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# Tailor-made: Therapist to patient 'responsivity' in counselling and psychotherapy

*by*

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January, 2015



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**pp 170-188:**      **Section C. Client Study:** “I can’t get my point in”: the danger of therapist turning into abuser working with a childhood sexual abuse patient.

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**Declaration**

I grant powers of discretion to the University Librarian to allow this thesis to be copied in whole, or in part, without further reference.

## **Section A: Introduction to the portfolio**

My first placement as a counselling psychologist was at an NHS addictions service. My supervisor was predominantly existential/psychodynamic in orientation, but he also valued other modalities. I began working with the person-centred approach, because it was the first clinical module on my training course and the frame within which I felt least anxious. I then used CBT and, finally, after beginning personal therapy with a psychoanalyst, psychodynamic psychotherapy. At this stage I was particularly interested in the notion that different patients were better suited to different forms of psychotherapy. Following psychological assessment sessions I would discuss with my supervisor which modality to adopt. In one instance we initially agreed that I would use CBT, before changing to a psychodynamic approach after a few sessions. These early experiences would inform the topic of my critical literature review, and the initial idea for my research project: 'Responsivity' in psychotherapy, tailoring the work to the idiosyncratic needs of patients (e.g., Marshall, 2009).

This interest led me to literature and research on 'common factors' (Hubble, Duncan, & Miller, 1999). 'Common factors' models are embedded in the humanistic tradition, and emphasise client, therapist, and client – therapist interaction factors, above model specific technique (Wampold, 2010). Significantly, Bohart and Tallman (2010) stated that, to date, the client was the neglected common factor in the available research. My initial aim was to address this imbalance. Thus, my critical literature review, titled 'The role of client factors in psychotherapy treatment outcomes', explored the existing research in this area. This included findings that clients are more likely to benefit from therapy when they like the form of treatment (Swift & Tallahan, 2011), when it is consistent with their personal values (Whalley & Hyland, 2009), and when they believe in its efficacy (Kirsch, 2005).

I planned to build on the available research in my doctoral thesis, by exploring more nuanced and subtle forms of 'tailored treatment'. For example, Maggie Turp (2008) draws on Bick's (1968) and Brigg's (1998) concepts of 'toughened' and 'porous' psychic skin defences, in outlining her adaptive psychodynamic work with Kate. Turp (2008) reduced the frequency of her interpretations with Kate because of her 'porosity'. That is, Kate took in interpretations without question, before "quickly allowing them to leak away" (p 205). This change in tack provided her with the necessary containment to develop a more boundaried self. However, Dr Jay Watts, a past course tutor at City University, encouraged me to venture into more uncharted territory. She suggested I study stand out moments in psychotherapy, where therapists did something out of the ordinary, which they may feel reluctant to disclose to their peers. This would remain in the

remit of 'responsivity' as such interventions may be perceived as highly unique to the patient, imbued with a sense of: "It couldn't have happened with anyone else, at any other time".

Soon thereafter, I happened upon a book edited by Salman Akhtar (2011), titled: "Unusual interventions: Alterations of the frame, method, and relationship in psychotherapy and psychoanalysis". Unusual interventions were described as 'radical departures from the set and familiar rules of technique', 'creative exceptions to good general rules' and 'the occasional throwing out of the rulebook' (from the back cover). This is how I came to study 'unusual interventions' in counselling and psychotherapy. I discovered that there was a paucity of research and literature in this area and, so, set about contributing to an emerging theory. I interviewed 10 psychologists and psychotherapists, of varying theoretical orientations and training backgrounds. 8 were seasoned practitioners with at least 10 years clinical experience. Further, I included 2 pilot interviews with trainee counselling psychologists in the data analysis. Constructivist grounded theory (Charmaz, 2006) was my chosen methodology.

My client study outlines my psychodynamic work with Sarah (pseudonym), at a service for survivors of childhood sexual abuse, over a period of one year. This piece of work is fitting because it straddles core elements of both my critical literature review and research project. That is, it necessitated clear examples of 'responsivity' and, further, contains an 'unusual intervention'.

### **Additional references**

Bick, E. (1968). The experience of the skin in early object relations. *International Journal of Psychoanalysis*, 49, 484-486.

Briggs, S. (1998). The contribution of infant observation to an understanding of feeding difficulties in infancy. *Infant Observation*, 1(3), 44-59.

## **Section B: Research**

'Unusual' interventions in counselling and psychotherapy: A grounded theory analysis

## **Abstract**

This study explores unusual interventions (UIs) in counselling and psychotherapy, as defined by Akhtar (2011, p. xvii): “Clinical surprises...when the [therapist] makes a radical departure from the set and familiar rules of technique”. There is currently a paucity of literature and research in this area, and the present study aims to contribute to an emerging theory: Under what circumstances do UIs occur, how do they manifest, and what are the therapeutic consequences? A qualitative methodology, constructivist grounded theory (Charmaz, 2006), was used in this endeavour.

10 psychotherapists and psychologists, of varying theoretical orientations and training backgrounds, were recruited via email, and subsequently interviewed about UIs. 2 pilot interviews with trainees were included in the final sample, which, otherwise, consisted of practitioners with a minimum of 10 years clinical experience.

The Grounded Theory is comprised of 21 UI proposals, derived from 4 core, sequential categories. A distinction is made between Full and Partial UIs, with the former denoting a spontaneous, ‘not thought through’ therapist response. The UIs reported in this study predominantly had a positive therapeutic effect. The UI process may lead to therapist self-conflict as it represents a deviation from prescribed, standard technique.

## Chapter 1: Literature review

### Introduction

The study of unusual interventions is unusual in itself. There is a paucity of research in this area and, therefore, it is perhaps unsurprising that I alighted on it in a round-about way. I initially planned to explore how therapists tailor their work to meet the individual needs of their patients (responsivity/adaptation; e.g., Marshall, 2009). However, Dr Jay Watts, a past course tutor at City University London, suggested that I venture into more uncharted territory. Her idea was to study stand out moments in psychotherapy, precipitated, in part, by therapists taking a risk and doing something different. This line of enquiry would remain in the remit of 'responsivity', as such interventions may be highly unique to the patient, i.e., 'it couldn't have happened with anybody else, at any other time'.

Given the nature of this study it was fitting that a moment of synchronicity would give me the confidence to pursue it. Shortly after meeting with Dr Watts the quarterly Karnac book review was delivered to my home. I do not always peruse its contents, but on this occasion I did. I stopped in my tracks as I read the title: 'Unusual interventions: Alterations of the frame, method, and relationship in psychotherapy and psychoanalysis', edited by Akhtar (2011). Nancy McWilliams' (2011) back-cover review confirmed my hope and alleviated my concurrent anxiety. It was clear that this text would be central to my study:

*'This book is a godsend to those of us who view psychotherapy, not as an orthodox technique, but an art of the open mind and learned heart. Notions of "standard practice" are useful to therapists, especially early in our careers, but even more valuable are opportunities to learn how seasoned practitioners think, how they may translate their understanding of a person's suffering into creative exceptions to good general rules. In the heyday of psychoanalysis, a "classical" technique was idealised, sometimes whether or not the patient was helped. A current parallel to this elevation of means over ends is the pressure on clinicians of all orientations to manualise our work – as if one size should fit all regardless of a patient's unique personality or context... In this welcome volume, nine seasoned therapists describe clinical challenges that called for an exceptional response. Beginning practitioners will find inspiration in their honest, creative, and humane accounts. Experienced therapists, who will recognise the struggle that goes into the occasional throwing out of the rulebook, will find Unusual Interventions compelling and confirming.'*

This is how I came to define my study as an exploration of unusual interventions (UIs).

### *Presentation of the available literature*

The literature review covers a broad range of concepts. Akhtar's edited text (2011) was the only literature I was able to find, which used the label 'unusual'. However, descriptors of UIs therein, such as spontaneous, improvisational and authentic, would point me in the direction of further reading. First, I will present UIs from Akhtar's text, followed by a more specific focus on the use of touch and humour in psychotherapy. Examples of improvisational practice (Ringstrom, 2001) precede theories of human development (e.g., Laing, 1960) and clinical practice, e.g., person-centred counselling (Rogers, 1961), that are pertinent to the use of UIs. I then take up modern attachment theory (Schore & Schore, 2007) and the concepts of intuition (Welling, 2005) and flow (Csikszentmihalyi, 2000), which valorise unconscious processes in psychotherapy. Finally, I turn my attention to concerns surrounding UIs, with a focus on the psychoanalytic concept of 'enactment' (Bohleber et al., 2013).

Akhtar (2011) stated that although we are fascinated by UIs we are unable to ground them in theory. The aim of the present study is to do just that, to contribute to a burgeoning theory of UIs. So, without much further ado, let's begin.

*Note:* Varying terms are used to denote 'therapist', 'patient' and 'psychotherapy', largely contingent on the literature under discussion. For example, in outlining psychoanalytic concepts I refer to psychoanalysis, psychoanalyst, and patients or analysands. In discussing person-centred viewpoints I speak of counselling, clients and counsellors. Following Fink (2007), the therapist will be a 'she' and the patient a 'he' in odd-numbered subsections. This use of pronouns is reversed in even-numbered subsections.

## **Part 1: Unusual interventions (UIs)**

### **1.1. The frame**

Akhtar (2011) describes UIs as “clinical surprises...when the analyst makes a radical departure from the set and familiar rules of technique” (p. xvii). This definition suggests that a prominent quality of UIs is that they represent a deviation from the frame within which a clinician is working.

The fixed times, place and fee (in private work) imbue all forms of psychotherapy with a ritualistic quality (Hoffman, 1998). Further, divergent approaches prescribe norms and conventionally therapeutic interventions (Ringstrom, 2001). Ringstrom highlights the general importance of frames and rules in the interest of public safety; if treatment does not work it should at least do no harm. Thus, schools of therapy need to prove their efficacy, which entails a clear defining of metapsychology and derivative technique (Richards, 1999). For example, in terms of technique, the psychoanalyst makes interpretations and works with the transference (Fink, 1997). Automatic thought records and behavioural experiments are predominant in CBT (Bennet-Levy, 2003). The core conditions of empathy, congruence, and unconditional positive regard largely inform the interventions of the person-centred counsellor (Mearns & Thorne, 2007).

It is unsurprising that proponents of these theoretical orientations urge practitioners to adhere to the specific components of their model. These are, after all, believed to be the most important drivers of change in psychotherapy. For example, as stated, working with the transference is a key aspect of psychoanalytic psychotherapy (Fink, 1997). It is argued that maintaining the frame, e.g., neutrality, is vital to facilitate the full evocation of the transference (Milner, 1952). Bennet-Levy (2003) found that outcomes in CBT were largely contingent on the competence of the therapist. Significantly, competent therapists were more likely to adhere to the model and implement the main techniques: Automatic thought records and behavioural experiments. Similarly, Waller (2009) reported that ‘therapist drift’ was the biggest obstacle to successful outcomes in CBT. This was most problematic in terms of implementing behavioural experiments, which were anxiety provoking for both therapist and patient. Waller argues that therapist failure “to push for behavioural change” (p. 121) not only rendered treatment less effective, but may also be damaging to the patient. For example, it may decrease the patient’s confidence in his ability to change, and exacerbate avoidance pathology. Linehan (1993) notes that failure to complete homework (a key component of CBT) is a significant therapy-interfering behaviour.

Thompson-Brenner and Westen (2005) found that therapist drift occurs in different modalities in the face of challenging work. With complex patients psychodynamic therapists become more

behavioural in their interventions. Contrarily, CBT therapists adopt psychodynamic methods, shifting from a 'doing' to 'talking' therapy (Waller, 2009). Thus, there are compelling arguments for therapists to adhere to the frame of the model they are working in. However, it is overly simplistic to outline an all-or-nothing, adherence or non-adherence dichotomy. On her back-cover review of Akhtar's (2011) text, Nancy McWilliams defined UIs as "creative *exceptions* to good general rules" [italics added].

In this context, Brenner (2011) highlights the importance of consistent policies, which enable the psychoanalyst to recognise enactments that emerge in the therapeutic relationship. But he also argues that "one size does not fit all" (p. 20). Similarly, contradictions can be found between Freud's own (1913) guidelines and his actual practice. For example, he stated that free treatment should not be given, without exception. He believed this would increase the patient's resistance to treatment, as he would be less motivated to end it. However, he also reported that excellent results occurred for individuals who received free analysis, when their financial plight was not of their own making.

## **1.2. Examples of unusual interventions – Akhtar (2011)**

*"The analyst who respects the book, but is also able to permit himself flexibility, will find the right technical solutions..."* (Akhtar, 1999, p. 75).

It is time to present some examples of UIs. All of the clinical material in this subsection is taken from Akhtar's (2011) text, and provided by psychoanalysts.

Kurtz (1988) ran over time in a session without realising, which enabled the patient to disclose material about his childhood trauma. As a result Kurtz suggested that the patient's session be moved to the last clinical hour of his day, so that they could potentially run over time and allow space for further meaningful material to emerge. The patient was able to experience feelings more readily, and the time it took to reach these decreased. Sessions ended more and more on time before the patient reverted back to his normal session slot, earlier in the day.

Jacobs (2011) describes a patient who did not like his use of his title, Dr. Jacobs. When he had to contact this patient because of a schedule change, he was conflicted about how to introduce himself. He felt he could either gratify his patient's wishes, a perceived submission to avoid an angry response, or maintain his title in stubborn refusal, thereby eliciting his patient's anger. Jacobs was also anxious to not break the analytic rule of not gratifying the patient. In the final

analysis he decided to introduce himself with his first name, Marc. Significantly, he concedes that this was a last ditch decision. He didn't really understand why he had made this choice, or whether it was the right thing to do. This precipitated a major shift in the work. Jacob's patient told him that he felt respected and perceived him as a real human being. He no longer felt that Jacobs was keeping him at an arm's length. He became more open in expressing his desire and his relationship with his partner flourished as a result. Jacobs argues that rigid adherence to technique may inhibit potentially important interventions, in this instance through the fear of gratifying an impulse of the patient.

Morrison (1997) outlines her self-disclosure to patients of her terminal breast cancer. Subsequently, a patient felt more able to talk about the trauma of her childhood sexual abuse, because she understood that her therapist's illness was also traumatic. Like Jacobs (2011), Morrison stated that she could not predict the impact her self-disclosure would have.

~

The majority of UIs in Akhtar's (2011) text are *planned*. Jacobs (2011) planned to introduce himself to his patient with his first name, Marc. Morrison (1997) planned to use self-disclosure with her patients. Although it initially occurred unintentionally, Kurtz (1988) then planned to allow his patient to run over time.

Similarly, in CBT the 5-minute session (Waller et al., 2007) is used when a patient is consistently failing to complete his homework tasks. With eating disorders it is also used when a patient refuses in-session weighing. These items are prioritised and if the patient still refuses to engage, the session is terminated. This is done non-confrontationally and, in most instances, leads to the tasks being carried out (Waller et al., 2007). This is ostensibly an UI, but it is also planned.

Jacobs (2011) states that interventions without clinical intention do not fall under the rubric of technique. In this regard, Ogden (1994) instructs therapists to silently preverbalise the intention of their actions. Jacobs (2011) does not adhere to such a formulaic approach but believes that the therapist must have some type of formulation in mind, if it is not on the tip of the tongue.

Otherwise, he fears that any action can be rationalised post hoc. Jacobs (2011) argues he put a great deal of thought into his UI (use of first name), even if he didn't know what the effect would be: "I did not shoot from the hip, as in an interpretation through serendipity" (p. 135). I propose that Jacobs contradicts himself in this instance. He also informed the reader that he did not really understand his decision. If this is the case, could he really have had a therapeutic intention or

formulation? Using Jacob's own words, an important distinction emerges here between UIs that are 'thought through', and those that may represent a 'shooting from the hip'.

### ***Unplanned, spontaneous UIs***

2 of the 10 UIs in Akhtar's (2011) text are unquestionably not planned.

#### *Refusing to listen*

The first spontaneous UI, by Akhtar (2011), is also stand out because it would probably be described as unusual by practitioners of all theoretical orientations. The UI is with a patient in his final session after 6 years of psychoanalysis. This patient believed that his father did not like him. Unsurprisingly, this belief had manifested in the transference throughout and was worked through again and again. In this last session the patient once again questioned whether Akhtar actually hated him. Akhtar interrupted him with an exaggerated and mocking groan, augmented with the verbal message that he really did not want to hear this anymore! The effect was to jolt the patient who burst out in laughter. Subsequently, the session ended in good spirits.

This is an example of refusing to listen. Akhtar (2011) states that the function of listening has become institutionalised and achieved exalted status in psychoanalysis. Thus, it may also fit in with the therapist's 'analytic super-ego' and bolster her sense of being competent. In other words, it is concordant with "internalised analytic ideals" (p. 96). Pre-empting later themes in this study, he also proposes it is vital for the therapist to be able to deal with the aftermath of such a confrontational intervention. The therapist's holding functions have to be in place so that it can be worked through if necessary.

#### *Spontaneous touch*

In the second unplanned UI, Smolar (2011) spontaneously touched a patient as she left her office. The patient was concerned she might not be able to look after herself if she left her husband. She initially recoiled and Smolar felt uncertain if she should have followed her instinct and made the UI. She questioned whether she might have enacted a sense of competition with the lady's husband. Regardless, this UI helped the patient access her fear and avoidance of touch, which served to keep a latent "endless pit of need" at bay (p. 190). Therefore, she perceived the UI as a gift from her therapist. Smolar acknowledges that it cannot be known how her patient's therapy would have proceeded without her UI.

Like Jacobs (2011), Smolar (2011) outlines a number of factors to be taken into consideration in the use of UIs. These include the phase of therapy, the therapeutic relationship and the patient's

capacity to explore and understand the UI. She proposes a cost-benefit analysis of risk in the decision-making process. As with Jacobs, I also propose that Smolar's recommendations are abound with contradictions. She states that the analyst should allow herself to be guided by her intuition, and what she feels is best at any given moment. But is intuition reconcilable with the aforementioned, conscious decision-making processes? Further, she suggests that the analyst should stop whenever the impulse arises to do something different, and question how the patient may be unconsciously pressuring her. This is tantamount to keeping spontaneity in check with a healthy level of restraint. But she described her own UI as spontaneous.

Although Smolar (2011) urges therapists to untangle their counter-transference reactions and to ascertain their motives, she also acknowledges that they may be mistaken in their judgements. In this context Renik (1993) highlights that the correctness of an intervention can often only be ascertained post hoc, and there are times when it may never be clear.

### **1.3. Touch and humour**

The use of touch in psychotherapy is germane to the present study because, next to humour, it represents a form of UI that has been subject to research and theoretical conjecture. It is important to note that touch is not equally unusual for all practitioners. For example, Milakovich (1998) reported that humanistic therapists are more likely to use touch than psychodynamic psychotherapists.

Touch in psychotherapy has been shrouded in controversy since Freudian times (Bonitz, 2008). As outlined, Freud (1912) propagated his rules of abstinence, which precluded physical contact with patients to facilitate the full evocation of the transference. Further, Freud's pleasure principle rendered touch inherently sexual and as a gratification of infantile sexual wishes. It was to be avoided by clinicians to frustrate patients, so they would be sufficiently motivated to change (Bonitz, 2008).

Sandor Ferenczi (1953), a disciple of Freud's, strongly disagreed with this emphasis on frustration. He believed that excessive frustration served to repeat patients' early experiences of deprivation, and resorted to touching and kissing his patients (Hoffer, 1991). Given that Ferenczi would go on to have sexual relationships with at least 2 of his patients, it is unsurprising that the use of touch has become associated with fears of therapist sexual exploitation (Pope & Bouhoutsos, 1986). The validity of this concern was powerfully underlined by Holroyd and Brodsky's (1977) findings that

12.1% and 2.6% of male and female psychologists had at least one sexual relationship with a client.

However, touch is a powerful form of nonverbal communication that can have a healing effect in psychotherapy (Durana, 1998). Horton, Clance, Sterk-Elifson, and Emshoff (1995) reported that almost all the participants in their study of 'touch in psychotherapy' had experienced it positively. In Gérard Miller's (2011) documentary, 'Rendez-vous chez Lacan', Suzanne Hommel describes Jacques Lacan's powerful use of touch in her analysis with him in 1974. After telling him about a dream, she reflected that she woke up at 5 o'clock every morning, the time the Gestapo had come to take Jewish people away from their homes during the Second World War. Lacan jumped up from his chair at that moment and caressed her cheek gently. Suzanne Hommel understood this as a 'geste à peau', an extraordinarily tender gesture. Gestapo had been transformed to 'geste à peau'. She reflected: "It didn't diminish the pain, but it made it something else. The proof now, 40 years later, is that when I recall that gesture I can still feel it on my cheek".

Historically there have been varying positions amongst psychoanalysts. Menninger (1958) was strictly against touch; others incorporated it into their practice (e.g., Reich, 1945), whilst some adopted a middle ground, stating that it could be appropriate with certain patients (e.g., Winnicott, 1965). Gabbard (1994) acknowledged that boundary violations, for example touch, can be therapeutic. However, he maintains that these should be avoided as they may pave the way for the inappropriate expansion of boundaries and unprofessional conduct. This is the 'slippery slope' argument, which eschews all deviations from classical technique (Gutheil & Gabbard, 1993).

