Becoming unstuck himself has enabled him to assist Eve in a way that might otherwise have been avoided. Will is quite aware of his strengths and weaknesses in relation to the micro skill of challenging; however this highlights not only awareness of self but also the limitations of that awareness. In particular the more personal aspects of the therapist's self awareness, including the opportunity to reflect on the parts of the self that may continue to impede the work. This would normally occur in clinical supervision. For example Will said, "I let them go on for too long without challenging them." So this implies a theme for Will in all relationships not just with Eve. The question that emerges is, what is it about Will that "allows" this, and how does it map onto Eve's tendency "not to tackle the uncomfortable things." The work entered uncomfortable territory and Eve mentioned there were "some really profound, um, and difficult issues, that [she] was addressing" and the impact of talking about them.

> As we were talking and as we were dealing with these things, and, and, it was very interesting cause I think probably for many months, almost a year I would go in and we would talk, and I'd walk out and I'd have absolutely no memory, of what we had talked about. (Eve)

By linking the difficulty of the issues she was addressing with her lack of memories about the content of the sessions, Eve was confirming that her threshold for dealing with the issues had

been reached. She did not express what the difficulty was other than to say, “I’m so notorious for not remembering.” Will mentioned the phenomenon but did not give it a label.

> There was a long period of where it was very slow, and she would forget everything that we talked about as soon as she left the room, and that kind of stuff. A lot of times she’d come back and she couldn’t remember what we talked about, and she’d say, “I’ve been really angry during the week, but I don’t know what it’s about”... she’s a long way ahead from that now. (Will)

Eve mentioned that is was vitally important for her to get feedback from Will because of the fact she could not recall the content of their previous sessions. “Initially when we started he would um [sigh] hold those reactions I think to himself ... it was really hard sometimes to come back and think what did we talk about last week? I’ve have absolutely no idea.” Eve began to keep a diary of her conversations with Will to assist her memory, but even that proved difficult because despite good intentions that task was relegated to the background.

> I’m well not, I’m not that, it’s interesting [slight exclamation], it still doesn’t take um pre-eminence, ah, in among all the other things. I think that maybe it should take a bit more but it doesn’t take as much as I’d like it to sometimes. Maybe there’s some resistance there I don’t know [laughing]. (Eve)

I asked Eve what she made of the fact her diary had not been given pre-eminence?

> It’s interesting you know you asked that because immediately what comes to mind is I wondered whether I’m using these other things as a distraction [we both laugh]. You know, getting away from the nitty gritty of, you know? (Eve)

I did not want to intrude further here around why she needed the distraction as it seems obvious that it is linked to an avoidance of the profoundly difficulty issues she was facing. This

dynamic also interfered with Eve not being able to take in particular feedback or information that touched her deeply, or that she did not want to acknowledge. For a long while Will's input fell on deaf ears.

> Oh it's, it's been painful sometimes, it's been very difficult, and um, initially you know um, it would be things that I would be constantly rejecting no, no, no, no, no, no, no, no, [laughing]. I don't think so. No, and forgetting very rapidly. (Eve)

The overly slow style that Will mentioned somewhat self-critically was a good fit for Eve who described Will as "very sensitive and aware." She said Will would always "check out really carefully" if he thought he had pushed too far (quite unlike his own therapist). For Eve this gave the relationship a spiritual quality.

> It's not quite a confessional, but it has that sacred feeling about it. I think there is something very, very special about the relationship, and I think when you, I think I'm privileged that I've got Will, who I think, he's got an awareness of that sacredness in a way, even though he may not even say it in those words. (Eve)

Despite expressing he was "overly patient," Will had become impatient with the slow rate of change over the course of the relationship and had been seduced into problem solving.

> I'd given up trying to sort of influence her directly to tackle them, which is what I'd done before, I'd spent quite a lot of energy sort of saying, I really think, could you do this, you know, which of course you're not supposed to do [both of us laugh] and she'd say yes, it's a good idea, but she'd never do it. She won't do what she doesn't want to do really [laughing]. (Will)

The dynamic in this relationship had its pushes and pulls, but the reluctance to embrace change whilst also wanting it was part of the tension. Will's "overly patient and slow to

challenge "style has no doubt influenced the pace of therapy; however Eve showed that "pushing" was not going to work or stop her "deciding to do something quite different."

> What I've learned, I suppose, is that, like with her, and I've had my face rubbed in it, you can't make people change, and they change when they're good and ready, and now she is changing, so now all I have to do is stand on the sidelines and cheer. (Will)

Eve recounted a time when she held on to her position in the light of what she remembered as being close to advice giving by Will. Putting these two perspectives together it is clear that Will did not influence Eve from a position of power, in fact quite the opposite.

> I think at one stage I got to a point where I thought, um, don't tell me what to do, or don't tell me who I am, not quite as severe as that, but I came back thinking well, it was about advice. Um, and it wasn't really that advice was given, but it was an interesting situation, because I think I could turn back and say well you know, even though this is what um you're saying, I've, I'm deciding to do something quite different yeah, so you know. (Eve)

Will admitted he became "too invested" in his own agenda for Eve to change. He did not mention where this came from in his own life, but it is usually those issues closest to our own that get in the way.

> I've told her that I've gotten too invested in her relationship with her son for example, and really too invested in wanting her to change what she's doing, because it's so negative for him, as well as for her. And I've just said, I've just acknowledged that. I said look I've really pushed you on this haven't I, you know, on a number of occasions, and you know, it's very clear that you're not ready to do that, or you don't want to do that, um, and I think I've been unhelpful by pushing you. (Will)

It would only be a short leap to hypothesis that Will has in some way identified with Eve's son, or at least the position he is in. I asked Will: "If you were able to be totally uncensored with Eve and there were no consequences for it, what would you like to tell her that you [Will laughs loudly] have not, could not or would not at this stage?"

> I have to acknowledge that I've been quite, you know, irritated and, you know, impatient with you, and, come on Eve get a move on kind of thing. I suppose it'd be more, more of that kind of stuff, more like get a move on, you know, you're wasting your life. (Will)

Will's desire for Eve to "get a move on" had bled through into the relationship regardless when he began "pushing" fruitlessly. Withholding judgement and desire does not speak to the concept of reciprocity as an equal two-way process, but more a way of relating that is very giving of the self, a capacity that requires maturity and awareness to master. The reciprocity according to Will was not so much about expecting change but the fact that he did not get anything out of a session himself if a client "chatters on and spins their wheels". His attitude was as long as there had been a "meaningful discussion" he felt satisfied.

> I mean I get something out of most sessions with most people simply because I enjoy them and I feel like if we've if we've had a meaningful discussion, then I've benefited from that too. I mean I do this, because I enjoy talking with people about things that matter rather than, chit-chat. So if we have *that* [italics added] kind of talk, I'm happy. If we have the kind of session where the client chatters on and spins their wheels and really just goes over stuff they've been over a million times, then I don't feel very satisfied, um and I don't feel I've got anything out of it then, but with Eve, it's sort of half way between those two extremes. (Will)

The length of time it took to have a "meaningful discussion" and for change to take effect was a dominant theme. Eve presented in therapy with a work issue, and as with most presenting

issues it was not the core problem. However the internal conflict it generated propelled her into therapy. Even then it has taken quite a while for Eve to take a step to repair that work relationship.

> The initial work problem that took me there was um a conflict situation where the other person came back and apologised, and I could not um, I could not find myself able to um, react to that, or respond to that person, um in a way that healed that breech. I was hanging on to it, and hating the fact that I was hanging on to it and not liking the way that um, I don't know lack of generosity or something? I don't know what it was, but um just appalled with myself really, yeah, so I guess wanting to do it differently and thinking about it, and imagining doing all of that, and not being able to take that step. Although it's now taken me probably 18 months to actually take that step finally, you know. (Eve)

Eve reflected on the long time it took for her to "finally take that step." She put it down to the fact that she had gone along to therapy with the idea of "problems to be solved," whereas the process of therapy had changed her focus.

> Now I'm thinking more about soul, and thinking what is the purpose of these things, and, and um, growing with it I guess more in that sense of soulfulness rather than you know, let's eradicate the problem. (Eve)

Eve has moved towards a spiritual or existential way of being that she sees as a "transformational process." Part of the transformation has been accepting that Will cares about her. Will described a significant session about a year prior to the interview where he purposely told Eve that he cared about her.

> There was a session which stands out in my memory where I actually did say I do care about you. I wanted to challenge her because I thought she knew that I did, but whenever I

> would make an empathic statement or something it would, she would kind of dismiss, this is the wrong word, but um it was kind of like it didn't get really acknowledged, or it didn't count, you know. That I would care about her didn't count, or something. (Will)

When Eve talked about the impact of knowing that Will cared about her she found it hard to believe. "It's sometimes shocking and sometimes wonderful. Like *really*! Is that, *really*? And it's also, *really*? [italics added]." Will said that many sessions later Eve referred back to that particular session as an important moment for her. He was unable to recall the finer details from a year back, but said that things subtly changed after that session. In chapter 4 Eve used the metaphor of snow white eating the poison apple to describe her "process of awakening" and coming back to life within the therapeutic relationship. So I asked Will if he had a metaphor to describe his relationship with Eve. He paused for a very long time and offered the following.

> The pictures that came, like in free association, were quite, um, you know, kind of much more negative and, um, and dramatic, and intense, and dreamlike than I would have guessed. That's just what came spontaneously, and I thought why am I thinking of a fat spider in a web? My God! Is that how I see her subconsciously or something? Of course she's fat, you know ... I'm sorry, I'm using the politically incorrect term. But, it doesn't stop me liking her or anything. I'm emaciated and I stoop, so you know, I feel like everybody's got the right to say that to me and I've got the right to say they're fat [we both laugh]. (Will)

Will was genuinely shocked at his spontaneous metaphor, but was unclear where it had come from or what it meant. A short time later when Will was commenting on the external changes in Eve's life he had an insight into where the picture of a spider might fit in the scheme of things.

> In the last year there has been a lot of change, starting with external changes in her life, and I was quite cynical about that, and I thought oh she's one of the people who sits and waits, and maybe this is where the spider comes from, who sits and waits for things to change around her, like for other people to change, or for circumstances to improve, and then she gets new energy from that stuff. (Will)

These uncensored reactions give an insight into Wills attitude to Eve's previous attempts at change based on his insider evidence. If, as Modell (2009) suggests, metaphors are an embodied form of cognition that have a privileged relationship to feelings, I could speculate that Will's image of the spider may have embodied his underlying feelings of apprehension or fear at the possibility of being captured in a cobweb that meant he might end up as Eve's next source of new energy. I could also speculate that he was picking up feelings from Eve about her own waiting energy. While Will liked Eve, there was no sense that he reciprocated Eve's possible attraction. Whatever the symbolism meant, it was intriguing. Will brought up the new relationship in Eve's life where her "energy" has been focussed and is assisting to generate change in her outside life.

> Now there's this man that she's interested in which again has sort of liberated this ginormous amount of energy and stuff [he laughs]. The power of sex even at the age of 60 is quite, she's about the same age as me too that's another thing, it's quite amazing [chuckles], but I'm now sure that there's a self-generating change process happening inside of her. It isn't dependent just on things that are changing outside. She is relating differently and she's, she's reported changes in a number of aspects of her life, you know, like with her friends and work and a lot of areas where she was very, very stuck. She's still stuck in some areas, particularly in her close family ones, but I believe now, that change will eventually happen even there too. (Will)

Will credits Eve for helping him learn about and gain a different perspective on the particular issue that was at the core of their work together. While the issue was never stated, an educated guess from the content would be some form of sexual abuse.

> I haven't seen somebody, um, now this is a bit delicate, but let's say, that particular issue, which I'm sure you can guess anyway, I haven't seen an adult woman, who, on one level, hadn't been that affected by what had happened in her childhood. But at another level had been profoundly affected by what had happened. And I hadn't ever had the opportunity to see somebody work through it over such a long period of time. Um so that's kind of changed my understanding of that issue. (Will)

Will is a very experienced therapist, lecturer and author he is widely read and his theoretical knowledge is extensive. Therefore his knowledge of Eve's core issue would have been very sound. However the fit between Will's existing knowledge and what he learned from Eve's experience was not parsimonious. Will was open to having his existing knowledge challenged and influenced which shows awareness on his part, and also highlights the limitations and possible dangers of mapping existing models or theories onto a person. Eve commented that while she had originally presented with a work issue "it was much deeper than that and had been very, very long standing." The fallout of this issue had a major impact on all Eve's relationships. She was thoughtful and realistic about what remains "to be looked at," but the relationship with Will has enabled her to feel more hopeful even though some things have not changed.

> I'm not saying that life has suddenly become perfect and all the problems are solved. I can see that there are many, many, many things that um, you know, still need to be looked at and addressed. But it's happening now within a, hmm, a context that's not really despairing, yes. (Eve)

The emotional lift and ability to cope differently with her life situation has had as much if not more impact as the changes she has managed to put in place. Only recently Eve had an "ah-ha moment" where she realised "this is what it's about" which fits with Wills explanation of Eve's self generating internal change now starting to take place. Eve credits her relationship with Will as the main force that motivates her towards self-knowledge. "Being in this therapeutic relationship is the motivator to, to push myself, to know myself really ... we can deceive others, and we're, we're best at deceiving ourselves." The unfolding of insight and awareness was an evolving process rather than an event. Eve said, "I'm learning about it, you know, as we go along." Will's respect for the fact that Eve may not want the same outcome from therapy as he did meant that that Eve was free to drop "the good public mask and say the most outrageous things. The invitation is constantly there to be oneself, to be yourself to actually react in a really genuine way." Will said he encouraged Eve to be honest with him in their here and now interactions. He wanted her to be able to use their relationship as "a source of information" in her life.

> I do address our relationship in the room and I try to challenge her to be honest about her reactions to things I've said ... there are going to be parallels between what, how she is with me and how she is with other people. (Will)

While the relationship was foreground, Eve liked the fact that regardless of Will's reactions, "it doesn't require any approval." She thought "there was a selfish thing about the therapeutic relationship ... I think that I'm so invested and so self-absorbed I don't care." Eve viewed Will very positively, using a string of qualities she saw in him, but she was conscious that the relationship was asymmetrical and that was acceptable because it was a professional relationship.

> In a very selfish way really, as a professional first of all I guess as a [long pause, loud sigh], as um a person with humour, uh with insight, with challenge, that he you know puts out that challenge. Ah, as a resource, as an ear, [pause] as safety, he's safe, but I, I'm very aware of um, yeah. It's a horrible thing to say it's a using, it's using, ah you know because he is a resource, because he's a professional um, yes, so um, yes that wonderful thing of you know you can say anything, and it's, it's just you know, grist for the mill, something, something to sort of explore. It sounds terrible, it sounds as though I'm experiencing him as a dumping ground [laughs loudly and heartily]. But it's more than that. (Eve)

Eve reflected further on the theme of her using Will. She liked the fact that she was able to influence Will, it was all about her needs. "It actually comes out of myself, out of my needs, out of my desires or whatever it is, and I shape this other person from myself and, and it's a reciprocal thing." Will said there was no pressing life issue for him that was tapped into while working with Eve; however he has had moments of panic with other clients wondering how to help with an issue he has been unable to resolve himself. The interesting parallel was with Wills personal therapy.

Despite having a "stable" and "charmed life," Will entered his own therapy twice a week for the last three years. He took it very seriously and was motivated to understand himself more fully. "You know, why I am the way I am, and why do I keep doing the same type of things" [both chuckling]. He says it has been fantastic, but at the same time says his therapist who is an analyst is "unbelievably arrogant. Oh, they're (analysts) so, oh! They're so sure that what they know is right, and there is no other way." Will's gentle and respectful style seems diametrically opposed to his own therapist and he says his own therapy has helped him learn "how to do it." Meaning therapy in general not only challenge. It has also made him more aware of what to pay attention to and what to leave alone with particular clients, not just Eve. One of the things Eve was grateful for was that her relationship with Will was "not rigid, dogmatic, and inflexible."

She maintained that the relationship was more important than adhering to theory. “Sometimes you know even what is said is not that important as the relationship that you develop with, with the person that you’re working with.” Eve’s transformation has not finished however the personal aspects of this relationship have played a significant part, in particular the fact that she has been able to influence Will to work with her in a way that suited her pace, personality, “desires” and “needs.”

Thomas and Bella: The Healing Power of Love

Thomas and Bella’s relationship as described in the previous chapter began with a series of double booked appointments described by Thomas as “stuff ups.” They survived the bumpy start and have been in a therapeutic relationship for six years. I asked Thomas how he used the relationship in his work with Bella and he found the question difficult to answer. After a long deliberation he chose to talk about how Bella had “very readily idealised” him, and how he had initially “left that alone,” because he thought it was important to Bella. Through leaving the idealisation “in the background” Thomas said he “discovered a client who had not had good experiences with male counsellors, who she might idealise, and might feel safe with, and who might acknowledge her inner world, and reflect on that inner world with her.” He was conscious of his own reaction to being recipient of Bella’s idealisation, especially as he had surpassed her experiences with previous counsellors.

> I left that where it was. Not because it makes me feel terrific, although I have to watch for that, um I think one has to be careful of that … which is another thing that is kind of in the background, of why I choose Bella, it kind of levels us out, we’re two colleagues in the counselling world helping someone do some research, that feels important to me to level it out. (Thomas)

Idealisation was a salient dynamic in the relationship and he had worked with it in a particular way with Bella. Thomas was aware that, "some models would not even pitch at that as being something to use, but ah, we have actually." He thought idealisation had its place, although did not offer what it meant specifically within his relationship with Bella except to say it was important they were able to "bring it down to something they could talk about, and reflect on. To become more of an ordinary bloke which is what I am of course, um, yeah, no I'm not compelled to try and completely undo it." Thomas thought the idealising contributed to Bella feeling safe and taken care of by him. He was also mindful especially in the early days of the fine line in making sure Bella did not merely take in what he said rather than decide if it fitted for her. Bella did not name the idealisation, however it was evident she thought highly of Thomas. Another reason Thomas chose Bella for the study was because she was training in counselling, and therefore he thought she would have an idea of what the study was about without "stretching or intruding" on the relationship. At this point in time they are discussing finishing the therapy, and they agreed that taking part in this research might give them an "interesting springboard" towards that ending. When remembering back to the beginning of therapy Bella said she "felt very good about going back, um, and there was an intuitive sense of this, this will be okay." Despite the good feeling she had about Thomas, it took "eight months" before Bella was able to really "experience that safety" and could risk truly "exposing" herself.

> I started off with little things, and then as time went on, exposed things that I would find harder to tell someone about myself, and um having that acceptance sort of um, for the little things, I could become braver and yeah, divulge other things, yeah. (Bella)

Thomas provided the acceptance and security for Bella to "become braver" and incrementally allow him to see who she truly was. Having "that kind of relationship" was "really important" to her hence finding the right therapist was imperative. However if Bella did idealise Thomas, it did not make the feeling of safety happen any faster. Because of the counselling

language she was using I deducted that her counselling training also influenced her attitude towards what was needed. However the familiarity with the jargon also possibly prevented new ways of expressing certain phenomena.

> It's been really important for me to um, have that kind of relationship with someone who ah, listens very carefully and takes on what I say, and, is very accepting, I think the acceptance yeah, probably is one of the, one of the biggest things, so no matter what part of me that Thomas sees there's that unconditional regard, that acceptance, that feeling of safety that I can, I can expose myself and it will, things will still be okay between us. (Bella)

One of the most significant influences for change within this relationship was humour. Bella said that Thomas had a "fantastic sense of humour" and when she might have an "inappropriate way of perceiving something" Thomas would use humour to "open [her] eyes to a different way of looking at things."

> His humour's actually a really big one, um because it's really helped, yeah, helped me to see things in a different light, and put things in a different perspective, and to lighten up a little bit, um because I can be very, very serious and take myself far too seriously [laughing], and um, and with great sensitivity, he's able to um, make a little joke about things [laughs gently]. (Bella)

Thomas also named humour when I asked for his thoughts on how Bella viewed him. "She'd include, I imagine she might speak of me as being kind or caring. I don't know, I expect that she might say funny, because I use humour a lot." The humour has served a few purposes. Bella said, "I think it's been a nice bonding part of our relationship too cause we have little 'in' jokes, they're significant things too." Their "in jokes" also helped Bella to relate to Thomas in an exclusive way that she felt was special and unique to their relationship. "Whereas anyone else,

well I wouldn't with anyone else, but it wouldn't mean a thing to anybody else." There have been times when the humour has backfired, but according to Bella, when this happens Thomas picks it up "pretty quickly. And I'm much more able [now] to let him know what's happening between us." The act of freedom involved in expressing her opinion or reaction to Thomas and having him respond to her concerns has been liberating.

> It's very freeing, it's really [pause], it's a very new experience for me, because I haven't really, well there haven't been many relationships, particularly with men that I felt safe enough to say, you know, that that was hurtful or whatever. (Bella)

Thomas used those moments of disjunction and rupture in the relationship to be transparent rather than an opportunity to turn Bella's comments back onto her as a form of pathology or transference.

> He'll be um, upset if I'm feeling, I get offended or whatever by something that he said, he's very, I mean he'll apologise, um, you know make it very clear that it wasn't his intention at all, and usually explain where his comment was coming from. (Bella)

Working in the 'here and now' of the relationship worked well for Bella. She found Thomas's acceptance of her point of view and his apology quite "incredible." She did not grow up in a family where her concerns were heard, let alone received an apology. Thomas and Bella would continue on to discuss what the relationship rupture meant from their different perspectives. These types of discussions opened up the real possibility in Bella's mind that Thomas actually cared about her and was "committed to see the relationship through until it finishes." Although it took time to convince Bella, Thomas said he would challenge Bella to acknowledge that she actually knew at some level that she mattered to him.

> I'll say I think you've got a hunch as to whether I give a damn or not, and Bella realises well yeah, of course I pick that up. Because you're not just doing it for the money, you know, when you get that speech, you're paid to listen to me, you know that one. (Thomas)

Thomas was adamant that the caring aspects of their relationship were picked up at an intuitive level and he was convinced this process worked both ways. "I think she really likes me, I think she's very, very fond of me, I know that. She knows I'm fond of her, and if she thinks about it, she'd realise that she knows it." Although Thomas thought that Bella might not allow his feelings of care to register with her if they were filtered through the lens of her past hurts.

> I mean I'm intrigued by the fact that we spend an awful lot of time not listening to all we intuitively know, particularly if we've had a lot of hurt we may not listen to the messages. But Bella would know that she matters to me, without necessarily asking me, or me saying it verbally. (Thomas)

Thomas thought it was important to invite Bella to name what she already knew without him telling her. However Bella remembers something Thomas told her that has stuck in her mind and proven to be true.

> I remember him saying to me probably in the early days, you know, you can pay me to listen and respond or whatever, but you, you know, you can't, you can't buy my caring for you, or go the extra, and I've always remembered that, and I guess I've always felt that it is. (Bella)

Apropos of this when I asked Thomas what he thought had been most healing about his personhood in this relationship, he answered very quickly, "that I give a damn."