Glickauf-Hughes and Chance (1998) also posited that the use of touch should be contingent on the client. They found that touch could have therapeutic effects with acutely distressed clients and individuals who felt ashamed of their need for physical contact. Contrarily, they reported that it was inadvisable with patients with a borderline personality organisation. An interesting finding in the available literature is that therapists are more likely to use touch when they themselves have had a positive experience of it in their own therapy (Milakovich, 1998).

More recently, Bonitz (2008) provided tentative guidelines to help therapists decide when it is appropriate to use touch, based on a review of the available literature. She argues it is important to have a strong therapeutic rationale, for example the provision of a corrective emotional experience. Touch should only be used in the context of a strong therapeutic alliance, and the therapist is advised to closely examine her motivations. The therapist should ask the client to touch him. It is vital to monitor his reaction to being touched and to subsequently explore the

meaning of the experience for him. It is important for the therapist to be aware of the type of issues that may be evoked in the client through the use of touch. It is apparent that a number of Bonitz's guidelines are antithetical to the spontaneous use of touch in psychotherapy.

### ***Humour***

Franzini (2001) defined humour in psychotherapy as: "The intentional and spontaneous use of humour techniques" (p. 171). However, the available literature predominantly pertains to the intentional usage. For example, to humanise the therapist (Bloomfield, 1980), and to disarm patients and touch them deeply (Lusterman, 1992). Franzini (2001) noted that there were 4 handbooks on the use of humour in psychotherapy, e.g., Buckman (1994), and further, that humour training had been recommended in psychotherapy training courses. Guidelines include a direct relationship of humour to the patient, and that it should only be used once a strong therapeutic alliance has developed (Thomson, 1990). In this regard, Richman (1995) argued that the use of humour can be learned. Contrarily, Bloomfield (1980) proposed that it should be used naturally and authentically. Similarly, Salameh (1987) stated that humour should be a real aspect of the therapist, through which she gives of herself and demonstrates her humanness. Jolley (1982) argued that therapists against the use of humour had issues with power and closeness, because it is an act of sharing that may equalise the relationship.

Humour has a positive, curative potential on physical and mental health, through impacting on emotions, attitudes and perceptions (Martin, 2007). Squier (1995) found that spontaneous humour increased patients' trust in the therapist and the process as a whole. Marci, Moran and Orr (2004) measured skin conductance in video-taped, psychotherapy sessions with patients with serious mental illness (SMI), e.g., schizophrenia and borderline personality disorder. They reported that laughter increased rapport. Significantly, the therapeutic alliance is a strong predictor of outcomes with these patient groups (Gelkopf, 2009). Winnicott (1971) reported that the use of humour with borderline patients facilitated the exposition of significant conflicts through the provision of a playful space that loosened rigid defences.

It is significant for the present study that the available humour literature foregrounds the tension between spontaneous and intentional usage, which emerged in Jacobs' (2011) and Smolar's (2011) accounts of their UIs.

#### **1.4. Summary and concluding thoughts**

An important distinction emerges in Akhtar's (2011) text between planned and unplanned, spontaneous UIs. The contradictions in analysts' recommendations for UIs are noteworthy. For example, Smolar (2011) urges therapists to be spontaneous and intuitive as well as thought through. This tension between the spontaneous and intentional usage of UIs is also found in the 'touch' and 'humour' literature.

A large number of psychoanalysts agree that decisions about UIs should be made on an individual basis (e.g., Fosshage, 2000). This is consistent with reports of Freud's (1913) deviations from his own rules of abstinence, as well as guidelines derived from research on the use of touch and humour in psychotherapy.

## **Part 2: Embracing the improvisational**

*“All growth is a leap in the dark. A spontaneous, unpremeditated act without benefit of experience”. –Henry Miller*

### **2.1. Improvisation**

The previous section has finished in a state of tension between spontaneity and intuition on the one hand, and conscious thought processes on the other. I proposed that Jacobs’ (2011) and Smolar’s (2011) recommendations for UIs were not in line with their own clinical examples, i.e., that they had overemphasised the presence of conscious thought processes.

Using the search term improvisation I found a central piece of literature for the present study, by Phillip Ringstrom (2001): “Cultivating the improvisational in psychoanalytic treatment”. In this paper Ringstrom unabashedly embraces the spontaneous and improvisational nature of his UIs, drawing on metaphors of theatre:

*“...the metaphor of classical theatre is analogous to how the theoretical predilections of each school of psychoanalysis has its own set of prescriptions (‘sets’, ‘roles’, and ‘scripts’) for how an analyst influences mutative moments of change with a patient. In contrast, the metaphor of improvisational theatre refers to actions that arise on the spur of the moment, without preparation...”* (p. 727).

Ringstrom (2001) gives an example from his clinical practice with Jonathon, a patient who fit the diagnosis of borderline personality disorder. Jonathan’s mother portrayed herself as a ‘saint’. As a result, he had learned to castigate and attack himself violently if he ever had a bad thought about another human being. Jonathan’s son, Andrew, also ruminated obsessively about ‘bad’ thoughts. Jonathan was becoming increasingly frustrated with his inability to soothe his son’s anxiety. Ringstrom suggested that he might help Andrew to explore and discuss his ‘bad thoughts’, rather than minimising his concerns. Jonathan was delighted with this idea. However, he was also amazed by his ‘stupidity’ that he had not been able to see this answer. After all he had been discussing his own obsessions in therapy for 3 years at this point. He began a vitriolic and sustained attack on himself.

Ringstrom began to feel trapped, and he blurted out: *“But of course, Jonathon, your stupidity was soooooo understandable!”* (p. 728). Jonathan burst out in uninhibited laughter. He then repeated this line 3 times, and expressed his wish to remember it verbatim.

I feel that Ringstrom fully owns the spontaneous and unplanned nature of his UI. This is undoubtedly a brave step. In terms of classical analytic technique, e.g., abstinence and neutrality, he is aware that his UI is anathema. He describes it as an unexpected, outrageous intervention, and that his patient would also have perceived it as the wrong thing for a therapist to say. Ringstrom believes he expected him to do the therapeutically correct thing, as his mother always did, even if this was insincere. That is, to “lord it over him” (p. 728). By contrast, his spontaneous gesture was genuinely empathic: How could Jonathon not have difficulty tolerating the evil thoughts of his own son, just as his mother had been unable to tolerate his own?

Later in the work Jonathon informed Ringstrom about his sadistic poisoning of squirrels that were damaging his back garden. There was no further mention of squirrels for some time until, getting up at the end of a session, Jonathon commented: “Oh, what a cute squirrel in your backyard”. Ringstrom began to form a response, before being jolted out of his reverie to aggressively and playfully assert: “You keep your fucking hands off my squirrel!” (p. 733). Again, Jonathan burst into laughter. Ringstrom hypothesises that Jonathon felt met in his totality through this UI; he could feel that his aggression was not only known by his therapist, but also embraced (and potentially enjoyed, I might add). In this instance a more careful intervention may have left the patient feeling: “Stop being such a fucking therapist!” (p. 734).

Ringstrom highlights the *authenticity* of his UIs, which stood in stark contrast to his patient’s inauthentic being in the world. He argues that a spontaneous, unplanned intervention represents the purest form of authenticity on the part of the therapist. It is what is most true of the therapist at that moment in time, which cannot be attained with a traditional, thought-through intervention. It follows that there is no technique for improvisation, it either happens or it doesn’t. Further, it cannot become a technique as this would render it ‘not improvisation’ (Watzlawick, Weakland, & Fisch, 1974).

~

*“As spontaneously as I reacted to Jonathan, such a reaction is unlikely to emerge from me with a new patient – a patient with whom I lacked a certain intuitive sense that might enable me to engage in this ‘high-risk, high-gain’ response with some instantaneous faith that it would more likely yield the latter than the former” (Ringstrom, 2001, p. 735).*

As demonstrated in the preceding quotation, Ringstrom (2001) is eager to dispel potential concerns that he is promoting a wild treatment where anything goes, described by Stolorow and Atwood (1994) as a ‘structureless chaos’. He asserts he is not advocating a continual flow of

improvisation and that the study of theory and technical manoeuvres is never rejected. However, Ringstrom believes it is vital to maintain a tension between what is prescribed and spontaneous engagement. This may be achieved through not holding onto the 'book' (prescribed technique) so tightly that the therapist becomes closed off from the patient, but also not dismissing it with wild abandon.

## **2.2. Summary and concluding thoughts**

I proposed that Ringstrom (2001) fully embraces the spontaneous and 'not thought through' nature of his UIs, which he labels the 'improvisational'. This is potentially unsurprising given his assertion that such interventions represent the purest form of authenticity on the part of the therapist. Ringstrom states that his UIs were unique to his patient, and he acted on intuition and trust that they would benefit him. He describes his UIs as 'high-risk, high-gain'. Ringstrom also highlights that UIs may represent extreme deviations from conventional technique. I believe this validates Akhtar's assertion in part 1 that UIs may challenge an analyst's 'analytic super-ego'. Ringstrom dispels concerns that he is advocating an 'anything goes'. If clinicians can maintain an appropriate tension between the 'book' and spontaneous engagement, they may be open to the improvisational in their work. However, Ringstrom argues that the improvisational cannot become a technique.

### **Part 3: Relevant theory**

I believe that Phillip Ringstrom's (2001) 'owning' the spontaneous, 'not thought through' quality of his UIs is important, because it wholly opens the door to theoretical conjecture. His valorisation of UIs as the purest form of therapist authenticity is potentially unsurprising, given that questions of 'authenticity' are at the heart of significant psychoanalytic and psychological theories of human development, and what constitutes mental health.

In this section I have chosen to briefly summarise, in part, the theories of the psychoanalysts Carl Jung and Donald Winnicott, the psychoanalyst and existential philosopher Ronald Laing, and the person-centred counsellor Carl Rogers, as these pertain to the aforementioned question of authentic functioning. Subsequently, I will focus on relational psychoanalytic (e.g., Stern et al., 1998) and person-centred counselling theory (e.g., Mearns & Thorne, 2007), to increase our understanding of why therapist authenticity may be a key factor in the potential therapeutic effect of UIs.

#### **3.1. Carl Jung**

Jung (1967) describes the 'persona' as a mask, derived from the perceived social expectations and aims of the individual. This mask functions to conceal aspects of the self, which are deemed socially unacceptable. Disavowed psychic contents subsequently find refuge in the unconscious 'shadow' or concealed 'private self'. Thus, the development of the persona represents a duplication of character. Although this is viewed as a universal process, it represents a painful division and diminution of self. Significantly, excessive identifications with the persona provide fertile ground for the development of neuroses (Jung, 1970).

Optimum development necessitates an affirmation of all those elements that constitute the individual (Jung, 1970). This process may lead to both an appropriate adaptation to the conditions of social life, and provide the foundation for self-determination and 'individuality'. Whereas the persona is an unequivocal and safe role, individuality is unpredictable and there is an unknown quality to how the burgeoning personality will develop and manifest (Jung, 1967). The 'individual' has access to his innermost feelings, thoughts and beliefs. Although the realisation of our whole being is deemed unattainable it is an ideal that the organism strives towards.

### **3.2. Donald Winnicott**

Donald Winnicott distinguishes between 'true self' and 'false self' positions in human development (1960). The extent to which an individual operates from either position is primarily contingent on the quality of the mother's early care (1963a).

The baby is initially only aware of a state of relative wellbeing or a converse terror of potential annihilation (1962). The 'good enough' mother protects her baby from this latter, overwhelming experience through her sufficient attunement (1963b). She enables the baby to reside in a state of 'unintegration', an undefended and relaxed position in which the true self can develop as an authentic, spontaneous and consistent experience of being. The baby learns that its needs and desires will be adequately met. If aspects of the mother's attunement are inadequate for prolonged periods the baby's sense of being real is endangered. A false self, characterised by compliance and an illusory sense of coping, emerges to keep at bay the concomitant, terrifying anxiety of disintegration (1960). The false self is contingent on perceived external demands and, in neurosis, subverts relating from a position of genuine need (1963b).

### **3.3. Ronald Laing**

Laing (1960) distinguishes between an 'inner self' and 'false self' system to provide an account of the schizoid and schizophrenic experience. Parental indifference and excessive criticism are examples of early experiences that are implied in the pathological development of the false self system. Compliance ensues as a defensive manoeuvre to protect the inner self that is invalidated by the external environment. For example, one patient stated: "I am only a response to other people, I have no identity of my own" (p. 47).

In extreme cases the schizoid individual's subjectivity is perpetually withheld to protect itself. Significantly, nothing is felt as a true expression of self, he feels unreal and that he is not properly alive. Spontaneity and creativity is inhibited as it represents a direct threat against the inner versus false self split, which is contingent on the absolute conscious control of actions and personal expressions.

### **3.4. Carl Rogers**

Carl Rogers (1961), the father of person-centred counselling, proposed that the most important process in psychotherapy was becoming one's true, authentic self. A loving and supportive environment helps us to value and trust our thoughts, feelings and judgements (Mearns & Thorne, 2007). Conversely, through experiences of criticism and negative judgement people become increasingly focused on doing things that will bring approval. Because of the strong and universal need for positive regard they develop a facade to hide 'unacceptable' aspects of their experience.

Rogers (1961) found that in positive examples of psychotherapy patients moved away from what they thought they 'ought' to be. He reflected that his clients wanted to be real, and to not hide behind a mask. Further, patients moved towards becoming a 'process', in constant flux, and less certain about what will happen next, what they will say, do or feel. They became more spontaneous, creative, unpredictable in their responses, and found that their intuitive sense of what is right was a fulfilling and competent guide to living their lives.

#### ***Intermittent summary and reflections***

In the outlined theories of human development there is a striking link between compliance to perceived external demands in the face of overly critical early experiences, as a manifestation of an inauthentic, false self or persona, and the inhibition of spontaneous and creative self expression. Authentic, true self functioning is dynamic and unpredictable, as opposed to the controlled and unambiguous false self. Therefore, it is potentially unsurprising that significant clinical perspectives on technique foreground the importance of therapist authenticity and concomitant spontaneity.

### **3.5. Person-centred counselling**

Congruence, empathy, and unconditional positive regard form the three core conditions in person-centred counselling (Rogers, 1973). On congruence, Rogers reflected (p. 186): *"I believe it is the realness of the therapist in the relationship which is the most important element...our experience has deeply reinforced and extended my own view that the person who is able to openly be himself at that moment, as he is at the deepest levels he is able to be, is the effective therapist. Perhaps nothing else is of any importance"*.

The person-centred counsellor David Mearns (2003) questions how far patients who struggle to be authentic can be helped by counsellors who offer an incongruent version of themselves. In the endeavour to be congruent Mearns and Thorne (2007) challenge counsellors to ask: “Can I dare to step out from behind my professional facade?” (p. 120).

According to Mearns and Thorne (2007) congruence is the most difficult of the core conditions for the beginning counsellor, who may make the mistake of censoring her negative responses. Initially counsellors will conscientiously adhere to the ‘norms’ of the model, emphasising the core conditions. However, through experience the counsellor learns to trust her intuitive judgement of the appropriateness of an intervention. This skill is slow to develop for good reason. Open use of the self is powerful, but therefore, also has the potential to be dangerous. Such interventions may be distorted by the counsellors own fears and needs, or ‘self-resonance’ in person-centred terms. It is proposed that increased self-awareness can help the counsellor to trust her spontaneous actions. Highly congruent interventions are generally spontaneous interventions.

Mearns and Thorne (2007) argue it is the counsellor’s willingness to take risks, and to be vulnerable, that may help patients face their own pain and risk change. The primary goal in person-centred therapy is to meet the patient at ‘relational depth’ (Mearns & Cooper, 2005). Relational depth is defined as: “A state of profound contact and engagement between two people, in which each person is fully real with the other, and able to understand and value the other’s experiences at a high level” (Mearns and Cooper, 2005, p. xii). It is proposed that counsellor congruence is key to working at relational depth with patients, which is valorised over the correct use of a therapeutic skill set.

### **3.6. Relational psychoanalysis**

Stern et al. (1998) provide a compelling theoretical account of the pathways through which authenticity, and concomitant spontaneity, may exert a positive therapeutic effect. Drawing on anecdotal evidence they argue there are 2 primary pathways to positive change in psychoanalysis: Insight, facilitated through interpretations, and moments of authentic person-to-person connection, which “alter the therapeutic relationship...and thereby the patient’s sense of himself” (p. 2). The latter are described as ‘moments of meeting’. It is proposed that classic analytic technique has neglected this relational realm, and that therapies may fail in the absence of meaningful human connection.

According to Stern et al. (1998) mutative relational processes exert a positive effect through their impact on 'implicit relational knowing'. Implicit relational knowing is described as an unconscious, procedural knowledge about relationships. It develops in infancy, as children learn which responses are valued by their caregivers, and constitutes a set and standard way of being in the world with others. 'Moving along' is the trial by error process in which the infant-parent dyad moves towards regulation goals in early development. Significantly, the steps along the way are not known a priori, but rather, are ad-libbed.

'Now moments' are the gateway to moments of meeting. These are affectively hot, stand out moments that provide the opportunity for authentic and unique responses from both parties. To seize the now moment the therapist has to respond in a way that is discordant with the habitual framework, and carries her personal signature. It cannot be a rehearsed or routine technical manoeuvre, which could readily be used with a different patient. Significantly, the response is spontaneous and reveals something about the therapist's affective state or actual experience. According to Hoffman (1994), authentic, spontaneous engagement is not contaminated by intentionality, a critique of the corrective emotional experience (Alexander, 1944), that may be contrived and manipulative. Therefore, it may represent the most direct route to gaining a patient's trust (Ringstrom, 2001). In a moment of meeting both parties are largely stripped of their ascribed roles and meet as equals. Lichtenberg, Lachmann, and Fosshage (1992) suggest that such stand out moments have a special capacity to penetrate defences and facilitate a memorable, and curative interpersonal moment.

### ***Why not throw the 'book' away?***

The notion that an uncritical, slavish adherence to the 'correct' technique may not best serve our patients, begets the following question: Why don't we just throw the 'book' away in favour of spontaneous, personal engagement? Ringstrom (2001) argues that this is not an option, as therapy would then represent a personal relationship with the idea that the mere act of spending time together will be helpful. 'Authentic engagement' as an overarching technique would be no different than a rigid classical stance and, paradoxically, its authenticity would be questionable. Hoffmann (1994) proposes a dialectical tension between the 'book', i.e., formal analytic authority, and authentic self-expression and immediate responsivity. This position changes the analyst's attitude towards frame deviations, which are no longer perceived as such a sharp shift.

### **3.7. Modern attachment theory**

Like relational psychoanalysis, modern attachment theory (e.g., Schore & Schore, 2007), a biopsychosocial perspective, foregrounds the role of unconscious processes in human development. It is argued that the non-conscious, right brain hemisphere is the seat of a bodily based, emotional 'sense of self' (Schore, 1994). The right brain develops in an implicit attachment relationship between mother and infant (Schore & Schore, 2007). In this relationship communication is automatic, characterised by rapid decision-making processes, and nonverbal, for example through facial expression, posture and tone of voice. It is through this right brain to right brain process that the infant's capacity for self regulation emerges and develops. Thus, self regulation is contingent on the mother's ability to intuitively attune to the infant's affective state. Attachment experiences find their manifestation in 'internal working models' (Bowlby, 1988), with non-conscious strategies for affect regulation (Schore & Schore, 2007). Thus, the right brain is placed at the heart of mental health, with positive therapeutic outcomes contingent on changes in implicit relational knowledge (Stern et al., 1998) and the reassessment of deficient internal working models.

This perspective is significant for the present study because it also valorises the role of non-conscious communication in the therapeutic dyad. Clinicians are encouraged to become receptive to the implicit realm, to receive communications from patients and to express bodily based, intuitive responses to them (Schore & Schore, 2007). It is stated that this endeavour can be enhanced by adopting a position of 'reverie' and using intuition (Marcus, 1997). In this regard, Rustin (2013) reflected that neuroscience, with its focus on implicit, right-brain processing, has helped her to trust her intuition. She particularly emphasised research on mirror neurons and shared circuitry, which enable us to nonverbally apprehend others' intentions and affective states.

### **3.8. Summary and concluding thoughts**

Significant psychological theories of human development foreground the role of authentic, true self versus inauthentic, false self functioning in mental wellbeing (e.g., Jung, 1967). Further, a strong link is proposed between authenticity and spontaneous self-expression. Similarly, modern attachment theory, a biopsychosocial perspective, places non-conscious, intersubjective processes in early attachment relationships at the heart of human development. From a clinical perspective, relational psychoanalysis and person-centred counselling foreground the importance of meaningful human connection in psychotherapy. It is argued that a slavish adherence to

technique can be a barrier to authentic meeting, as we lose our naturalness and spontaneity (Stern et al., 1998). Significantly, authenticity is most present in spontaneous gestures, which tend to momentarily equalise power imbalances in the therapeutic relationship. Therapist authenticity is viewed as an important counterpart to patient in-authenticity. It may also provide a fast-track to the patient's trust, as the therapist is, to a large extent, in sight, not obfuscated by a professional facade.