> That I do genuinely, I am genuinely very, very fond of her, um, very fond of her, without the transgression of any ethical boundaries, but you know, I care about her, and she picks

> that up ... the fact that I have contradicted her expectations, which is sooner or later, I will lose interest in her and I'll turn away. (Thomas)

Thomas's commitment meant that at times he has "determinedly" persevered through some very difficult sessions when Bella was very depressed and he became very bored with her. There were times when Bella was "very, very flat for a very, very long period of time," and Thomas found staying with her very hard going, "like pulling teeth."

> Sitting with, and through, that flatness was hard work. She's expanded my repertoire definitely, definitely, and then going back a notch to what we were talking about earlier on, she has greatly helped me expand what I know myself to be able to sit through. (Thomas)

Thomas had a "determination to wait patiently" and credits Bella with assisting him to work outside his theoretical comfort zone and try some new techniques. As a gestalt and psychodynamic therapist he was unfamiliar with cognitive behaviour therapy, and was not comfortable working in that model. "She's helped me actually become more comfortable with that is the truth of it." Bella was aware that she had some influence on the way Thomas worked. In particular she did not want him to try any gestalt techniques on her.

> I was quite shocked when I realised he was trained in Gestalt ... I remember the first time I saw him I said I'm not doing empty chair [laughing], empty chair techniques, I've done that with someone else, I'm just not doing it, but he was really good about it [laughing], we haven't ever done it. (Bella)

Bella also felt that she had influenced Thomas by, "widening his understanding on issues of being single and not having children." However she thought her main influence was intrapersonal and related to the way Thomas responded to her by taking her concerns seriously, and his sensitivity to her moods and "fine tuning" of his approach when she was upset. Bella did

not appear to have a sense of the depth of Thomas's difficulties in working with her through her depression, either personally or theoretically. Her perspective on Thomas's view of her was very positive and complimentary, indicating that Thomas has emphasised those aspects of her in their relationship.

> I think he'd say I'm a fairly happy soul, who, ah, sometimes struggles with things, or um [long pause]. I think he, I think he'd view me as pretty self aware, um, yeah and an empathic person [pause], and someone who is willing to put in effort um, you know to work through issues and to look at things within myself [long pause]. Ah what else [long pause]? I think he, I think he would view me as, as a um, ah what's the word, as a person who is ah [sighing] okay, or rounded or, whereas I don't, whereas I haven't viewed myself like that, which is nice [laughs gently], I don't think he thinks there's anything terribly wrong, wrong with me [both laughing]. (Bella)

The message she received was that she was doing very well and was okay the way she was. There was the hint of acknowledging the difficulty of the journey when I asked Bella how they managed when there was a rupture in the relationship. She said that early in the relationship if she was upset or angry she would turn up but not talk to him, "give him the cold shoulder [laughing loudly and slowly]. I'd eventually be able to tell him what was wrong but the anger would've gone by then, so just, it'd just be a discussion." Bella has played it safe and not risked the perceived rejection that might have followed telling him off. Her anger was presented in a passive way in the relationship and her laughter and delight in talking about "the cold shoulder" was obvious in the interview.

> My memories are of him trying to, of him saying things like I've really upset you, and I might say yes, but I wouldn't tell him why [laughing very loudly], I'd just be completely

> uncooperative [laughing loudly] he has earned his money [laughs loudly] at different times, yeah, other times I'm really easy. (Bella)

Bella elaborated that when she was hurt or angry in the past, she would "swallow it, go to despair and withdraw." This led to her cutting people off and she has lost friends over it. This was also the way her family dealt with conflict, "everyone being in a huff and not speaking." Therefore in her mind it was a great achievement to "turn up" and eventually be able to talk about it. Change has been slow, because Bella continues to start off with the same pattern but for now she is happy that she does not let "things slide or go on and on" and then implode. Working on her expression of emotions, especially anger has been a big part of the relationship. She has learnt that it is "okay to be angry" and is able to "acknowledge when she is angry" and that there are situations where she has a "right to be angry and to express it." When I asked if Thomas had encouraged that within the relationship, she laughed very loudly and said, "big time, big time ... he'd love me to really tell him off [laughing], but yeah, I've never been really angry with him, and he's [laughing loudly] he's waiting, he's waiting for that." I ask if that is ever likely to happen and she replied, "well probably not." Because of the protracted amount of time and difficulty getting Bella to even get in touch with her anger let alone express it, Thomas wondered out loud about his contribution to that dynamic.

> We have not had terrible ruptures, and perversely I often wish we had, and perversely I've invited her to be angry with me so many times, but she just flat out refuses, because that's part of who she is, she, she's not someone, well, she does increasingly get in touch with her anger but maintains that it's never really been much around myself, which I find hard to understand. (Thomas)

However Thomas has focussed on and worked hard at trying to get Bella to express anger and it is usually him that notices any small change in how Bella feels or manages her reactions.

So Thomas has really pushed the agenda along despite Bella remaining "uncomfortable with it." Yet Thomas talks about it as if it they are in it together.

> We both think that, you know, um, it's kind of exciting that we discover her getting more and more frustrated and irritated by people in her world. She doesn't always see it, I'm usually the first one to get excited by that, I think oh, this is great, that person is pissing you off, fantastic, she's looking very uncomfortable with it ... I question myself on that, I wonder if somehow I've helped in constructing a relationship that doesn't leave room for that, but gee, I've, I've put up the invites. (Thomas)

While expressing anger might have been an important learning for Bella, it remained Thomas's agenda and was difficult to shift, as was Bella's despair. Despite feeling that his relationship with Bella had expanded his capacity for sitting with despair, Thomas questioned whether he was being of use to Bella "because it went on for so long" and appeared intractable.

> Maybe this all adds up to me being a useless therapist ... I have questioned myself, usefully and a few times a little more harshly about, well am I, am I actually being of use to this client ... and I suppose in truth I still do wrestle with that ... sometimes I wish I could go back six years and start again with what I've learnt by being with her. But it doesn't work like that. (Thomas)

Thomas recalled "a stand out moment" last year when Bella went "into a slump" and became "very, very low" again. Thomas found himself in the same "useless" space full of self-chastising questions.

> Have you been useful to this woman, has there been change, how far have we come, I sat through the silence, quite pained myself with those questions, and, felt like I offered very, very, very little in that session and came away feeling pretty flat myself. (Thomas)

Yet when Bella returned the next week she thanked Thomas for the previous session, "for just being with her," and said she had been feeling better ever since. In reflection Thomas stated that he thought that's how healing happened, through "meeting." He had been reading Buber's philosophy about "healing through meeting," and it was fresh in his mind as he related it to the story of that session. The session had affected him deeply, not only his flat mood but his feelings of incompetency. However in hindsight his understanding of what he needed to do in that session was quite different. "To meet all of her, or as much as she brought, including her darkness, her fears and her misgivings and staying there, and not being repulsed by that, or turned away by it." Bella thought the most healing thing about Thomas was the fact that "he actually sees it [her concerns] as being very important, he listens and really goes deeper to make sure that he really has understood." Bella has always, "put other people first or been worried about other people's reactions," before her own, whereas she now has more of a sense of her own importance. But her attitude runs deeper than mere self-acceptance.

> A much stronger sense um of I'm okay, um, yeah, I think that, having been accepted by someone else, warts and all, who have stuck and stuck and stuck with me, has um, helped me to develop self-acceptance um [long pause], yeah, and that um [very long pause] that's probably, that's, that's the most significant thing um, and [very long pause] yeah I mean, and also I'd say yeah, a sense um not just I'm okay. I'm lovable. Because I'm, I do know that Thomas loves me in that therapeutic way [laughs], and that's um, that's, that's been um yeah, really powerful for me. (Bella)

The qualities of the relationship highlighted by Bella are not necessarily new, acceptance (both self acceptance and therapist acceptance), trust, care and commitment. In Bella's words to have someone who "stuck and stuck and stuck" with her was a "powerful" experience in itself. However the language used to describe the qualities expressed by Bella also describes the concepts that under-pin secure attachment and foster the growth of love. When I asked Thomas

what was it about him that enabled him to form a deep relationship with a client, his answer came without hesitation.

> That I care, that I'm interested. I mean there's a feeling and a cerebral bit to that, um, that I care very much and I get very, very, very interested, um, ah [long pause], and a sense of commitment that comes with that, that I think is picked up on, um [pause], do you know, I think it is almost that simple, to be honest with you. You know we can, I don't feel, I certainly don't feel drawn to leaping off into theory, or models ... we've looked at the relationship all the way through, that's my interest, what she expects to see, how she expects to see me respond and how I did respond, um so, I am for sharing what's in the therapist's mind, for a number of reasons I think that's important and useful. (Thomas)

Thomas worked with the relationship as foreground and he was very passionate about how harmful he thought it was to "foster a fantasy." He felt strongly that withholding in order to be a "blank sheet" for the clients projections was "absolute rubbish." He started to give his theoretically sanitised version and then changed his mind.

> Kleinian's wouldn't give away a thing, but I think that's, I'm censoring myself. I think that's abusive, to let someone roll around with some fantasy idea about what's going on, when all along you think no, no, no, if I tell you what's going on for me, you'll make perfect sense of what's going on. I think it's just ridiculous to leave them hanging with a story that makes no sense. Um, there's no reality checking or theory of mind or all that stuff, how can you foster that? … this idea that I can be a blank sheet and you can project whatever on to me. It's absolute rubbish. I'm impacting you all the time and you're reading things from me all the time, and I'm just further confusing you if I don't give you any reality checks when you think that you're picking up one thing, and actually, no it's this

> thing over here, or you're absolutely right, I am depressed today or tired today, or whatever it is. It's real life. (Thomas)

Bella did not comment specifically on Thomas's level of self-disclosure. They have lived through several significant events in their relationship, Thomas's chronic fatigue and his wife's death. Grief and depression were a dominant theme both within and outside of the relationship. However despite his passionate stance on the inter-subjective impact one person on another, Thomas did not see any overlap between Bella's long period of flatness and his own life difficulties outside the therapy room. "Was there an overlap? Well yes there was overlap, ah, do I see them as being connected? All I can say is not in my awareness. I don't know. Not that I'm aware of." Thomas had a belief that he could "switch off" and "be totally there for someone else." He maintained there must be "some kind of cut off." Therefore he thought the events in his life helped him to empathise without contaminating Bella's issues with his own. "But that [Bella's issues] have skirted very close to my world, ah in a way that I think has not interfered, I think it has helped me understand sort of what she's going through, I think, I do think." However Bella commented that sometimes the personal aspects of Thomas's life would leak into their work together. "It's leaked out and he's very shocked if I mention it to him [she laughs loud and slow], yeah." She did not elaborate on the specifics, however it shows that clients notice a lot more than therapists realise. Given this it is surprising that Thomas would be shocked considering his belief that he is impacting on clients all the time and they are constantly reading him. Despite this contradiction, Bella expanded her previous comment to confirm that it was Thomas's ability to relate to her that was the healing force.

> The relationship, for me that's been the really healing thing, that relationship, um, I mean I can see his skills, I think he's very skilled, and very quick, very quick thinking and very able to draw things together to help me to see things in a bigger picture that I wouldn't draw together. So all those things are fantastic and have been really important, yet none of

> that would have, for me it wouldn't have happened or wouldn't have meant anything if that relationship, if I didn't feel safe with him and feel accepted and um, feel that I could relate to him easily, the skills wouldn't have meant anything. (Bella)

It is difficult to tease out the skills from the person using them, but the outcome for Bella's life has been profound. As a visitor to this relationship it is evident there has been change, but the changes have been slow and incremental, and not particularly significant in terms of behavioural shifts in the outside world; especially considering this has been a six-year relationship. But despite the small external changes Bella is satisfied that it is time to finish because she feels transformed. "It has been a life changing experience for me, and a relationship that I really treasure and that I do hold very close to me." Bella and Thomas have not mentioned working with transference; their process was more about working on what was happening in their relationship in the present. Bella had some early relational deficits to revisit however she did not relate to the idea of Thomas playing a re-parenting role as is often theorised in psychotherapy. "I've experienced things with him that I haven't experienced perhaps with my parents, but no I would describe it more like a peer relationship." The care she has received from the relationship with Thomas has been both life changing and healing. Bella may not have expressed anger the way Thomas preferred but her internal landscape has been transformed and maybe the behavioural expression is less important. The most telling thing was when I asked Bella what she would most like to tell Thomas on finishing therapy.

> Oh, oh, oh, [laughs long and loud] I'd tell him how much I love him, and how important, yeah how important the relationship has been, and how it's been such a healing experience. There are times when I look back especially at the beginning and I think I don't know what I would've done, because I was very, I was yeah, very down when I first went to him and, um yeah, and I'd think oh my goodness, I'm so lucky that, you know that I found him, and

> that it was a good match, I don't know what I would've done without him, yeah, he's been, yeah just been so important, yeah, so, so important to me. (Bella)

The therapeutic relationship between Thomas and Bella relied on what Bella called "acceptance" and "safety" as its underpinning virtues. There was a solid history of reliable care, support, interest and challenge. However the prevailing outcome was that Bella was healed by the force of human love, and she not only learned to love, she learned she was "loveable." Love may not fit into the current wave of scientific paradigms or mental health care plans, but it was certainly the result of this therapeutic relationship.

Anne and Chloe: An Intuitive Space; Like Particles Connected

Anne and her client Chloe have been in a therapeutic relationship for two years. As discussed in chapter 4 Chloe's experience of previous therapy relationships had been very negative and unsatisfactory. It was extremely important to Chloe to have a relationship where she did not feel "under pressure," or forced to "accept" the therapist's opinion, which had been the case with her past therapists. According to Chloe, Anne "approaches subjects in a way that is not abrupt and it's not patronising, it's literally an open invitation." However when asked how she would have let Anne know in the beginning if she had not felt understood, Chloe laughed softly and said, "I probably would have just never come back." But that did not happen.

> Yeah, you don't feel like your um there because you have a problem to be rectified, your just like having a discussion, so it kind of takes that pressure off, and that's a good self feeling, because then I don't feel like I have mental problems, and it takes all that edge off it , which means you don't feel quite as um under pressure should I say, like they're the experienced person, they know what they're talking about, and I've just got to accept what they say. Because it's not like that, she knows that, and she encourages you. (Chloe)

Anne's more egalitarian and nurturing approach engaged Chloe. Chloe commented frequently throughout the interview on her previous negative experiences of therapy. They were still alive in her mind. Chloe juxtaposed Anne against her previous therapists as the epitome of all that is good about therapy.

> It's also the way she says it, it's not um undermining, it's not, it's literally just there as a question to be thought provoking, it's not for any other reason, whereas some therapists are [pause] I'm not going to say the word. (Chloe)

I invited Chloe to be uncensored and she said, "well excuse the French but they're mind fuckers." Chloe was astute at picking up on any underlying agenda; however she was able to accept "thought provoking" questions from Anne. She seemed to know they were "not for any other reason" than to help her. There was no sense of a hidden agenda, or the force-feeding of expert opinions. According to Chloe "the way in which Anne does it [therapy], it's just a discussion. The tone of her voice is settling, and um her demeanour." Anne was also conscious of Chloe's tendency when upset to "become volatile and lash out." However there were no reports of Chloe lashing out at Anne. According to Chloe, Anne had a different style of assisting Chloe to explore her life difficulties that Chloe viewed in a positive light.

> It's actually good for me cause it makes me face how I feel, whereas what I would normally do is go and punch a door in, or just curl up in bed, and either way is not really actually dealing with it. But Anne, she encourages me to face it, because obviously that's the next step, and that's what I needed. (Chloe)

It is salient that Chloe was able to identify and trust what she really needed when it was delivered in the right context and by the right person. For Anne "it was about going with who she [Chloe] was, and how vulnerable she is." Anne's own personal history of trauma mapped onto Chloe's in a way that enabled Anne to see Chloe through different eyes than her previous

therapists and therefore provide the necessary relationship for Chloe to utilise therapy. Anne thought her ability to connect with Chloe was assisted by the similarity to her own personal history plus her subjective conviction of what was needed.

> It's the relationship stuff, and also again I think I connect, I'm able to identify most of the feelings a lot of the time, particularly in this kind of situation with past trauma. Now that's probably my past stuff as well, that I've done a lot of work around. So I've often pulled on my experiences and thought, this is the hard bit, and I *know* [italics added] that this is just what she's got to go through, I don't always do that. (Anne)

Anne put her responsiveness down to working on an "intuitive level." This inner intuition was based on Anne's personal experiences of trauma, as well as her own past therapy relationship. In this context Anne was not drawing on a particular theory, or participating as an objective observer. She was both invested and involved. Apart from mentioning the concept of inner child work and attachment, which had been a focus in her own therapy, Anne did not have a particular theoretical discipline or school that informed her work with Chloe.

> Do you know what, I'll come out of a session and not have a clue what I have done, except I'll know the general stuff and some things come back to mind, but sometimes in an intense session I'm actually working on such an intuitive level that afterwards it is very difficult to remember the detail. I'm actually working on a very intuitive level a lot of the time. With this kind of trauma I'm into that um very intuitive space if you like, connected space whatever, quantum mechanics stuff like particles connected. (Anne)

Anne still had to understand Chloe's experience as unique and different to hers, but the overlap with her own past enabled Anne to feel for Chloe in a way that no other therapist had managed to attain. This kind of *feeling for* went beyond mere empathy to a deeper understanding of Chloe's human struggle. Working in an "intuitive space" is a concept that resonates with

theoretical and anecdotal evidence (Schore, 2003; Siegal, 2009), who have written in the last decade on the importance of right brain connections and intuition and emotion regulation within therapy. This inner wisdom is a pan-theoretical capacity that springs from being emotionally aware. Anne put her ability to work this way down to having lived and worked through her own past trauma and the relationship she experienced with her therapist."I'm forever grateful to my therapist all those years ago who just held the space you know, and it was so important to me just witnessing the moment, just holding that space."

This therapeutic relationship had a reciprocity that resonated and touched the personal lives of both therapist and client in a way that has enhanced the outcome for Chloe. Anne has "pulled on" her own experience of "feeling revolting" (and I imagine, like Chloe, behaving in a way that pushed people away from her), to be able to support Chloe and understand her. It was Anne's personal experience of not being rejected by her own therapist that was the main catalyst for helping her know how to respond to Chloe. The significance of Anne's capacity to understand Chloe is evident in Chloe's comparison between Anne and her previous therapists. Chloe was viewed as a lost cause; someone who had been labelled, diagnosed and discarded as contraindicated for therapy according to previous professionals. To take on someone that the majority of therapists would be advised to avoid (for both clinical and practice management reasons) is an act of kindness and compassion, and one that has made all the difference to Chloe's life. Chloe still has "bad days and low spots," but says, "Anne has taught me to see things a bit differently, and I can now talk to myself about it." According to Chloe Anne's positive encouragement has helped remind her "of the good things" because when she has a "bad day" she has trouble "believing the positives."

> I still have to consciously make myself stay positive and sometimes if I'm in a bad space I have trouble believing the positives, whereas when I talk to Anne she is encouraging and

> reminds me of the good things and that helps a lot, I'm getting better at it though ... there's often times when I think what would Anne say to me here? (Chloe)

Anne's "consistent" and reliable presence provided the fertile ground for Chloe to be able to take in feedback without needing to defend herself. Chloe was able to use this relationship and Anne's influence to see another perspective. Being able to stop taking things personally and think about her "actions" as separate to herself has been "very constructive." These fundamental relational skills of helping separate the person from the action were assisted by the fact that Chloe felt safe and trusted Anne's motives.

> I have learned to distinguish between what people are saying. I didn't like the way you acted, but that it was not against me but that was against my actions at the time. It's not a personal attack. So Anne has made me learn to constructively decipher my actions, does that make sense. (Chloe)

For Chloe it has been slow going, and at times intense emotions have managed to override the progress that she had made. According to Anne when Chloe loses a grip on her emotions she slips backwards and "goes into one of her deep holes" and might go on a binge involving drugs and, or alcohol. This has become less frequent over time and the relationship has provided a strong and supportive buffer. While the setbacks are difficult for both Chloe and Anne, the relationship has managed to survive the relapses. Chloe has also learned to become mindful of noticing the subtle differences in the severity of these events. However when Chloe reflected on her progress she said somewhat resignedly "it's just slow."

> It's such a slow process to get better and when you get down days, um because it's such a slippery slope to get better and when you do go into that, that whole thing, you disassociate so much you don't actually remember how deep you've gone. So when you go back you

> feel like you've gone back to that depth, whereas in effect you haven't, um because your reactions weren't quite as severe, but it feels it. (Chloe)

Chloe said she realises that she is gradually becoming emotionally stronger and able to cope in more healthy ways. The goodness and the positives in the relationship between Chloe and Anne is triumphing over the destructiveness, but it is a long slow haul and Anne is there for the duration. Anne's constant and non-punitive presence is "holding the space" for Chloe, just as Anne's former therapist did for her. Anne mentioned that Chloe has been through some "pretty scary stuff ," but she is able to see more and more that she has agency in a given situation. "She has come a long way." Although frustrating at times for Anne, this relationship does not burn her out.

> I think having gotten rid of a lot of stuff myself, it does bring up some sort of layers in different areas which I'm very good at identifying most of the time. I suppose cause I'm older too, I'm sixty this year. So life experiences as well as being a therapist to me are just one core aspect of being able to deal with it. The other part of me, I'm not just a therapist, I'm trained in social welfare, and I've been working with highly traumatised families, the inequality, the poverty, the social justice stuff, that's a head space on one level and it allows me in some ways to separate out. I don't know if that makes sense, but I've always been extremely grounded in a lot of the work that I do. (Anne)

Anne sounded like a proud parent at times when she spoke about Chloe's progress. Chloe was originally from the United Kingdom and she has a young son, aged nine who lives with her mother. She wants her life back on track so she can go back to England and gain back custody of her son. Anne alluded that the circumstances under which he was taken from her were quite horrific. The therapeutic relationship with Anne has assisted Chloe to become more emotionally resilient and therefore more comfortable in her own skin.

> Sometimes I can walk out feeling really, really drained, and other times I walk out and I'm still sitting with feelings which make me feel quite uncomfortable and that's the toughest one that's where I know the therapy is helping to change me because um I used to very much if I'd let anything slip in the therapy sessions I used to go and self medicate um, to stop me feeling those feelings, um whereas now I kind of try and sit with them as much as I can. (Chloe)

Chloe was ready for things to change. "I kind of wanted it to happen you just get so tired of everything being so chaotic." However the "slippery slope" proved difficult to climb at times and Anne became the "secure base" that Chloe returned to for security and encouragement while her life was in flux.