There is a potential, important difference between relational psychoanalysis and person-centred counselling theory. Authenticity, or congruence, is a core condition in the person-centred approach. Thus, ostensibly, it is technique. In contrast, Hoffman (1998) stated that 'authentic engagement' as an overarching technique would be no different than a rigid classical analytic stance and, paradoxically, its authenticity would be questionable. This question is taken up further in the discussion section of this study.

## **Part 4: Unconscious processes**

In the preceding section I outlined theories of human development and clinical perspectives that valorise spontaneous and intuitive functioning. Therefore, part 4 provides a more detailed exploration of the concept 'intuition'. In addition 'flow', a further 'non-conscious' process, is taken up to potentially increase our understanding of why UIs can facilitate significant, positive therapeutic moments.

### **4.1. Intuition**

Intuition represents "a rapid form of understanding, knowledge, or meaningful cognition, arrived at without the conscious use of reasoning or deliberation" (Rea, 2001, p. 98). Significantly, non-conscious, intuitive thought processes are faster and can be more accurate than conscious, analytical thinking (Lewicki, Hill, & Czyzewska, 1992). For example, in de Vries, Witteman, Holland, and Dijksterhuis' (2010) study clinicians made more accurate psychiatric diagnoses when they were distracted from conscious reflection. This is potentially unsurprising, given that the combined conscious and unconscious processing system has a capacity of approximately 11 million bits; in contrast, about 7 units can be kept in conscious awareness at any given time (Miller, 1956).

Although intuition is a universally recognised phenomenon, and despite its undoubted presence when clinicians follow hunches, gut-feelings and lines of enquiry without really knowing why, little is known about its usage in psychotherapy (Welling, 2005). The available literature emphasises the use of intuition to gain a superior understanding of patients and the therapeutic process, as opposed to intuitive action per se. For example, Welling (2005, p. 32): "*Intuition has proved essential for arriving at decisive insights about my cases*". Similarly, according to Eisengart and Faiver (1996) intuition is vital to gain a more complete understanding of a patient, which, subsequently, may inform therapeutic interventions through the application of conscious thought processes.

This emphasis can also be observed in Welling's (2005) 5-phase, cognitive model of intuition. The model is based on the premise that intuition is a cognitive function of pattern recognition (e.g., Lewicki, 1986). Thus, it is proposed that intuition can represent the recognition of a known pattern, or a deviation from it (Welling, 2005). In this context, Prietula and Simon (1989) noted a positive correlation between intuition and experience. They argued that experts are more able to recognise patterns because of the large volume of information at their disposal.

Each phase in Welling's (2005) model is defined by different forms of knowledge representation, and a hierarchical increase in available information. In the first 'detection phase' the individual becomes aware of a change in his affective experience, e.g., feeling troubled, but does not know what it is about. The second 'dichotomic awareness phase' is characterised by the sense that something is wrong, or that there is a solution without knowing what it is. In phase 3, the 'related object phase', it becomes apparent to what objects the intuition is related, without knowing what the intuition actually is. In the fourth 'metaphorical solution phase' the intuition is discerned as it presents itself in the form of words, images, or feelings. In the fifth and final 'explicit verbal understanding phase' the link between the intuition and the elements is understood. Welling provides an example of a man sensing that something is wrong (phase 2) with his marriage (phase 3); subsequently he has an image of a prison cell, or feels trapped (phase 4) and, later, understands that he is feeling trapped in his marriage (phase 5). According to Welling the phases generally become conscious in a hierarchical and fixed order. If it appears that earlier stages are absent a number of stages have actually presented themselves simultaneously.

Given the universal view of intuition as a rapid form of understanding, insight and meaningful cognition (Rea, 2001), the aforementioned focus on this phenomenon as a source of information is potentially unsurprising. However, Goldberg (1983) stated that intuition may also manifest as an impulse towards action. Studies of intuitive learning have demonstrated that individuals not only detected patterns in a stimulus field unconsciously, but also utilised this information to inform intuitive action, without even being aware of this process having taken place (Lewicki, Czyzewska, & Hoffman, 1987).

In this regard, a manifestation of intuition in Welling's (2005) fourth 'metaphorical solution phase' is 'action tendencies'. Shapiro (1995) provides a relevant example from her clinical practice: *"...I suddenly had a strong image of myself sitting next to her on the couch. Without thinking, I got up and went to her, sat next to her and put my arm round her"* (p. 144). This tallies with Eisengart and Faiver's (1996) proposal that intuition may be used directly and immediately, rather than informing practice in conjunction with conscious thought processes. This pertains to intervening without thought, 'just doing'. It is also consistent with a significant proportion of the UIs that I have found in the available literature and presented in this study. Given the unconscious quality of intuition it is unsurprising that clinicians have emphasised the importance of self-knowledge in its usage, e.g., Goldberg (1983). Rea (2001, p. 104) advised "know thyself", as personal fears, prejudices, and vulnerabilities may colour our intuition and render it harmful. In this regard, Weisel-Barth (2014) asks a fascinating question: "Where does clinical intuition end and counter-

transference begin?" (p. 72). She warns clinicians of a naive assumption that intuition represents a pure form of information about the patient, which can be trusted without question.

## **4.2. Flow**

The concept of 'flow' places a greater emphasis on 'unconscious action'. The flow state is characterised by a loss of self-consciousness, as action and awareness merge, and the perception of time is transformed (Csikszentmihalyi, 2000). It occurs when an individual is fully immersed in a task, in which the balance between skill and challenge is optimal. Further, it is associated with peak moments, where individuals experience a high level of mastery and tasks feel effortless (Csikszentmihalyi, 1997). They also feel authentic, competent, and intensely concentrated (Wrigley & Emmerson, 2013). Wellbeing is enhanced, as well as meaning and creativity (Csikszentmihalyi, 2000). These flow effects have been reported in a variety of life domains, e.g., business (Csikszentmihalyi, 2000), sports (Jackson & Kimiecik, 2008), and artistic endeavours, such as writing and music (Byrne, MacDonald, & Carlton, 2003).

More recent research has demonstrated that individual differences also play a role in the occurrence of flow. Keller and Bloman (2008) found that individuals with a weak internal locus of control did not experience flow, even if the skill-challenge balance was optimal. Similarly, Baumann, Kazen, and Kuhl (2010) reported that flow motivation was positively associated with self-determination, as opposed to an external, incentive based motivation. It is considered that self-determined individuals are less influenced by external forces, e.g., social expectation. According to Baumann and Scheffer (2009) the motivation to attain flow is divided into 2 function components of personality, 'seeking' and 'mastering difficulty'. Very few participants in Wrigley and Emmerson's (2013) study achieved high levels of flow in their music examinations. What is noteworthy is that 'loss of self-consciousness' was the least attained aspect of the flow experience, with only 23% of participants reporting high levels.

### ***Flow in psychotherapy***

Flow has also been explored in psychotherapy, with a focus on moments that both therapists and clients experienced as significant and particularly helpful (Grafanaki & McLeod, 1999). Like sportswomen and men, psychotherapists also described these peak moments as 'being in the flow', where they experienced high levels of connection and trust, both in themselves and their clients.

Grafanaki, Brennan, Holmes, Tang, and Alvarez (2007) explored a key moment in the work of a person-centred, experiential psychotherapist, which had represented a turning point for the client. The therapist had been immersed in the moment, concentrating intensely on a challenging task. Both participants felt a strong level of connection and their time perception was altered. They overestimated the duration of the significant moment, but felt that the session passed quickly. It was reported that the flow moment precipitated significant growth in the work, and optimism was increased. They also highlighted the importance of the therapeutic alliance as a foundation for flow. This is consistent with Csikszentmihalyi's (2000) proposal that flow is more likely to occur within positive relationships.

#### **4.3. Summary and concluding thoughts**

Modern attachment theory, perspectives on 'intuition' and the concept of 'flow' emphasise the positive effects of unconscious processes in psychotherapy. I argued that perspectives on intuition foreground cognitive processes, e.g., using intuition to attain a greater understanding of patients, whilst 'flow' emphasises unconscious action. The vast processing capacity of the unconscious system is implicated in the potential superiority of unconscious processes. However, clinicians posit that intuitive processes can also be harmful when they are contaminated by our neuroses, and therefore emphasise the importance of self-knowledge.

## **Part 5: UIs, risk, and enactment**

Significant psychological theories of human development and clinical practice, anecdotal evidence, and research findings on the use of touch and humour suggest that UIs are worthy of our attention. Why then, do they remain neglected in our research and clinical reporting?

The link between UIs and risk is prominent in the available literature. Ringstrom (2001) described his UIs as ‘high-risk, high-gain’. The person-centred literature (e.g., Mearns & Thorne, 2007) outlines that counsellor ‘use of self’ is powerful, but also has the potential to be dangerous. In this regard, it has been suggested that intuitive interventions may be distorted by clinicians’ neuroses (Rea, 2001). Given that public safety is a priority in psychotherapy it is unsurprising that, as practitioners, we are concerned that our own unconscious motives and blind-spots do not lead to misguided action (Kris, 2011). Further, Akhtar (2011) proposed that UIs may challenge the clinician’s therapeutic ‘super-ego’ because they represent a deviation from technique. In this section I will explore the relationship between UIs, therapeutic risk and enactment to potentially increase our understanding of the aforementioned marginalisation.

### **5.1. Enactment**

The term enactment is used to denote both therapist and patient discharges in psychotherapy, which occur without conscious awareness – it is an umbrella term which captures ideas commonly associated with acting out, such as transference, counter-transference, and repetition (Bateman, 1998). In explicating enactment I believe it is important to first outline the concept of counter-transference. Racker (1957) summarises the meaning of the counter-transference as “everything that arises in the analyst as a psychological response to the analysand” (p. 731). Thus, it incorporates the effect of the therapist’s own unconscious conflicts and needs on his therapeutic work. Intense emotions point towards counter-transference reactions, i.e., that the analyst’s own unconscious feelings and transferences onto the patient are in play; for example, an intense dislike of a patient may stem from the analyst’s inability to understand him (Reich, 1951).

Reich (1951) distinguishes between 2 forms of counter-transference (CT): “CT in the proper sense” and “the analyst’s using the analysis for acting out purposes” (p. 26). According to Reich, ‘proper CT’ reactions are acute and arise suddenly. For example, with certain patients as a result of their personality or material presented. Consider the trainee analyst who wanted to get rid of his homosexual patient. In supervision he realised that his own defended against, latent homosexuality was at the heart of his strong emotional reaction. By contrast, the second form of

CT is based on a deep rooted aspect of the therapist's character and may permeate the whole analysis. Therefore, it takes on an unconscious meaning for the therapist. For example, the therapist who is using an analysis to remain removed from her own conflicts.

From a classical perspective, Reich (1951) argues that analysts must maintain neutrality and "not respond to the patient's emotion in any kind. She must be able to tolerate love and aggression...without being moved" (p. 25). The analyst's own analysis is considered essential to attain this ideal. However, other theorists proffer contrasting views. Casement (1985, 2002) argues that enactment or 'mistakes' are inevitable (note the conflation of the terms enactment and mistake, which prevails in the literature). He emphasises the importance of recognising and addressing these when they occur, and having the courage to allow ourselves to stand corrected.

~

Bohleber et al. (2013) noted that the divergent schools of psychoanalysis have their own conceptualisations of enactment. They explored the predominant Anglo-American theories, e.g., Kleinian analysis, ego psychology and relational analysis, to integrate enactment into a common understanding. As stated, divergent views abound as to whether CT-enactments are inevitable, whether they can be prevented, and if they should be welcomed. Some see it as failure and others view it as an opportunity. Significantly, enactments manifest as unexpected deviations from technique. Bohleber et al. (2013) note the paradoxical task of integrating enactment into an event that represents both the breaking of technical rules, and as an inevitable aspect of therapy which can have a positive effect. It is questioned how this contradiction can be resolved. In using the concept of enactment to describe action that otherwise might be dismissed as inadequate technique, the analyst's subjectivity, and vulnerability, is brought to the fore as a central aspect of the analytic process. Through comparisons of clinical descriptions, Bohleber et al. (2013) defined enactment as a 5 stage process.

*Stage 1: The status quo, the normative analytic relationship*

Both therapist and patient have expectations of the responses they can anticipate from the other. However, the unconscious fantasies of both parties exert pressure on each other to deviate from the normative. Thus, there exists a tension between what is expected from the analyst and what is hoped for based on transferential fantasy. The neutral analyst resists this pressure or 'pull' to enact a transference role for the patient.

### *Stage 2: Breakdown of the normative process*

Enactment represents a deviation from the normative process, which the analyst experiences as a rupture in her conscious experience of herself. Jacobs (1986, p. 294) stated, “the analyst gets emotionally involved, in a way that she had not intended”. She is thrown off balance and her theory collapses. Bohleber et al. (2013) describe enactment as an automatic, unconscious act with the goal of alleviating tension. Preceding enactment, clinicians experience a pressure to act, which is not understood at the time. The pertinent question is: Why now? Was it the level of pressure applied by the patient, or the analyst’s diminished capacity to deal with the pressure at a given moment?

### *Stage 3: Enactment discovered after it has happened*

Subsequently, the analyst recognises that she has become embroiled in an enactment with her patient, and deviated from the ‘best analytic technique’.

### *Stage 4: Collusion acknowledged, back to normal*

The analyst acknowledges that the patient’s transference fantasy has been actualised, and that she has colluded with his unconscious desires. According to Bohleber et al. (2013) the technical deviation will be noted by the patient, but will not necessarily lead to a disruption.

### *Stage 5: Solving the enactment: From threat to opportunity*

There are divergent approaches to working with the enactment: Kleinians emphasise the patient’s role in evoking a counter-transference reaction from the therapist. Contemporary Freudians and relational analysts begin from their internal world (Bohleber et al., 2013). Further, if the enactment represents a re-traumatisation of the patient, relational analysts argue that the analyst should acknowledge her failure of empathy (Benjamin, 2009). In their book ‘Mentalisation based therapy with borderline personality disorder’ Fonagy and Bateman (2006) urge therapists to model honesty and courage in acknowledging enactments, and using these to aid the therapy. It is proposed that both therapist and patient have a responsibility to look at their individual contributions.

Bohleber et al. (2013) conclude that enactments are inevitable and that, when subjected to analysis, they can be fruitful. For example, an enactment may unearth aspects of the self that had been dissociated, and were unavailable to consciousness. Like other authors presented in this study, Bohleber et al. (2013) emphasise that their model does not imply ‘anything goes’ in psychoanalysis.

## **5.2. Enactment, relational psychoanalytic theory, and the intimate edge**

It is potentially unsurprising that relational psychoanalysis offers a profoundly different take on enactment than the traditional 'mistake' perspective. As outlined, relational psychoanalysis emphasises the relational field between patient and therapist (e.g., Stern et al., 1998). Significantly, it does not urge the therapist to avoid 'transference – counter-transference enactments' (T-CT-Es) at all costs (Jacobs, 2011). It is argued that T-CT-Es can actually benefit the therapeutic endeavour. For example, enactments of a relational dynamic between analyst and patient may become conscious and amenable to analysis (Bohleber et al., 2013). Further, just as the transference has to be enacted for the patient to become aware of it, it is argued that counter-transference enactments are necessary for the therapist (Jacobs, 2011). In enactment the therapist is being a real object in a transference relationship and, therefore, the patient may experience an intervention as uniquely tailored to him (Salo, 2011).

Consider the following 2 clinical examples of 'mistakes'. Following a temporal failure on the analyst's part, a patient who felt that the environment failed in infancy was now able to voice his distress, and feel that the impact of the analyst's error was heard and validated (Salo, 2011). Theoretically, this is in line with the 'corrective emotional experience' (Alexander and French, 1946): The patient re-experiences a situation he was not able to manage in the past, but, significantly, the therapist's response is different in the present, which may facilitate the resolution of his conflict (Palvirini, 2010). In this context, Erskine (1993) and Stern (1994) outline how defences are built up in a 2-thronged process. First, the emotional needs of the child are not met satisfactorily; the second trauma is that the first trauma is not acknowledged. It is proposed that it is the second trauma which leads to a 'fixation of defences'. It follows that therapist 'mistakes' may offer the opportunity for a new relational experience regarding the second aspect of trauma.

Ferro (2005) describes how an inexperienced analyst offered a patient a later time because she had to cancel a session. The patient felt that he had no choice but to accept. However, this enabled him to access his split-off violent self, which felt that his analyst had committed theft and should be punished. These examples demonstrate how therapist 'errors' can bring important material into the analysis (Salo, 2011). The latter is in line with Winnicott's (1971) theory of 'therapist survival'. Winnicott proposed it is important for infants to experience their mother surviving their aggression. If a mother was insufficiently robust it will be therapeutic when the therapist survives a patient's attacks, which have a more benign outcome than anticipated (Salo, 2011).

Ehrenberg's (1974) concept of the 'intimate edge' also provides a compelling theoretical account of how the subsequent working through of stand out moments (including enactments) in psychotherapy can be curative. The intimate edge is approximated by the therapist through acknowledging those moments, and becomes a vehicle for maximum expression of the self. If the analyst is able to be open about her reactions, she conveys to the patient what it is like for her to be in mutual interaction with him. Thereby, the analyst may validate the patient's impact and foreground his agency. As a result he may become aware of his power and responsibility in relation to the choices he makes, and begin to take tentative steps away from a potential position of victimhood.

Jacobs (2011) argues that relational enactments can break through an impasse in the work and move the therapy forward when a stalemate has been reached. Similarly, Stern (2004) stated that crisis points in therapy (e.g., relational disconnect) can be opportunities for significant moments as they call for a spontaneous response rather than classical technique. Hoffman (1994) proffers the following, fascinating theoretical conjecture. Even if a spontaneous therapist intervention constitutes enactment, participation in a transference pattern as a 'bad object' (e.g., punitive parent) may transform the therapist into a 'good object', because of her immediate responsiveness to the patient. Thus, the analyst should allow herself, to some degree, to be pulled in the direction of the bad object. Not doing so, and adhering to the technically correct move may, paradoxically, render the therapist a bad object. Significantly, Hoffman (1994) argues that uncertainty is a central feature of the 'good object'.

### **5.3. Enactment and person-centred theory**

There is a further, potential difference between the person-centred and contemporary psychoanalytic positions regarding authenticity and spontaneous engagement. From my reading of the literature I propose that person-centred theory eschews enactment ('self-resonance' in person-centred terminology). Congruence, as a technique, is viewed as an antidote to it. For example, Mearns and Thorne (2007) argue that if the counsellor censors 'negative' responses to the client, these may build up and lead to anger, and unspoken judgements of the client. Mearns and Thorne (2007) describe this as a potential "emotional abuse" (p. 128) of the client, which may culminate in a venting of the therapist's pent up frustration. Significantly, they state that this does not represent real congruence. Further, congruence is viewed as a poor therapist excuse to impose his needs onto the client. I believe that, contrarily, and as demonstrated, some

psychoanalytic schools of thought have a more inclusive relationship with enactment, which is even viewed as potentially necessary.

#### **5.4. Summary and concluding thoughts**

This section outlined the concept 'enactment', which is commonly conflated with the label 'mistake' in the available literature. This is potentially unsurprising, given that enactment implies the presence of the therapist's unconscious needs and conflicts in the work (Racker, 2007). Significantly, it is recognised that enactments generally manifest as deviations from the therapeutic frame (Bohleber et al., 2013). This tallies with the prevalent notion in this study that UIs, as well as being spontaneous, also represent 'high-risk' interventions (Ringstrom, 2001). The classical analytic perspective promulgates the neutral stance to avoid enactments (Reich, 1951). Contrarily, contemporary psychoanalytic theorists (e.g., Hoffman, 1994) suggest these may be fruitful, and even necessary. It follows that therapists are urged not to eschew enactments at all costs. I argued that in person-centred theory, enactment (or self-resonance) is subtly imbued with negativity.

Most importantly, I believe this section has brought the blurry boundary between enactment and therapeutic error to the fore. In this context, Bohleber et al. (2013) noted the paradoxical task of integrating enactment into an event that represents both the breaking of technical rules, and as an inevitable aspect of therapy which can have a positive effect. I propose that the 'enactment' section has expanded on Akhtar's (2011) assertion that UIs may challenge the analyst's 'analytic super-ego', as these are not consistent with internalised technical ideals. In addition the literature reviewed in this study suggests that UIs may be challenging for therapists because of their close proximity to, or further, their inextricable link with enactment and potential therapeutic error.

## **Part 6: Final reflections and the present study**

### **6.1. Final reflections**

#### ***Authenticity, spontaneity, and unconscious processes***

Authenticity and spontaneity are terms that have been prevalent throughout this literature review. As outlined, significant psychological theories of the self propose that authenticity is vital for optimum human development (e.g., Laing, 1960). Spontaneity and creativity is viewed as a natural manifestation of authentic, true self functioning, which is described as dynamic and unpredictable. Contrarily, inauthentic, false self functioning is characterised by a rigid control of self-expression.