> For me it's was knowing that she's still ok, when she goes into this stuff, and being able to see it and put it into a context of all the changes that she has undergone. She's undergone massive changes, massive changes, I mean this whole thing about the court case and going back to England, its huge it's so scary. It's that cold fear stuff, and she's going through this and she is surviving well. No she's doing more than surviving she's managing it. She's working! We've got her into working, but you know she went out and found the job, she's working with children, in a child care centre, she loves the job, she's terrified! She got the first job that she went for, and she hadn't worked for eighteen months. (Anne)

Anne is certainly a strong advocate for Chloe and her rationale of herself as an attachment figure means that she is prepared to support Chloe "for as long as it takes."

> That's part of the process for me, its understanding that, and until I understood about the attachment stuff I didn't understand that that's what worked. It's almost like it gave me permission to identify as that. So when people say how do you work I'm able to say well I use the attachment element of this because I'm often the first secure adult in that person's

> life and that's a really, really, really tough role to play because you've got to be there, as long as it takes. (Anne)

For Chloe this means just having somewhere to go and someone to talk with. The simple act of talking does not always feel like therapy. "Even if we're just sitting here and it feels like, well this isn't therapeutic; it still means that I can get stuff off my chest." Chloe was not sure what it was about talking, or therapy, that actually made it work. "Mm, it's a hard one, sometimes things that work, you don't know why, they just do, but you don't get to think about it too much." According to Chloe she has learned that "it's not a case of feeling yucky it's how you deal with things." She is realising only now after two years of seeing Anne that she is feeling emotionally stronger and can manage her emotions more effectively. It makes sense that according to Chloe the most significant thing has been;

> Just being able to come and just be honest about how I was feeling rather than just carrying on, on auto pilot and um, just dismissing the fact that I'm um trying to lie to myself, well, lying very badly to myself, and certainly not lying very well to everyone else, without feeling like a failure. (Chloe)

The relationship has been supportive but honest. Anne said she has said things to Chloe like "'that was pretty stupid' and she'll laugh and say 'Yeah it was'. That's also part of our relationship I think that she's safe enough not to feel condemned or judged." Despite the occasional setback Anne has faith in Chloe and sees her as someone who desperately wants to show her she is doing well.

> I think she sees me as a kind of motherly figure, I think she sees me as being safe, and I think she trusts me, and um probably wants to please me as well um, and, to work hard for me. You know she wants to show me she's doing well, and "look what I've done". She loves it when I acknowledge things for her and she sees me as someone who gives her

> those reassurances, and hopefully fairly non judgemental, fairly accepting and interested in her. (Anne)

Chloe commented similarly. “Anne’s very important to me, cause she’s I guess, I spose um I see Anne as the same way I see my Mum, I want to make her proud of me.” Although this did not mean accepting Anne’s influence wholesale. However it is Chloe’s respect for Anne that has changed her attitude and in turn the way she would behave towards Anne if she had a difference of opinion or perspective. “Now, I feel confident enough actually I think, as much as I’d be nervous about it, just out of respect for Anne as a person I’d be able to tell her.” Anne’s values have transposed into Chloe who in the past would have “simply not come back.” Anne’s attitude was, “we work as a team on these issues. We’re human beings you know, woman to woman, that’s the other part of feminism about supporting others.” Anne would carry through the support even if Chloe was not able to afford to pay for her sessions. “She pays me, but look if she had a time where she didn’t have any money to pay for sessions I would continue to see her.” Chloe has completely changed her opinion of therapy as a result of her relationship with Anne.

> I’ve learnt that you need to talk it is very important when I was younger I was like, Oh my God! I can’t believe I’m being sent to a therapist I’m a freak. So for me in the position I’m in now I see nothing wrong with counselling or therapy I think it’s a very healthy thing to do. Because you don’t have to be mentally ill or insane to go and see someone, it’s just putting it all in perspective and its learning about yourself from a different angle, which if in turn is going to help you in the long run, well hey! (Chloe)

Chloe found someone who could connect with the person in her, not just observe on her symptoms or behaviour. According to Anne that was simply because she felt “incredibly affected by the depth” of Chloe’s pain. “She was really suffering.” Anne disclosed that she has at times been so affected she has cried with Chloe. “Again that’s my stuff you know being a mother and a

child who's actually had similar problems to what she did." However Anne was conscious of where her reactions came from and was not in danger of becoming the patient. "That doesn't do the client any good, my stuff, and you know I'm alright." Anne once again referred to her own personal therapy relationship as the template for her knowing how to be at those times.

> I've been in that space, I've been in the wounded animal space, and knowing that I was supported and protected allowed me to go into stuff that was so terrifying for me that I would never have been able to do it, I have great trust in the process. (Anne)

Chloe's comments concur. She felt that Anne was with her and watching over her, but at the same time recognised it was her journey. "I know she's there but I know [long pause]. But I know I have to do this." Anne had both a spiritual and a pragmatic view of how they walked that path together.

> I'm not religious at all, but there was something about this idea of being a soul friend where you walk beside, and sometimes your paths are wider and sometimes together, but you cannot walk in that person's shoes, you really can't. All you can do perhaps is support them when they need it, and sometimes they may actually be supporting you ... that element is very strong in a lot of my therapeutic relationships. I am open to a client wanting to look after me a bit or ask me how I'm going. I see that as part of the development of the relationship. (Anne)

Chloe put it more simply, when I asked her what part of Anne she would most like to emulate. "It's that thing where you can put everything into perspective but where you can still have lots of empathy and compassion." In other words Chloe was attracted to Anne's capacity to think and to love and in doing so see her as more than her illness. Chloe's attachment to Anne was secure and strong to the point where Anne was the one and only model for a therapist. "I just wish everyone had a therapist like Anne." Like a true attachment figure, there is no substitute, no

utilitarian means of replacing the person once a true emotional connection has been forged. Along with their connection and most importantly according to Chloe there is "mutual respect."

Giselle and Jim: Co-Creating Something of Substance

Giselle and Jim's difficult beginning was outlined in Chapter 4. The theme of relational boundaries remained a significant and continuing aspect of their work together and permeated the whole relationship. Giselle chose Jim for the study because she thought he was "a somewhat unusual character" and "quite unique." She found him "very challenging to work with" however conceded that she had "definitely grown through that" challenge. She considered it her job to help him learn how to be in a relationship without pushing people away. This task took quite a bit of time, energy and critical thinking to accomplish, especially when the issue at hand related to their relationship, as it did when Jim physically touched Giselle during a session. Giselle disclosed that she had been "raped as a young girl" and her personal history catapulted with automatic immediacy into the relationship dynamics with Jim. "It was just gross." However Giselle separated the roles of her social or personal reactions and her professional reactions into different compartments. "On a very social level, there's a gross creepy weirdo in him." However Giselle also saw Jim as someone who "doesn't have the basic things in place" in terms of his early development. "But from the moment that I stepped into that responsible therapist position, I no longer had permission to only do that [see him as creepy]." Giselle was attempting to articulate her professional responsibility as different and separate to her personal reactions in response to my question as to how her own personal history might have been touched in her work with Jim.

> I would say it doesn't touch me at all in the sense that from the moment I said yes to working with him therapeutically, I no longer permit myself to operate from a level where it touches me. The level where it touches me was just pure revulsion, it was disgusting. It

> was like, fuck off. However, I would go along as his therapist from the point of view that I was not … not for a millisecond did any part of me think I would be handling it in that way. (Giselle)

Giselle has struggled to work with Jim in many respects. She remembered that at one point he "would have loved to be partners." While this was something she would "never even consider" she tried hard to explain how she separated the personal from the professional with an example, but decided mid way through that her personal history was always present.

> I move very slowly, very slowly, I quite often would very slowly move my chair away from him in certain moments [chuckling as she speaks], and he moves forward, and I do a bit of work on myself and I, what the hell you know, working with Jim is a constant working with myself, working with my own abuse, you never get away from it. (Giselle)

It is clearly a huge struggle for Giselle to work with Jim when the main issue is crossing personal boundaries. However she has managed to handle her responses to some very challenging situations by showing great emotional courage and compassion, especially considering Jim was constantly triggering a very private and painful episode in her personal life. She would prepare herself and then deliver the feedback, using the relationship as the "learning spot."

> I've given him some hard information, with enormous care. I bend over backwards and do all kinds of things to give him difficult information ... to help him learn, it matters that he learn boundaries. I work on myself first, I prepare myself, I've thought about it and then the next session, I mentioned that I wasn't all that comfortable with him just sort of touching me, and it was a big problem, and we worked on it. So I use our relationship now and then, not most of the time, but now and then, I use our relationship as the learning spot. (Giselle)

While the "learning spot" was challenging and difficult Giselle has learnt a great deal from Jim through these encounters. Jim however, did not mention these events within the relationship, however he did mention times when he felt upset after sessions, although his reactions were not aimed at Giselle.

> A few, and there's certainly been a few session when I've come away feeling less than okay about my situation, they're far and few between, fortunately. You know I'm not that really into coming away feeling more trashed from a session with a therapist than I do going in, that's less than useful from my experience. (Jim)

Jim said it was the content of the sessions that upset him. He would manage those times by emailing Giselle and letting her know what didn't work for him during the session. He had a rudimentary understanding and great belief in the POP process work model. He would then stipulate to Giselle the particular process he wanted for their next session. Jim spoke in a flat rote style, and could regurgitate long quotes and excerpts of theory verbatim.

> Give her some feedback, and say ok what we need to do is this, and I want lead in, I want lead in process, like process kind of work, and then lead out process. I want to be walking out of here integrated and collected rather than disintegrated and totally unwell. (Jim)

Jim focussed on the process rather than Giselle, there was no sense of blame aimed at her for her management of the session, and he did not name any specific events that ruptured the relationship. However he had "terminated" several previous therapists, so I asked him if he had ever felt like leaving the relationship with Giselle.

> A couple of points in time, but then when I went and spoke to my gestalt process work mentor, he's got a pretty good, he's a mutual friend of ours, then I um yeah I came back to it with another perspective, like my working with my least occupied channel. (Jim)

I responded by saying, so you were able to repair that rift or whatever happened? Jim answered quickly and confidently saying, “no rift it was just like this is my inner work.” He clarified that for him, it was about “exploring the movement channel” and how he could “access that and use that as a healing therapeutic tool.” I’m still not clear why he needed to ask someone else other than Giselle if the problem was not about her, but Jim seemed quite clear about the solution in his own mind. While Jim quickly vied off into a theoretical explanation, according to Giselle there were times when he was upset with her and would bring it back to the next session. Jim’s background was one of extreme neglect and abuse. He was neglected by his manic-depressive mother until she eventually abandoned him at age four, then left with his grandparents, and horribly treated and abused by his grandfather. Therefore Giselle is mindful that her “forthright style” makes it easy for her to “bump into people” and although she has been very mindful with Jim it has not always worked smoothly.

> It’s happened a few times, I’ve set a limit, probably towards the end of the session a time before, maybe to not touch anything and there’s been a few, or a money issue maybe. So I’ve been really firm on some boundary thing, and I haven’t done it in the perfect way. You can never do it the perfect way with Jim because you can never be sensitive enough to everything. So then the next session he comes in and he’ll let me know, plus I know by now it’s coming anyhow, and he’ll spill out and he’ll be a little bit assertive and a little bit agg, not aggressive, that’s exaggerating but he’ll tell me how it wasn’t okay for him. (Giselle)

While these ruptures were not frequent they were none the less emotionally challenging moments for both of them. Giselle consistently mentioned more difficult and challenging scenarios than Jim. Her narrative of the relationship flipped between positive and negative, highlighting the extremes she was experiencing. However Jim did not focus on the difficult moments or sessions. Unless pushed by a question he spoke consistently and positively about

Giselle's feedback and how he found it "great" to discover the "less known" parts of himself as a result of their interactions.

> It's great actually. She gives me different points of view, reflects back to me different aspects of myself that I'm not aware of in the moment. So what's secondary and or less, like in process work which is the model we both operate in, what's secondary or less known to me. (Jim)

When Jim explained his experience he tended to regurgitate passages of texts and speak in quasi-theoretical manner which gave a detached feel to his comments, and he frequently and rapidly crossed over into his personal issues. It was difficult to keep the conversation focussed and on track which gave me a taste of the struggle within their therapeutic relationship. This was a relationship that required constant vigilance on the part of the therapist as to the effect it was having. Jim's life was littered with difficult and untenable relationships and Giselle could have easily added herself to the list. "The way he relates to people is why people don't treat him that well, and don't like him. People are always not wanting him around." However her compassionate understanding of him and her response to his challenging behaviour has been steadfast. She has been open to Jim's criticisms and sees them as important moments of learning for both of them.

> It's so complicated cause he's also hurt, he's so dependent on me and I guess I'm very aware of that. He so needs me, that he can't afford to be outright critical to me so it'll only happen in these situations where it's like, it's kind of like a life and death thing, you know. A couple of times he's fired me, which is fine by me and then you know, he's come back some time later. But my job I think, is to be respectful to him then, to really hear his point, because if it's come to the point that he's willing to criticise me, he really has something important to say, and I really need to get it. (Giselle)

Giselle has been extremely non-defensive. Quite the opposite to a defensive stance, she tells him how much she appreciates and values him for having the courage to state his needs and says she genuinely feels that way. She takes responsibility and owns her part in the interactions and attempts to repair the rift.

> I try and respectfully learn from what he has to say. A couple of times and a good example doesn't quite come to mind, a couple of times I've just thought, you're right, you've got a really good point, I didn't do that well. And I say so. I say, you're right Jim, I'm really sorry, I really apologise. I didn't do that well, I'm really sorry. (Giselle)

There was no attempt to work with the possibility of transference and Jim's concerns were not turned back on him as part of his pathology. Giselle was mindful that she has a "special position" with Jim and as such thought he could be more easily "devastated" by her actions. "I've got two biological and two step-kids. I think I'm more careful with Jim than I ever am with my own kids, for sure. I would scream at my own kids." And there has been much to tolerate. Even at the agency setting Jim would turn up early for sessions and his behaviour was at times confronting for staff and other clients. "There was a day he was walking, pacing, dancing in the waiting room area, and the head admin person pulled me aside and said, look Giselle your client … it's disturbing to other people waiting." Giselle was aware that Jim's behaviour was way out there however she did not label him with a diagnosis. Her perception of his behaviour was that it was "extreme" but only "close to" being diagnosable.

> His state got very extreme, you know, he … he was close to what could have easily been psychiatrically diagnosed, so again it, you would say that he's helped build my confidence in working with really extreme states, cause on numerous occasions I've had to be there for him and really help him come back to earth, back to the shared reality that we … we all

> need to function in, when his inner state was really way, way out there and I got complaints. (Giselle)

Again, despite there being a considerable amount of chaos in this relationship, Jim's comments remained very positive about the gains he has made, and Giselle's contributions to those gains. "Actually the first thing that came to me was an increase in my confidence through her positive input, because there's not many people I know who have a consistently positive focus." Giselle's reliable and consistent presence has provided the context for Jim to form a strong bond with her, very possibly his first from all accounts. Jim has been able to use the therapeutic relationship to help him with what he calls his "inner work," and he utilises the positive input and relational learning to help him stay well.

> She's pretty clear in telling me, and um very affirming, you know she tells me how well I'm doing and how I'm looking well, you know, despite all the things that are going on, and that has helped me develop an inner model, an inner figure, that really will pull me out of the deepest parts of not being so well. (Jim)

Jim was aware of the developmental deficits he had to work with, saying that Giselle provided him with "a healthier model for relationship which [he] never had." It was evident he was slowly developing the capacity to reflect and think about his own thinking.

> I grew up with people who didn't know how to do relationship and did it really poorly, and ah were very fear based, and so when I catch those fears I go, so that's where that's coming from, okay. I'm now different to that and so it's been a, what feels like a reclaiming of myself and getting to know aspects of myself that I didn't know about before. (Jim)

Apart from his slowly developing self-awareness, Jim is content that he is "doing a pretty good job" as long as he is caring for himself in a given situation. "Working with my internal

process, so intently focussing on what I can do to look after me at the moment in those situations." Giselle has couched Jims learning about relationships and the effects of his behaviour under the topic of self-care. At times getting the help he needed has meant accepting very concrete direction. "Sometimes the way that she's helped me is just like giving me direction, like go home and just do that." Jim trusted Giselle's suggestions, because he had no internal compass to follow. "When I get direction from Giselle I check it out "how's that feel for me" but then I pretty much go there because if I hadn't had relationships practice then I've got no hope of doing a good relationship." Jim relies on Giselle's "guidance" and takes his personal work very seriously and despite being challenging at times he seems to understand that learning to relate well to another is vital for him and therefore without this relationship his "life will not go so well."

> So I'm sitting here at 45 thinking it's been a constant learning, learning how to relate, cause not much else is going to happen without it, I'm either relating to myself or I'm relating to someone else, and the way I relate to myself is going to be the way I'm going to relate to someone else. (Jim)

While Jim's comments sound like he is reciting from a theory book or possibly regurgitating something he has heard from Giselle, he takes in the messages and works with them.

> She'll give me inner work exercises to do, and I'll go off and do them, and ah I'm ah intently focused on my inner work, like I deliberately took a lot of time out to do that because if my life wasn't going the way I wanted it to then it was pretty much up to me to do something about it. (Jim)

Despite all the hard work, change has been slow and incremental for Jim. Giselle is convinced "without any doubt," she has been a positive influence on Jim's life. She is content to

know things are continuing to move in a positive direction without measuring the extent. “That must be good enough for me ... I think I am making a big impact, really subtle, and really inner and now and then you actually see it in sort of tangible ways.” She thinks it would be unfair to measure Jim’s progress against a “normal population.”

> I think I’ve seen already his relationship life is a little more healthy, he’s a little more aware of his own needs, he’s, it’s a little more balanced so I guess I’m willing, I’m quite happy to just keep being a positive influence knowing it’s going in a good direction without measuring how big, because what scale are you going to measure it on? It could be unfair to ever measure Jim on a scale as if he’d been given something he never was. Like it’s good, it’s a good direction. (Giselle)

One of the most difficult parts of the relationship for Giselle has been working with “Jim’s huge inner critic. That’s another thing I’ve learnt from him is, to try to work with someone with a huge enormous critic, it’s the hardest thing to train someone who is having to fight off the critic all the time.” Jim has not yet developed a strong enough inner voice of his own and uses Giselle’s voice to bolster himself up in front of other people.

> Definitely he sees me as his therapist, I belong to him in the sense that, I’m *his* [italics added] therapist and he will feel free to use that in conversation with somebody to bolster himself up, you know, ‘Giselle told me, and Giselle thinks’. In his inner life he’ll use me to defend himself against his critic. He has a devastating critic it’s probably the biggest thing we work with actually. I always fight so hard to give him negative feedback it’s so hard to tell him *anything* [italics added]. (Giselle)

It makes sense that Jim focussed on Giselle’s positive influence in his interview. He particularly liked the way she would complement him, because his mind could not maintain that positive focus.

> Noticing when I do it well and complementing me when I do it well, and maintaining that focus, whereas my critic, my inner critic and my shame monster will completely slam me from both sides. (Jim)

This relationship was a united effort against the "shame monster" and a relationship that many therapists would not consider worth the effort under the current regime of immediate change within the first six sessions as the benchmark for successful therapy. This relationship was about commitment, and steadfast reliability and availability. The availability aspect was difficult due to Jim's complete lack of boundaries, but they have worked out a compromise where Jim gets "special treatment." Giselle has reflected on her decision making with Jim and came to the conclusion it was the process of revisiting the boundaries and her particular relationship with Jim that made her feel clearer about where the boundary needed to be.

> I'm making this up in the moment, but I think you're constantly working with yourself, and each time I go round the block with it, I feel better at being clearer about where I will have a boundary, some things must not be tolerated and it moves a little the boundary. If I'm more vulnerable I might need more boundary, and if I'm really strong in myself, I'll hug him occasionally at the end of a session, he'll say, 'I need a hug'. I think I've never refused him. If he says, 'can I have a hug?' In my home practice that kind of thing's quite normal thing. With this practice I have almost no one, sometimes if something's ending after a long period of time, I give them a hug. But John gets special treatment [chuckling]. (Giselle)

Giselle was aware of the many contradictions within her relationship with Jim. Giving a client a hug, who has difficulties with boundaries, especially after having had a rupture around Jim touching her in a session and having to place a limit on that behaviour. Giselle also tolerates out of session contact from Jim that she does not encourage with other clients.

> It was a lot harder in the earlier days. He would write me emails when he feels like it, no other client from this work here ever, even has my home email, or write me emails when they feel like it, but I tolerate it, not only tolerate it from Jim, I say it's fine ... Like I go away for a month, twice a year and I say to him, you know, feel free to write me if you want. I don't feel obliged to write very much back, he writes big long reels of stuff. I eventually read it and I write a couple of sentences warm and supportive back. (Giselle)

However working with Jim has made Giselle become clearer on how she views her role as his therapist and it is not about expecting significant outcomes or completely smoothing out his personality of all flaws. In reality Giselle thinks Jim is "still way behind the eight ball," and her belief is that he will "never catch up" to someone who has had a secure and stable start in life. "But why shouldn't I make up the shortfall? I don't know, it must be the way I relate to my profession."

> There's something about once I crossed the line into being his therapist, I'm his therapist. So I now look at this person in that context. He's a person that started life without a meaningful Mum, no Dad at all, no loving adult figures, a very mean and nasty grandfather, like, I don't know, I feel like, from the role I've taken on, he has the right to ask that of the world. The fact that it happens to be my lot in life, you know that he landed on, fair enough. (Giselle)

Jim spoke positively about his progress and attempted to articulate how the relationship is assisting him to reach his potential.

> I'm noticing which is working really well for me, and um, [pause] yeah then like holding out the hope, the optimistic hope which is like the higher dream of process work and I may never reach my higher dream, but I'm getting pretty close I imagine, and that's to be hearing the language that Giselle uses and to hear the language that other process workers

> use, and to, [long pause] yeah to really be able to be with the whole of what I'm being which is very difficult. (Jim)

It is obvious that Jim is inspired by Giselle and the process work paradigm. I found it difficult to understand what he meant at times, however one had to admire his perseverance in reaching for his "higher dream" whatever form that took. Yet while talking about that topic Jim suddenly shifted into a completely different psychological space. He had mentioned earlier that his ex-wife had kidnapped his two daughters and he had fought for a long time through the courts for access. He was passionate about rescuing his daughters from "unconscious violence" and started talking about how he would love to dispose of his ex-wife and her mother.

> There's a song line, I contain the blood I could have shed, like I could have quite cheerfully yesterday just, put an end to Monica's life it would have been really easy It's not complicated, the complicated part is the paperwork, explaining to authorities dadadada, and explaining it to the children dadadada. I'm just really noticing the part of me that would like to put a garbage bag over her head and gaffa tap, and let her see the fish's first hand, and her mother [he chuckles softly] the job wouldn't be complete without the two of them. (Jim)

I turned our conversation towards what it was like to be uncensored and dark in his sessions with Giselle. He said that he was "reasonably free" to do that with Giselle. He worried at times that she might not be "able to contain that material." However he was also remembering how the people at the agency "freaked out" when he did "hard core anger work," which he was able to do "more freely" when Giselle was at the home private practice. "She gets a bit freaked out about it sometimes, but what she says to me is that I want things to go well for you when you're dealing with people who would not understand that level of um violence." Jim would get so intense about his anger work he seemed oblivious to the impact on the people around him.

Giselle would couch things in terms of how he could look after himself when he was around other people and he accepted that, however he was a little "scared" at times that he was too much for her, "it was over her edge." Jim and Giselle's relationship has found them in volatile territory. They have survived a stormy time negotiating the boundaries, the setting, and almost every aspect of the work, but in the process have gone to some very dark and violent places. I asked Giselle what it was about her that she could find compassionate for Jim rather than feeling scared. She thought the motivation was personal.

> I think it's a fascination by the states where, my own inner states, spiritual states or whatever, my own inner states that are not sort of the standard run of the mill state of mind ... so it was already in me before I ended my training. You said what was in me, what was in me is a passionate love of what's beyond. ... a spirit of exploration I just was born with. (Giselle)

Jim had tried hard to find someone who would or could help him with no success. "Coming from a very psycho-emotionally violent upbringing, so my ability for self-care and to be very gentle with myself, up until I really hit Giselle yeah it just wasn't happening." He found other therapists to be "unconsciously violent and provocative. I'd get interventions like, "I hear that's what you make of it" [we both laugh]." Despite his obvious developmental deficits Jim was very aware when his previous therapists were not able to connect with him and he found their interventions to be abusive. He thought Giselle's "gentleness and sensitivity" was the key ingredient for him, and when I asked what he found particularly sensitive or comforting tears welled up in his eyes. He associated his tears with the fact his daughters had gone back to their mother yesterday. However sitting with him I imagined that he had become emotionally touched by the feeling of being cared for by Giselle. When he began to speak again he talked about the nurturing things Giselle would say and his "lack of a strong model for that." The praise he received from Giselle was attractive and compelling; however any encouragement entered what

was portrayed as a bottomless well in Jim. “He always wants a lot more [laughing heartily].” Giselle commented that she had been on a POP workshop the night before, and Jim was a participant. She gave an example of the way she would praise Jim.

> I’m his therapist always, even if we meet in a social situation. I praised him for how beautifully well he was holding himself … and his wisdom. On a normal scale ... we wouldn’t praise him in that population as having a huge amount of wisdom and containment. But, given the scale of people who have no parenting, no grand parenting, mean, nasty, horrible treatment from zero on, on that scale he’s amazing, and I have the inside information to know that’s the scale he’s on. But yes, he is changing and I’d hate to think what would happen if I dropped him. (Giselle)

This relationship has no expected ending.

> I don’t envisage ever shifting him out of the category I’ve got him in. He’s in protective category in my psyche. I don’t think I’ll ever take him out of this like, protective category ... I took John on, and he chooses when he doesn’t need help from me, for months or, so far it hasn’t been for years, I could easily imagine he wouldn’t come for years. But all he’d have to is say, Giselle can I see you? And I will maintain a respectful care of him. (Giselle)

Giselle’s sense of care has reciprocity to it, because she has gained from her relationship with Jim despite the challenging times they have endured together. The relationship has brought to fruition a wish to work with someone who has “extreme states.” This was not a completely altruistic challenge.

> He’s a good example of a sort of a functioning extreme states person. It’s partly why I’ve enjoyed working with him cause he’s way out on a limb there, so I think he has strengthened my confidence, my capacity. I know that’s what I fundamentally would have

> wanted to work with, and I know I can work with it because I've worked with Jim. I've seen him strengthen. It's subtle in terms of, he still does weird things, he still looks weird, but he's a little more strong in himself, so he, you know he has not made a fundamental change. He's helped me practice what I always believed in and he's given me a real live human being to do it with, and like I said before I've grown to admire him. So is that a fundamental change? No, but it's a human relationship, it's something substantial. He's given substance to what before would have been intentions, and I believe in people with extreme states, I'm sure they can be helped, but he's the real person. (Giselle)

After some thought Giselle attempted to explain that the two of them had "built" the relationship. "You arrive at something." She did not view it as changing her fundamentally but acknowledged the existence of something new.

> We've built something, Jim and I, we've built something. Something's come into being that without Jim, would never have been. So even though you said, does it fundamentally change me, I don't think so. But then I, I question it just a little bit in that we've built something that, something exists because Jim and I have at a very deep level, chugged along with this stuff, his lack of parenting, his lack of any models of a person who can with great love, set boundaries, and so we're approaching it while he's in his forties. We've really built something here. (Giselle)

Jim also felt strongly about the relationship continuing, when I asked how he envisaged the relationship ending. "One of us dies [we both laugh]." He said he would still have "the need for that guidance" and Giselle's help to "keep [him] on track." He credits the relationship with keeping him sane, and "[sighing heavily] did not want to think about" what his life would be like if he had not run into Giselle. After all the compliments he has received from Giselle he was able

to return the compliment to Giselle. “She’s ten times the therapist than some of the other people that I’ve come across.”

> The affirming on one side, and the lack of judgement on another, like that’s been pretty um key for the health of my therapeutic relationship with her ... it’s kept me sane, well, and what is sane anyway apart from my total focus on self care, you know what can I do today to look after me ... I can be self affirming thanks to Giselle. (Jim)

As we finished and for the second time in the interview Jim’s voice cracked and his eyes filled with tears as he responded to my last question: “Is there anything else that you didn’t get a chance to say about Giselle that you wanted to say before we finish?” He said “Yeah I love her dearly she’s really good.” I don’t think I was imagining it this time when I reflected that what was touching Jim was the profound impact of being loved and loving in return.

Conclusion

Each of the therapeutic relationships described in this chapter are quite different and unique, hence the themes that emerge from them are also varied. However some common threads run undeniably through the fabric each dyad. Whether the presenting issue was addiction, depression, anxiety, dissociation, emotional deficits or a relationship difficulty each relationship had the common threads of interest, care, compassion, support, belonging, security, commitment and love. These human elements are similar to those that drive an attachment bond and fuel optimism and hope. Underneath each presenting issue for clients was emotional suffering which was quieted through talking with their therapist. As Chloe suggested sometimes it felt like a simple conversation rather than therapy, therefore “even when it didn’t feel therapeutic” it helped. Or as Peter said, the person is the one who “does the magic” not the process. The relationships were more than simply having access to an empathic and sensitive therapist.

Therapists described being invested and committed to the well-being of their clients and the challenges of bringing about change no matter how arduous.

The relationships were not necessarily smooth sailing and the progress for most was quite slow and recursive. All clients had made changes to their inner and outer lives some more significant than others depending on the particular difficulty that needed to be overcome, the history of the client and how the dynamics of mutuality played out between therapist and client. In general therapists tended to keep a focus on the client and the clients issues rather than the inter-subjective field. It was only during the interview that some of the therapists reflected on this aspect of the relationship and their contribution to the relationship dynamic. To take an example, Thomas acknowledged that his chronic fatigue had somehow been picked up by Bella, and how retaining the focus solely on Bella's issues did not make sense of their work together. Yet he did not see any overlap between Bella's long periods of flatness and his own grief after his wife's death. Therefore subjective blind spots, even in experienced and relationally oriented therapists can blur the field.

Most relationships were therapeutic but there were many areas of theory and practice that were overridden by the therapists subjective and intuitive sense of what was needed either structurally or clinically. Intuition and gut instincts were utilised frequently over and above a conscious relating to theory. At times when theory was drawn upon it was at odds with the client's needs. An example from Thomas and Bella again, was Thomas's unsuccessful mission over six years to get Bella to express anger towards him. Having such a long and trusting relationship surely Bella could have achieved that aim if it was salient for her. However the main theme in the relationship was Bella's constant fear that Thomas would leave her. Therefore seeing her fear of abandonment and the appeasements that come from that, being overly tolerant, being taken for granted, would more likely reinflame her own self-loathing and shame that she does not have what it takes to hold onto a close relationship. Giving up her vigilant caretaking

and clutching stance would mean getting in touch with her anger towards herself more than Thomas. However there are many different ways to view a human dilemma and Thomas and Bella arrived at a point where Bella feels able to finish because she feels lovable, and all without her getting angry at Thomas or herself. What this example highlights for all the relationships is that these therapists despite their years of experience or seniority were not always performing well conceptualised, neat or perfectly administered therapy, but it worked regardless. Paying attention to the whole person of the client and their context, rather than just their symptoms, enabled these relationships to meet the emotional and relational needs of the clients and in doing so flourish.

Chapters 4 and 5 have laid out the inner workings of seven therapeutic relationships as perceived and described by both therapist and client. Chapter 6 explores the common and unique themes that emerged from the seven relationships examined and aims to understand the relevance of these findings for the therapeutic relationship and the wider field of counselling and psychotherapy.

Chapter 6

Discussion: Mutual Influence in Context

Introduction

Understanding mutual influence in any relationship is challenging when viewed outside the context of that relationship. Context was paramount in gaining a fuller understanding of the complexity and meaning of mutual influence for each person and dyad. The interpersonal dynamics within the different relationships elucidated the interplay of mutuality and its impact on the development and maintenance of the therapeutic relationship. As such this study adds to the existing body of knowledge on the therapeutic relationship by examining seven current therapeutic relationships in context. As mentioned there are few known studies that have focussed on both therapist *and* client, and of those even fewer utilising a qualitative methodology. Therefore this study has provided the opportunity to explore the richness and complexity of the therapeutic relationship in significant depth. This chapter connects the relationships portrayed in Chapters 4 and 5 to weave together the common and unique themes found in the seven therapeutic relationships. Findings are discussed in relation to the existing literature and the original questions posed for the purpose of the study.

Learning from Previous Negative Therapy Relationships

There was a consistent theme of previous negative therapy relationships for clients in the study. By most accounts the negative experiences and outcomes were due to relationship failure. This was reported as resistance, or theoretical rigidity on the part of the therapist that prevented them accommodating to the relational needs of the client. Admittedly only the client's perspectives were gleaned. However when therapists find the task of relating person to person too challenging and retreat into theoretical certainty, defensiveness or rigidity, the capacity for

relatedness is greatly diminished (Otte, 2010; Slavin, 2010). Clients let their feet do the talking and were capable of sacking their therapist if they found the relationship unsatisfactory.

The information clients shared about previous therapy highlighted how prevalent the ratio of failed therapeutic relationships might be, with six of the seven clients in the study having at least two, sometimes three, previous attempts at therapy. In each case the clients had elected not to continue with the therapist and each client had different and specific reasons for terminating therapy. However, collectively those reasons all related to the clients perceived lack of relational connection with the therapist. This finding links with therapy outcome research that posits regular monitoring of client feedback (Duncan & Miller, 2004; Lambert, 2009) is essential to ensure positive results. This study indicates client feedback, both negative and positive, is also essential for the development and maintenance of the relationship. Previous experiences as perceived by clients included being pathologised and infantilised, lack of interest from the therapist, feeling disrespected, feeling analysed rather than related to and receiving nice but rather benign treatment. One client described being further pathologised for the way she responded to being treated disrespectfully; therefore acting to solidify the view that she was solely responsible for the interpersonal dynamic. One therapist, Anne, offered her own story of a previous negative therapy experience in which the therapist treated her requests for a more human connection with silence. These negative experiences were still fresh in the memories of participants'.

Previous therapy was significant because of the personal impact and resulting attitudes the clients brought to their current therapy relationship. It is a common belief in therapy that a negative therapy history bodes badly for the newly acquired therapist and the predicted trajectory of the proposed therapy. This belief was not borne out in this study. A narrow focus on the client's history in therapy perpetuates the attitude of blaming clients for early terminations or failures of therapy. As such when patterns of relating are repeated in therapy, clients can be held

responsible for replaying their interpersonal problems as if the therapist were not present. The therapy relationships in this study show that sensitive attention to the client's interpersonal style and needs aided in the joining and engagement process. While there was also some evidence of repeating interpersonal patterns of relating, the mutuality between therapist and client even at the very beginning phase of therapy, impacted on how those patterns played out. How the therapist adapted to the client was imperative. This finding adds weight to the view that "it is in the therapeutic relationship that therapists either make or break therapy." (Blow, Sprenkle, & Davis, 2007, p. 306). This applies particularly for the beginning phase of therapy and the broader question of the significance of particular therapist factors and contributions. As found in a very recent study (Westmacott, Hunsley, Best, Rumstein-McKean, & Schindler, 2010), the most common reason clients terminated therapy unilaterally was because they did not like their therapist or the therapy. This study also reported that clients rated the early relationship and barriers to treatment more highly than did therapists, which points to contextual factors at play. It also seems unlikely that all previous experiences were due entirely to the commonly held but simplistic notion of a mismatch. After all, what creates the mismatch? Previous therapy experience was not explored in detail, however the evidence from this study shows clearly that all of the clients who discussed their previous therapy have managed to form and maintain a successful relationship with their present therapist. These findings raise many questions for research on the reasons clients terminate therapy and how therapist education addresses the relationship, which will be discussed in Chapter 7.

Choosing a Therapist

All clients in the study put careful thought and energy into choosing a therapist. This theme was consistently strong for all participants. Being able to observe their prospective therapist in a non-counselling role ahead of time, talking to a friend who had sought help (Vogel, Wade,

Webster, Larson, & Hackler, 2007), or getting a trusted referral, was an important part of the process of finding a therapist. The basis for decision making and choice represented three key belief systems. Respect for the therapists reputation or known work, a perception of the kind of person the therapist was and most importantly faith they were the "right" person to help. The word "right" indicates a rigidity of meaning, however it was the language used by clients to describe their belief and hope that their choice of therapist would be "right" for them. The perceived personal and professional qualities and competencies of the therapist were highly significant for clients in choosing a therapist.

Even when a therapist was carefully sought out, or referred by a trusted source, the beginning of therapy was still a tentative process and did not necessarily translate into immediate or early progress in therapy. It stands to reason that for clients who do not have the opportunity to choose their therapist, the beginning of therapy could be a much more arduous joining experience. This raises the question: how do therapists manage this beginning phase, especially with clients who have been allocated to them, rather than making a choice? The range of previous negative therapy experiences reported by client's shows that attention to the developing relationship may not be happening as an integral part of the process of early joining and ongoing assessment and relationship maintenance.

The findings from this study support the assertions of Gelso (2009a), Horvath (2006) and (Safran & Muran, 2006) saying the relationship is more than, and different to, the alliance, where the main focus centres on the overt tasks and goals of therapy. In this study, clients early assessments were implicit and focussed on the trustworthiness and integrity of the therapist more than their goals for therapy. However in the early phase of therapy clients did not readily divulge to their therapist if they were dissatisfied with the relationship, felt misread, or if their agenda was skewed by the therapist. Clients had their own subtle and less direct ways of addressing gaps or misunderstandings in the relationship. Refusing to speak to their therapist, revisiting the issue

at another time or simply ignoring the therapist's opinion or agenda were some of the strategies clients used to overcome misinterpretations, misattunements or therapist driven agenda's. Therapists were made to "earn their money" at those times. The critical difference between previous therapy experiences and the current relationships was the level of trust clients had in the underlying motivations of the therapist. Mistakes and imperfections could be tolerated once trust had been established. Therefore a careful assessment of the initial engagement and development of the relationship (not only tasks, goals and treatment progress) seems vital. The significance of the careful search for a therapist shows that clients, at least amongst this sample in Australia, do not merely place blind faith in the therapy process. Clients wanted a say in choosing the type of person, not just the type of therapist, in whom they placed their faith.

Faith, Hope or Desperation

The common factors research identifies *hope* as one of the vital pantheoretical components contributing to successful outcome in therapy (Hubble et al, 1999) The clients in this study were hopeful; however the hope was not an internal feeling of optimism that all would be well in the end, or that they could change themselves or their situation. Rather, hope was aligned to finding the "right" person. This extends the meaning of hope outlined in the common factors research (Asay & Lambert, 1999; Hubble et al, 1999; Snyder, Michael, & Cheavens, 1999) where hope was aligned to one's potential ability to achieve their goals. For clients in this study an internal sense of optimism and hope emerged once therapy had begun and progress could be seen and believed. The proof was in the pudding to quote an old maxim. It was the therapist who initially had faith in the client's potential when the client had lost hope and it was the therapist who conveyed the hope that change was possible until the client felt this possibility themselves. Therefore the client's sense of faith was placed in the person of the therapist first and foremost,

rather than in themselves. A dominant comment from all clients was how their therapist had *given them* hope that things could get better.

The opposite of hope is despair and clients mentioned feeling "bad, low, anxious, despairing or desperate" for things to change. In line with a study on former clients views of therapy (Binder, Holgersen, & Nielsen, 2010) the internal emotional climate and suffering that accompanied those feelings and the unbearable alternative of things staying the same made life untenable. The fear of staying the same and the suffering it brought was the main catalyst for clients persevering and trying therapy again. Fear and anxiety trumped hope when they were present. However even for those clients who did not report feeling desperate, the decision about their choice of therapist was a significant one. Therefore the relationship with the therapist was the conduit for hope, which was conveyed to the client through the therapists own feelings, presence and manner.

Mutual Influence, Equality and Self-Efficacy

In light of previous negative therapy relationships, it was significant to clients that they were viewed by their therapist as an equal and the relationship had a "flat hierarchy." This wish paradoxically sat parallel to the alternative wish to be helped by someone stronger and wiser. Equality for clients was based on not wanting to be seen as mentally ill and therefore pathologised. Further to this they wanted to be viewed as a whole person, not just through the lens of their particular life difficulty. This is in line with humanistic traditions, in particular person-centred (Cooper & McLeod, 2007; Rogers, 1951), existential (Bugental & Bracke, 1992; Yalom, 1980), and interpersonal (Henry & Strupp, 1994; Safran & Muran, 2003) approaches. For clients having a sense of equality went further to include feeling respected as a co-participant and most significantly being able to have an impact or influence on their therapist. Relational approaches (Orange & Stolorow, 1998; Slavin & Kriegman1998), feminist theory (Brown, 2006;

Marecek, 2001) and relational cultural theory (Jordon, 2001) all emphasise the importance of the phenomena of clients making a personal impact on the therapist. As one client stated, “it’s important that the relationship is not one of, I’m the expert and you’re the supplicant”. Having an attitude of equality facilitated client’s sense of agency in the relationship. Self-efficacy emerged as a result of a relational act or shift, where the client could see they had changed the way their therapist responded or acted in relation to their influence. The striving for equality was manifested from the intake and joining process through to the more intimate way therapists and clients responded to each other emotionally and behaviourally. Therefore through personal impact and counter-impact, adjustments were co-created within the relational context. Adjustments were not purely internally driven or autonomous decisions, just as the decision to sack previous therapists had been made in relation to a particular person and context.

While it was apparent in practice that the relational dynamics in the dyads were not equal in a participatory sense and therefore asymmetrical (Aron, 1996; Slavin, 2010), the relationship was viewed as being equal in a respectful person-to-person sense. For these participants equality also meant that therapists gave generously of themselves in regard to addressing difficult relational dynamics or being judiciously transparent about personal information that was alive and operating in the relationship. Equality therefore reflected an acknowledgment of the two-way nature and inter-subjectivity within the relationship. It was evident that the personal aspects of the therapist were inevitably present and operating in the relationship despite the asymmetry of personal disclosure (Aron, 1996; Otte, 2010; Slavin & Kriegman, 1998). Participants described relationships with generous structural and personal boundaries that honoured the clients as co-travellers and peers in relationship, albeit with separate knowledge and expertise. Clients wanted to be related to rather than just the object or recipient of treatment.

Another aspect of being related to was clients wanting their therapist to show their humanness as well as their professional self. This meant being allowed in to the therapist’s world

through small gestures such as borrowing a book or engaging in a brief chat about everyday things. This phenomenon ties in with Gelso's (2009a) assertion of the real relationship. Only one client felt awkward about having some inside knowledge of her therapist; however that was also partly an injunction that came from within the dynamic of that particular relationship where the boundaries were held very firmly. The sense of equality and agency for clients came from therapist participation that was active, involved and open to influence. This runs counter to the stance of waiting for the client initiate or take responsibility in the relationship. This stance can leave clients feeling isolated, as well as perpetuating past patterns of absence or neglect and the illusion of the therapist as the all knowing expert. Clients wanted some authorship over the process, not necessarily the whole process; being on an equal level or "flat hierarchy" as human beings was good enough. Clients were satisfied to share the power and influence if they felt, and trusted, they had an equal footing in the relationship with contingent self efficacy. Therapists' generosity of self, in essence, was an act that helped to restore faith in humankind and was an outward acknowledgment of a shared common humanity.

The Therapeutic Relationship, Mutual Influence and Client Mental Health

All clients in the study presented for therapy initially with underlying relationship difficulties. Clients described emotional patterns of relating where they were either over or under regulating their affective states and suffering as a result. Client mental health however covered a larger spectrum, including descriptions of symptoms that indicated anxiety, depression, dissociation, personality disorders, addiction and relationship difficulties.

The relationships where mental health was a more salient factor of the therapeutic work showed that regardless of the presenting issue very strong bonds had been formed between therapist and client. This finding is counter to many studies where poor mental health is seen to either preclude or render too difficult clients effective participation in therapy (McCabe &

Priebe, 2004). The strength and quality of the relationship was determined predominantly by the relational capacities and resources of the therapist. Therefore therapists necessarily *contained* and *held* the emotional content of the relationship for a time. Clients with mental health or social difficulties persevered through stressful therapy sessions, but had a limited capacity early in therapy to tolerate emotional intensity or connection, or at times even remember the content of sessions. However those clients did have the capacity to form a secure emotional attachment with their therapist in the first instance. The therapist's ability to read the implicit emotional communication and ability to empathise were significant. Voice tone and rhythm, gestures, posture and emotional states became the vital elements that assisted clients in soothing their internal world. This was a common theme for most clients but more so for those further down the continuum of suffering psychological and relational traumas and developmental deficits. The interaction of both mutual and self regulation was evident as therapist and client adjusted to the felt security of the relationship. However therapist self awareness and contingent emotional and empathic responsiveness were vital components of this endeavour (Bion, 1962; Fonagy, et al. 2004; Schore, 2003).

Therapist's who found themselves unwittingly in a difficult situation or uncomfortable territory, did not report becoming overly contaminated or infected by the client's personality or behaviour. This appeared to be due to a strong level of emotional resilience and sense of self that buffered them from becoming prey to absorbing too much of the client's subjectivity. Therapists did not become defensively impenetrable and stayed in emotional connection during difficult interactions. The therapists own history of emotional relatedness is seen to be a major contributor to what happens in therapy and the manner in which the relatedness is constructed will bear the mark of both people in the relationship (Fosha, 2004; Wallin, 2007). For example Giselle's fascination with her own inner states acted as a catalyst for her interest Jim's "extreme states." This highlights how the personal histories of both personalities contribute to and influence the

relationship. However the adaptive function of this mutual participation is that Jim benefits from the fact that their separate contributions are not equivalent. “Through mutual coordination, the more vulnerable members of dyads get access to capacities that are not quite theirs but that become theirs through the interaction; thus their functioning is enriched” (Fosha, 2001, p. 231). This mutual exchange is crucial to the phenomena of personal transformation from participation in a therapeutic relationship that safely unlocks and activates the client’s emotional experience. Most clients managed to co-create and access experiences previously foreign to them. Such graciousness assumes some progress in each person’s personal struggle and therapists and client both sharing the historical emotional baggage rather than only seeing pathology in the client. In each case the therapist had to unlock a part of themselves for the transformation to take shape and in doing so co-created a mutual transformation. “We cannot abandon the injured or the maimed, thinking to ensure our own safety and sanity. We must reclaim them, as they are part of ourselves” (Dowrick, 1997, p. 345). The therapist’s willingness and level of emotional resilience for flexibly entering challenging psychological territory appears to be a significant component of healing.