It is therefore potentially unsurprising that practitioners and clinical perspectives on technique valorise therapist authenticity, spontaneity and self-trust. In this regard, Jung (1966, p. 137) reflected: *“How can the patient learn to abandon his neurotic subterfuges when he sees the doctor playing hide-and-seek with his own personality?”* UIs in this study are described as spontaneous, ‘not thought through’, creative and intuitive expressions of the self, that are inherently risky. Thus, they may epitomise true self, authentic being. In this regard, Ringstrom (2001) described his UI as the most pure form of therapist authenticity. It follows that UIs can function as a form of modelling (Mearns & Thorne, 2007), and provide a corrective emotional experience (Ringstrom, 2001).

The link between UIs, authenticity, true self functioning and non-conscious processes can also be found in the flow literature (e.g., Csikszentmihalyi, 2000). It is stated that individuals with a strong internal locus of control and high level of self-determination are more likely to experience the flow state, which is characterised by a loss of self-consciousness, increased authenticity and self-trust (Keller & Bloman, 2008). Significantly, there is a growing body of research (e.g., Dijksterhuis, 2004) which supports anecdotal evidence (e.g., Kuhn, 1970) that non-conscious, intuitive thought processes can be superior to conscious, analytical thinking. Further, modern attachment theory (Schore & Schore, 2007) and contemporary psychoanalytic perspectives (e.g., Stern et al., 1998) foreground the primary role of unconscious processes in early attachment relationships, which shape individual development and, more specifically, the capacity for self-regulation.

### ***Why is there a lack of literature, research and clinical reporting of UIs?***

As outlined, theories of human development, clinical perspectives on technique, anecdotal evidence and research findings demonstrate that UIs are relevant and of importance. Why then, is there a lack of literature, research, and clinical reporting in this area?

Akhtar (2011) stated that UIs may challenge the analyst's 'analytic super-ego' because they represent a deviation from prescribed technique. For example, Ringstrom (2001) reflected that his UIs were outrageous viewed from a classical psychoanalytic perspective. Further, UIs have close ties with enactment and therapeutic 'error'. Enactments may represent expressions of the therapist's unconscious conflicts, and manifest as frame deviations. This is consistent with assertions that spontaneous and intuitive therapist self-expression is inherently risky because it may be distorted by the clinician's neuroses (e.g., Mearns & Thorne, 2007).

### ***Critique of classical psychoanalysis and modern day psychology***

The fact that UIs are an understudied phenomenon foregrounds an important critique of classical psychoanalytic theory and technique. In contrast to contemporary, relational psychoanalytic perspectives, e.g., Stern et al. (1998), the classical stance eschews enactment and advocates therapist neutrality to combat it and to avoid 'mistakes'. In this regard, Sandler (1983) stated that analysts' fears of being criticised by their colleagues for the use of 'improper' techniques has led to a 'public theory' versus 'private theory' split. This is reminiscent of the true versus false self positions outlined in the relevant theories of human development. Shapiro (1995) reflected that analysts are fearful that their intuitive creativity will be judged negatively.

According to Shapiro, Freud's initial rules of abstinence are overly cautious and inhibit spontaneity in the name of 'proper' technique. Consider Freud's (1912) proposal that *"the doctor should be opaque to his patients and, like a mirror, should show them nothing but what is shown to him"* (p. 118). The paradox is that Freud did not follow his own guidelines. For example, he gave a herring sandwich to the 'Rat Man' when he was hungry, and met with patients outside of his office (Akhtar, 2011). Thus, he trusted himself to be intuitive and spontaneous, but not others (Shapiro, 1995).

Lichtenberg (1994) believes that Freud's conventional, technical guidelines were a product of his anxiety that followers and disciples would not adhere to his theories. In this regard, Spinelli (1994) reflected that clinicians may become overly invested in theory as an immutable truth, not to benefit their patients but, rather, in the name of power. That is, ascribing to their work a *"unique authority and wisdom"* (p. 14), and thereby unnecessarily mystifying the therapeutic process.

Roazen (2001) proposed that Freud was primarily concerned to preserve the reputation of psychoanalysis. Shapiro (1995) believes that, like Freud, many teachers in the present day err on the side of caution and pass on rules rather than a true reflection of their own practice.

More generally, Murphy (2012) stated there is a high level of stigma in psychotherapy around mistakes, which are perceived as shameful and unethical, and rarely shared in public.

Psychoanalytic case reports, written to demonstrate attained perfection, may propagate the illusion of perfect practice (Chused & Raphling, 1992). Murphy believes that literature in her field of transactional analysis commits the same disservice, observing that there is no mention of 'mistakes' in most psychotherapy texts.

Similarly, Elkind (1992) proposed that most therapists are overly concerned to maintain a harmonious relationship with their patients, and believe that a 'correct' therapy will lead to success. Subsequently, shame is evoked through ruptures in the therapeutic relationship. I propose that the manualisation of CBT in the 'Improving Access to Psychological Therapies' (IAPT) National Health Service programme (2007) also foregrounds the notion of 'proper' practice. In this context, Marshall (2009) stated that therapy manuals fail to adequately describe essential therapeutic processes, e.g., therapist style and empathy, which pertain to the delivery of therapy, rather than model specific procedures. This is important because a strong focus on 'proper practice' may inhibit therapist 'use of self', a potential, vital component of psychotherapy that works (Rogers, 1973). In this regard, Woskett (1999) argued that clinicians could be more effective if they held the theories and therapeutic processes they learn in training more lightly, in order to nurture their own "*unique healing attributes*" (p. 3).

## **6.2. The present study**

Although UIs may represent a potent form of authentic therapist self-expression, and may have significant positive therapeutic effects, they are an understudied phenomenon. The present study aims to generate a theory of UIs in counselling and psychotherapy, which will increase our understanding and provide clinical guidelines for practitioners. For example, is the quality of the therapeutic relationship important in the use of UIs, as stated by Ringstrom (2001)? Are therapists more likely to use UIs when they trust them-selves, and is self-trust enhanced through experience, (e.g., Mearns & Thorne, 2007), self-understanding and personal therapy (e.g., Elfant, 2000)? Are UIs inherently risky interventions (e.g., Ringstrom, 2001)? If so, is it important to monitor clients reactions closely and to be aware of the issues that may arise when using UIs, as prescribed in

Bonitz's (2008) guidelines for the use of touch in psychotherapy? Are there potentially instances where UIs should not be used? And what about the apparent tension between intentionality and conscious practice versus being spontaneous and 'not thought through' (e.g., Smolar, 2011)? Similarly, where is the line drawn between intuition and counter-transference enactment (Weisel-Barth, 2014)? These are the some of the important questions that the present study aims to address through 10 in-depth, qualitative interviews with clinicians of various theoretical orientations, about their use of UIs.

## **Chapter 2: Methodology**

### ***Introduction***

Charmaz's (2006) constructivist grounded theory, a qualitative methodology, was used in this study. Creswell (1998) stated that researchers must have a compelling rationale for using a qualitative approach. The research questions and goals are important determinants in the decision-making process (Punch, 2005). Further, good qualitative research is grounded in a clearly defined epistemological position (Drisko, 1997).

I concur with Elliot, Fischer and Rennie's (1999) assertion that it is vital for researchers to own their chosen perspectives. I found it very important to feel confident in my choice of methodology, and to feel that my epistemological stance was authentic. In outlining my choices I first provide an overview of quantitative methodology. Until recently quantitative methods, anchored in positivist and post-positivist paradigms, have dominated research in counselling psychology (Ponterotto, 2005). Subsequently, this dominant approach is contrasted with qualitative research methods, which are anchored in the constructivist-interpretivist paradigm. More broadly, my decision to use qualitative methodology is explained, before, more specifically, justifying my choice of grounded theory as the best fit for the present study. In parallel the process through which I arrived at my chosen epistemological position is outlined.

### **Part 1: Research methods**

#### **1.1. Quantitative methodology**

Quantitative research has its roots in the dominant positivist and post-positivist research paradigms (Rennie, 2002). Positivism posits that objective, immutable truths exist in the world, and that these can be apprehended through rigorous research methods; it is proposed that an unbiased researcher can attain the goal of discerning phenomena in the one and only correct way (Willig, 2008).

Similarly, post-positivists postulate the existence of an objective reality; however, by contrast, it is argued that this reality cannot be perfectly apprehended because of the limits of the human researcher (Ponterotto, 2005). Further, post-positivism emphasises theory falsification (hypothetico-deductivism), in contrast to the positivist, theory verification approach (inductivism) (Lincoln and Guba, 2000). Karl Popper's (1969) primary criticism of inductivism was that no matter how often a given process was observed, e.g., *a* follows *b*, one could never be certain that the

next observation would conform to the same pattern. Post-positivism emphasises the derivation of hypotheses from extant theory, which are tested through observation or experiment (Willig, 2008). The aim is to falsify a theory's claims, rather than to verify them. Through this process, disingenuous claims can be identified which, in turn, moves the researcher closer to the actual truth (Willig, 2008).

Despite these differences positivism and post-positivism share significant common ground and, taken together, form the epistemological foundation of quantitative research (Ponterotto, 2005). Both paradigms emphasise prediction and the study of universal cause-effect linkages that can be generalised (Denzin & Lincoln, 2000), and view the role of the researcher as unbiased and detached (Willig, 2008). Therefore, quantitative studies generally use large-scale representative samples, carefully control empirical variables, and analyse group means and variances through statistical test procedures (Ponterotto, 2005).

## **1.2. Qualitative methodology**

Qualitative research methods, anchored in a constructivist-interpretivist paradigm, provide an alternative (Ponterotto, 2005). Constructivism posits that reality is constructed by the individual perceiving it, i.e., human perceptions of nature are not independent of the mental processes of the perceiving subject (Hamilton, 1994). This represents a relativist ontological stance regarding the nature and reality of being (Ponterotto, 2005). In contrast to the 'naive realist' view of the positive paradigm, i.e., the existence of a singular objective reality, a relativist stance proposes the existence of multiple and equally valid realities, dependent on the mind of the individual constructing that reality (Schwandt, 1994). Constructivism also takes into account the mediation of human experience through culture, history and language (Willig, 2008). It is proposed that individual experience is embedded in a historical social reality, although this may be outside of the individual's consciousness (Ponterotto, 2005).

Thus, constructivism locates reality in the mind of the individual, and not out there in the world as a singular entity (Hansen, 2004). This central tenet of constructivist thinking, which foregrounds the lived experiences of research participants, can be traced back to Kant's (1781/1966) *Critique of Pure Reason* (Hamilton, 1994). Where positivism is concerned with prediction, explanation and generalisation, constructivism emphasises description and the in-depth understanding of unique individual experience (Ponterotto, 2005). It is proposed that individual meaning is best discerned through intense reflection, which places researcher-participant dialogue at the heart of the data

collection process (Sciarra, 1999). Further, emerging findings are viewed as a co-creation between researcher and participant (Ponterotto, 2005).

Generally, the qualitative researcher does not define variables before the data collection process, as this may represent an imposition of the researcher's meanings, and foreclose the research participant's own unique experience (Willig, 2008). As outlined, qualitative studies tend to emphasise participants' experiences, meaning-making and negotiation of processes, rather than causal relationships between variables (Schwandt, 1994). Thus, qualitative research is participant led. It aims to facilitate the emergence of new information and to minimise data reduction at the point of collection (Willig, 2008). It follows that qualitative data collection techniques need to be open-ended and flexible in order to capture vivid participant descriptions of their experiences and actions. Data is most commonly collected through semi-structured interviews in qualitative research studies (Willig, 2008).

### **1.3. Rationale for using a qualitative methodology**

As stated, Creswell (1998) posits that researchers must have good reason to use a qualitative methodology. The lack of research on UIs, and the overall paucity of available literature, was a strong determinant in the present study. Qualitative research methods are suitable for the exploration of unstudied phenomena, about which little is known (Creswell, 1998).

The nature of the research questions and the aims of the present study were also important factors. The research questions are predominantly exploratory and open-ended: 'How' do UIs occur, 'what' happens before and after? These are typical qualitative research questions, which stand in contrast to the quantitative emphasis on universal, cause-effect linkages and explanatory accounts (Cook, Mead, & Perry, 2001). Through such questioning I aimed to capture rich and vivid data about therapists' experiences of the occurrence of UIs. It was hoped this would increase understanding of the studied phenomenon, generating explanations and, in the final analysis, a grounded theory. Similarly, these aims are in line with those of qualitative research methods (Ashworth, 2003).

## **Part 2: Grounded Theory (GT)**

### **2.1. Rationale for using GT**

The next step was to choose the qualitative methodology with the best fit. Again, it is important to identify the goal of the research (Willig, 2008). As stated, this study aims to increase our understanding of, and generate a theory about the occurrence of UIs in psychotherapy. GT is ideally suited for research questions oriented towards action and process, e.g., “How do people do x?” (Willig, 2008). Translated to the present study this question may read: “How do UIs occur?” and/or “How do psychotherapists make UIs?” Significantly, GT was developed to generate theories that delineate dominant processes in the social phenomena under study (Coyne & Cowley, 2006). Further, McCann and Clark (2003) stated that GT was ideal for the study of novel topics that focus on social interaction. In relation to the present study GT is the stand out methodology.

### **2.2. Origins of GT**

Glaser and Strauss (1967) are the creators of GT. Their aim was to develop a method to generate theories grounded in research data, rather than relying on existent theory and reductionist principles. This would bridge a proposed gap between theory and research promulgated through positivist research designs (Charmaz, 2006). In the 1960’s quantitative research methods dominated the social sciences (Seale, 2004). At this time qualitative methods were unpopular and considered unscientific, for example because of perceived researcher biases impacting on the data (Charmaz, 2006). GT developed in response to such criticism (Johnson, Long, & White, 2001). Glaser and Strauss (1967) proposed that a systematic approach to qualitative research was needed. They outlined analytic guidelines to code data into meaningful units and, thereby, to increase its analytic power (Charmaz, 2006).

Glaser and Strauss brought different influences to GT. Given Glaser’s quantitative background it is unsurprising the method became imbued with positivist assumptions. Explicit analytic guidelines, a focus on rigorous coding and emphasis on explanation (rather than description) are manifestations of this (Charmaz, 2006). However, the development of GT was also influenced by Strauss’ pragmatist stance. Pragmatism (e.g., James, 1948) is concerned with the social utility of theory and, therefore, emphasises knowledge that is based in individual experience (Anastas, 2012). Pragmatist notions of human agency and subjective experience informed symbolic interactionism, which Strauss would adopt (Charmaz, 2006). Symbolic interactionism (Mead,

1934) posits multiple realities and that truth is provisional. It assumes that reality and meaning is constructed through interaction and is therefore dependent on communication and language; this perspective places the construction of action at the heart of GT (Charmaz, 2006). Humans are seen as active agents who create and think about their meanings and actions (Hallberg, 2006).

### **2.3. Versions of GT**

At the beginning of this section I explicated the differences between quantitative and qualitative research, with a somewhat over-simplified categorisation of these as either positivist or constructivist-interpretivist. Although this distinction is helpful it is important to note that, on the ground, qualitative researchers espouse different epistemological positions, encompassing positivist and constructivist outlooks (Willig, 2008). Variance in epistemology is particularly relevant to GT. Thus, after identifying GT as the best qualitative methodology for a given study, the next step for the researcher is to identify her epistemological position. In turn, this will guide her use of the method (Charmaz, 2006).

Since its original conception, GT has been taken in different directions dependent on the epistemological stance of the researcher (Henwood & Pidgeon, 2003). According to McCallin (2004) there are currently 3 main guiding versions of GT. Glaser and Strauss' (1967) initial conceptualisation, with its positivist underpinnings, is considered the classic version. Later, Glaser and Strauss would split, with Strauss joining Corbin (Strauss & Corbin, 1990) to place a greater emphasis on pragmatism and symbolic interactionism. This represents a move away from a positivist to constructivist epistemology, with the researcher taking a more active and interpretive role in following leads and thereby shaping the data (McCallin, 2004). Further, Strauss and Corbin proposed a more balanced focus on both description and explanation. The 3rd main application of GT is Charmaz's (2006) constructivist version, with an even greater emphasis on rich description over explanation, co-construction of the data, multiple realities and action-oriented coding (McCallin, 2004).

Thus, the positivist/constructivist distinction I made more broadly between quantitative and qualitative research, can be found, on a micro level, within GT. Charmaz (2006) highlights that objectivist/constructivist distinctions in GT are not necessarily clear cut. Whether a study is deemed predominantly one or the other will depend on the extent to which its key characteristics are on either side of the continuum. Ponterotto (2005) noted that even though positivist underpinnings exist in classic GT, different components of it can be located in different research

paradigms. For example, Glaser and Strauss (1967) posited that their analytical tools were not designed to assure that different researchers reach the same conclusions from a given set of data. This focus on multiple realities fits with a constructivist ontology (Ponterotto, 2005).

## **2.4. Rationale for using constructivist GT**

I have decided to use Charmaz's (2006) constructivist version of GT. As previously outlined this approach emphasises the co-creation of data in the relationship between researcher and participant. Ontologically aligned with relativism, it foregrounds the existence of multiple realities and therefore moves away from GT's original focus on causality and explanation, to understanding and the identification of patterns and connections in the data (ibid.). Further, constructivist-interpretive theory assumes that data is not created in a social vacuum; it is alert to the potential impact of social context on the studied phenomenon (ibid.). Given that I interviewed psychotherapists and psychologists of different theoretical orientations and levels of experience, I felt it would be important to consider the context in which each analysis was situated.

In deciding my epistemological and ontological position in the current study, I initially felt drawn to a post-positivist, critical realist stance, i.e., that an objective truth exists but cannot be fully apprehended, due to the limitations of the researcher and her impact on the interpretation and understanding of the data (Willig, 2008). Taking this perspective I would be able to identify objective processes, and further GT explorations of these processes would derive similar constructs (Dilks, Tasker, & Wren, 2010). Given the strong focus on quantitative research in my undergraduate psychology degree my positivist leanings are perhaps unsurprising. However, in the final analysis, I feel most comfortable with a constructivist worldview. I feel strongly aligned with the constructivist principle of multiple realities and the notion that a studied phenomenon cannot be separated from the social and historical context in which it is embedded (Charmaz, 2006).

The constructivist approach also foregrounds the role of the researcher (Willig, 2008). Charmaz (2006) stated that theory cannot be seen as independent from the researcher who created it. This places reflexivity at the heart of constructivist GT, as the researcher attempts to understand how she contributes to the data that is produced. It posits that resultant theory is itself an interpretation (ibid.). This stance resonates with my experiences as a therapist and patient, where I perceive myself and the therapeutic relationship as ever evolving and changing. I may see the world differently from one day to the next. An interpretation may feel right one week, but later be

augmented or replaced by a new perspective. Similarly, as a researcher I may produce quite different data studying the same phenomenon at a different time in my life, where my focus, interests, and outlook may have changed. Charmaz (2006) acknowledges that different researchers may well come up with similar results with a given data set, but their theoretical interpretations may be different.

Charmaz's (2006) version of GT felt like the best fit for reasons other than epistemology and ontology. She places a particular emphasis on being interpretive with the data, and encourages the researcher to listen for what is being said behind the words. For example, by attending to nonverbal forms of communication such as intonation and body language. This approach is consistent with my work as a psychotherapist, particularly when using a psychodynamic approach.

Finally, Charmaz (2006) also highlights Glaser and Strauss' (1967) invitation to use GT flexibly. She emphasises the flexibility of her own guidelines, rather than viewing these as rules and requirements to be slavishly followed. There is a focus on using the various tools of GT as one sees fit. This is in line with Lincoln and Guba's (2000) description of qualitative researchers as 'bricoleurs' who employ the techniques and methods available to best achieve their research goals, drawing on different traditions regardless of where these are anchored on the positivist to constructivist continuum. In the final analysis I followed Charmaz's (2006) guide to GT closely (see analysis section). However, I believe her emphasis on flexibility gave me a sense of freedom that enhanced the quality of this study and my experience of it. This was most noticeable in identifying the 4 core, sequential categories, the categories they subsumed, and the relationships between them, through a free-writing technique, diagramming.

### **Part 3: Participants and recruitment**

#### **3.1. Sample**

The sample consisted of 10 participants, 7 females and 3 males, aged between 32 and 58 years. Sampling was naturally purposeful: All participants practiced one-to-one psychotherapy. I recruited 4 counselling psychologists and 1 clinical psychologist, who used either CBT, schema therapy, or an integrative approach. Further, 3 psychoanalytic psychotherapists, a specialist CBT therapist, and a humanistic/integrative psychotherapist were interviewed. I initially planned to obtain data solely from experienced practitioners. However, in the final analysis, I decided to include the 2 pilot interviews with second year, counselling psychology trainees. The remaining

practitioners all had at least 10 years of post-qualification clinical experience, ranging from 10 to 30 years. All of my participants were UK residents and white European.