Rethinking Boundaries in Therapy

Traditionally boundaries have been discussed in the literature in terms of the structure and ethics of therapy (Koocher & Keith-Spiegal, 2008; Pope & Keith-Spiegel, 2008) or within psychoanalysis as patients violation of the frame (Almond, 2008). As such boundaries are seen to be set in place by the therapist and are considered the therapist’s responsibility and duty of care to maintain. Either way client’s behaviour in relation to the set boundaries are inevitably viewed in a negative or pathological light. Some authors (Gutheil & Gabbard, 1998; Zur, 2007) suggest that therapists have been frightened into a mechanistic and rigid application of boundaries due to risk management practices, others (Koocher & Keith-Spiegal, 2008) caution

ominously of the inherent dangers for therapists in boundary management. Guidelines for what constitutes professional boundary management are set and generally agreed by the various codes of ethics and practice in the field. Despite this therapists in this study covered a wide range of views and knowledge on boundaries and how they translated into practice. The variety of views and lack of consensus possibly points to a heterogeneous range of education and training experiences, or a lack of focus on this area of therapist education, leaving considerable room for interpretation.

It was evident from the relationships in this study that a therapeutic relationship requires mutual negotiation of *the frame* and, if reduced to a set of rules put in place prior to the relationship may cause harm to the developing relationship. Previous negative therapy experiences pointed to the fact that when rules or dogma dominated over and above what was necessary for the relationship to build trust and safety, the relationship was compromised and unsuccessful. Contrary to existing notions of boundary setting by the therapist, it was the mutual influence involved in negotiating the boundaries of the therapeutic relationship that created the foundation of security and trust for the relationship to continue (Bond, 2007).

Literature on the development of ethical guidelines relating to boundaries historically mentions the *slippery slope* phenomenon (Strasburger, Jorgenson, & Sutherland, 1992) referring to the theory that serious boundary violations are frequently preceded by lack of attention to minor boundary transgressions. However not all professionals who take professional risks end up slipping into seriously unethical territory and many with generally strict boundary management, even those in high office, have transgressed into a sexual relationship with their clients (Koocher & Keith-Spiegal, 2008; Schoener, 2001). Yet the newly revised Code of Ethics for Psychologists in Australia (Australian Psychological Society, 2007) continues to use the *slippery slope* argument to warn against the inherent dangers of boundary crossings and dual relationships. The American Psychology Association recently included an update to its Code of Ethics (American

Psychological Association, 2002), relaxing the rules around boundaries, however there is some disagreement with the new liberal stance (Koocher & Keith-Spiegal, 2008). The British Association for Counselling and Psychotherapy (BACP) recently updated their professional code (British Association for Counselling and Psychotherapy, 2009) to a virtue based aspirational model. All in all, the recent changes highlight the differences more than the similarities in the current trends worldwide in relation to boundaries in therapy. Despite the continued interest and necessity for guidelines in the area of boundary management, and the development of several decision making models to assist the process (Corey, Schneider-Corey, & Callahan, 2005; Cottone, 2001), how decisions were actually made in practice came down to individual differences and interpretations. A comprehensive discussion of this topic is beyond the scope of this study; however some pertinent aspects can be highlighted from the findings in this study. The trend and emphasis on structural boundaries and professional risk management (Gutheil & Gabbard, 1998; Zur, 2007) can be detrimental to the therapeutic relationship, in particular the relational development of trust. The impact of professional codes has gravitated into areas of law and away from moral and mutual responsibility. "The therapy room is not hermetically sealed from all external forces and how these are managed can be critical to trust" (Bond, 2007, p. 440). Therapists appear to be engaging in risky areas regardless of codes and as Schoener (2001) found, the differences in boundary management between those found to be serious offenders and those who were not, is very small. If this is the case it raises the question of the moral development of practitioners over and above their actual application of boundaries in practice. Therapists in this study crossed boundaries but were moral and ethical in their behaviour and treatment of their clients. As one of the therapists, Thomas expressed, "Rather than this neat tightly bounded thing we're all seemingly presenting to each other, but so few of us are really doing it the way we present it".

Therapists also place trust in their client when they cross a boundary. It is safer not to in terms of the therapist being more protected from any pathology present in the client or becoming prey to a formal complaint. Therapist self protection against litigation has now surpassed the original reason that professional codes were developed, which according to the Australian Psychological Society (2007) was to prevent harm to clients. This situation raises the question, how much harm to the relationship does fear of professional retaliation promote? While it can be debated if each therapist's decision was a wise one, the choices did not result in a serious transgression. Each case showed that the crossing has been of some benefit to the client, and the overall relationship. Yet therapists in this study worried about the consequences of others knowing about these crossings more than the crossings themselves. They were also concerned about being viewed as unprofessional by their colleagues or profession. This secrecy could jeopardise much needed consultation and supervision.

This study provided examples of how boundary crossings aided the relationship from client's perspectives, however there is more to discover. For instance it would have been beneficial to know more about the impact on Leo's client Paul of being privy to the way his therapist responded socially and personally to things he would not normally know about. What comes to mind is drinking habits, responses to lurid jokes or even how he treats his wife. According to (Zur, 2007) knowing someone intimately is precisely the reason this sort of arrangement works well, which is exactly the reason the client Paul gave. However Zur (2007; 2008) is an atypical voice in the field at the moment and comes under criticism from professional colleagues (Koocher & Keith-Spiegal, 2008) for his views. The very reason so much caution and fear abounds around this topic is the ironic reality that the practice of risk management has facilitated complaints due to the defensive and detached behaviour they evoke in the relationship. This is not to say that therapists do not at times need protection from clients who may have tendencies towards manipulation or dangerous behaviour. However the paradox of

therapeutic power versus client fragility and dependency makes little sense in the new world of risk management. Relationships in this study were messy at times but relational connection was the key to negotiation and repair.

Relational boundaries had just as much to do with the inter-subjective meeting of therapist and client as with the structural aspects of space and time in therapy. The meaning placed on responsiveness was a significant aspect of the non-verbal negotiations between therapist and client. The relational context was the place where meaning and trust developed. Yet there is sparse literature available that directly relates to relational boundaries in therapy. The focus on boundaries as purely structural or protective, places instrumental focus and solutions onto dilemmas of human nature that require relational resolutions. At another level an instrumental approach demands compliance from clients within a context that already evokes anxiety and tentativeness. According to the attitudes of clients in this study, codes of practice are moving away from and may be counterproductive to what clients require when they embark on a therapeutic relationship.

Mutuality and Relational Boundaries

The relational boundary negotiations between therapists and clients were both explicit and implicit, and impacted on where each dyad positioned the boundaries for their relationship. The different and various attempts within these relationships to find a good enough fit with each other highlighted the relational exchanges for both therapist and client. For the therapist it was related to the direct pressure of an unorthodox request or situation, or in sessions how their psychological intrusion impacted or mapped onto the clients. For clients their relationally based needs and anxieties motivated the steps of the exchanges and consequent adjustments to the emotional demands and intimacy of the therapeutic relationship. As well as tolerating the anxiety of containing their emotional life between sessions. Mutuality involved a constant adapting and

regulating to the others emotions, behaviour and state of mind. Therefore the therapeutic relationships were constantly adjusting to each other in ways that were not always transparent, or as simple as putting a structural or prescribed boundary in place. Unless familiar with the counselling field, clients do not understand the theory or ethics of counselling and psychotherapy, and therefore how therapists think about or manage boundaries in practice, either personal or structural. Therefore the way therapists respond to unusual relational requests from clients can be construed as confusing, rejecting or plain condescending.

Mutuality also entailed aspects of how the therapists and clients personal lives dovetailed in unexpected ways and, at times, included life events for the therapists, both past and present that were tapped into by the client (Aron, 1996; Otte, 2010). A dilemma or struggle in the therapist's life would permeate into a salient theme for the client, or the therapist's historical experience was touched by the content or interpersonal dynamics elicited in sessions. Whether these events were disclosed in full or not, it enhanced the relationship and deepened the trust when therapists were able to become aware of and actively engage with personal knowledge that was functioning within the relationship (Audet & Everall, 2010; Renik, 1995). However there was also a range of attitudes and applications of inter-subjectivity within the relationships. Therapists own personal material was often used as a last resort to understand the current relational dynamics. Therefore there was more focus on the client's inner experience and a lesser focus on the therapist's personal contribution. However particular themes within the relationships played out regardless of where the focus lay (Bornstein, 2010; Renik, 1995).

Significant themes or dynamics within the therapeutic relationship were not always discussed explicitly, and at times, were dealt with superficially. When this occurred the underlying issue in the relationship was played out symbolically, creating a relational metaphor for what could not be expressed in words (Aragno, 2009; Modell, 2009). While all seven relationships had a strong bond, there were occasions where the relationship was not utilised as

the vehicle for learning when it could have been. Some strong themes remained underground and thus unexplored. For example one therapist, Will, mentioned that he felt unequipped to deal with erotic transference. While there is the expectation that therapists should not work beyond the limits of their training, sexual attraction and expression is a topic that touches most lives on a human level, not just on a theoretical level. The therapist was convinced he did not give out sexual vibes and the topic was not explored; however the client used the metaphor of "Prince Charming" except with "no kisses." The particular relationship in question was never-the-less a strong and trusting one, albeit with some blind spots. This highlights the reality that successful relationships are not always professionally faultless. The mutual processing of certain topic areas (Hill & Knox, 2009) or the repair of relational ruptures (Lewis, 2000; Safran & Muran, 2003) appear to be more relevant to success than faultless treatment.

While firm boundaries serve a vital and containing function in the therapeutic relationship, therapists who operated out of a relational value system versus a rule-driven system created stronger bonds with their clients. Having a relational value system assisted the therapeutic relationship to fully engage and facilitated trust. Therapists both loosened or tightened the relational boundaries to meet their clients' needs without collapsing into a relationship where the boundaries became overly blurred, or tightening up to the point of detaching from the relationship (Zur, 2007). The one relationship where social roles overlapped considerably remained bounded in those social situations; however the effect of the overlap of roles in this relationship on the work of therapy was less clear.

Mutual Trust

Clients saw their therapists as trustworthy, someone they could trust to be honest with them, even if the honesty came in a "soft" or "convoluted form" as one client called it. However taking the risk to trust and be trusted was sometimes a leap of faith for both clients and

therapists. The capacity to trust was facilitated by the generosity of self that therapists displayed in stretching a boundary to meet their clients in the space they inhabited. Stretching boundaries to accommodate the relationship facilitated trust and, in turn, was the dominant predictor for clients as to whether the therapist had their best interests at heart. This was the case regardless of whether the issue had been discussed overtly or not. Trust emerged and developed out of the internal dynamics of each dyad as they mutually adjusted to each other's style of relating. Therapist responsiveness facilitated client confidence in the dependability of the therapist as someone safe, reliable and committed. This phenomena runs counter to current beliefs about client autonomy (Koocher & Spiegal, 2008; Witty, 2005). According to O'Neil (2002) measures to improve client autonomy have failed to secure trust and may even damage trust through an abdication of responsibility. Autonomy is meant to foster a capacity for independence and freedom of decision making; however according to O'Neil (2002) autonomy is always autonomy from something and therefore increasing individual autonomy may only serve to increase the autonomy of those in positions of power. This idea was compelling in light of the attitudes and meanings that clients attributed to assessing if their therapist was trustworthy, coupled with their views on the attitudes of their previous therapists. Clients in this study were not assessing trust based on their perceived level of autonomy from the therapist; in fact quite the opposite.

Both therapist and client brought personal value positions into the new relationship, and it was this more personal position that took the foreground and became the context for assessing trust in the relationship. Therefore, therapist's boundary decisions in practice extended well beyond concerns about client safety or therapist protection. When therapists changed their usual mode of working as a result of client influence the shift implied acceptance, respect, equality and most significantly enabled client agency. Joint trust supported the reciprocal adjustments necessary to engage with personal differences, conflicting interests, challenging behaviour and

the potential intimacy of the therapeutic encounter. The development of trust required reciprocity more than autonomy.

The mutual nature of trust elucidated the context and conditions required by the client to engage in and sustain the relationship. Chloe exemplified this dynamic with her "trust test." As frustrating as this might have been for her therapist Anne, she proved herself to be trustworthy simply by not becoming punitive. As the relationship between Giselle and Jim showed, counterproductive dynamics can occur, but risks or mistakes do not become unethical merely because they produce unwanted results. The perpetuation of the situation, or turning it back onto the client and disengaging from the mutual responsibility in the relationship is more likely to lead to misunderstandings and create the breakdown of trust (Bond, 2007). When the boundaries collapsed unexpectedly at her home office, Giselle did not run for the cover of the *DSM-IV* or disengage from the relationship, she rectified the collapse through remaining in relationship, or what Bond (2007) calls *interactive autonomy*. Jim did not like the new limits and changes but benefited from being included in the honest exchange of dialogue that was used skilfully to advance both their interests moving forward. Giselle did not stifle the dynamic aspects of the relationship by retreating into defensiveness and putting up professional barriers that could go unchallenged. The nature of a reciprocal exchange involving interactive autonomy means that neither person can completely control the process.

Most clients had a history of relationship difficulties and problems placing trust in others. Mistrust does not grow in a vacuum, it usually develops from relational experience and as such requires a relational remedy. According to Safran and Muran (2000) the negotiation of needs assists the capacity to experience both self and other as subjects, and therefore the development of a true capacity for intimacy and authentic relatedness. It also stands to reason that conflicting needs emerge within the relationship and therefore cannot be prescribed in advance of the reality of the relationship (Safran & Muram, 2003). Mutual trust therefore challenges the conventional

notion of a unilateral application of principles where the client places blind faith in the therapist. As the relationships in this study showed, the source of meaning resided within the relationship itself and was therefore the context in which appraisals of trust were made. Trust was a significant issue for clients, and they reported when trust was present it ameliorated other desired criteria in the relationship, even over and above skill level. Therefore trust was the foundation upon which the relationship was based. Risk and uncertainty were inescapable challenges that faced each therapist and client and took courage for both parties to face. Clients wanted the capacity to be self-governing and experiencing the negotiation of trust within the crucible of the relationship was powerful and empowering learning.

Generosity of Self and Responsiveness

Seeking professional help held a palpable fear and anxiety for clients. The therapists who stretched themselves to accommodate difficult behaviour, or what could have been construed as pathology, showed a tolerance and generosity of self that allowed those particular clients to feel safe enough to remain in the therapeutic relationship. In the relationships portrayed, clients were respected rather than treated as a diagnostic label, even though some professional jargon was used to describe particular client symptoms. When therapists were responsive and allowed themselves to be influenced by their clients, the mutuality did not mean a loss of self for either person in the intensity of the dyadic emotional field, or a collapse of values.

Responsiveness was not only about generosity of self, it encompassed the prosodic aspects of the relationship. The non-verbal, behavioural and emotional sources of information as described by the dyads, showed how the unspoken aspects of the relationship had a large bearing on the perceptions and beliefs about the attitude and responsiveness of the other, especially client perceptions of their therapist. Therapists' generosity of self enabled them to be sensitively responsive in difficult or frustrating situations and clients eventually reciprocated with their own

version of generosity of self. Clients described tolerating and forgiving the human failings of their therapist at times when their therapist was less astute, insensitive or operating from a therapist centric agenda. During these relationship lapses, the underlying trust in the person of the therapist and his or her motivations overrode any flaws or imperfections in perceived clinical skills. Peter expressed this phenomenon best when he said he had a "very good sense" of Graham's mental states and he thought Graham also had a "good sense" of his. Generosity and responsiveness were the outward signs of an underpinning of trust in the other and therefore a tolerance for their humanness. There were many times that responsiveness played a hidden role in the relationship, yet at an implicit level it was also recognised and known. For Eve "what was spoken was not as important as the relationship you developed," and Peter said "things that are unsaid are more profound than things that are said". Therefore the implicit knowing within the relationship was operating under the surface and was a powerful connecting force.

Therapist's Subjectivity and Boundary Decisions

Therapists varied greatly in their conceptualisation and practice of boundary management. Decisions made in relation to boundaries were predominantly based on the informed intuition (Siegal, 2009) and subjective assessment (Aron, 1996) of the therapist. Where a boundary was adjusted or crossed, the thinking behind it was influenced by the therapist's personal experiences more than the external influence of professional practice standards. Therapists own history, previous training and personal therapy all contributed to the rationale with which they approached intake and therapy, along with their perception of the client and their situation. There was no mention of decision making models, consultation, supervision or codes of conduct. This phenomenon was striking in that therapists relied on their past experiential learning to inform their thinking and assessment precisely because of its experiential power. Thomas vividly remembered his experience as an intern when therapy went from bad to worse and ended up

being a “complete disaster”. Anne remembered her personal experiences of her own therapy, both good and bad, plus her own experience of healing from trauma. Graham went with his “gut” to change his mind about taking Peter on as a client. Will “knew” professionally that loaning a book of fiction was an exception to the usual rule; however he thought Eve would relate to the author and the relationship benefited as a result. Experiential learning therefore came to mind quickly and impacted therapist’s decision making in the immediacy of the moment. As such therapists integrated experiential reality or procedural memory was activated and utilised before academic learning was recalled and used for self reflection.

The therapists who took the risk to join with clients when they may have been placing themselves in a compromising position professionally were guided by an internal moral compass. Dual roles were rationalised through the same lens. The decision to risk crossing a boundary for a client also places trust in the client and extending the hand of trust places an emotional demand on the client. Therefore a trusting environment is not something that the therapist alone offers, or provides for the client. Trust was a reciprocal and relational undertaking and the shifting of boundaries was an integral part of entering the process. Most therapists were none-the-less concerned with how boundary crossings would be viewed by colleagues, supervisors or the profession. The threat of disciplinary action was not far from the minds of some therapists, even when they could justify the thinking behind their decision. For example Will had not mentioned to his supervisor that he had loaned Eve the book and Thomas had not told anyone about showing Bella the picture of his dog on his mobile phone. Consequently boundary decisions were not disclosed readily to peers or supervisors. The one exception to this was Leo a senior practitioner and revered figure in the profession who openly entered a dual relationship with significant social and family overlap. Whether this was hubris, complacency or something more altruistic is unclear. However it was clear that the social contact was handled in a bounded way. One paper from the analytic field (Pepper, 1997) suggested situations like these

are about grandiosity and covert narcissistic gratification. Generally most postmodern approaches would question the possibility of being able to interact on all social levels while still protecting the client's best interests. While Leo's decision would be considered unwise in relation to current understandings, the client Paul stated that the reason the arrangement worked for him was precisely because he knew Leo. This is the case with less theoretical or research based views from rural practitioners where contact across all social levels is simply a way of life. However the same scenario is not advocated for non-rural therapists. A fuller understanding of this scenario from the perspective of therapists and client was not gleaned. Contrary to the slippery slope concept, when relational boundaries were crossed they did not collapse into exploitation or sexual misconduct. Most therapists in this study crossed a boundary at some point and those crossings according to all accounts caused no harm and were of likely benefit to the client.

One of the quintessential underpinnings of the discipline of counselling and psychotherapy is that therapists should be non-judgmental (Rogers, 1957). However the therapists in this study had many and varied judgements, including quite negative thoughts and feelings about their clients. Giselle mentioned her very negative reactions to Jim, Will offered the image of Eve as a fat spider in a web and Thomas said sitting with Bella when she felt flat was like pulling teeth. Therapists showed they were human and had human reactions to aspects of their client's personalities or behaviour that upset, irritated or even revolted them. However the therapist's reactions all had a meaning within the relationship rather than being purely individual (Bornstein, 2010). Giselle's personal history was touched, Will was wary of an aspect of Eve's personality and Bella's flat affect tapped into Thomas's admitted "avoidant" style. Yet only Giselle courageously brought back a palatable version of her reactions to the work of the relationship. While it would not be acceptable to tell a client you cannot stand sitting with their depression any longer, or that you think they are lazy, because they sit and wait "like a big fat

spider," creatively working with personal reactions or relating the material to the therapist contribution was less likely to make the agenda. Reactions were interpreted mainly with a focus on the client's material, leaving the source of a rich well of relational learning untapped. Therapists did not seem to have many alternative ways of thinking or working with relational themes apart from the concept of counter-transference. Recent literature linking therapist's attachment style to clinical practice (Dinger, et al., 2009; Holmes, 2010) sheds light on how therapists learned emotional patterns of relating can impact on levels of empathy and lower alliance ratings. There is also a link in this literature to the finding of client tolerance of mistakes, saying that in secure intimate relationships there is an expectation that misunderstandings are the norm. Holmes states that the important point is to focus on the feelings associated with the difference and to find a way to talk about it. Therefore therapist's attachment style may prove to be a factor in how therapists manage intense emotional material with their clients.

Only one therapist brought up the topic of contracting with their client prior to therapy and none mentioned giving information to clients about their practices. Contracting was either verbal or absent and therefore left quite loose and open. Therapists' different educational background modality or discipline did not make a significant difference in regard to how they navigated the intake process and structure of the therapy. Clients had some elementary knowledge about therapeutic boundaries. Three clients had training in the counselling field and therefore had more information about what was expected and used the correct language terms, although without necessarily a full understanding of the meaning. Three clients had a lay-mans view and limited sense of how boundaries were meant to function within therapy. One client had some rudimentary paraprofessional training. All seven clients were heavily influenced in their attitude and behaviour to relational boundaries by their therapist's initial modelling. The variety of ways used to conceptualise structural and relational boundaries was a good indication of the diversity and lack of consensus in the field around how to think and work in this area.

The Personal Relationship

The findings from this study support Gelso's (2009a) assertion that there is *something more* operating in the therapeutic relationship that is different from the transference relationship and the working alliance in very important ways. However it was not realism and genuineness as defined by Gelso (2009a) that occupied the foreground. This study found that clients certainly wanted their therapists to truly see them and understand them as they were; however if misreading occurred clients did not deem the relationship to be unreal. At the risk of being slightly repetitive the theme of client tolerance continues briefly as it relates to and differs from Gelso's theory. As already mentioned clients were tolerant and forgiving of times when the therapist got it wrong or did not share their view, although by all accounts this was rare. This tolerance was not a benign or passive acceptance of inaccuracy, but more an acceptance that their therapist was human and fallible (Holmes, 2010; Manthei, 2007) which sometimes disappointed, hurt or angered them. Importantly, underpinning this acceptance for all clients was the notion their therapist meant well and had their best interests at heart. In other words clients trusted their therapist's motives. After all a therapist could potentially understand accurately and convey that understanding but still not care or be committed to the relationship. Mutual respect and trust as discussed previously infused the interpersonal process and aided and enabled the repair of any ruptures or lack of fit that might have been encountered in the relationship. Contrary to not feeling real (Gelso, 2009a) the relationship was experienced as real but imperfect, or of strong enough quality to bridge differences. Clients' gratitude and appreciation of the care and commitment shown by their therapists surpassed any imperfections in the relationship.

Therapists and clients also had attitudes, feelings and judgements that were private and not disclosed to each other. This did not necessarily mean the relationship was inauthentic, as Giselle demonstrated one can be authentic and genuine while censoring ones thoughts. Pretending or

conjuring up responses would not be genuine, whereas privacy is somewhat different. Therapists and clients both had moments where they did not feel free to be completely uncensored, and for good reason. Holding on to opposite and opposing feelings and thoughts was challenging but not insincere. Restraint was about protecting the relationship and this was the case for clients and therapists. Even Jim who had limited capacity for reading the internal reactions of Giselle knew that at times his "material was over her edge" and that he might be too much for her and "freak her out".

Intuition: Interpenetration of Minds

The other phenomena that emerged in the various relationships were the interpenetration of minds through intuition. The notion of mind reading (Baron-Cohen, 1999; Perner, 1996) or *mentalization* (Fonagy et al. 2004) has been part of the theory of mind debate over the last decade. Some of the clients in this study intuited or picked up on the emotional state of the therapist and in doing so inadvertently tapped into life issues for their therapist that were operating behind the scenes and unknown to them. The overlap and dovetailing of therapists and client's private lives made for uncertainty about whose issue was foreground.

The best examples of these phenomena were the instance where Bella's focus on Thomas's health also picked up on the fact that Thomas was suffering chronic fatigue. There was also the possibility through Bella's focus on death and grief that she also sensed the grief in Thomas after the death of his wife. Another was Sarah's struggle around feeling "important" which neatly dovetailed with her client Lily's need for someone strong and dependable. Anne identified that she often worked in an intuitive space with Chloe, "like particles connected." Will and Eve played out the dance of attraction symbolically and thereby unwittingly found a way to mutually avoid making a place for the erotic or unappeased feelings in their relationship to be explored explicitly. Giselle and Jim found themselves in a relationship where the lack of boundaries

touched on Giselle's history in a very tangible fashion. The metaphor of intrusion played out in another form that signified the breach of a boundary long ago. Even the act of Jim placing his milk in Giselle's fridge symbolised the intrusion in a very literal fashion that evoked indignation and anger in Giselle. The different therapeutic relationships showed how the two people involved were touched in unexpected and profound ways. However these were not unconscious enactments, they were based on real lived experience that was not unknown to them. Therapists tended to keep their focus on the client and minimise their own contribution to the powerful dynamics that played out between them until an impasse alerted them. Therefore the relational stance of inter-subjectivity again played a lesser role in therapists conceptualising of the couple dynamics.

The relational literature (Aron, 1996; Bornstein, 2010; Eshel, 2010; ; Slavin, 2010) says mutuality is inevitable, however when therapist's personal material entered the therapy relationship it was not always recognised at first or taken seriously as having an impact. Therefore the co-constructed reality could easily get lost and the focus on the client's behaviour can look increasingly like transference. Therapists can and do have difficulty acknowledging that their daily emotional states, character issues, illnesses and experiences of loss affect the client and ultimately the treatment (Kottler & Carlson, 2005a; Orbach, 2007; Otte, 2010). Therefore the reality of everyday life for the therapist outside of therapy needs to be taken into consideration and just as seriously as the client's transference or projections onto the therapist. When there was evidence of this phenomenon in a relationship and the therapist and the client could safely embrace an awareness of themselves in concert with each other, this intimate edge of the work had mutual benefits for the relationship.

Picking up on the therapist's state of mind can potentially be explained theoretically through the concepts of embodied emotional communication, including emotional resonance (Cozolino, 2010; Fosha, 2001; Greenberg, 2004) emotional contagion (Krystal, 1988; Schore,

2003) and somatic states (Adolphs, Damasio, Tranel, Cooper, & Damasio, 2000; Lane, 2008). These extremely fast responses are non-verbal, automatic and unconscious (Cozolino, 2010; Schore, 2003) therefore rendering the therapeutic relationship open to instantaneous inference and assumption, but also the inevitability of a shared emotional journey. What made the difference in relationships where psychological or emotional interpenetration occurred to a more significant degree was the reflective self awareness of the therapist to stop conceptualising from the perspective of a one person psychology (Safran, 2002). Once therapists realised their embeddedness in the process, their capacity to extend themselves emotionally, to self disclose, apologise or challenge was harnessed in a way that enhanced the relationship. Emotional tuning in and mirroring were essential (Jordan, 2000; Myers & White, 2010) but the shared understanding needed to go somewhere and this required holding on to one's own mind and individuality.

The push and pull of the different relational dynamics showed that therapists often had to work hard at empathy. Controlled empathy (Hodges & Wegner, 1997; Lane & Schwartz, 1987) went beyond emotional contagion and identification into an effortful stance of perspective taking that was intentionally produced and other-oriented. This level of cognitive empathy required self reflection and exploration as shown by all therapists. While this was the case to varying degrees in all seven relationships, the very obvious and clear example was Giselle and Jim. Giselle was the exemplar of a therapist who could step outside herself to feel for another. Personal identification with a client is often viewed as problematic, whereas the inevitable nature of sharing unconscious information (Cozolino, 2010; Decety, 2010; Schore, 2003; Siegal, 2009) makes avoiding identification almost impossible. The key for therapists was not to allow one's own experience to prevent or limit empathic awareness of another's experience. Therefore emotional separation was also necessary. The theme of emotional relating embellishes this phenomenon further.

Emotional Relating

Emotional regulation was a dominant theme in all relationships. Even though depression, anxiety, addiction and relationship difficulties were the main presenting issues for clients, it was feeling stronger emotionally and more emotionally comfortable in their own skin that made life bearable. This ranged from learning how to feel by using bodily signals, identifying and facing feelings, staying with feelings longer, being able to tolerate and manage them more effectively and also realising that feelings would eventually pass. Therefore despite the variety of different presenting problems, it was not the resolution of those problems that clients found most helpful. The calming of the underlying emotional distress around their particular problem was highly significant. Even Peter, who was adamant that he wanted wise input and none of this western processing nonsense, said that having his feelings of "distress" and "impending doom" lifted, was the most helpful aspect of his relationship with Graham.

Therapists managed emotional regulation and expression in different ways. Giselle, Sarah and Anne had a more direct approach to emotional issues and dynamics within the therapeutic relationship. Leo used more indirect means such as being playful, teasing and telling stories or anecdotes to approach challenging emotional territory. Graham consistently attempted to direct Peter towards reflecting on his feelings without much success. Will worked in a gentle empathic way focussing on reflecting feelings with less emphasis on challenge. Will preferred a "safe" style of working and was admittedly less comfortable with challenge. Thomas often used humour to lighten the sessions with Bella. It would be useful to understand these findings more fully in relation to the inter-subjectivity of emotional relating and empathy and how much the subjectivity of the therapist helped or hindered the emotional depth reached in the relationship. Sarah and Lily for example had two years of many silent sessions and Lily found the emotional intensity overwhelming. Anne and Chloe had very emotional sessions and Chloe was learning how to pull back and control her strong reactions. Giselle and Jim's sessions were often about

containing anger. Thomas and Bella sat through many "flat" sessions and Thomas's self confessed "avoidant style" found the sessions extremely difficult. Therapists often felt their way along with clients, doing the best they could within their personal emotional range.

It is well documented that emotional awareness and its companion empathy are necessary and vital ingredients in the therapeutic relationship (Fosha, 2001; Greenberg, 2001; Jordan, 2000; Myers & White, 2010). Current understandings of emotional communication have been enhanced through study on emotional intelligence (Goleman, 1995) and research on neurobiology (Adolphs, et al., 2000; Damasio, 1994). Allowing and identifying ones feelings and having them acknowledged and understood is also seen to be the underpinnings of reflective self awareness and is a function of secure attachment (Fonagy & Target, 2005). Evidence pertaining to the role of emotion in healing posits the limbic area of the brain (or emotional centre) as the royal road to relationship success and change (Cozolino, 2010; Lewis, et al., 2000; Siegal, 2009). Emotional attunement, understanding and empathy therefore play a large role in the phenomena of mutual influence within the therapeutic relationship. Clients in this study certainly mentioned that feeling understood and accepted was very important to them, and therefore the therapist's emotional repertoire was essential to the work. Yet it was evident that some relationships took time to adapt and attune to each other emotionally with two clients in particular having difficulty with memory due to anxiety and dissociation. As Lily commented about her therapist Sarah "she knows when she's gone too far", meaning past Lily's threshold for tolerating the emotional intensity of the interactions. The anxiety frightened Lily back into the safety of dissociation. This ties in with the literature from neuroscience (Schore, 2009; Siegal, 2009) and attachment (Sroufe, 1996; Wallin, 2007) stating that it is not just accurate attunement of emotional states that is necessary for experience to be laid down in procedural memory and therefore integrated; the attunement needs to take place under average states of arousal. According to Fonagy (2001) emotional understanding must also be reflected in a manner that shows awareness of the person's

mental state or mirroring, whilst also showing coping, therefore, “mirroring the distress while also communicating an incompatible affect” (p. 166).

This study supports the view that emotional regulation is not just about expressing feelings. Clients also described behavioural and nonverbal cues that alerted them to the attitudes, feelings and intentions of the therapist. Several clients thought that at times what was said was less important than what was unsaid. Peter mentioned feeling good about his reading of Grahams states of mind. Chloe “just knew” that Anne was with her. Therefore empathy was a complex and potent variable with emotional, cognitive, behavioural and kinaesthetic aspects that linked very closely to the notion of presence (Geller, et al., 2010; Tannen & Daniels, 2010). The level of explicit emotional connection and expression in the different relationships was quite varied. Not all relationships entered the delicate or deep emotional terrain described in the literature as bringing about healing (Fosha, 2001; Ryback, 2001). Some relationships took several months to achieve the trust necessary for emotional intimacy, while others operated at a more pragmatic and solution focused level, yet emotional relief and healing still took place. According to Schore (2003) affectively charged moments do not always have to involve displays of emotion, because emotional communications are transacted at conscious and unconscious levels. This area of neuroscience relates closely to the concept of presence which is a phenomenon familiar to most therapists.

A recent paper by Tannen and Daniels (2010), states that presence is noticeably absent from both theoretical models of counselling and the research literature. Tannen and Daniels proposed that presence is an important and powerful common factor in the therapeutic relationship and that healing is the result of presence. They call into question the recycling of existing models of the relationship that fail to encounter new phenomena and therefore perpetuate limited definitions of the therapeutic relationship. The concept of presence may help

redress the gap between the evidence in the literature of the significance of emotions in healing and the variations found in emotional expression and processing in the relationships under study.

Accounts from both therapists and clients consistently mentioned non-verbal aspects of the relationship playing a significant part in the co-creation of the relationship and on their particular inferences and decision making. Gut reactions, intuition, prosody and pure subjectivity, were therefore vital contributing factors to the assessment of the state of the relationship and the way issues were approached or avoided. The fact that many thoughts went unspoken within these relationships indicates an area that could use more investigation. Stern (2004) stated that implicit knowing was part of the *present moment* of lived experience that is experienced through voice tone, body language and eye contact that can give a consciousness of sharing a similar mental state. This limbic resonance is what Siegal (2009) calls "feeling felt". Therefore these unspoken aspects of a relationship convey emotional content and messages and as such touch the other person emotionally without the necessity of explicit processing. Bella "scanned" Thomas when she arrived for her sessions to assess his health and according to Thomas it was extremely fast and "elliptic". Sarah felt physically "deadened" by Lily during their silent sessions. This interpersonal phenomenon also fits with the recent notion of sharing neural circuits, or right brain to right brain connections (Decety, 2010; Schore, 2003) hence the co-creation of connection and understanding that emerges without the client necessarily having to enter emotional territory that is beyond their capacity. As the quote from Fosha (2001) stated in the literature review, the client gains access to the therapists capacities, that are not theirs, for a time. While this investigation did not set out to study neuroscience, there was enough mention of nonverbal phenomena by clients and therapists to create a hypothesis about how emotional healing took place in relationships that were not necessarily about plumbing emotional depths. Clients in this study were touched deeply in many ways and presence, for those who find being

emotive too demanding or exposing, might explain how emotions and mutual empathy (Jordan, 2000) can cross the gap between two minds.

Emotional relating on all its levels has repercussions for the ending of therapy. There was no space to include the data on client and therapists perspectives of ending therapy in this thesis; however all relationships in this study had an open door policy for ending and revisiting the therapy relationship. As described by Lewis et al. (2000) when a close relationship ends it means that "literally a part of you is missing". The notion of sharing neural circuitry and using another person to self regulate explains the difficulty of ending such a sustaining relationship more usefully than theories of unhealthy dependency.

Paradox and Metaphor

The relationships in this study show more congruence of opinion between therapist and client than have been previously reported (Manthei, 2007; Scheel, Hanson, & Razzhavaikina, 2004). This is possibly due to the strength and quality of the relationships. However it was also evident within each relationship there were contradictions and paradoxes where therapists and clients thought and felt differently about the same dynamic or relational theme. Therefore the meaning placed on the particular dynamic was also different. Will said boundaries had been easy due to Eve "knowing about those things". Eve said the relationship was safe because the boundaries were inviolate (put in place by Will). Thomas pushed and pushed for Bella to express anger. However Bella said it was unlikely to happen, she was satisfied with knowing she was loved, and therefore lovable. Sarah thought that Lily was emotionally repressed, while Lily said she was "just being stubborn" because she felt very anxious. Graham thought Peter looked on him as a father figure and described him as having an idealised transference. Whereas Peter did not relate to the idea of a father figure and held a realistic view of Graham as humanly fallible; however he had trust in Graham's "substance" and integrity. When therapists attempted to map a

theoretical interpretation on to the relationship dynamic the fit between them and their client's view became less parsimonious. Therefore forcing a theoretical notion such as, anger must be expressed at the therapist for mature growth, or, client resistance is always about anger, could produce a seemingly skilful outcome for the therapist but a spurious outcome for the client.

Carl Whittaker (Napier & Whittaker, 1988) coined the term *battle for structure,* and psychoanalysis commonly mentions the battle for control. While not disagreeing completely with these notions and their meaning, they do not appear to fit for the clients in this study and therefore do not tell the whole story. Attachment theory (Cassidy & Mohr, 2001; Harris, 2004; Slade, 1999) would interpret the client's behaviour as shown in chapters 4 and 5 as the battle for proximity. The tension between the need for proximity and emotional security was evident and raised questions for clients such as: Can I trust you to look after me and honour me? Will I be safe with you? How close can I get to you and not become engulfed or abandoned? Will you be able to see who I am not what you want me to be? Will I be able to reach, touch and have an impact on you? The paradox between theory and practice is sometimes in itself a challenge. When a client was resistant, difficult or simply stuck, theory did not always give a full or accurate picture (John Norcross & Marvin Goldfried, 2005). Therefore reflecting on the therapist's contribution to the dynamic rather than a sole focus on the client honoured the reciprocal influence and could assist in making sense of the paradox.

Giselle and Jim highlighted the contradictions of opposing thoughts, feelings and judgements. For example the paradox of feeling dislike yet acceptance, frustration alongside tolerance, impulse against restraint, wariness versus trust and revulsion and respect. The private inferences and attitudes of therapists added to the paradox of also having to be authentic and honest. Even empathy itself was a paradox, being able to show accurate understanding and acknowledgment of the emotional life of clients while also having an accompanying opposite reaction. Therapists had normal human reactions to recalcitrant or irritating attitudes or

behaviour. The juggling of contradictions placed the onus on the therapist to expand their repertoire in the service of the client. The nexus of the mixed philosophical agenda between the ideals and realities of practice required self awareness and a form of mature *controlled empathy* (Hodges & Wegner, 1997; Preston & de Waal, 2002) and moral development (Hoffman, 2000; Tangney, 1991).

Clients also experienced contradictions: fear and yearning, faith and dread, desire and disappointment, self-efficacy versus dependency, vulnerability alongside competency and desperation to change alongside ambivalence. The therapeutic relationships were riddled with contradictions and the boundaries between who owned what thought, feeling or confusing conflict were not always completely clear. Only mutuality with its sense of interpenetration gets nearest to the phenomenon. While transference and counter-transference are not ruled out, they did not appear to be at the centre of the issues in the relationships under study. What was happening between therapist and client could not be explained fully using those existing constructs. For example Will and Eve's relationship with its strong metaphor of attraction carried the paradox along in high relief, like secrets hiding in the open, "prince charming only without kisses". Relationships that could withstand the *here and now* intensity of a direct encounter handled with sensitivity and "loving care" managed to remain connected and deepen their understanding of one another. Tolerating the profound inconsistencies of human nature and having the emotional courage to engage in honest and authentic exchange was yet another act of generosity and human love.

The Growth of Love

Love in the therapeutic domain is controversial. Freud said psychoanalysis was a cure of love; however his theory of libidinal love focussed on the sexual aspects of love and he cautioned about its dangers within the therapeutic relationship. Psychoanalytic constructs such as

erotic sadism or masochism, oedipal desire or just plain erotic transference, ominously outlined the seething cauldron of human desire waiting to entrap the therapist. Ferenczie (1932) was barred for years for trying to cure patients with love, literally. Love therefore remains a nebulous and intangible part of relationships, often left to literature and the arts to unveil its many mysteries. The current trend towards proving a scientific basis for counselling and psychotherapy (Hubble et al., 2009; Wampold, 2001) renders the distance between love and treatment even wider. However, the role of love in healing has been well acknowledged in the literature (Cozolino, 2010; Jordon, 2000; Kottler, Sexton, & Whiston, 1994; Seethe, 2010). But where and how does love fit with the therapeutic relationship without causing scientific or empirical unease. Language has become part of the clinical veil constructed to disguise and explain how the therapeutic relationship can navigate the awkward notion of love in a professional setting. Language such as unconditional positive regard, like, and fondness, are considered far more acceptable than love when talking about a professional relationship.

Several clients named feeling love, gratitude and deep appreciation towards their therapist for the thoughtful care they had received. Clients' experiences and feelings of love and gratitude were real and palpable, not simply abstract constructs or forms of transference. Bella commented that she did not know what she would have done if she had not found Thomas. For her the therapy relationship was about her psychological survival, as it was for Lily, Peter, Chloe and Jim. Eve mentioned the "sacred space" or "soul" aspect of her relationship with Will, in line with Hillman's (1996) definition of a psychotherapist as "an attendant to the soul". When asked if there was one thing she would like to tell Thomas when they finished therapy, Bella said, "I'd tell him how much I love him". Jim's words, when asked if there was anything else about Giselle he would like to add to his interview simply said, "I love her dearly". Peter described love differently as meaning "what we have been through together" and therefore the shared pleasure and pain of knowing and being known. Sarah said of Lily, "she's in my heart". Eve said she had

"awakened to life" and love was the key. Clients were opened up to an emotional connection with themselves and their therapist and in doing so "re-entered the human community of responsiveness and love" (Jordon, 2000, p. 1008).

According to Ferenczi (1932) healing could only happen from love and for others (Jordon, 2000; Myers & White 2009) empathy lies at the heart of healing. Yet it was also the tensions, opposing interests and negative emotions in the relationships that contributed to growth and transformation. Love could transcend and allow honest communication and was not synonymous with being overly nice or accommodating. Lily mentioned that her previous therapist had been, "nice but nothing happened". Love was not just a feeling it was a complex mix of values held in the relationship. According to Greenberg and Paivio (1997) love has no single definition and is a complex blend of emotions, cognitions and drives. "Love in the most general sense is an emotion that connects us to others and is our response to what we value most highly" (Greenberg & Paivio, 1997, p. 269). For some clients the therapy relationship is their first truly close relationship to another human being and therefore is experienced as highly valued. Recent research on the concept and science of compassionate love (Fehr & Sprecher, 2009) states that compassionate love, which they show is different to generalised love, cannot be defined as a set of criteria but is best conceptualised as a prototype with core features, including trust, care, support, kindness, honesty and putting the other ahead of self, yet not necessarily providing protectiveness or comfort. Fehr and Sprecher maintain that compassionate love develops and lasts over time and has "nothing to do with sex" (Fehr & Sprecher, 2009, p. 348). This relatively new area of conceptualising compassionate love holds promise in regard to implications for practice and research in therapy it certainly fits for the type of human love shown to Jim by Giselle. Giselle did not literally love Jim; however she did behave in a loving way despite at times having negative reactions towards him. Fehr and Sprecher argue that "people experience this kind of love in many types of close relationships, as well as for strangers and humanity"

(Fehr & Sprecher, 2009, p. 344). This form of love and compassion is considered to be a broad concept beyond empathy which is more of a moment to moment understanding of the client (Vivino, Thompson, Hill, & Ladany, 2009).

Rather than sanitise love into a clinically acceptable form for therapy it can be theoretically legitimised through the literature on attachment, neuroscience and emotion. These theories combine to make sense of the growth of love between therapists and clients. Secure emotional connections such as those found in the relationships in this study were the catalyst for clients opening up to the influence of their therapist. The urge to have access to someone who was seen as wiser and emotionally responsive was true for all clients. Attachment theorists view the ability to turn to others for emotional support as being a healthy and well functioning form of dependency (Cassidy, 2001; Lewis et al,. 2000; Wallin, 2007). This is quite different to current psychological views of healthy adult functioning that foster self sufficiency and independence. Attachment needs are seen to operate "from the cradle to the grave" (Bowbly, 1980, p. 129) and therefore the need for physical proximity, security, emotional closeness and intimacy are the same forces that shape adult attachments, especially during times of stress, fear, grief and relationship breakdown. Whereas in therapeutic circles terms such as overly dependent, enmeshed, symbiotic, undifferentiated or fragile are used to describe people who are not independent and self reliant. According to Cozolino (2006) love de-activates the fear system in the brain and gives relief from "scanning the external environment for threat and the inner world for shame" (p. 316). Thereby a strong emotional attachment regulates the emotional states of the other, figuratively and literally. According to Coan, Schaefer and Davidson (2006), in a close relationship especially one involving love, the other person becomes the *hidden regulator* of our bodily processes and emotional lives. This was evident for most clients in particular Jim, Chloe, Peter and Lily who utilised their therapists in a very similar fashion to the *hidden regulator* described by Coan et al. As the famous Harlow (Karen, 1998) experiments on baby monkeys so

painfully proved, the need for emotional warmth and security surpasses even the practical and basic need for food.