My first aim in interviewing psychologists of various theoretical orientations and training backgrounds was to increase the scope of the present study (Morse, 2007). Further, through a diverse sample the researcher can ascertain potential, interesting contrasts between groups (Charmaz, 2007), which may provide worthwhile avenues for future research (Glaser & Strauss, 1967). This is pertinent in initial samples when little is known about the phenomenon under investigation, and can help the researcher to attain a more complete understanding of the overall process (e.g., Morse, 1992).

In the process of theoretical sampling, Glaser and Strauss (1967) advocate the use of comparison groups to fully explicate categories and, subsequently, to develop a more complete theory, with enhanced scope and generality. In grounded theory this is most evident when researchers move across substantive areas to develop formal theory (e.g., Glaser & Strauss, 1965). Glaser and Strauss (1967) encourage researchers to flexibly include further groups in the course of their study, in order to collect theoretically relevant data. For example, the minimisation of group differences can aid the process of verifying basic properties of categories, and increase confidence in the emerging analytic framework. This was one important consideration in my inclusion of the pilot interviews, which will be taken up further in subsequent sections of this report.

It is also important to note that data inclusion can be based on the criterion of an excellent informant (Spradley, 1979) and the efficiency of data (Morse, 2007). The quality of a GT is naturally contingent on the quality of the collated data (Charmaz, 2007). For this reason an initial sample inclusion criterion was that clinicians had at least 10 years post-training experience. I assumed that more experienced practitioners would likely have more experience and a better understanding of UIs, and, therefore, provide the best examples of the process (Morse, 2007). I realised later that the trainees had provided valuable data in the pilot interviews that was “significant, pertinent, [and] informative...” (Morse, 2007, p. 233), and which I felt was worthy of inclusion.

During the analysis stage it transpired that my pilot interviews were theoretically relevant in relation to the emerging theme of ‘therapist experience’ in the analytic framework. It was apparent that inclusion would enhance the GT and subsequent guidelines for practice, research, and teaching.

### *Initial inclusion criteria*

- Participants had to be one of the following: Counselling psychologist, clinical psychologist, psychotherapist, psychoanalytic psychotherapist/psychoanalyst.
- A minimum of 10 years post qualification, clinical experience (As stated, I included the 2 pilot interviews with counselling psychology trainees.)

Table 1: Demographics of participants

| Participant (pseudonym) | Title                          | Approach                     | Years Experience (post training) | Gender |
|-------------------------|--------------------------------|------------------------------|----------------------------------|--------|
| David                   | Counselling Psychologist       | CBT                          | 2nd year trainee                 | Male   |
| Alexander               | Counselling Psychologist       | Integrative                  | 2nd year trainee                 | Male   |
| Sarah                   | CBT Therapist                  | CBT                          | 10 years                         | Female |
| Theresa                 | Psychotherapist                | Humanistic/integrative       | 17 years                         | Female |
| Joanne                  | Counselling Psychologist       | Schema-therapy               | 12 years                         | Female |
| Annette                 | Psychoanalytic Psychotherapist | Psychoanalytic psychotherapy | 15 years                         | Female |
| Melanie                 | Psychoanalytic Psychotherapist | Psychoanalytic psychotherapy | 17 years                         | Female |
| Brian                   | Clinical Psychologist          | CBT                          | 30 years                         | Male   |
| Susan                   | Psychoanalytic Psychotherapist | Psychoanalytic psychotherapy | 25 years                         | Female |
| Courtney                | Counselling Psychologist       | Integrative                  | 20 years                         | Female |

### **3.2. Recruitment**

It is noteworthy that recruitment was not easy. I had to send approximately 30 emails for each participant recruited. By contrast, a colleague from my counselling psychology training, researching the role of therapist hope in psychotherapy, sent out approximately 5 emails for each participant recruited. This was the first indication that disclosing UIs may evoke anxiety for psychotherapists, e.g., fear of negative judgement. This theme is taken up in the results section. Participants were recruited via email (see Appendix 1). I used the British Psychological Society (BPS) and British Psychoanalytic Association (BPA) websites to identify suitable participants, and to attain their contact details.

### 3.3. Ethics

This study received ethical approval from the Senate Research Committee at City University London. I adhered to the key principles of the Code of Human Research Ethics as outlined by the BPS (2010):

- Respect for the autonomy and dignity of persons
- Scientific value
- Social responsibility
- Maximising benefit and minimising harm

I adhered to the Health and Care Professions Council's (HCPC, 2010) 'Guidance on conduct and ethics for students'. Key points from the guidelines include:

- You should respect the confidentiality of your service users (research participants).
- You should keep high standards of personal conduct.
- You should behave honestly.
- You should get 'informed consent' from service users (research participants) to carry out any intervention, except in emergencies.

A procedural summary of ethical working, using Willig's (2008) basic ethical considerations for qualitative research, is given below:

#### *1. Informed consent*

*I ensured that research participants were fully informed about the research procedure and obtained their consent to participate before the interviews took place.*

My recruitment email outlined that I was training as a counselling psychologist at City University London, and that my research was for my doctoral thesis. I informed the recipient about the nature of my study and provided a definition of UIs derived from Akhtar (2011). I stated inclusion criteria for the study and that a 45-60 minute interview would take place at a location convenient to the participant. Participants read and signed the consent form (see Appendix 3) immediately before conducting the interview.

## *2. No deception*

*There was no justification for deception in this study and it was completely avoided.*

As stated, participants were informed about the nature of this study in the recruitment email. After a participant agreed to meet with me I sent them my information sheet (see Appendix 2). This reiterated the aims of the study and the research procedure. It also outlined ethical approval and assured ethical working on my part.

## *3. Right to withdraw*

*I ensured that participants felt free to withdraw from this study.*

As stated all participants read and signed my consent form before the interview. Therein, it was stated that participants could withdraw from this study at any time and request that their data be destroyed.

## *4. Debriefing*

*In this study participants were informed about the full aims of the research before their interview. Further, I informed participants that they would have access to any published material derived from this study.*

I ensured participants that I would send them a summary of my findings when I completed the study. Because of the use of clinical material in this study I offered to send participants my results section before it was submitted for examination. One participant was concerned about data being used that could potentially identify her patient, and took me up on this offer. I also informed participants that I would offer to send them the full study when I emailed them the aforementioned summary. Finally, I highlighted that my contact details and my research supervisor's contact details were provided on the information sheet.

## *5. Confidentiality*

*I maintained complete confidentiality regarding all information acquired in this study, about both the therapists and their patients.*

I assured participants that their audio recordings and anonymised transcripts would be secured safely on a password protected computer and destroyed after the study was examined. After I had transcribed an interview I deleted the audio recording from my computer, copied it onto a

usb stick, and secured it in a home safe with hard copies of transcripts. Consent information was stored separately and also securely.

#### **Part 4: Data collection and analysis**

This section outlines the steps conducted in collecting and analysing data in this study. As stated, the aim of GT is to generate theory that is grounded in data; it follows that a good GT is derived from data that is rich and focused (Charmaz, 2006).

##### **4.1. The interview**

The interview, described as a directed conversation, is a primary data collection method in qualitative research (Lofland & Lofland, 1984). Through the interview, participants can interpret their experience of the studied phenomenon, which, in turn, will inform the generation of theory (Seidman, 1998). The semi-structured interview was chosen as the most appropriate method of data collection for this study. Interviews were 45 – 60 minutes in duration and audio-recorded using 2 devices.

Blumer (1969) advocates the use of sensitising topics to develop research questions. These are initial areas of interest for the researcher to pursue in the data collection process. I used a process focus to develop a few open-ended interview questions, as recommended by Charmaz (2006), i.e., what was happening before the UI, what was the UI, and what happened after it? I began the interview by simply asking participants to tell me about their UI. My interview schedule evolved throughout the research process. The final version can be seen in Appendix 4.

I discussed with my research supervisor that it would be important to gain my participants' trust in this study. As previously outlined it was considered that the disclosure of UIs may engender anxiety and fear of negative judgement. Dey (1999) emphasised the need for researchers to develop a strong rapport with their participants to gain the richest data possible.

In GT it is important not to force the data into preconceived categories when conducting interviews (Charmaz, 2006). The challenge is to find the right balance between asking questions and honing in on areas of interest to the researcher. As stated, Charmaz (2006) also encourages analytic interviewing, looking beyond common sense tales of an experience for implicit and tacit meanings. Alasuutari (1996) calls for the researcher to confront participants with their tacit

actions, and to push for further discussion in interview. This focus helped me to ask challenging questions about identificatory processes that I felt may have played a role in the occurrence of UIs.

Charmaz (2006) recommends that each interview is analysed before the next is conducted. This helps to maintain focus on action and process and, secondly, ensures that subsequent data collection best informs the emerging analysis. Throughout the interviews the researcher may reduce the range of topics explored, as she attempts to gather specific data pertinent to the emerging theory. This is theoretical sampling and will be discussed in further detail below. In the present study I was not able to fully analyse the first 6 interviews before the next was conducted. This was because of the frequency of those interviews across a short time span. Nevertheless, I listened to, and took notes from each interview before the next. This helped me to be more strategic and specific in each interview where I felt this was necessary. Further, full analysis of the interview data during an extended break between my 6<sup>th</sup> and 7<sup>th</sup> participant facilitated this process.

## **4.2. Coding**

Coding is the process of defining the data (Charmaz, 2006). It is the first step in moving beyond the concrete material to analytic interpretation and the development of categories. Coding consists of 2 phases: *Initial coding* and *focused coding*.

### ***Initial coding***

Charmaz (2006) recommends speed and spontaneity in initial coding. She encourages the researcher to remain close to the data, and to use short and simple codes which reflect action. The use of gerunds can facilitate coding for action and the identification of processes (Glaser, 1978). It is important that codes emerge from the data rather than forcing the data to fit codes (Charmaz, 2006). At this stage the researcher should ask:

“What is this data a study of?” (Glaser, 1978, p. 57). “What does the data suggest?”, “from whose point of view?” (Charmaz, 2006, p. 47), and “what theoretical category does this specific datum indicate?” (Glaser, 1978, p. 57).

I used line by line coding in this phase, i.e., naming each line of data (Glaser, 1978). Detailed studies of settings with consequential actions are well suited to line by line coding (Charmaz,

2006). This approach also aids the process of defining action, tacit meanings, significant processes, and the early comparison of data with data (Charmaz, 2006).

Table 2: Example of initial coding (interview 1)

This data segment is taken from my first pilot interview. I underlined keywords on my initial reading of the text before coding these, using gerunds, in the right hand margin (Chesler, 1987).

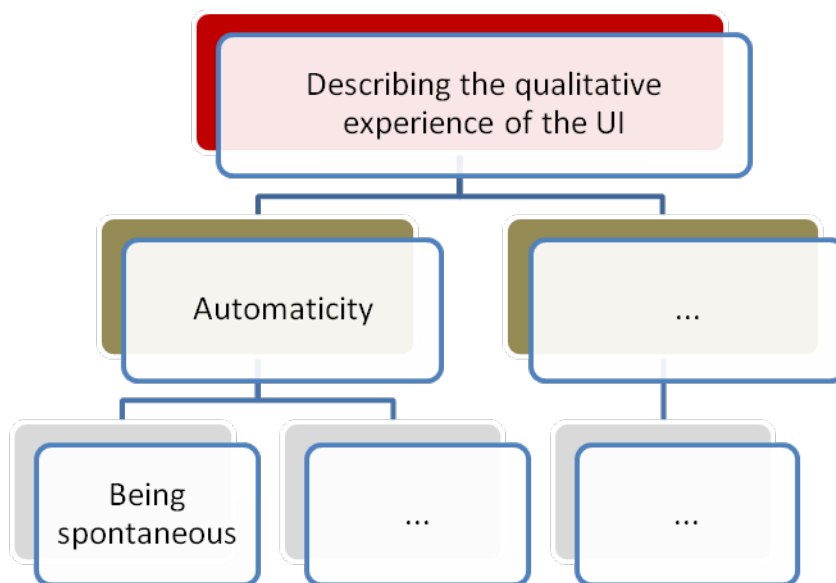
|                                                                                                                                                          |                                                  |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------|
| ...I just sort of came out with that (excited),                                                                                                          | <i>Just coming out with it. Feeling excited.</i> |
| and I sort of said it a bit like with a Yoda voice,                                                                                                      | <i>Using a Yoda voice.</i>                       |
| and I was a bit more accurate, a bit better than I did it there,                                                                                         | <i>Comparing the impersonation.</i>              |
| I was like fuck (gasp), y'know (nervous laughter),                                                                                                       | <i>Feeling surprised, shocked, anxious?</i>      |
| and he was like "huh?",                                                                                                                                  | <i>Describing patient reaction (surprise?).</i>  |
| and I was like yeah, does that make sense to you what Yoda says?                                                                                         | <i>Checking patient's understanding.</i>         |
| And he was like I guess so, so we talked a bit about that,                                                                                               | <i>Talking about the UI.</i>                     |
| the reason that came to mind                                                                                                                             | <i>Finding reasons (retrospectively?).</i>       |
| was that there were 2 things the guy had talked about, how he was quite into sci-stuff earlier when he talked about his hobbies, he talked about sci-fi, | <i>Drawing on patient hobbies.</i>               |
| so I was like he's got to know star wars,                                                                                                                | <i>Making an assumption (certain).</i>           |
| and his age, he's probably grown up, he's probably seen this film,                                                                                       | <i>Making an assumption (less certain).</i>      |
| I didn't actually know that,                                                                                                                             | <i>Not knowing.</i>                              |
| but it just kind of came out,                                                                                                                            | <i>Just coming out.</i>                          |
| and he sort of laughed and thought it was quite funny,                                                                                                   | <i>Describing patient reaction.</i>              |
| and he's like "what?"                                                                                                                                    | <i>Patient feeling surprised?</i>                |

### ***Focused coding***

Focused coding is the second stage of the coding process (Charmaz, 2006): Focused codes are more selective and capture the meaning of larger segments of data. The frequency and salience of codes is a guiding criterion in this phase, as the researcher decides which initial codes best categorise data more completely. Coffey and Atkinson (1996) describe focused codes as broader conceptual categories. The codes remain action oriented and close to the data, whilst condensing it and making it more manageable (Charmaz, 2006). Within and across interviews data is compared with data to develop the focused code, then data is compared with the code to potentially refine it. This is the constant comparative method (Glaser & Strauss, 1967).

My approach was to first define broad focused codes that captured large segments of data. So, for example, the first initial code in Table 2, *Just coming out with it*, was raised to the conceptual category, *Describing the qualitative experience of the UI*. I then progressively refined the initial codes that this broad category subsumed through constant comparisons, thereby raising these to sub-categories. *Just coming out with it* was labelled *Being spontaneous*, which, in turn, became one of a number of examples of *Automaticity*.

Figure 1: An example of a broad conceptual category and sub-categories (focused codes), derived, in part, from the initial code *Just coming out with it*.



#### 4.3. Memos

Memo writing is a key process in GT (Charmaz, 2006): It begins at the initial coding phase and continues throughout the data collection and analysis. It is a creative endeavour, where analytic thoughts and associations to the data are recorded without censure, in the moment. This helps the researcher to make connections, to reach new insights, and to ascertain new avenues to pursue (Lofland & Lofland, 1984). In focused coding the researcher determines the codes which best capture larger segments of data (Charmaz, 2006). Writing memos facilitates the constant comparison of data and, in turn, the analysis of emergent categories and theory generation (Hood, 1983). Charmaz (2006) recommends that memo writing be done in a way that works for the researcher. I found it best to use memos frequently, creatively, and throughout the analytical process. This helped me to distinguish between major and minor categories (as demonstrated in the focused code section), and to discern the relationships between them (Beck, 1996).

Significantly, memo writing deepened my immersion in the data and, thereby, shaped the form of the analysis.

As you will see in the results section the second of the 4 core categories is labelled: 'Decision making: Conscious – Unconscious Continuum'. Memo writing helped me to identify unconscious processes operating in the occurrence of UIs and, therefore, to fully explicate decision-making (see Table 3 below).

Table 3: Memos written during the analysis and presented in their original form. It is important to note that memos were written without censure. It was not considered that they would be presented in this study.

#### Interview 1

##### *Memo 1: The mystery*

The idea of 'the mystery' really stands out. There is a wealth of information at the therapist's disposal, yet the UI feels spontaneous, as if it just came out of nowhere. I am struck by how intentional the whole process seems. It feels spontaneous, yet it also feels as if there is such a fine level of intention. There is an acknowledgement that we are not just saying the first thing that comes to our minds, yet there seems to be a lack of awareness of all the processing that has occurred.

#### Interview 3

##### *Memo 24: Contradictions*

She states that the therapeutic meaning may not be seen in the moment, although she would be able to discern it retrospectively. I feel she demonstrates the mysterious quality of UIs again, informing me that UIs are not completely out of the blue before describing her UI as just that, out of the blue! It's as if it is difficult for the therapist to hold onto those qualities simultaneously: The experience of a UI feeling completely out of the blue, yet informed by unconscious information processing, and with intention.

#### Interview 7

##### *Memo 16: Unconscious processing - intention*

It really stands out for me what is going on in terms of processing. Nothing occurs in a vacuum. All interviews seem to have intention, and more than the therapist is aware of. It's amazing how rich the thought processes are and these have contributed to the occurrence of the UI, unbeknownst to the therapist. As Sarah said, "you often don't know at the time". It feels amazing how everything comes together, especially in this interview, how the background processing leads to an intention to be a certain way. There is so much processing going on, so much intention that is there!

#### **4.4. Theoretical sampling**

In theoretical sampling the researcher strategically seeks out data to substantiate emerging categories (Charmaz, 2006): The aim is to develop solid, robust and full categories, ideally interviewing until no new properties emerge. In this endeavour it is important to start the analytic process as soon as data is collected. It is through the immediate analysis of data that the researcher may ascertain areas of interest to pursue in subsequent interviews. Thus, theoretical sampling is the process of conducting further interviews, or re-interviewing, with a strategic, specific and more concentrated focus on a theoretical category developed to explain the data. GT is therefore described as an emergent process.

Further, theoretical sampling renders GT an abductive method, with both inductive and deductive properties (Charmaz, 2006): Hunches and theoretical conjectures emerge through initial data collection. This is inductive in that data is developed from the bottom up. The researcher then goes back to the field to check these ideas, a deductive process. The full and rich explication of categories helps the researcher to make distinctions, ascertain variation, and to identify relationships between them. Through theoretical sampling the analysis may become more abstract and generalisable.

After my first 2 interviews I asked participants more specific and focused questions about unconscious decision-making processes implicated in the occurrence of UIs. In later interviews I would become even more focused regarding this theme, seeking more specific information about the unconscious processing of patient risk factors. Further, after my first interview I strategically questioned participants about the operation of identificatory processes in UIs. It was through theoretical sampling, as categories were defined and my memos became increasingly focused, that my confidence grew in my perceptions of the data and theoretical conjectures (Charmaz, 2006). My immersion in the data was key as I began to sort and organise it into core categories, sub-categories and linking processes.

#### **4.5. Saturation**

Category saturation is achieved when no further theoretical insights or properties emerge (Charmaz, 2006). It is important to highlight that saturation is not the repetition of a pattern over and over again, i.e., nothing new happening. It is when no fresh properties of a pattern are revealed.

It is stated that GT studies should aim for saturation (Charmaz, 2006). However, saturation has been criticised on different levels. Morse (1995) cautioned researchers against proclaiming saturation when in fact it has not been achieved. He stated that this occurs frequently in GT studies. Dey (1999) challenges saturation as a construct altogether. He highlights that GT researchers develop categories through partial coding (e.g., line by line coding) of the data, and that this is not compatible with the term saturation. Further, whether saturation is achieved or not is contingent on the researcher's viewpoint (Charmaz, 2006). Dey (1999) outlined descriptors, which he believes reflect the type of data that is collected in GT studies more accurately. He alludes to categories suggested by data, and achieving theoretical sufficiency rather than saturation. Charmaz (2006) states that these terms better capture how GT is conducted in the field.

Dey (1999) also questions whether the notion of saturation is in fact a product of how GT theorists collect and manage data. In this context Charmaz (2006) states that coding systems, e.g., Strauss and Corbin's (1990) axial coding as well as Glaser's (1978) theoretical codes, may foreclose analytic creativity and lead to surface level analyses. She encourages researchers to grapple with data, to tolerate ambivalence and uncertainty, and to use the method as a tool to better understand material rather than a machine to produce a desired outcome.

#### **4.6. Axial- and theoretical-coding**

Axial coding (Strauss & Corbin, 1990) is a process of synthesising and organising data, and bringing disparate codes back to a more complete whole. Categories are organised in relation to each other on a dimensional axis at increasing levels of abstraction (Strauss & Corbin, 1990). Further, scientific terms are used to explicate links between categories, and organising schemes are used to answer questions such as "when, where, why, who, how, and with what consequences" (Charmaz, 2006, p. 60). The aim here is to attain a rich and full description of the studied experience. Glaser (1978) uses theoretical codes to organise categories into a coherent analytic story. He presented 18 theoretical coding families, which include the 6 c's: Causes, contexts, contingencies, consequences, covariances and conditions, as well as temporal ordering. Robrecht (1995) stated that axial coding can make GT cumbersome. Further, both axial coding and pre-determined theoretical codes may lead to the application of an analytic frame to the data (Charmaz, 2006). She concludes that it is questionable whether this is a help or hindrance.

As put forward by Charmaz (2006), I decided to develop categories without recourse to an explicit frame, i.e., axial or theoretical coding. I became immersed in the data through the interview process, transcribing, initial and focused coding, constant comparisons, and extensive memo-writing. Through these steps I developed ideas about the order of relationships and processes (Coffey & Atkinson, 1996), and refined and consolidated categories. I then used theoretical sorting as the final step in developing my GT.

#### **4.7. Theoretical sorting, diagramming and integrating**

Theoretical sorting, diagramming and integrating are common methodological strategies in qualitative research (Charmaz, 2006). In GT they are used in the service of generating theory. As outlined, memo-writing throughout the analysis strengthens analytical constructs and facilitates theory development (Charmaz, 2006): Once the data has been organised into concrete categories the sorting process can begin. Sorting further facilitates the generation of theory by comparing the categories at a more abstract level. The organisation of the data may become more logical and refined, and observed processes in the data are integrated into a coherent order.

Through the analytic process I became confident in my perceptions of the data and theoretical conjectures. Therefore, when the time came to pull the data together through sorting, I decided to use a free-writing technique, diagramming (Charmaz, 2006). Diagramming provides a visual representation of the categories and relationships between them. Without recourse to written notes, I trusted my immersion in the data and understanding of the significant processes. It felt nerve-racking to sit down with a blank flipchart sheet and begin to map out my GT of UIs. I still doubted that the data had depth and substance. Significantly, it was actually through diagramming that my GT really took form and came together into a coherent whole. It enabled me to identify the power and direction of the categories as well as the relationships amongst them. The core categories, the categories that these subsumed, and the defining processes emerged. I was amazed by the creativity of this process and felt that I had, at least in part, allowed my GT to spring forth from my unconscious.

Classic GT emphasises the identification of a core category (Charmaz, 2006). However, there may also be a number of core categories (*ibid.*). If this is the case, as it was in the present study, the researcher's task is to ascertain how these best fit together. Diagramming helped me achieve this goal.

## **Part 5: Reflexivity**

### **5.1. Previous knowledge**

Classic GT (Glaser & Strauss, 1967; Glaser 1978) encourages researchers to analyse their data before beginning the literature review. The rationale is to safeguard potential novel and fresh insights. A literature review may lead to 'received theory'. That is, seeing the data through the lens of past research, which is imposed on the present study (Charmaz, 2006). However, Glaser's (1992, 1998) position on prior knowledge is not always consistent. He argues for theoretical naivety but states that the researcher can only discern subtle relationships in the data through an intimate knowledge of theoretical codes (Charmaz, 2006).

A number of scholars (e.g., Dey, 1999) have rejected Glaser's, and to a lesser extent also Strauss', tabula rasa approach. Bruce (2007) stated this was hardly possible for the researcher who would have to study existing literature to write proposals and recruit participants. Hutchinson (1993) proposes that literature reviews should actually precede data collection, as this can help the researcher identify current gaps in knowledge. Smith and Biley (1997) state that knowledge of the relevant literature will give the researcher a feel for the important issues to be addressed.

Adopting a middle ground they warn that the review should not be too extensive. Henwood and Pidgeon (2003) call for theoretical agnosticism, where the researcher has knowledge of existent theory but takes a critical stance towards it. This stance is consistent with Glaser's proposal that existent theory must earn its way into the data (1978).

Following Smith and Biley's (1997) guidelines I read minimally before collecting data. It should be noted that there is a paucity of literature about UIs. Cutcliffe (2000) highlights that even if the researcher has no prior knowledge, she is not an empty vessel. This is an important observation, given that I am a trainee counselling psychologist and have used interventions that I perceived as unusual.

### **5.2. 'In-between' researcher**

An important aspect of reflexivity is determining whether one is an 'insider' or 'outsider' researcher (Bonner & Tolhurst, 2002). A researcher is broadly defined as insider when she belongs to the group and outsider when she doesn't. However, as a trainee counselling psychologist collecting data from qualified clinicians I believe that I occupied an 'in-between' position in this

study, as outlined by Breen (2007), subject to advantages and disadvantages of both insider and outsider positions.

For example, I believe my insider status increased my ability to interact naturally with my participants, and facilitated relational intimacy (Bonner & Tolhurst, 2002). Contrarily, I found that I took some descriptors of interventions for granted, e.g., spontaneity. In this regard Pitman (2002) warns that the insider position can result in an illusion of sameness. Further, insiders can struggle to balance this role with their role as researcher (DeLyser, 2001). I felt anxious not to displease my participants. For example, I found it challenging to ask about the impact of therapists' personal experiences on their UIs. Similarly, I excluded an analytic observation from the results section, which I did not feel comfortable with a participant reading. DeLyser (2001) stated that probing for information could annoy interviewees if they felt that the researcher knew the answers. I did not find that my probes evoked a discernible negative reaction, which may be attributed to my outsider status as a trainee.

### **5.3. Self-interview and pilots**

I conducted a self-interview and 2 pilot interviews before collecting data. This highlighted the importance of reflexivity throughout the research process. Two factors stood out: First, the potential impact of my reading literature on UIs before interviewing participants, and secondly, my identification with therapists as an insider researcher. Following my self-interview and pilots I felt I had already become invested in specific categories emerging in the data. For example, that therapists would like the patients with whom UIs occurred (based on my own experience). Further, that UIs would be experienced as an 'act of faith' (Bion, 1970), and that a trust in one's inherent desire for the benefit of the patient would facilitate this leap.

I felt a strong level of identification in my first pilot interview, with a trainee counselling psychologist. His experience was so similar to my own. As in my self-interview, he also felt noticeably excited recounting his UI and I found myself re-experiencing this excitement with him. Subsequently, I felt assured that excitement and high energy levels would emerge as an important category, and as synonymous with UIs. In my first interview with an experienced therapist I wanted this to be confirmed. Looking back, I feel I tried to force myself to repeat my counter-transference experience from the pilot interview, i.e., experiencing excitement myself. My participant was fortunately not swayed by my exuberance and informed me that she had not felt

excited. Subsequently, my investment in this theme diminished and I became more open to capture my participants' actual experience.

#### **5.4. Motivation to conduct this research**

It is important for the researcher to reflect on her motivation to conduct her work (Breen, 2007). As stated, I initially planned to study a more thought through type of 'therapist to patient responsivity', e.g., varying the frequency of interpretations (Turp, 2008). Perhaps as I became less 'other' focused throughout my training, interest in this area waned, and I was open to my tutor's suggestion to study stand out moments in psychotherapy.

In discussing my UI study in personal therapy I explored how it was linked to an inner conflict of spontaneity versus censorship and inhibition, in both my personal life and work as a therapist. An UI, after all, was something that might just happen, with less conscious thought. A pertinent question for me was how much of myself I could show in my life and work as a counselling psychologist, without censorship? Could I risk spontaneity, and might things go wrong if I did? Would I harm others and, therefore, myself? These questions pertain to a process of 'being authentic' that transcends the substantive area of counselling and psychotherapy, consistent with the theories of human development outlined in chapter 1.

In relation to my clinical work these questions increased in significance when a patient of mine discontinued her therapy after I made an UI, using humour. In supervision and personal therapy I reflected that I had used a form of intervention that I had experienced positively in my personal therapy, and become embroiled in a transference – counter-transference enactment. I believe I was also motivated to find answers to my unanswered questions in this study.

## Chapter 3: Findings

### The Unusual Interventions

David. [Imitating Yoda from Star Wars] ***“Try not, do or do not, there is no try”***

David’s patient had stated that he would ‘try’ to do his CBT homework tasks during the week. David is a trainee counselling psychologist.

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Alexander. [‘Joining’] ***“He was talking about the huge quantity of what he used to drink and how much money he’s spent on crack, a sort of wild abandon: I’d spend whatever I had, depending on how much I’d robbed, and I blew the whole fucking lot, everything. And that was the moment where I joined in with him in his enjoyment of this memory, of how wild it was, and I was there with him in that moment”***

Alexander is also a trainee counselling psychologist, and was using an integrative approach with his patient.

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Sarah. [Spoken with a sarcastic and high-pitched tone of voice] ***“Oh my God, you’re cured then, so there is nothing for us to work on, how did you do that? This is what your diary card says, you’re absolutely cured, my gosh, I must be a miracle worker then, I must have done amazing work with you”***

This is Sarah’s response to her patient’s not completing her self-harm diary card as homework. Sarah is a CBT therapist and was using a CBT/DBT approach with her young female patient with borderline personality disorder.

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Theresa. ***“My concern is you have a long drive ahead, and you look very tired. Do you have to be there as soon as possible or could you have a rest? [I have time to rest] You’re very welcome to stay in the room then and have a sleep for an hour. I’ll be out, I have things to do but I’ll give you an alarm clock, and you can let yourself out in an hour”***

This is Theresa’s offer to her patient who looked overly tired following a session, and had a 3 hour drive to visit a relative. Theresa’s private practice was in her own home and her patient took her up on the outlined offer. Theresa is a psychotherapist and was working with an integrative approach.

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Joanne. [Singing] ***"Just say no"***

'Just say no' was a lyrical slogan Joanne had heard on a government funded anti-smoking advert. This was her response to her patient's assertion that he could not say no to drug dealers and, therefore, would continue to use. Joanne is a schema therapist.

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Annette. [Spoken with an outburst quality] ***"You've got a serious personality disorder"***

This is Annette's assertion to her patient who obstinately clung to her 'intractable' depression for months in psychoanalytic psychotherapy.

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Melanie. ***"Why don't you get medical advice? A specialist in this field might well advise you to have surgery"***

This is Melanie's suggestion to her patient who complained about a physical health problem over a period of several months, but did not take action to treat it. Melanie is a psychoanalytic psychotherapist.

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Brian. ***"I tell you what, I'm going to ask all my colleagues in this department to come in near lunch time. I'm going to ask them the obvious question and I won't have said anything to them or debrief them, you're just going to have to believe me about that"***

Brian, a clinical psychologist using CBT, immediately set up a behavioural experiment with his patient, who was convinced that he smelt, in their first and last session.

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Susan. ***"I suggest you go and see your doctor whilst I am away"***

Susan is a psychoanalytic psychotherapist. This is her suggestion to her patient who was becoming increasingly anxious leading up to her holiday break.

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Courtney. ***"I've told you that it is huge for me that my mother died, but I'm telling you I've also felt mad"***

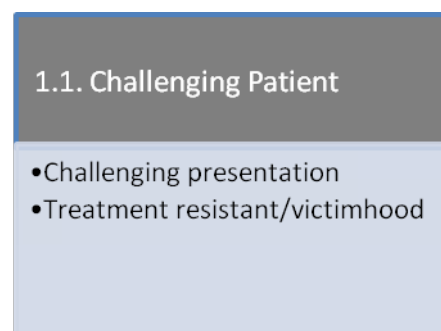
Courtney is a counselling psychologist working with an integrative approach. She used self-disclosure with her patient who was struggling with her father's death and, at times, felt mad. Courtney uses self-disclosure routinely, but perceives this as unusual practice in general.

## **Category 1: Patient and Therapist Factors**

Without a patient or therapist there would not be any form of intervention. Therefore, 'Patient and Therapist Factors' represent the natural starting point of the unusual intervention (UI) process and constitute the first category in this section.

### **1.1. Challenging Patient**

It was stand out that all of the UIs reported in this study occurred with what I have termed 'challenging patients', in terms of their presenting problems and/or engagement in treatment.



#### ***1.1.1. Challenging presentation***

Alexander's patient was seen in a forensic setting and was a former crack cocaine addict. Joanne's patient was an ex-offender with a crack cocaine and heroin addiction. Both Sarah and Annette's patients were seen in personality disorder services. Theresa and Melanie's patients had suffered from childhood sexual abuse and severe early emotional abuse respectively. Susan described her patient as "*somebody who was quite ill*" (126), and "*on and off fairly heavy anxiolytics*" (128-129). Courtney's patient felt 'mad' after her father's death.

#### ***1.1.2. Treatment resistant/victimhood***

6 of the therapists described their patients as resistant to treatment and/or wedded to a 'victim' position, which precluded positive change. For example, working with a CBT approach David's patient resisted the behavioural change aspect of the therapy:

*"I think there was a lot of ambivalence with him...he's saying what he wants but not doing anything to change it" (380-382).*

In the session in which Sarah's UI occurred, her patient had not done her dialectical behaviour therapy (DBT) homework: *"She came after self-harming every day one week, she came back the next week and nothing was on the diary card" (143).*

Joanne: *"He was not the most regular attendee" (130), "I'm sure I'd suggested this a million times [going to NA]...but he constantly said no, the drugs are the only escape" (143-145). Further, "[He was] endlessly moaning about his life...just everything had gone wrong" (118-120), "he couldn't do anything and then he'd have to steal...it was just a resounding cycle of self-pity" (127-128).*

Annette: *"She said that nothing worked for her depression...she'd been depressed for about 6 years and she'd had an inpatient period of treatment" (13-15).*

Susan: *"He is quite unable a lot of the time to accept and go along with the help that is offered" (189-190), "he says no, I can't do that, or I'll try it and it won't work" (191-192), "yeah, huge resistance" (194).*

Brian's patient's depression had not been helped by past therapy or psychotropic medication: *"He'd had another therapy, he'd had anti-depressants" (192).*

Melanie stated that her patient *"is rather wedded to being a victim" (262).*

## 1.2. Therapist Factors

- Challenged therapist
- Identificatory processes
- Rebel/risk-taker

### **1.2.1. Challenged therapist**

Given that the therapists in this study were working with ‘challenging patients’ it is potentially unsurprising that, in turn, a significant proportion of them felt challenged. 6 clinicians reported feeling at least one of the following: Stuck, under attack (in a battle), frustrated/desperate, and that their ‘therapist identity’ was under threat.

#### ***Feeling stuck***

5 of the therapists felt stuck in the work, and that the therapy was not progressing positively for the patient. Thus, a link emerges here between the outlined ‘patient resistance to treatment’ theme and this manifestation of the challenged practitioner.

Joanne: *“I just thought I don’t really know what to say anymore, I don’t feel we’re going anywhere, I don’t know what’s happening here anymore”* (139-140), *“I was also up against the wall”* (160), *“nothing was [working]”* (184).

Annette: *“I think it was a sort of growing feeling of stuckness”* (122).

David: *“Everything you’re doing is just not working”* (350).

Sarah reflected: *“Sometimes you do feel quite stuck as a therapist”* (164).

Susan: *“I wasn’t getting anywhere with her...I felt very hopeless about her”* (100-101).

#### ***Under attack (in a battle)***

Preceding their UIs, 5 of the therapists described being on the receiving end of their patient’s hostility, or that they were involved in a ‘battle’.

Melanie: *“She wants to always put me in the wrong”* (295), *“she wants me to make a mistake”* (126).

Susan: *"Whenever we start to talk about him not being able to manage, I suppose what I feel is a criticism of me in that: You're not able to manage me. You're not skilful enough or experienced enough"* (157-159).

Annette: *"She'd got me in a corner where she wasn't going to change"* (155), *"it's almost like you're involved in a kind of fight"* (231).

Joanne: *"He used to bring poetry, which was very disgusting, some of it was kind of pornographic...I used to feel that some of it was inappropriate"* (133-135).

David: *"There might have been a bit of a battle going on"* (354).

### ***Frustration & desperation***

5 of the therapists experienced notably high levels of frustration with their patients. Some not only linked this experience with their patient's resistance and sense of victimhood, but also with the subsequent occurrence of their UI. The data suggests that frustration can build up and reach a crescendo point, experienced as desperation and of having had enough.

Annette: *"I tried to find ways of talking to her about her taking some responsibility...and I got absolutely nowhere...and I got more and more frustrated"* (35-38), *"I became so exasperated"* (73). Further, *"I wasn't prepared to be put in that corner any longer"* (157), *"I got more and more frustrated and I think one day I sort of cracked, and this was, I suppose, the unusual thing that I did"* (38-39), *"I have said to her that it [the UI] was partly my desperation"* (108).

The following quotation captures the intensity of Annette's experience: *"I felt like I physically wanted to shake her"* (130).

Melanie: *"I was frustrated with her"* (225), *"she is rather wedded to being a victim, and I got cross with that"* (262).

David: *"The instinct was frustration"* (353). David links his frustration to the UI: *"I think I just had a reaction to it [his resistance]"* (112).

Similarly, Susan: *"At times you're very frustrated with this person and your own impatience with him comes out, your own: I don't want to deal with this kind of thing"* (199-200).

Joanne's frustration is palpable in the following quotations: *"Oh no, he's going to come in and moan again"* (189), *"I can't face it, I hope he hasn't brought one of those awful, grisly poems"*

(191). Linking her emotional experience to her UI she stated: *"It smacked of desperation"* (335), *"I'd had enough"* (160).

Susan: *"I didn't want to see her back, I was fed up with her"* (100).

Reflecting on the link between increasing frustration and UIs, Joanne stated: *"Absolutely, and I think that is often when I do resort to a song or a joke or something"* (303).

The following quotation from Annette highlights her experience of a build-up of frustration over time: *"That must have been building up over weeks and weeks before, if not months, of a feeling a sort of desperation"* (157). Similarly, Joanne: *"I'm aware that in me these things often come out of a point where I'm just fed up of hearing rather self-indulgent stories over and over and over again"* (87-89).

### ***Threat to therapist identity***

Thus far the data suggests linkages between patient factors and the therapist's sense of feeling stuck, under attack and frustrated. 4 clinicians reported 'threat to therapist identity' as a further derivative experience. One therapist also linked this sub-theme to his UI.

Joanne: *"I have a huge desire to fix, so sitting week after week with something that I perceive as unfixable is very frustrating and I'm probably not good at sitting"* (304-306).

Susan: *"I suppose my own sense of my professionalism was dented, I wasn't helping her"* (101-102).

David provides a powerful illustration of the need to keep the therapy progressing and attaining positive results: *"I've got to pull the rabbit out of the hat, the session was coming to a close...it's like a football match and we're going into injury time, everything you're doing is just not working and it's like shit, somebody needs to step up and hit the wonder goal"* (347-351).

In the weeks leading up to Melanie's UI her patient had used complimentary therapies to treat a physical ailment: *"It angers me that people are so critical of psychoanalytic therapy whilst at the same time dabbling in weird and wonderful things [complimentary therapies]"* (244-246). Further, *"it can be a weakness...whenever I've kind of jumped out of my therapeutic frame as it were, I think it's when that has been evoked, when somebody has gone on the internet and decided that something else, whatever it is, is better"* (253-257).

### 1.2.2. Identificatory processes

This sub-theme is the first to highlight the potential role of unconscious processes in UIs. Through the interview process 6 therapists became aware of identifications with their patients that may have contributed to their UI. A distinction emerged between what I will term 'positive' and 'negative' identifications. The former denotes qualities of the patient, which therapists recognise as an aspect of themselves. By contrast, the latter captures facets of the patient, which the therapists perceived as alien to themselves.

The provision of trust was a key aspect of Sarah's UI: *"Yes, as I heard you talk about that [identification], yes, I guess so, because she found it difficult to trust, I historically probably would also have issues for different reasons...so the identification, yes, a cautiousness in relationships with others...yes, I think there definitely was an identification"* (332-335). Further, *"I was thinking of parallel issues between me and the client, I would imagine that was an important contributing factor"* (364).

Alexander, reflecting on his joining in with his patient's enjoyment: *"Yes, in some way I could identify with it"* (44), *"I went along with his laughter about craziness because there's a part of me...it's tapping into a part of me that likes to be a bit mad and go a bit wild, a sort of wild abandon"* (17).

Susan: *"She reminded me a bit of myself in ways, and I was getting frustrated with aspects of her that were quite pertinent to myself"* (118-119).

David's UI was telling his patient to 'not try, but do it' (CBT homework). I subsequently asked him whether he could identify with his patient's difficulty in 'just doing it'. He reflected: *"I think it might be more about having to always do, and never allowing myself to amble along or not really engage with things"* (personal communication). In this instance the therapist is confronted with a behaviour that is potentially threatening to his identity, i.e., 'not doing'.

This process may also be in play for Annette and Melanie. Annette stated: *"The bit that I absolutely didn't identify with was her sort of perverse or passive, well I'm not sure if it was passive, but her sort of perverse attachment to her depression"* (265).

Melanie: *"I think I am rather triggered by people who want to be victims"* (265). Further, *"I think it's a particular irritation of mine that people don't go for proper evidence based care"* (246).

### **1.2.3. Rebel/risk-taker**

This final sub-theme stands out in that it is purely about the therapist. In contrast to the previous sub-themes 'Challenged therapist' and 'Identificatory processes' it is not a reaction to the patient or an interactive effect. 6 of the 10 therapists described being rebellious, and having a propensity to take risks.

David: *"I love a bit of rebelling against authority...the system...I don't like being told what to do"* (836). Further, *"I'm probably thinking, there's probably not a lot of therapists who would do something like that [the UI]"* (149).