If love is "fundamental to human nature" (Greenberg & Paivio, 1997p. 269), "a basic primary need like oxygen or water" (Johnson, 2008, p. 27), "the good we all search for" (Karen, 1998, p. 1), and "the essence of healing" (Kottler, et al., 1994, p. 280), then receiving, feeling or accessing love appears a necessary ingredient in the therapeutic relationship. A full theoretical outline of the different styles and types of love and how they are expressed is beyond the scope of this study. Suffice to say the clients who learned how to open up to love did so in relationships that were not exploitative or sexual. Love was shown through a variety of means, intense interest, respect, commitment, trust and emotional connection that was supportive, real and challenging. Love emerged from being loved, but importantly love did not mean being re-parented. None of the clients related their experience to being re-parented and were adamant that their relationships were more adult to adult or peer to peer. Bella expressed the reality for most clients when she said she had experienced things with Thomas that she had not experienced with her parents, but in her mind that did not change the fact it was a peer relationship. Therefore the theoretically driven but common practice of mapping mother, infant interactions onto the therapeutic relationship did not fit with client's perceptions of the emotional care or love they had received from their therapist. This is not to say that the client's developmental deficits and needs were not prominent, but the infant to adult analogy did not relate to these post modern clients and their adult needs.

Bowlby (1977) originally proposed that the propensity of humans for relatedness was biologically wired in and client's persistence in their search for a therapist who would relate to them bears witness to Bowlby's claim. "The move towards relating is the drive" (Harris, 2004, p. 192). The experience of existing in the mind and heart of a trusted person, someone who related to them and soothed their emotional storms was the catalysts for feeling secure enough to

continue with the real work of therapy once they had overcome their initial anxieties and apprehensions. Clients, like Bella, Chloe, Eve, Lily and Jim came to see themselves in their therapists mind and feel themselves in his or her heart as emotionally alive beings. This notion of *holding in mind* is seen to be the roots of resilience (Bowbly, 1965; Fonagy & Target, 2005; Schore, 2003). Therefore emotional relating, both conscious and unconscious plays a vital role in the therapeutic relationship (Cozolino, 2010) and emotions are seen to play a significant role as "the messengers of love" (Lewis et al., 2000, p. 37). The physiology of love is therefore dependent on the mutuality within a close relationship. "To be able to love, one must feel at some point that someone has loved you" (Slavin, 2007, p. 208), as Bella called it, "going the extra". The clients in this study chose the relationship as being more important than therapist's skill and technique. Emotional comfort came before practical concerns.

Summary of Key Findings

Mutual influence was present from the very start of the therapeutic relationship. Clients carefully chose a therapist they hoped would be the *right* person for them and the initial interactions with their therapist facilitated a sense of trust in the person of the therapist. In particular therapists were open to the human encounter of being impacted and influenced by their clients. This reciprocal dynamic operated at explicit and implicit levels of communication and held private and undisclosed meanings for both therapist and client. Clients were not passive recipients to the influence of their therapists, but co-creators of the process (Lewis Aron, 2007; Otte, 2010; M. Slavin & Kriegman, 1998). Client self efficacy emerged as product of the bi-directional nature of the relationship and the responsiveness of the therapist to their particular needs which created the sense of a *flat hierarchy* (Brown, 2006; Jordan, 2000; 2001). It was hypothesised that previous negative therapy experiences were a result of clients *drive to relate* (Harris, 2004) being thwarted by therapists who lacked relationship skills and intuition. Similarly

to the clients in Manthei's (2007) study, clients in this study were wise consumers when it came to knowing what they needed and had a striking internal wisdom regarding what was destructive for them and what would be most helpful. Considering also that clients are quite tolerant of imperfections and mistakes (Holmes, 2010; Manthei, 2007) it seems that failed therapeutic relationships may have less to do with mismatch of personalities and more to do with relationship deficits in the therapist.

For most dyads it was the therapist's ability to generously stretch a boundary in order to accommodate client needs or anxieties that initially shaped the relationship and facilitated trust. The concept of the *slippery slope* (Strasburger, et al., 1992) was not supported by this study. Boundaries were shown to be a relational negotiation and responsibility where *interactive autonomy* (Bond, 2007) rather than a unilateral application of principles assisted the quality of the relationship. The fact that therapists operated in a more egalitarian manner and had flexible and generous boundaries did not equate to a collapse into unethical behaviour, therefore one's own mind and morals do seem to exist despite the "soup" of influences we live in (Renik, 1995; Stern, 2004). Considering the findings that there is little difference in practice and application of boundaries between therapists who do and do not engage in unethical behaviour (Schoener, 2001) moral character might have more to do with ethical behaviour than way one manages therapeutic boundaries.

Clients often communicated unmet expectations or irritations through being unco-operative, unresponsive, avoidant or overtly pushing the therapist to adapt. Therapists' who could read, understand and address the clients behavioural and emotional cues deepened the relationship. Therapists were at times pushed into new interpersonal territory that expanded the therapist's personal and clinical knowledge base and practice. The continuing theme of being able to make a personal impact on the therapist was evident in shaping and maintaining the relationships over time. The relationship also benefited when therapist's noticed and

acknowledged their personal impact on the nature of the therapeutic interactions. A consistently strong theme that ran across several topic areas was that clients sensed and trusted their therapist's motives and intentions and were therefore tolerant of a therapist's imperfections (Holmes, 2010; Manthei, 2007). This was slightly different to Gelso's formulation of realism and what it meant for clients; however in line with Gelso the personal relationship was a prominent and significant part of the therapy relationship.

Counter to existing literature (B. Duncan & Miller, 2004; Manthei, 2007) clients were not independent agents of change. Clients were certainly motivated and ready for their lives to change; however they were aware they could not effect change alone. In line with (Klein & Elliott, 2006) clients attributed change to the therapy, in particular the relationship with the therapist. Therapists contributed to the success of the relationship through their generosity of self, care, tolerance, restraint, commitment, human presence and a form of compassionate love. The client and therapist contributions were different but complementary. Clients had a significant influence on the success and outcome of the relationship, even seemingly compliant clients influenced the process and subtly worked at achieving a sense of agency and equality in the relationship. However it was evident that without the relational responsiveness of the therapist, especially in the beginning phase of therapy, the relationships could have failed as had previous attempts with other therapists. According to Wampold (2010), therapists account for a large proportion of the variance in treatment and therapist and treatment effects become confounded in quantitative designs. This study shows that mutual adaptation was vital to the success of the relationship; however the differential impact of the emotional and relational skills and capacities of the therapists were the significant factor that initially facilitated successful adaptation, security and trust.

Clients took credit for their part in any personal changes and for having done the work; however as stated previously they also said change would not have been possible without the

relationship with their therapist. As such, change would not have occurred as the result of time passing or changes in external circumstances. Clients emphasised it was the therapist rather than the process or the model of work that was significant for them. All therapists commented that change was predominantly due to the client. Therapists were in general agreement that despite their many unsuccessful efforts to push for change, it would happen only when the client was ready. Therefore clients effected change in their lives despite the model of treatment and without completely taking on the opinion and agenda of their therapist. The one consistent factor for clients in relation to change was that positive internal changes facilitated positive external changes in their lives. Clients generally had a more positive view of themselves and their level of functioning and progress than their therapists. However for therapists the current relationship was one of many relationships, therefore their broader perspective possibly shows a higher bench mark for quality of relationship and change. Whereas for clients the current relationship has been their one and only benchmark for success and it was preceded in most cases by several unsuccessful attempts.

The similarities between the different relationships were based around overarching qualities and values. Common to all relationships were trust, respect, safety and security, availability, dependability, commitment, presence, honesty, compassion and love. Underpinning these common qualities and values were the vital ingredients of emotional connection and empathy. Emotional expression was varied and unique to each dyad, yet whether deeply and overtly expressed or dealt with more superficially, emotional relief and resilience was gained. Therefore clients utilised the relationship and "used" the therapist, or "shared" their neural network (Coan, et al., 2006; Cozolino, 2010; Siegal, 2009) to assist them in feeling emotionally regulated and strong enough to implement changes themselves.

The role of human compassion and love in therapy plays a significant role and needs inclusion but is difficult to define (Fehr & Sprecher, 2009; Lewis et al., 2000; Seethe, 2010;

Slavin, 2007). Possibly a new construct based on the evidence from neuroscience, attachment and the science of compassionate love (Sprecher & Fehr, 2005). There is enough evidence from practice that something more than empathy exists. Therefore a broader model is needed that encapsulates the reality of two whole people (Bornstein, 2010) in an emotionally responsive and secure non-sexual relationship. A relationship that encompasses the expression of all feelings, positive and negative, yet exhibits the compassionate and altruistic nature of restraint. As such, the personal aspects of the therapeutic relationship equate to more than is captured by the construct of the therapeutic alliance. For clients the experience of the therapeutic relationship was the most powerful factor reported.

Conclusion

The inner sanctum of the therapeutic relationship is usually a private affair. Seven therapists and their clients have graciously allowed their relationships to emerge from behind closed doors for the purpose of this research. The findings of this study highlight the rich and diverse worlds they occupy. What stands out is the unequivocal mutual nature of the therapeutic relationship. Models, theories and treatments do not feature strongly and neither did diagnosis or pathologising of the client. The whole of the client was taken into account rather than a narrow focus on symptoms. Implicit and procedural knowing constitute a significant amount of the work, despite the fact that therapy is based on the premise of verbal communication. As such therapists are not able to leave their personal lives outside the therapy room door and their personal contribution to the relationship cannot be ignored. Being a neutral and objective observer is not an option. When therapists are responsive and allow their clients to impact and influence their personhood and their practice, mutual influence and transformation can take shape, love for self and others can grow and healing can occur. Chapter 7 looks at the

implications of these findings for clinical practice, counsellor and psychotherapist education and further research.

Chapter 7

Conclusion: The Clinical Heart

Introduction

The views of therapists and clients in a current relationship have provided a comprehensive picture of the role of mutual influence in the context of the therapeutic relationship. The findings for this study highlighted the reality that the therapy relationship is very much a reciprocal encounter (Aron, 2007; Eshel, 2010; Jordan, 2010). A contextual view is quite removed from the current trend towards evidence-based treatment approaches and places the therapeutic relationship at the heart of clinical practice (Hill & Knox, 2009; Jordan, 2000; Safran & Muran, 2006). According to clients in this study, the relationship with their therapist was reported as unequivocally essential in bringing about change. The success and effectiveness of the relationship was linked to the relational qualities and capacities of the therapist to a greater extent than their professional skill and knowledge. The healing context, as proposed by Wampold (2001) and the meaning attributed to it by therapists and clients, was critical to understanding the nature and quality of the relationship.

The mutual negotiations between therapists and clients highlighted the importance of meeting clients on a human person to person level (Audet & Everall, 2010; Holmes, 2010; Slavin, 2010). Secure attachment, mutual influence and therapeutic love formed the matrix that encompassed the underlying elements of a successful therapeutic relationship. Within that matrix mutuality included two broad areas: 1) Negotiating relational boundaries with the client rather than a unilateral approach and, 2) Acknowledging the mutual impact of the co-created nature of the relationship rather than a singular focus on the client's constructions or a one-person psychology (Eshel, 2010; Otte, 2010; Safran, 2002), broadly speaking, working relationally across all aspects of the relationship. The views of the fourteen participants in this study provide

the context and meaning that add to the existing body of knowledge on mutual influence in therapeutic relationship and form the basis for the following implications for practice, education and further research.

Contribution of this Research

To date the majority of research on the therapeutic relationship has focused on the construct of the therapeutic alliance (Castonguay, et al., 2006; Horvath, 2006; Tryon, Collins Blackwell, & Fellman Hammel, 2007). This study supports emerging paradigmatic research (Gelso, 2009b; Safran & Muran, 2006) that the relationship between therapist and client is more than and different to the construct of the alliance. Research evidence on the alliance has produced modest effects (Beutler et al., 2004; Safran & Muran, 2006), pointing to the fact there is more to the picture and a sole focus on the alliance construct in research may not capture the essence of the relationship. Overarching values and qualities including commitment, compassion, presence, mutuality and human love formed the core of the relationship and facilitated healing.

This study indicates that working relationally, across all aspects of the therapeutic relationship is essential and that mutuality is significant from intake onwards. The ongoing mutual nature and co-creation of trust, boundaries and "interactive autonomy" (Bond, 2007) highlight the need for the ongoing monitoring of the personal contribution of the therapist. This finding runs counter to current trends, particularly in Australia, towards client autonomy as self-responsibility. The notion of autonomy can unwittingly subvert the protection of the client into a legitimate way to implement unilateral therapist risk management. Clients in this study did not place their trust in therapists who operated from a distant and autonomous stance. While codes of practice are vital to guide professional conduct, the pendulum appears to swing widely over the course of history and between continents. In Australia at present, if this study is any indication,

practitioners appear to be using their personal judgement more than professional guidelines to make therapeutic decisions and according to client reports there is a case for thinking about boundaries in a more egalitarian and relational manner.

This study also supports and adds to the debate about the primacy and importance of emotional relating and regulation in therapy. A focus on emotions is seen to varying degrees to be a valued aspect of therapy depending on the particular model or discipline and the role of mutual empathy (Jordan, 2010; 2000) and mutual presence (Geller, et al., 2010) contributed positively to the phenomena. It was evident in this study that therapists and clients shared emotional connection and clients gained emotional relief and understanding; however not always through expressive shows of emotion. The concept of "feeling felt" (Siegal, 2009) captures this phenomenon where emotional connection and relief just seem to happen because it occurs at the non-verbal level. Being touched emotionally through eye contact and voice tone also produced a calming effect for clients and achieved emotional regulation. Mutual regulation of emotions over time, implicit and explicit, influenced the client's capacity to self regulate (Coan, et al., 2006; Fosha, 2004; Lane, 2008). The dodo bird effect (Duncan & Miller, 2005; Luborsky, Singer & Luborsky, 1975) where all models of treatment show little difference in outcome might therefore be tapping into the effects of the emotional aspects of the therapeutic relationship, from initial symptom relief which can look like early change, through to more lasting changes.

A non-pathologising and non-diagnostic stance contributed to clients feeling more secure and self-governing. Current treatment plans require diagnosis, yet clients more readily engaged in relationships where they were not going to be labelled as mentally ill and where they felt there was a shared sense of equality and humanity. Therefore a more holistic approach to assessment encompassing all facets of the person of the client might serve to facilitate a better understanding of the individual and their situation. Recently, Beutler (2010) urged the field to pay attention to

non-diagnostic traits to distinguish amongst clients in more relevant ways. In the current study mental health did not preclude clients from forming a strong relationship.

This study supported the view that therapists do not have to be thoroughly evolved and analysed themselves in order to take a client where they have not been themselves (Yalom, 2009). While therapists did show they had personal limitations and emotional biases that blocked exploration of certain topics and emotions, it was also the case that therapists found themselves pushed into new situational and emotional territory by being with the client. These experiences expanded the therapist's repertoire and future capacities through the power of experience. This was the heart of mutuality in action. The threshold of tolerance and awareness could be discovered and crossed together.

Implications for Professional Practice

According to this study, therapists who work from an egalitarian stance in regard to relational boundaries and transparency are more likely to fully engage clients and in turn earn their trust. Once mutual trust is established, clients will allow themselves to be more open to the influence of the therapist. Transparency also meant including clients in the thinking and rationale for therapeutic decisions and opinions in order to demystify the process (Lambert, 2007). This inclusive approach enhanced trust and, in turn, the quality of the relationship. Therapists should remain mindful that clients often gauge the trustworthiness of their therapists through observing the personal integrity of their therapist. Ruptures, impasses and blocks to progress were often closely related to what was happening in the relationship dynamics, therefore indicating a relevant relational issue needed attention and processing (Eshel, 2010; Hill & Knox, 2009). Relational events and impasses could not be attributed simply to pathology in the client; therefore in practice therapists could pay extra attention to the contribution of the their own life issues (Bornstein, 2010).

Clients also had a good sense of what they needed and a folk wisdom about what was destructive, unbearable and not working for them. Therefore clients were not passive and compliant recipients of the therapist's influence and were not inclined to accept the therapist's opinion as gospel. In line with other recent studies it was evident that clients at times wanted more feedback, guidance and direction (Lilliengren & Werbart, 2005; Manthei, 2007). This was a dilemma for some therapists who found the notion of having an opinion counter to the underpinning philosophy of counselling. However in practice therapists may underestimate the reality that clients do not necessarily agree or acquiesce to their therapist's opinion. In essence providing necessary information, addressing gaps in knowledge and explaining concepts and opinions appears to be important to clients. Therefore finding a balance for the judicious use of therapist input in practice would not be counter to a client-centred philosophy, whereas therapists who remain non-directive or evasive when confronted with a clear request from a client could be construed as non-client-centred and certainly not relational. This seems vital for intercultural clients where certain beliefs and expectations means that information, opinion or even a form of advice may be warranted. Therefore therapists need to fully understand the clients experience no matter how unusual or removed from theoretical philosophy it may seem, especially when there is an impasse or rupture. These clients were benefited by their therapists operating in a non-pathologising and holistic way rather than a sole focus on the client's symptoms or possible transference. Therefore it is not always useful for therapists to interpret client needs through theoretical constructs which can become decoupled from the realities of the relationship in practice (Fonagy, 2003; Norcross & Goldfried, 2005b; Yalom, 2009). Theory fulfils an important clinical function; however theory needs to be informed by clinical practice and research. At present this research, in line with Cooper (2010) shows that what is theoretically important is how the therapist relates. There was no evidence to support eliciting transference had a better outcome than an egalitarian reality based relational approach. It could benefit

practice for therapists to have different ways to think about the relationship dynamics other than only through the lens of transference and countertransference. For example mutual empathy and presence emerged in this study as core ingredients of a successful therapeutic in practice.

Evidence from this study showed the embedded attitudes and non-verbal and unconscious facets of the relationship were significant for clients. When focusing solely on the overt aspects of the relationship therapists can underestimate the sheer simplicity, power and reach of their human presence and what this may mean for the client. Therefore it may prove useful to pay equal attention to the non-verbal and somatic aspects of the work (Benecke, Peham, & Banninger-Huber, 2005; Shaw, 2004), the felt experience of being with the client, rather than a higher emphasis on conscious collaboration and technical aspects of the work and client progress. For these clients emotional security, trust and therapist presence opened the way for healing and change. This went beyond the mechanistic use of skills and techniques into the realms of human love through acts of kindness, generosity of self, compassion, interest, commitment and honesty. Love in the therapeutic setting did not mean literally loving a client; love was a rubric of emotions, cognitions and values (Greenburg & Paivio, 1997) very akin to the new construct of *compassionate love* (Fehr & Sprecher, 2009). Part of the underpinning of love is the therapist's genuine accessibility and openness to a *real* personal relationship of equal adult status (Slavin, 2010). According to Slavin clients crave this humanness and access to the mind of the therapist, therefore an ongoing checking and processing of the therapeutic relationship from inception to finish potentially enhances the relationship and the work (Hill & Knox, 2009; Hubble, et al, 2009). Clients could benefit from the transparency of being informed about the process and why it was happening, as well as adjusting to an interpersonal approach that is sensitive to their emotional and cognitive level of development.

In practice managing boundaries in a relational and flexible way benefited clients. Therefore therapists could enhance the development and maintenance of the relationship by the

judicious tailoring of boundaries to the particular needs of the client and the relationship. Therapists could enhance the quality and safety of the therapeutic relationship by including the client in the decision making process and thinking through ethical dilemmas to the satisfaction of both therapists and client, rather than operating out of a single ethical perspective or belief. This might at times mean that the client does not have their particular request met by the therapist; however the transparent process could possibly demystify boundary management for the client and this understanding could avoid a possible rupture in the relationship and assist a reciprocal outcome. This form of ethical practice honours the relationship itself as the source and context of ethical meaning; therefore it follows that assessment and consideration of boundary issues in practice lies within that same context.

Implications for Counselling and Psychotherapy Education

Counsellor and psychotherapy education in Australia pays anecdotal homage to the relationship, but from personal knowledge most training courses are geared towards teaching models and theories above a specific focus on preparing intern students for the ups and downs of the relationship in practice. Relationship capacities and qualities are either woven into theoretical units or taught as a skill set. Micro-skills have therefore become the current training of choice, which, depending on the model, can reduce the relationship to a kind of mechanistic performance art, rather than learning about true engagement and empathy (Hill, Stahl & Roffman, 2007). The exception to this would be the attempt, by some private, usually unaccredited, psychotherapy training courses, to address developing relationship efficacy by mandating therapy as part of the training. However therapy is not mandated, and would not be sanctioned, in most higher education courses within University settings. Psychology education in Australia does not commonly include education in counselling therefore most psychology interns learn counselling on the job under supervision. As standards of practice rise in the therapy

professions, and the different disciplines compete for supremacy, courses forgo experiential learning, which is seen to be less rigorous and less cost effective, in favour of a focus on academic units.

Therapists in this study relied heavily on their experiential history when making relational decisions. Personal experience was what stuck in therapist's minds, especially when spontaneity was required. Therefore education that equally emphasises experiential learning and taps into procedural memory could assist therapists to draw from a more personally integrated theoretical base. The implicit or private theory of the clinician (Fonagy, 2003; O'Hara & Schofield, 2008) could be further enhanced, and more fully integrated, into the person of the therapist during the training course. The predominance for this study of therapists utilising their implicit knowledge and subjectivity in their work means that education that is too heavily weighted towards academic and theoretical learning can become redundant in practice (Divino & Moore, 2010; Miller, Duncan, & Hubble, 2005; Norcross & Goldfried, 2005a). Education and training could prepare students for effective relational practice by including units on emotional development, and working with emotional deficits and disturbances in the body, brain and mind. Essentially this would also require experiential units of study that draw on new evidence from neuroscience and attachment (Divino & Moore, 2010) to develop and hone the capacity for emotional awareness and somatic and non-verbal phenomenon along with critical self reflection. Small group work is particularly suited to experiential learning and may be more readily accepted in the higher education sector than mandated therapy. According to Fauth, et al. (2007) counselling and psychotherapy training does not prove to be effective because of the emphasis on theory.

Education focused on relational boundaries would assist students to create the security and trust necessary for a positive relationship. Education in principled ethical thinking (as opposed to rules) and management of relational boundaries rather than memorising codes would assist students to take a relational stance of "interactive autonomy" (Bond, 2007). Working with

relational boundaries benefits clients; however because it is operating above the level of minimum standards as set by codes it requires more attention than a cursory attending to the fundamentals in educational courses. Education could expand on the ways mutual influence can operate within the therapeutic relationship by placing more emphasis on the full complexity of relationship dynamics rather than perpetuate a narrow focus on existing constructs. For example this study found that overly relying on transference as an explanation of phenomena only served to continue defining the therapists experience in terms of the personality of the client. Student counsellors do need tools, strategies and firm guidelines to assist them in the beginning stages of training and practice (Hill, Sullivan, Knox, & Schlosser, 2007) as well as a solid grounding in ethics. However education and training can benefit students by teaching a judicious blend of codes and rules with a focus on disciplined attention to personal clarity in the role of counsellor, and in the relationship, that maintains ethical engagement and personal and professional integrity.