Similarly, Theresa: *"I don't think my supervisor would have done that"* (187).

Brian: *"I don't think other people would do it"* (288), *"some people wouldn't take that personal risk"* (426).

Courtney: *"I do go places like this [using self-disclosure] that as far as I'm aware a lot of us don't go"* (143), *"I choose to take risks, I'm a person who takes risks"* (329), and *"my primary concern is bugger rules and regulations, and what we've been taught to believe we should or shouldn't do, I mean obviously, there are limits"* (243).

CBT therapist Sarah: *"I never had a rulebook in a way...I never followed a protocol from beginning to end"* (414-416).

Psychodynamic psychotherapist Melanie: *"I've always been resistant to this notion that only transference interpretations are mutative"* (324).

### Category 1.3. Patient and Therapist Factors – reflections

I would like to pause at this point, to take stock of emerging links between some of the outlined themes in the first category, ‘Patient and Therapist Factors’, with the use of a table.

Table 4: Patient and Therapist Factors

| <i>Ps</i> | <b>Challenging Patients</b> |                                       | <b>Challenged therapists</b> |                     |                                      |                                     | <i>Identificatory processes</i> |
|-----------|-----------------------------|---------------------------------------|------------------------------|---------------------|--------------------------------------|-------------------------------------|---------------------------------|
|           | <i>Presenting problems</i>  | <i>Treatment resistant/victimhood</i> | <i>Feeling stuck</i>         | <i>Under attack</i> | <i>Frustration &amp; desperation</i> | <i>Threat to therapist identity</i> |                                 |
| David     |                             | TR/V                                  | Stuck                        | U-attack            | Frustrated                           | Id-threat                           | IP                              |
| Alexander | ✓                           |                                       |                              |                     |                                      |                                     | IP                              |
| Sarah     | ✓                           | TR/V                                  | Stuck                        |                     |                                      |                                     |                                 |
| Theresa   | ✓                           |                                       |                              |                     |                                      |                                     | IP                              |
| Joanne    | ✓                           | TR/V                                  | Stuck                        |                     | Frustrated                           | Id-threat                           |                                 |
| Annette   | ✓                           | TR/V                                  | Stuck                        | U-attack            | Frustrated                           |                                     | IP                              |
| Melanie   | ✓                           |                                       |                              | U-attack            | Frustrated                           | Id-threat                           | IP                              |
| Brian     |                             | TR/V                                  |                              |                     |                                      |                                     |                                 |
| Susan     | ✓                           | TR/V                                  | Stuck                        | U-attack            | Frustrated                           | Id-threat                           | IP                              |
| Courtney  | ✓                           |                                       |                              |                     |                                      |                                     |                                 |

As stated, it was stand out that all UIs in this study occurred with ‘challenging patients’, in regard to presenting problems and/or resistance to treatment. In terms of the ‘challenged therapist’ sub-theme, 6 participants described feeling ‘stuck’ and/or ‘under attack’. 5 of these participants also felt frustrated, with 4 further participants thereof reporting that their ‘therapist identity’ was threatened.

What about the remaining 4 participants? It is noticeable that Brian and Courtney do not contribute to any of the therapist factors outlined in Table 4. Significantly, we know that Brian’s CBT behavioural experiment was a planned UI. Courtney’s UI was a very open form of self-disclosure, which she perceived as unusual practice in general, but has integrated into her own work as ‘standard technique’. Thus, a potential distinction is emerging between UIs that are planned and/or represent individual technique and those which do not.

The 2 remaining participants, Alexander and Theresa, also stand out in Table 4 because of their lack of contribution to the ‘therapist factors’ theme. At this point it is simply worth noting that they were 2 of 6 participants to report the potential presence of identificatory processes.

## Category 2: 'Decision-making: Conscious - Unconscious Continuum'

### ***“To make an unusual intervention, or not to make an unusual intervention?”***

Category 2 outlines UI decision-making processes reported in this study. It is divided into 2 main themes, 'Therapeutic Intent' and 'Prior Knowledge', which both contain further sub-themes. The data suggests that varying forms of intentionality and prior knowledge influence the occurrence of UIs on a 'conscious to unconscious continuum'. Therefore, sub-themes in this category are labelled either 'conscious', 'unconscious', or as a 'conscious, unconscious' combination, in order to best capture the complexity in the decision-making process. It is important to ask the reader to hold these labels lightly; participants' accounts demonstrate that their location on the continuum is often ambiguous and contradictory. Furthermore, there were irregularities between some participants' reports of the nature of their decision-making processes, and the phenomenological quality of their UIs. This observation will be taken up further in categories 3 and 4.

#### **2.1. Therapeutic Intent**

- Breaking through resistance
- Corrective emotional experience
- Modelling
- Connection
- Giving the patient responsibility
- Normalising and validating
- Keeping safe
- Ego strength

##### **2.1.1. Breaking through resistance - conscious**

4 therapists intended to break through their patient's resistance with their UI, thereby establishing a link between the 'patient resistance/victimhood' theme in the preceding category and therapeutic intent. This was the most common form of intention outlined by the therapists.

Sarah: *"My intention was to bring her focus back on her real problem, instead of actually avoiding talking about problems and difficulties"* (192). Further: *"The rationale is actually you're surprising the client in the room, so their behaviour would stop in a way"* (204).

Annette: *"The bit that is intentional was a feeling of I'm in such a corner really. She'd got me in a corner where she wasn't going to change, and I was just supposed to sit here, it felt like for hours on end...and I just knew that I wasn't prepared to be put in that corner any longer"* (154-157), *"it's almost like you're involved in a kind of fight in which you're trying to be on the side of the bit of the patient...trying to kind of get the obstructive, resistant part of the patient to make room...to get to that bit of the patient that wants to change"* (231-234).

On his use of a 3<sup>rd</sup> party (Yoda), David stated: *"If maybe it just came from a 3<sup>rd</sup> party it might somehow be accepted more"* (83), *"instead of coming across like a psychologist...he might respond a bit better"* (91-93). Further: *"Maybe this isn't working, I need to like change tack here, just something different, and maybe because it was feeling a bit serious, it was like let's try something light-hearted"* (355).

Reflecting on his planned CBT intervention with a client whose fear of smelling had not been reduced through previous therapies, Brian stated: *"The intention was to give this man overwhelming evidence that would counter his delusion [that he smelt]"* (120).

### ***Breaking through resistance – unconscious***

Participants also spoke of their intention to 'break through resistance' in a manner which suggested that unconscious processes were in action.

For example, David openly reflected on the post hoc nature of his therapeutic rationale, and his uncertainty about the degree to which it was consciously formed prior to his UI: *"I had sort of a rationale [to motivate his patient to complete homework tasks] but I don't think it was so crystallised when I did it...afterwards I was almost like why did I do that? I've almost found my rationale. I don't know if it was so conscious at the time"* (113-116).

Similarly, Sarah stated: *"It [the UI] has a therapeutic meaning in it [to motivate her patient to complete homework tasks], and you might not see it in the moment, but you could see it on reflection sometimes"* (362-364).

Annette told me: *"I physically wanted to shake her. I think this kind of outburst if you like [the UI]...was an attempt to kind of metaphorically shake her, y'know, get her by the lapels and shake*

her and say: Look over here” (130-133). ‘I think...’ points towards an uncertainty around Annette’s intention.

### **2.1.2. Corrective emotional experience – unconscious**

Theresa acknowledged that her intention to provide a ‘corrective emotional experience’ was not clear to her at the time of her UI but, rather, discerned post hoc based on her formulation of the patient: *“I didn’t think about it so clearly at the time [the therapeutic intent], but in terms of thinking of the developmentally needed relationship, it was permission to look after herself, it was an invitation that she obviously expressed, she had noted her tiredness which I think was important for that client”* (59-61).

### **2.1.3. Modelling – unconscious**

Theresa also hypothesised a post hoc rationale for her UI based on a potential intention to model a healthy adult relationship: *“I guess I also wanted to model: I’m not going to sit with you or hang over you. I will fulfil my own needs. I have shopping to do, I have stuff to do, so I’m not going to change my plans for you, but we can both have what we need”* (68-70).

Highlighting, and owning the unconscious nature of her decision-making process, Theresa stated: *“I always say you need to have a rationale for it [an intervention], but I didn’t really at the time”* (153).

### **2.1.4. Connection – unconscious**

Reflecting on his UI, where he had ‘joined in’ with his patient’s enjoyment in recounting his days of wild drug use, Alexander initially stated, *“I don’t know what I’m trying to do in those moments [UIs]...”* and, *“no, I haven’t really thought it [the theoretical rationale] through”* (2-3). However, later, he passionately asked me: *“Can you imagine the power differentials in prison? For a start there are disadvantages, secondly they think their lives are shit most of the time, they come and see me...quite well dressed, looking relatively affluent, and then I’m a psychologist doing all this assessment psychological this and that. Fucking hell, if there can be one moment out of that where they can think like ‘oh well, he didn’t seem to’...not that he didn’t seem to mind about my drinking, but if there’s some tiny little moment of spark of connection, I don’t think that can be a bad thing*

*really, maybe?"* (212-219). This quotation demonstrates that Alexander's potential unconscious intention was to establish a positive connection with his patient in prison, which he perceived as a challenging environment to conduct psychotherapy in.

#### **2.1.5. Giving the patient responsibility – unconscious**

Like Alexander, Joanne initially told me that she had not thought about a therapeutic rationale for her UI and that, further, she was not concerned to: *"I haven't done so far...I wouldn't want to particularly"* (352-354). However, earlier in the interview she had described aspects of her practice, which indicate that unconscious processes may have been operant in her 'just say no to drugs' UI. She had informed me: *"It's really, really important for me as a therapist to never put myself in a position of teacher, mother, or authority figure..."* (364), *"ultimately, if you give up drugs...it's for you, not for me, so don't start using me as a teacher...because I'm not really that interested"* (371). Further, *"I often find that those approaches are best, for example 'drugs are bad', and that's it, what's the point in discussing it?"* (340-342).

#### **2.1.6. Normalising and validating – conscious**

As outlined, Courtney's self-disclosure UI is usual for her own practice, although she perceives it as unusual practice in general. In terms of her conscious intention Courtney stated: *"A big part of the work I was doing with her was, it's alright to feel this way and there's nothing wrong with you for feeling this way"* (56).

#### **2.1.7. Keeping safe – conscious**

Susan, who was concerned about her patient's safety during her summer break reported: *"My intention was...this is an ill man, I'm going to hand him over to the doctor for his benefit"* (188).

#### **2.1.8. Ego strength - unconscious**

Finally, Melanie, who had suggested her patient seek medical advice, provides a further account of unconscious processes in action: *"My goodness, you don't always know until you look back, you think, God, you know, why did I do that?"* (145). She reflected, *"I think someone in that discipline*

*[contemporary Freudian] would probably say that this was helpful, that the patient's ego needed strengthening by a kind of engagement with her own ability to look after herself, so I was strengthening her ego's ability to look after herself" (320-322).*

## 2.2. Prior Knowledge

- The patient
- Experience
- Theories of good therapy

The second main decision-making theme to emerge from the data is 'Prior Knowledge'. Again, I will address the continuum throughout, labelling sub-theme components as 'conscious', 'unconscious' or a combination of 'conscious, unconscious'.

### 2.2.1. The patient

This sub-theme is about therapists' knowledge of their clients and the therapeutic relationship, and how this impacts on the occurrence of Uls. 'The patient' is the most prominent sub-theme in the decision-making process, with 7 of the 10 therapists highlighting its importance. The data suggests that this theme can have a strong unconscious component.

#### ***Knowing your patient – conscious***

Sarah: *"She was a young woman...I knew this chilly 'oh my god you're cured, that's amazing' would work for her" (326), "yes, [it's very tailored to her]...if I was doing it with somebody who was at a later stage in their lives they would have considered it quite rude. I would have done the same thing but in a much more thoughtful, matter of fact way" (332-335).*

David: *"He had talked about how he was quite into science fiction" (63), "I somehow thought that a character like that [Yoda] would resonate" (81).* David powerfully demonstrates the micro level

of 'responsivity' in his UI: *"It was idiosyncratic...it came from what I thought his interests might be"* (388-390), *"I don't think I would have tried that intervention with anybody else"* (425).

In terms of being direct with patients, Brian reflected: *"I think cutting to the chase, you don't do that with everybody with every condition, with people who are depressed and not working...I mean, I think there is a limit to the generalisability of these things"* (160-162).

Susan adds a further dimension to 'knowing your patient', arguing that it is not only a 'between-patient', but also a 'within-patient' process: *"Sometimes you can be more spontaneous with some people than you can be with others, with others you have to be really careful and weigh something up, and wonder will I say that or will I not, and it's different with everybody, it's different even with the same patient on different occasions, or depending on whether they're at the beginning of treatment or further along..."* (363-367).

### ***Knowing your patient – unconscious***

On her work with adolescents with borderline personality disorder, Joanne stated: *"I'm much more careful with them and probably a bit more thought out"* (415), *"if you're dealing with high risk then I realise that I'm much, much, much more cautious in anything that I say, I'm very often treading on eggshells"* (403-404). Further, in regard to her UI in the present study: *"I hadn't thought about this, with the robust, drug taking, drinking males who aren't suicidal I'd probably be a bit more ruthless in my interventions...I wouldn't be like that with my vulnerable teenagers"* (417).

Here, Joanne powerfully highlights the role of unconscious processes operating in her decision-making. It was only through our interview that she became aware of how dependent her use of UIs is on her patient: *"Yes, you're right [regarding unconscious processes], it's interesting, I hadn't thought about this"* (416), *"it's true, I am very intuitive"* (422). Further: *"Yes, there are codicils on all of this I think"* (452), *"you have to be able to tell the temperature in the room quite well and always hold risk in mind"* (394). *"I think the answer is always know the person in front of you as much as you can, particularly if there is risk"* (455), *"you know this person is robust enough to take it, but with most cases where there's risk, you're not going to try anything unusual at all"* (507).

Joanne's guideline for practice is fascinating, because it captures the emerging complexity of decision-making processes in UIs. She urges practitioners to 'know' their patients, and to be attentive to moment-to-moment fluctuations in the therapeutic relationship, whilst simultaneously demonstrating that this process was largely an unconscious one for her.

Melanie also became aware of unconscious processing in UIs during our interview. In terms of her advice-giving UI she reflected: *"I think it's to do with the patient, now I'm thinking about it, when I just said to you with narcissistic, brittle rather cut-off patients I wouldn't [have made the UI]"* (397).

### ***The therapeutic relationship – conscious***

3 therapists emphasised the importance of a strong therapeutic relationship when using UIs.

Sarah: *"It was a client that I had quite a strong therapeutic relationship with, which is very important. I wouldn't have tried it with somebody who had just started treatment"* (56), *"I think you can experiment quite a lot with different techniques in CBT, and go different pathways as long as you have a strong therapeutic relationship in place"* (126-128).

Brian: *"The guy thought I was genuine"* (139), *"yes, I realised that the relationship would be alright"* (181).

### ***The therapeutic relationship – unconscious***

Consistent with the recognition that her knowledge of her patient impacted on the occurrence of her UI unconsciously, Melanie reflected on the role of the therapeutic relationship in less certain terms: *"I don't think I would have done that [the UI] if I felt the therapeutic relationship was fragile in any way"* (424).

## **2.2.2. Experience**

There is a strong emphasis on 'self-trust' gained through experience, which incorporates confidence and a trust in intuition and feeling, with 8 of the 10 therapists underlining its importance. The 'unconscious to conscious continuum' stands out in regard to 'self-trust'. A number of therapists confidently assert its role in their decision-making. Contrarily, others' reflections are less certain, more hypothesis than assertion, pointing towards potential unconscious processes. The ambiguous and complex nature of the continuum is also prominent in therapists' accounts of trusting their feelings and intuition, where a paradox emerges of 'consciously trusting an unconscious process'.

### ***Self-trust – conscious***

Sarah: *"If I think back to the beginning of my career I wouldn't try anything like that, not because I didn't want to try them out, but I didn't have the experience yet to know how to contain it if it did go wrong...you have to be prepared that things might go wrong, and if it does, how would you fix it. When you start you may not have the tools in place to do that, you might not have the experience"* (259-263).

On his planned CBT UI, Brian reflected: *"I was confident that it would work, or probably would work, and of course confidence in your own therapeutic approach is very, very important"* (177). Further, on CBT invivo work: *"There's a risk to take, and I have gone overseas in private work to pick up someone who can't fly...I'm confident because I've dealt with hundreds of people, I mean I wouldn't have done that when I was 25"* (425).

Courtney, on her use of self-disclosure: *"There's a way that I have evolved over the years of thinking about things through all the research I've done, all the writing, all the talking to people, all the work I've done, there's a theme that runs through it I suppose, so I have enormous confidence in that theme"* (376). Further: *"I'm drawing on the belief that those interventions are helpful for my clients based on the feedback that I've received, and also an internal self-belief about those things"* (376-378).

David: *"When you trust yourself more you don't need to hold the models so tightly, you can take those risks, take those chances, step outside of it"* (660-662).

### ***Self-trust – unconscious***

A number of therapists' reflections were less assured and pointed towards a more unconscious role of 'self-trust' in the decision-making process.

For example, Theresa: *"I think maybe also I was more trusting of my own judgement at that phase than I had been with earlier interventions so maybe more experience in, maybe more confidence in my ability to make a decision like that"* (228-230).

Joanne: *"I think you have to feel very secure in not only elements of yourself and what you're doing..."* (393). Similarly, Courtney: *"I think there is a sort of confidence that comes with a degree of maturity"* (369).

Annette: *"I think I can trust myself to be spontaneous"* (206). Further, *"you would expect to have an ongoing internal supervisor that would restrain one from making wild interpretations or a grossly insensitive one"* (221-222).

### ***Self-trust: Feeling – conscious, unconscious***

As stated, the ambiguity and complexity of the continuum is particularly evident in accounts of trusting 'feeling and intuition'. The data suggests that some therapists may have acted on a conscious sense of trust in the manifestation of an unconscious process.

Theresa: *"It just came, it's what students always say, it feels the right thing to do, which irritates me, I always say you need to have a rationale for it, but I didn't really at the time"* (152-154).

Joanne: *"I am very intuitive, often people will ask me how I know things and I'll realise I don't know how I know, I just know, which wouldn't look brilliant if one was sort of accounting for oneself, but I go on my instincts a lot, and up until now, thank God, I've known what is safe"* (423-425).

Melanie: *"Yes, I think one has to be very mindful of one's own unconscious and sometimes it feels right and sometimes it doesn't, I've always wondered about it, but on balance I think it [the present UI] was the right thing"* (380).

Sarah: *"Somehow it [the UI] felt ok"* (316).

Trainee, David: *"I'm not completely kind of green, so I sort of think a lot of this information is filed away inside me somewhere and I think there's this idea that as you start to develop stuff it doesn't always have to be in your conscious mind, I think we can just instinctively do things that are quite good"* (637-640), *"you can just go for it, trusting your instincts"* (635).

This quotation from a second year counselling psychology trainee is fascinating, given the emphasis on the role of experience in self-trust. It begs the question how much experience is enough experience to trust one's instincts? David intimates that he felt ready to make his UI.

Theresa further emphasised her use of feeling, including the unconscious nature of this appraisal: *"There must have been other [unconscious] processes at the back, but they didn't feel turbulent or unsettling or making me doubt"* (227), *"I felt grounded"* (236). *"I guess for me, when I remember I didn't feel excited, and I think for me maybe that was important, if I think there is something going on for me I would have maybe a higher level of arousal, excitement, something interesting"*

*happening. I remember it felt very, very practical and that I think calms me down in terms of thinking what are my motives” (210-213).*

### ***Self-awareness – conscious, unconscious***

2 participants felt that high levels of self-awareness, gained through personal therapy, was an important aspect of experience, which is linked to self-trust. I have also labelled self-awareness as a ‘conscious, unconscious’ combination in terms of the continuum. As with ‘trusting feeling’, Annette and Theresa’s quotations point towards a certain level of conscious trust in the unconscious.

Annette stated: *“I think the whole idea of surprise interventions is or should ideally be linked a bit to experience, because if you have had a lot of analysis yourself and you know about your own capacity for cruelty or sadism...then hopefully something you do spontaneously isn’t going to be beyond some kind of, it’s not going to come out of some part of yourself that you’re not aware of” (198-204).*

Theresa: *“When I started practicing I hadn’t had as much therapy as I had later, so I knew myself less well, so you are then more likely to get excited by the job, it’s exciting to do therapy, to offer therapy, and you feel very powerful as a beginning therapist when interventions work, there is the excitement of the relationship” (270-273).* Further, *“I think then it is tempting to try out things because one feels maybe quite confident at times, and I think it is a combination of a lack of self-knowledge, from lack of enough therapy at that time, and to feeling maybe over-confident, that leads to I think those: ‘It felt the right thing to do’, that it can also go wrong” (273-276).*

### ***Learning from mistakes – unconscious***

2 therapists, Theresa and Melanie, reflected on ‘learning from mistakes’, as an aspect of ‘experience’ which may impact on their use of UIs. I find it fascinating that their accounts, in particular Melanie’s, point towards potential unconscious learning processes.