The underpinnings of Attachment Theory (Dinger, et al., 2009; Martin, Buchheim, Berger, & Strauss, 2007; Wallin, 2007) were a more parsimonious fit with the findings relating to relational dynamics than were the constructs of transference and counter-transference. Education in attachment theory could benefit students through an exploration of their own family of origin attachments and learned emotional style and its possible impact on their role as a therapist. Alongside this, secure attachment at its best includes the three main overarching concepts found in this study: trust and security, mutuality and a form of therapeutic love. A secure attachment relationship epitomises healthy relational functioning (Cassidy, 2001; Clulow, 2007), which does not mean the relationship is problem free but describes how a range of thoughts and emotions can be expressed and managed without the relationship disintegrating. Therefore a learning environment where students can practice and experiment with their interactive style through robust and authentic exchange could benefit preparation for new therapists. For therapists in this

study, the personal and the professional were inextricably intertwined; therefore personal development for the therapist, and being able to move beyond their own reactions, is essential for the success of the relationship. In terms of including the lens of mutuality, the development of the use of self in the context of a co-created relationship appears vital.

Recommendations for Policy

Medicare referrals in Australia at present require the diagnosis of a mental illness and a mental health plan based on assessment by a general medical practitioner (GP). The diagnosis goes on the public record and as such can be accessed when a client applies for a job or an insurance policy. The plan also means that any subsequent sessions after the first six must be approved by the original GP, after receiving a report from the counsellor or psychologist, to retain access to Medicare rebates. As far as I know clients' in this study were not part of the Better Access Medicare Scheme because long term therapy is not covered by the scheme. The finding that clients did not want to be pathologised or viewed narrowly in relation to their presenting symptoms despite not having to worry about being on the public record has implications for policy. This study indicates that the current Medicare referral system may be limiting access to people who require counselling due to fear of a diagnose giving employers access to their private information and impacting their job opportunities or access to personal, job or home insurance. A change in policy to a holistic rather than diagnostic approach would allow clients greater access to therapy without the fear of receiving a mental health record. A policy change would also mean that clients would not become pathologised for situational or contextual grief, anxiety or depression purely in order to gain access to affordable treatment. The clients in this study reported that change took time and was incremental. Therefore policy change could extend referrals to suit client progress rather than the treatment approach dictating the

length of treatment. This could assist clients to make more lasting changes by not having to exit therapy for financial reasons after initial symptoms relief.

Recommendations for Future Research

Further research could investigate short-term therapeutic relationships in context. Previous research shows that outcome of therapy is highly variable and poor outcome can be predicted early in treatment (Wampold, 2001) and according to Westen et al, (2004) more extensive treatments tend to get better and more lasting results. Therefore it would be useful to compare the difference in the findings from this study and those from short term therapy. What constitutes a successful relationship may be quite different in brief therapy relationships.

Given that both therapists and clients in this study had private and uncensored thoughts, feelings and inferences that went unexpressed, further research on what this means for the relationship from the perspective of therapists and clients could add to this topic. A focus on what is not expressed could include research on the prosodic aspects of the relationship and the views of both therapists and client in regard to the significant of non-verbal elements versus explicit interactions in the relationship. Less reliance on meta-analysis of multiple research studies towards a balance with more qualitative forms of inquiry could capitalise on the strengths of both methods to potentially expand these findings further into new areas.

This study indicated that outside change was client driven and paralleled internal and in-session learning. It could be of benefit to education and practice for research to investigate the link between internal change and external therapy events and processes to ascertain the difference between placebo, external events and impact and transfer of the learning gained in therapy. Apropos of this the development of new relational learning could be investigated in terms of how clients' new relational capacities impacted or transferred to changes in outside

relationships. Plus a broader focus on clients understanding of themselves in relation to others and what changes clients deem important and relevant for their lives (Binder, et al., 2010).

Studies could examine how mutual influence impacts early termination of therapy from the perspective of both therapist and client. In particular if the main reason for negative therapy experiences and early termination was the result of relational breakdown or other factors. Apropos of this, research investigating client's views of boundary management and what they found helpful, not helpful and why, especially in terminated relationships, could enhance the area discovered in this study linking relational and flexible boundaries to trust and self efficacy. In line with this theme it would be useful to know if declining to cross a boundary for fear of professional retaliation has negative repercussions for the quality of the relationship.

Further research could also be undertaken on dyads focussing on the personal relationship and investigating the prevalence of the phenomena of interpenetration of minds. If inter-subjectivity is inevitable (Aron, 2007; Slavin, 2010; Stolorow, 2002) this phenomena would be found to operate to differing degrees in all relationships. None of the therapists in this study reported becoming psychologically contaminated or damaged by the interpenetration of minds, anxieties or levels of depression in the clients. Fonagy suggests that secure attachment lies at the roots of emotional and psychological resilience, and it would prove useful for therapist education and training to understand what capacities are required to build resilience for clinical work, and how therapists emotional patterns of relating helped or hindered the relationship.

Considering the importance of relationship skills and capacities shown in this study, further research could focus on the much needed area of education and training outcomes to produce relationally competent practitioners for the professions of counselling and psychotherapy (Boswell & Castonguay, 2007; Fauth, et al., 2007).

Limitations of the Research Methodology

This research has presented some significant challenges. The first, being the difficulty in gaining access to participants to share an area of their lives that is normally kept private, confidential and protected. The ethical considerations involved in studying therapists and clients in a current relationship were considerable. Several therapists thought it would contaminate or interfere with the therapeutic relationship, while others generously welcomed the idea of an opportunity to enhance the relationship and help the profession. Clients who had been asked to participate by their therapists were keen to let people know of the positive benefits they had received and to confirm for others that counselling can be a positive and life changing experience. As it turned out participants indicated that reflecting on their relationship with an outsider had a positive impact on the relationship and opened up new avenues for discussion. However the polarisation of therapist attitudes may have contributed to attracting participants who were more open to scrutiny or less sensitive to the dangers of exposing their relationship and as such ruled out a section of the therapeutic community that treats the therapeutic relationship as being quite delicate and fragile.

Another possible limitation was the phenomenological nature of the interview. Therapists and clients were free to set the topic and direction of the discussion and as such pertinent aspects of the relationship may have been omitted. Common to all research of a qualitative nature there are limits to the extent the findings can be generalised and therefore accepted as common to all therapeutic relationships.

The dyads were all long-term therapeutic relationships, except for Peter who attended as needed and therefore irregularly. He and Graham had 20 sessions over a two year period which is considered more short term. Peter was also Chinese and the only Asian client in the study. Lily was British, but on the whole the conclusions drawn represent Anglo-Australian experiences.

Therapists were all very experienced, only Anne had worked for less than ten years, and therapist age was above forty. Therefore the sample does not represent young beginning therapists who might show a different style of therapeutic relationship. A strength and a limitation of this study is that I am a therapist and my own biases and explanations colour the analysis. Another researcher may discover different themes and meanings, the concept of mutual influence would deem it inevitable.

Conclusion

The phenomenon of mutual influence captures the findings from the privacy of the consulting room and provides a means to understand the inner workings of the therapeutic relationship. The heart of the phenomena of mutual influence places the person of the therapist in the caldron of the relationship, rather than being an objective observer or provider of treatment, the therapist is a key contributor to the co-created interactions. Intrinsic in the process is the clients wish to have an impact on the therapist rather than be the recipient of the therapists influence. Through being receptive to the clients influence and allowing the client to impact them, therapists create the necessary relationship for trust and mutuality to take place. The therapist's contribution requires understanding, compassion, emotional awareness and resilience, empathy and restraint alongside extensive clinical skills. Dealing with the complexity inherent in the therapeutic relationship takes considerable cognitive and intellectual skill, but not to the point where academic prowess overrules affective knowledge and competency. A successful relationship is not merely a skill set, it is a relational embodied process, that requires a limbic and emotional connection and mutual influence is at the forefront of process. Sometimes the body knows what the mind does not. This process honours personal subjectivity but is grounded in new evidence emerging from the paradigm of neuroscience. Presence links with intuition and personal wisdom that is informed by experience and neurally shared, for a time, in both the

conscious and unconscious communications in the intimacy of the therapeutic encounter. “That our reach exceeds our grasp is really the heart of the matter” (Eshel, 2010, p. 153). Central to the reach of the therapeutic relationship is the growth of human love; however matters of the heart can leave an empiricist researcher with little concrete certainty and even less scientific credibility. The resurgence of attachment theory and neuroscience as they relate to counselling and psychotherapy show a way forward to understand and give scientific credibility to the complexity of human relating that is also intercultural and universal. The investigations beginning into the science of compassionate love hold promise for legitimising a framework for the inclusion of an appropriate form of love in a professional relationship. For now this study provides another building block in the challenge to articulate the phenomena that helps create and sustain the therapeutic relationship and how it facilitates healing and change. The findings suggest the role that relational factors play and the context in which they unfold take centre stage in the process. Results from further qualitative research can inform and inspire theory and practice to profit from the knowledge gained from the lived and real experiences of therapists and clients. These personal and mutual relationships are at the heart of clinical practice.

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Appendices

Appendix 1: Therapist Letter of Invitation

SCHOOL OF HEALTH
Armidale 2351
Australia

Therapist Letter of Invitation

PhD Research Project: A Study of Mutual Influence in the Therapeutic Relationship

Dear

This letter is to invite you to participate in a research project that aims to explore the dynamics of mutual influence in the therapeutic relationship.

My name is Alison Turner and I am conducting this study for the award of PhD in Counselling at the University of New England, Armidale, under the supervision of Professor Jeffrey Kottler and Associate Professor Jeanne Madison.

You are being contacted because you have been nominated by your professional colleagues as someone who they consider to be highly effective in working with clients. I am only inviting participation from accredited professionals who have been identified in this way. Your details have been obtained either from the professional body you are registered with, or from those who nominated you.

The main focus of the study will be an in-depth examination of the interpersonal processes identified by both clients and therapists as being therapeutically helpful in facilitating change. It is generally agreed now that the relationship between therapist and client is a vital factor in contributing to positive outcomes in therapy, but it is as yet unclear what interpersonal processes underpin such outcomes.

In light of the importance placed on the therapeutic relationship for both therapy and training this research project has the potential to provide valuable and timely information and knowledge to the field, and could therefore contribute to both clinical and educational aspects of the profession, especially within the Australian context.

Involvement would mean taking part in an audio-taped interview with me. It is also important for you to know that all information in the study will remain confidential and your identity will not be disclosed at any time.

I hope that you will be interested in taking part in this study and contributing to the development of our field. If this is the case I can send you detailed information about the study process to help you make a more informed decision and I would be pleased to answer any questions you may have at any time.

Please feel free to call me on one of the numbers below if you wish to discuss the study or receive further information.

Thank you for considering participation in this study.

Yours Sincerely

Alison Turner
Locked Bag 2002
Strathfield
NSW 2135
Ph: 97468800
m) 0404029233
email: alison@institutecounselling.org.au

Appendix 2: Therapist Information Sheet

SCHOOL OF HEALTH
Armidale 2351
Australia

Therapist Information Sheet

PhD Research Project: A Study of Mutual Influence in the Therapeutic Relationship

Thank you for your interest in this research study which aims to explore the dynamics of mutual influence in the therapeutic relationship.

My name is Alison Turner and I am conducting this study for the award of PhD in Counselling at the University of New England, Armidale, under the supervision of Professor Jeffrey Kottler and Associate Professor Jeanne Madison.

Involvement in this study would require you to participate in an audiotaped interview, during which we would discuss the dynamics of how change is effected in the therapeutic relationship. I would be particularly interested to hear not only how you as the therapist influence the client but also how the client influences you.

Involvement would also mean that I interview one of your clients separately on the same topic. I would not expect your client to speak to me about the issue that brought them to therapy or the content of their sessions. The following information outlines how the process works so that your client is not pressured in any way to participate, and remains free to make their own choice.

You would be asked to send out (at no cost to you) a letter of invitation, and contact consent form to a current client to complete and return directly to me. I have included a draft of a cover letter you may wish to send to your client that explains why you are sending them this information. This letter can be altered if it does not suit your practices.

I would not have access to the name of your client unless they choose to return the consent form to me providing their contact details. After I receive their permission to be contacted, I would phone them and explain the interview process. If they still want to continue I will post them an information sheet and another consent form to be returned to me, and I would ask their permission to advise you of their decision. At every stage the client will be free to choose whether or not to proceed.

I would request that you nominate a client who, in your clinical judgment, is not unduly vulnerable in terms of their life situation and particular issues.

Confidentiality and Privacy

All information will remain strictly confidential and would only be accessible to myself and my supervisor. Your name and your clients name will be changed during the transcribing of the interviews to ensure anonymity will be maintained in research reports and any publications that may result from the

research. The audio tapes of the interviews will be erased after transcription, and transcripts will be kept secure by the researcher and destroyed after five years.

I will be pleased to answer any questions or concerns you may have at any time. Your participation is completely voluntary and you are free to withdraw your consent at any time with no adverse consequences.

The client will also be assured that they are free to decide whether they want to participate, and they can withdraw at any time, without affecting the relationship they have with you.

It is unlikely that this process will raise emotional issues for you, but if this were to occur it is advised that you take these issues to your supervisor.

Questions concerning this research project can be directed to Alison Turner using the contact information listed below. Alternately, you may contact my Supervisors, Professor Jeffrey Kottler jkottler@Exchange.FULLERTON.EDU phone (00111) 714-278-7537, or Associate Professor Jeanne Madison at UNE jmadison@une.edu.au or 02) 6773 3667.

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No HEO4/155 Valid to 3/11/07). If you have any complaints or reservations about any ethical aspect of your participation in this research, or the manner in which this research is conducted, you may contact the Research Ethics Officer at the following address:

Research Services
University of New England
Armidale, NSW 2351.
Telephone: (02) 6773 3449 Facsimile (02) 6773 3543
Email: Ethics@metz.une.edu.au

Thank you for considering participation in this study.

Yours Sincerely

Alison Turner
Locked Bag 2002
Strathfield 2135 NSW
Ph: 97468800 m) 0404029233
Email: alison@institutecounselling.org.au

Appendix 3: Therapist Demographic

SCHOOL OF HEALTH
Armidale 2351
Australia

Therapist Demographic

PhD Research Project: A Study of Mutual Influence in the Therapeutic Relationship

1. **Name:** _____
2. **Age:** _____
3. **Gender** **Male** ☐ **Female** ☐
4. **Discipline or Profession (tick more than one if applicable)**

   Counselling ☐ **Psychotherapy** ☐ **Psychology** ☐

   Social Work ☐ **Psychiatry** ☐
5. **Main models or theoretical orientation you employ:**_____

   _____
6. **Clinical experience:**

   Up to 5 years ☐ **Up to 10 years** ☐

   Up to 20 years ☐ **20 years & over** ☐
7. **Workplace:**

   Private practice ☐ **Private agency** ☐

   Government agency ☐ **Not-for-profit agency** ☐
8. **Number of clients seen per week …….**

Appendix 4: Therapist Consent Form

SCHOOL OF HEALTH
Armidale 2351
Australia

Therapist Consent Form

PhD Research Project: A Study of Mutual Influence in the Therapeutic Relationship

I am willing to participate in the study being conducted by Alison Turner, and realise that I am free to withdraw my consent at any time.

I have read and understood the information contained in the Information Sheet for Participant Therapists and any questions I have asked have been answered to my satisfaction.

I agree to an audio taped interview with Alison Turner, at a time suitable to me.

I give permission for research data to be published, provided my identity is not disclosed.

Therapist Signature

……. Date …. /…. /….

Witnessed by Alison Turner

……. Date …. /…. /….

Appendix 5: Draft of Therapist Cover Letter to Client

Therapist Letterhead

Dear (client name)

I have agreed to take part in a PhD research study being conducted by Alison Turner from the University of New England in Armidale.

I have been asked by Alison to send this information to several of my clients so they can consider if this is of interest to them and whether they would like to participate.

I have enclosed a letter of invitation from Alison that explains what would be involved, and there is also a contact consent form to fill out and return to Alison if you would like to take part.

It is important that you understand there is no obligation to be part of this because it has come from me, and if you decide not to respond to this letter it will not make any difference to our counselling relationship.

If you wish to take part, please complete the consent form and return directly to Alison Turner. Alison will then contact you to answer any questions you may have, and to make arrangements for an interview time.

Please read the attached letter carefully and feel free to make your own decision about whether you want to participate.

Yours Sincerely

Therapist signature and contact details

Appendix 6: Client Letter of Invitation

SCHOOL OF HEALTH
Armidale 2351
Australia

Client Letter of Invitation

PhD Research Project: Mutual Influence in the Therapeutic Relationship

You are invited to participate in this study which aims to explore the dynamics of mutual influence in the client-therapist relationship.

My name is Alison Turner and I am conducting this research for the award of PhD in Counselling at the University of New England, Armidale, NSW, under the supervision of Professor Jeffrey Kottler and Associate Professor Jeanne Madison..

Your counsellor/therapist has agreed to take part and to send out this letter and consent form to current clients. This letter has been posted from your therapist's practice and your name and address remains private and is not known to me. I will only know your details if you choose to return the consent form to me.

Participation in the study would involve having an audio-taped interview with me where we would discuss your experiences and perceptions of mutual influence in the relationship with your therapist. I would be interested to hear about the impact of this process for you and would not expect you to talk to me about the issue that brought you to therapy or the specific content of your sessions.

If you are interested in participating and decide to return the consent form providing your details, I will phone you to discuss exactly what is involved and to answer any questions you may have. You can then decide if you would like to continue, and if so I will post you further information about the study and a consent form for your participation.

It is important for you to know that all information in the study will remain confidential and your identity will not be disclosed at any time. Participation is completely voluntary and you are free to withdraw your consent at any time without any adverse consequences.

Questions concerning this research project can be directed to Alison Turner using the contact information listed below. Alternately, you may contact my Supervisors, Professor Jeffrey Kottler jkottler@Exchange.FULLERTON.EDU phone (00111) 714-278-7537, or Associate Professor Jeanne Madison at UNE jmadison@une.edu.au or 02) 6773 3667.

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No HEO4/155, Valid to 3/11/07)

If you have any complaints or reservations about any ethical aspect of your participation in this research, or the manner in which this research is conducted, you may contact the Research Ethics Officer at the following address:

Research Services
University of New England
Armidale, NSW 2351.
Telephone: (02) 6773 3449 Facsimile (02) 6773 3543
Email: Ethics@metz.une.edu.au

Thank you for considering participation in this study.

Yours Sincerely

Alison Turner
Institute of Counselling
Locked Bag 2002
Strathfield 2135
NSW
Ph: 97468800
m) 0404029233
email: alison@institutecounselling.org.au

Appendix 7: Client Consent Form A

SCHOOL OF HEALTH
Armidale 2351
Australia

Client Consent Form A

PhD Research Project: A Study of Mutual Influence in the Therapeutic Relationship

I have read and understand the information contained in the Letter of Invitation for Clients.

I give permission for Alison Turner to contact me by phone to discuss taking part in the study.

I understand that I will be free to decide if I want to continue following my discussion with Alison, and can withdraw my consent at any time.

Client Signature

…… Date …. /…. /….

Contact number 1. …….

Contact number 2. …….

Preferred day/time for contact …….

Appendix 8: Client Information Sheet

SCHOOL OF HEALTH
Armidale 2351
Australia

Client Information Sheet

PhD Research Project: A Study of Mutual Influence in the Therapeutic Relationship

Dear

Thank you for your interest in this research study which aims to explore the dynamics of mutual influence in the therapeutic relationship.

My name is Alison Turner and I am conducting this research for the award of PhD in Counselling at the University of New England, Armidale, NSW, under the supervision of Professor Jeffrey Kottler and Associate Professor Jeanne Madison.

Recently you returned a consent form to me and agreed to be contacted to consider taking part in this study. I am writing to invite you to participate further in this research, but you are under no obligation to continue.

Involvement in the study would mean having an audio-taped interview with me at a time and place suitable to you. I would be interested to hear how you think change is effected in the therapeutic relationship, in particular how your therapist has influenced you, and how you may have influenced them. The interview would take approximately one hour.

All information will remain strictly confidential and would only be accessible to me and my supervisor. The interview will be transcribed and during this process your name will be changed to ensure your identity is protected in research reports and any publications that may result from the research. Your therapist would not have access to your responses in the interview unless you choose to discuss this with him or her. The audio tapes of the interview will be erased after transcription, and transcripts will be kept secure by me and destroyed after five years.

Participation is completely voluntary and you are free to withdraw your consent at any stage with no adverse consequences. Importantly, if you do change your mind about participating it will not affect the relationship you have with your therapist in any way. Also I will be pleased to answer any questions or concerns you may have at any time.

Clients usually find this to be a positive experience, and therefore it is unlikely that this process will raise emotional issues for you, but if this were to occur it is advised that you speak with your therapist, or we can provide the contact details for independent counselling if that is preferred.

Questions concerning this research project can be directed to Alison Turner using the contact information listed below. Alternately, you may contact my Supervisors, Professor Jeffrey Kottler jkottler@Exchange.FULLERTON.EDU phone (00111) 714-278-7537, or Associate Professor Jeanne Madison at UNE jmadison@une.edu.au or 02) 6773 3667.

This project has been approved by the Human Research Ethics Committee of the University of New England (Approval No HEO4/155, Valid to 3/11/07)

If you have any complaints or reservations about any ethical aspect of your participation in this research, or the manner in which this research is conducted, you may contact the Research Ethics Officer at the following address:

Research Services
University of New England
Armidale, NSW 2351.
Telephone: (02) 6773 3449 Facsimile (02) 6773 3543
Email: Ethics@metz.une.edu.au

Thank you for considering participation in this study.

Yours Sincerely

Alison Turner
Locked Bag 2002
Strathfield 2135
NSW
Ph: 97468800 m) 0404029233
Email: alison@institutecounselling.org.au

Appendix 9: Client Demographic

SCHOOL OF HEALTH
Armidale 2351
Australia

Client Demographic

PhD Research Project: A Study of Mutual Influence in the Therapeutic Relationship

1. **Name:** _____
2. **Age:** _____
3. **Gender:** **Male** ☐ **Female** ☐
4. **How many counselling sessions have you had with your therapist?** _____
5. **Over how many weeks or months have you been seeing your therapist?** _____

Appendix 10: Client Consent Form B

SCHOOL OF HEALTH
Armidale 2351
Australia

Client Consent Form B

PhD Research Project: A Study of Mutual Influence in the Therapeutic Relationship

I am willing to participate in this study conducted by Alison Turner, and understand that I am free to withdraw my consent at any time.

I have read and understand the information contained in the Information Sheet for Client Participants and any questions I have asked have been answered to my satisfaction.

I agree to an audio taped interview with Alison Turner at a time suitable to me.

I give permission for research data to be published, provided my identity is not disclosed.

Client Signature

……. Date …. /…. /….

Witnessed by Alison Turner

……. Date …./…./….