Melanie contrasted her UI in the present study with an earlier UI she felt was a mistake: *“A patient once said ‘what do you think of me?’ and I kind of more or less told her that I didn’t like her, and that was awful” (385).* As previously outlined, she became consciously aware of the importance of ‘knowing your patient’ in the interview process: *“I think it’s to do with the patient, now I’m thinking about it, when I just said to you with narcissistic, brittle, rather sort of cut-off patients I wouldn’t [use certain UIs], she [the aforementioned patient from line 385] was like that, she was extremely narcissistic” (397-398).*

Theresa reflected: *"I've made mistakes with these types of interventions, some not panning out, some panning out, but me being very unsure...I think learning from my mistakes"* (244-246).

Theresa felt she had learned that maintaining boundaries was important when using UIs: *"Set boundaries in what you do. I think the one that went wrong had a lack of boundaries, so I think the fact that I finished the session on time, plus I had set a time limit...I think that made it safer, it wasn't limitless [allowing her patient to rest in her home]"* (248-250). Theresa can evidently discern how past experiences have potentially impacted on her UI, but she is unable to state with certainty that this is in fact the case, repeatedly saying "I think...".

### **2.2.3. Theories of good therapy – 'conscious, unconscious'**

This sub-theme is about the therapists' personal theories of what constitutes good practice, which potentially impact on their decision-making process and the occurrence of UIs. I have labelled this whole sub-theme as 'conscious, unconscious' in terms of the decision-making continuum.

Therapists neither claimed that they drew on their 'theories of good therapy' to inform a conscious decision about making an UI, or that these theories exerted an unconscious influence. They simply informed me of their personal theories, which, as will be demonstrated in the next section, were relevant to the qualities of their UIs. Further, in my view the data suggests that 'theories of good therapy' exert a conscious or unconscious effect on the occurrence of UIs, contingent on its phenomenological quality (see section 3).

#### **Being 'real'**

'Being 'real'' was the most prominent 'theory of good practice'. 5 therapists emphatically highlighted the importance of self-expression and being 'real'.

David reflected: *"They're [patients] not really being themselves, parts of themselves they've blocked off...if I start doing that then in a sense I'm full of shit, because I'm not actually being myself anymore either"* (680-682), *"there's a balance to strike between rules and bringing your own stuff in...if it's too much one way you're just cutting off a part of yourself I think"* (685-687).

Theresa: *"I find it difficult, because I think it is important as therapists we are truly who we are, and I think to make therapeutic use of aspects of ourselves, I think is really important, but at the same time of course...you have to rein yourself in"* (267-269).

Trainee David and Theresa both highlight the challenge of being 'real' as a psychotherapist, the tension between self-expression and prescribed technique, and limiting the use of self-expression.

Melanie: *"I don't hide behind a theoretical stance, I don't hide behind a particular persona, I try to be as real as I can be"* (448).

Courtney: *"I think that it's really important that those of us in the profession don't pretend to be other than human beings"* (172), *"yes, to be real, absolutely, that's me, that's who I've become in my years of practice"* (205), *"I can't see any other way forward, if I'm not being real with my clients"* (209).

Joanne: *"I want to be as authentic as possible and not coming at people from a position of teacher or authority"* (273), *"that isn't just me sitting there and you thinking that I've got a perfect life"* (284).

### ***Creativity and responsivity***

David and Sarah believe that therapist creativity is important, in order to meet patients as unique individuals.

Sarah reflected: *"Yes, 100% [creativity is important], because then the model, the whole treatment is tailor-made to meet the client's needs"* (421-423), and *"I think creativity is essential, I don't think a therapist can consider themselves good unless they are creative, otherwise you could have machines doing that, the 'beating the blues' program would have cured every single client that suffers from depression, but we know that it doesn't do that"* (438-440).

Sarah also highlighted the influence of clinical supervisors in shaping her views: *"My first 2 supervisors were very much into different kinds of things and were against any type of protocol, because it was all about the formulation"* (408-410).

David: *"I think if we don't relinquish the books to some extent, we're just going to be abiding by these really rigid rules, and I don't think therapy is like that, I don't think people are like that, I think people are kind of flexible, they don't all kind of fit into one box, you can get too stuck with that"* (668-670). Although he could not remember the source, David also reflected that he had read about the maxim: *"If you enter through the door of the client's interest you will exit through the door of your objective"* (372).

### ***Personal therapy***

The data suggested that therapists' experiences in personal therapy influenced their 'theories of good practice'. It stands out that there is a strong emphasis on being 'real' and therapist self-expression in the following quotations.

Theresa, regarding 'being real': *"I think when I have been a client I have found it valuable to experience my therapist revealing some vulnerability. I found that very helpful, I found it actually very relationship building, it made me feel very safe. I also felt this person lets me see some of what is inside...with a therapist where I never received that I didn't find it that helpful...just some genuine, I guess transparency at times"* (314-320).

Similarly, Joanne: *"I was in analytic therapy for 3 and a half years and I don't know why I stayed so long, I was very young, because I found the whole experience punitive, very cut-off, very cold, and I hated it, so I was always determined that when I went into the therapeutic industry I was going to provide an atmosphere where people felt I was presenting my own realness, my own authenticity and my own vulnerability"* (274-278).

Further, Courtney: *"I remember having a therapist many years ago who was a blank screen, and it used to drive me completely crazy, I mean I wasn't getting anything back from her"* (29-31).

Melanie gave medical advice in her UI. She reflected: *"I feel it's ok and I think that is based on my own analysis, my own analyst made all sorts of suggestions to me in one way or another"* (329).

Further, *"my analytic super-ego is very much modified by recourse to my own experience of analysis and wanting to be like her because she was so helpful to me"* (366).

In terms of potentially evoking anger in her patients through an UI, Susan reflected: *"Hopefully you get to be angry with your therapist and you find out what it's like and how you are treated in that, and then you see how valuable it is"* (304).

### **'Mistakes'**

3 therapists shared with me their thoughts on making 'mistakes' in the work. They all reported a certain level of willingness to make 'mistakes'. This is perhaps unsurprising given their concomitant emphasis on the potential therapeutic benefit thereof.

Susan: *"Yes, I think that's very important [not being overly concerned about making mistakes]"* (295), *"a very good supervisor I used to have said to me 'of course you will enact...you will fall'"* (295-296), *"because that is what the patient wants to do in a way, they want you to fit what they think you are...they don't want you to do anything different"* (298-300). Further: *"In a way, if there was a bona fide mistake, if the therapist can come back in and say look actually I think I got it wrong there, that might be terribly helpful"* (440-441).

Alexander: *“I don’t think I maybe have to be so controlled that I have to get it right all the time, and that it doesn’t really, maybe they can be quite valuable those times when you do sort of make a mistake”* (139-141).

Theresa reflected on using her counter-transference and how this had led to conflict with patients: *“It was almost an argument, almost a conflictual situation, which at the time didn’t feel right, but in most cases it has led to something being repaired, and through the repair the relationship has improved, so I do sometimes stick my head out a bit much...and make myself vulnerable to some extent by that”* (290-293).

### 2.3. ‘Decision-making: Conscious – Unconscious Continuum’ – reflections

Table 5: ‘Decision-making: Conscious – Unconscious Continuum’.

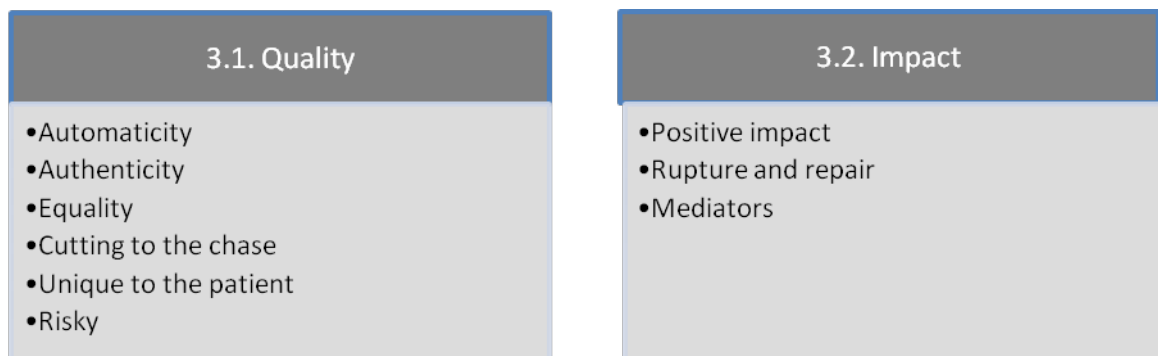
|           | Therapeutic Intent |                    | Prior Knowledge  |                    |
|-----------|--------------------|--------------------|------------------|--------------------|
| <i>Ps</i> | <i>Conscious</i>   | <i>Unconscious</i> | <i>Conscious</i> | <i>Unconscious</i> |
| David     | C                  | Uc                 | C                | Uc                 |
| Alexander |                    | Uc                 |                  |                    |
| Sarah     | C                  | Uc                 | C                | Uc                 |
| Theresa   |                    | Uc                 |                  | Uc                 |
| Joanne    |                    | Uc                 |                  | Uc                 |
| Annette   | C                  | Uc                 |                  | Uc                 |
| Melanie   |                    | Uc                 |                  | Uc                 |
| Brian     | C                  |                    | C                |                    |
| Susan     | C                  |                    | C                |                    |
| Courtney  | C                  |                    | C                |                    |

As outlined, all of the participants’ accounts of their UIs suggested that these were imbued with therapeutic intent. In Table 5 it can be seen that there is an almost even split of conscious and unconscious intentionality. It stands out that David, Sarah, and Annette spoke of their therapeutic intent in both conscious and unconscious terms. I believe this points towards the potential ambiguity and uncertainty around the decision-making process in UIs. ‘Breaking through resistance’ was the most prominent form of therapeutic intent, reported by 4 of the therapists. This is potentially unsurprising, given that they had all described their patients as treatment resistant in category 1.

There was also an almost even split between conscious and unconscious processes in the second main theme, 'Prior Knowledge'. Again, David and Sarah alluded to both conscious and unconscious forms of prior knowledge. 'Self-trust' was the stand out sub-theme of 'Prior Knowledge' with 8 of the 10 therapists highlighting its importance. It is apparent that 6 of the 7 therapists who reported unconscious therapeutic intent also pointed towards the role of unconscious prior knowledge in the UI decision-making process. It is also noteworthy that Brian (planned CBT UI) and Courtney (self-disclosure UI, integrated into general practice) were 2 of the 3 therapists who described conscious processes only.

### 3. The Unusual Intervention (UI)

Following on from the decision-making processes outlined in the previous section, category 3 pertains to the UI itself. It is divided into 2 main themes, Quality and Impact, each with sub-themes.



#### 3.1. Quality

This first main theme is about the phenomenological quality of the UI, and how it was experienced by the therapist.

##### 3.1.1. Automaticity

This first sub-theme captures an important quality of 7 of the UIs presented in this study. It subsumes descriptors such as spontaneity, instinctual, intuitive, in the moment, and not thought through, which, as the term 'automaticity' suggests, point towards an unconscious process. This is powerfully underlined by therapist statements such as 'out of the blue', 'popped out', and 'spur of the moment'. This unconscious quality of UIs is consistent with the unconscious aspect of the decision-making continuum in the preceding section.

##### *Spontaneity*

David: *"It was spontaneous, it just kind of came out naturally, it wasn't like a rehearsed thing, it was quite in the moment"* (365).

Alexander: *"Yes, it was spontaneous, it just came up in the moment, like, I'm there with you"* (78).

Annette: *"It was spontaneous and genuine, not a kind of artificially planned thing"* (145).

Theresa: *"It just arose out of the moment"* (54), and *"it was just, it just came"* (152).

Sarah reflected on what an UI meant to her: *"That I tried something completely out of the blue"* (358).

### ***Instinctual***

David: *"It was like instinct, something made me say it...I did something just on instinct"* (140-142).

Alexander: *"One feels more instinctual"* (135).

### ***Intuitive***

Theresa: *"At the time it was just, it just came, it's what students always say, it feels the right thing to do, which irritates me, I always say you need to have a rationale for it, but I didn't really at the time"* (152-154).

Melanie reflected: *"Sometimes it feels right and sometimes it doesn't"* (380). Similarly, Sarah: *"Somehow it felt ok"* (316).

### ***In the moment***

David: *"It was really in the moment, so it wasn't planned"* (110).

Alexander: *"It feels very present"* (114).

Sarah: *"It was very much on the spur of the moment"* (157).

### ***Not thought through: "Popping in/out"***

David: *"It wasn't like a cognitive pre-thought out thing"* (139), *"I think I just said it, first thing that popped into my head, just said it"* (178). Further, *"it's like the break wasn't there, the handbreak, you have an idea about saying something and then going 'ooh' maybe now is not appropriate, I don't know about that, and you sort of stop, and in that instance it just came out basically"* (178), *"it just sort of popped out"* (113).

Alexander: *"I suppose because it wasn't really consciously thought through"* (85).

Joanne: *"I wish I could say oh yeah I'd really thought it through, but it wasn't thought through at all"* (296), *"it just suddenly came to me that I'd heard some advert about drugs with the line 'just say no'"* (150), *"I find that lyrics pop out at me all the time weirdly, and I don't know why"* (317).

Theresa: *"It wasn't thought about, it was just something that popped into my head"* (162).

Melanie reflected: *"Rather than really think about that [the transference], I kind of jumped a bit"* (129).

### ***Unplanned***

Joanne: *"It's certainly not planned, and I don't quite know where it comes from"* (316).

Sarah: *"It wasn't planned"* (198).

### ***3.1.2. Authenticity***

5 of the therapists described their UIs as a form of authentic self-expression.

David: *"It's a bit more me, the kind of thing I might do with a friend"* (746).

Courtney: *"I offer something of myself"* (33), and *"I am admitting my vulnerability and showing myself and being transparent"* (36).

Alexander stated: *"It's just something that seemed quite human"* (5), *"maybe it was just like a good bit of being natural, being myself, being quite authentic"* (186).

Joanne: *"Singing is powerful...it's something that we could both relate to because it's very human"* (249).

Annette: *"It was more about my frustration...I think it had the validity of being genuine"* (148).

As outlined in the preceding section, 3 of these therapists, David, Joanne and Courtney, had told me they felt it was important to 'be real' as a therapist. Further, David and Joanne both described their UIs as 'automatic', which demonstrates that, as proposed, 'theories of good therapy' may exert an unconscious influence on practice.

### ***3.1.3. Equality***

5 participants described an 'equalising' quality to their UIs. Therapist and patient seem to be somewhat stripped of their roles in the relational dyad, meeting more as 'just 2 human beings'.

David: *"...there's something there from me to him in the same way you might give something to a friend, or share something with a friend that you maybe wouldn't share with other people"* (405-407).

Alexander: *"In that moment I was stripped of my role...it felt like we were equals"* (122-124), *"the power thing sort of slips away for a moment"* (153). Further, *"it goes beyond just psychological assessment, psychologist client, guy with his life sorted out to the guy who's not got his life sorted out"* (234-236).

Reflecting on the singing component of her UI, Joanne stated: *"[By singing] I'm not saying it from a patronising or lofty place"* (248).

On her use of a 3<sup>rd</sup> party Joanne reflected: *"Drawing on an outside source that they are familiar with, that again makes us all human, that I might be watching South Park"* (344).

Theresa: *"There was an equality, although it sounds bizarre because I think I was in a nurturing other role"* (76). She also hypothesised a mutual experience in terms of trust and getting needs met: *"I guess there was a trust on both sides"* (85), and *"I'm not changing my plans for you or because of you, but we can both have what we need...there are 2 adults in a relationship and both can get their needs met"* (70-72).

Brian told his patient with a fear of smelling: *"You don't smell and if you did I'd tell you what kind of deodorant to use, so would a brother or mate, or cousin"* (67).

### **3.1.4. Cutting to the chase**

'Cutting to the chase' was a further stand out quality of the UIs in this study. 7 therapists described their UIs as direct and challenging, with some of them using evocative terms such as 'punchy' and 'brutal'. Significantly, these 7 therapists were also the 7 participants who had described their patients as treatment resistant and/or adopting a position of victimhood.

David: *"I think it was quite simple, just do it or don't, don't kind of faff"* (197), *"it's just sort of delivered in a very punchy way"* (243). Further: *"I think it's a bit more direct...this is boom"* (247), *"it's giving an ultimatum"* (250).

Similarly, Susan stated: *"I think with him I've got quite prescriptive at times, well look, this is the way it is"* (194-195).

Melanie: *"I was quite persuasive about her getting a medical opinion"* (73).

Brian told his patient: *"I'm going to be direct with you, you don't smell"* (64). He was equally direct with the stooges in this exposure UI telling them: *"I'm going to ask you one thing, and could you please be honest for this guy's sake, I don't want any bullshit"* (88).

Joanne: *"I suppose from my perspective trying to bring reality checking into the room"* (64), *"but maybe sometimes I do it in a way that is quite challenging, maybe even a bit brutal"* (68).

Annette reflected: *"I think she needed confrontation"* (98), and *"I didn't feel she was telling me about something [depression] that I didn't know about, perhaps that gave me more of a right to be tough with her"* (268), *"it was quite attacking"* (41).

Sarah stated that when working with patients with personality disorders: *"You tell them things in quite a powerful way, that you wouldn't say with any other clients"* (53), *"sometimes you have to resolve with quite powerful techniques to actually bring some change in"* (44). In this quotation Sarah directly describes the potential need for challenging interventions with treatment resistant patients.

### **3.1.5. Unique to the patient**

6 therapists' descriptions demonstrated that their UIs were, at least to some extent, unique and tailored to their patients. This was most pronounced with David and Theresa who felt that their UIs could only have occurred with their individual patients.

Theresa reflected: *"I think it was this person, this point in time, I couldn't imagine that happening with anyone else, or certainly none of the clients I have worked with...I think it was that person at that time"* (297-299).

David also powerfully describes the micro level of 'responsivity' in his UI: *"It was idiosyncratic...it came from what I thought his interests might be"* (388-390), *"I don't think I would have tried that intervention with anybody else"* (425).

Sarah stated: *"She was a young woman...I knew this chilly 'oh my God, you're cured, that's amazing' would work for her"* (326).

In terms of being direct with patients, Brian reflected: *"I think cutting to the chase, you don't do that with everybody with every condition, with people who are depressed and not working...I mean I think there is a limit to the generalisability of these things"* (160-162).

Joanne: *"With the robust, drug taking, drinking males who aren't suicidal I'd probably be a bit more ruthless in my interventions...I wouldn't be like that with my vulnerable teenagers"* (417).

Melanie reflected: *"I think it's to do with the patient, now I'm thinking about it, when I just said to you with narcissistic, brittle, rather cut-off patients I wouldn't [have made the UI]"* (397).

### **3.1.6. Risky**

This final sub-theme related to the quality of the UIs in this study is the most prominent. In fact, all of the therapists described their UIs as risky.

#### ***On the edge***

Courtney: *"Yes, there is risk, there've been times when I've thought fucking hell"* (318), *"I'm sure there've been a couple of occasions where I thought I've pushed it too far, and wondered about it"* (431).

Annette: *"I think I was very much on the edge of going too far"* (205).

Sarah: *"It [the UI] could have gone 2 ways"* (208), *"when you try things like that you are working on a very thin line of going 2 ways"* (247).

Alexander: *"It's like abseiling or something, it's like base-jumping"* (373), *"it could be just on the borderline of good practice"* (375).

On his planned CBT UI with stooges, Brian reflected: *"Something could go wrong in the social mix of the group"* (223), *"one of the other therapists might have said the wrong thing"* (197).

#### ***Patient acting out***

3 therapists informed me how serious the consequences of UIs can be if they go wrong.

Sarah: *"She might have taken it completely the wrong way and go off, and actually threaten to kill herself"* (252).

Similarly, Joanne: *"With my more vulnerable teenagers for instance, they will go into very suicidal behaviours if you push them too far"* (395).

Susan: *"I think with him I've got quite prescriptive at times, well look, this is the way it is, and he doesn't like that and very often he'll go off and enact somewhere, he'll do something destructive towards himself"* (194-196).

### **Rupture**

A number of therapists reflected on how UIs may lead to ruptures in the therapeutic alliance.

Sarah: *"I think the main danger is to destroy the therapeutic relationship really, because sometimes it might go wrong"* (338), *"she could have become quite angry and never come back to therapy"* (250).

Brian: *"I think the risk was that he would be humiliated and say 'what's all this going on?'"* (195).

Annette: *"The danger is that you lose the patient completely"* (190).

Reflecting on her UI of giving her patient medical advice, Melanie stated: *"I suppose the problem for me is if this operation doesn't work and, y'know, it's still unsure, will it create a very difficult dynamic between us, will it destroy the therapy really?"* (273).

In this regard, 3 therapists reflected on the risk of misunderstanding between the patient and therapist.

Sarah: *"She might have taken it completely the wrong way"* (252).

David: *"It [the UI] could have been perceived as disrespectful, condescending"* (287).

On her use of self-disclosure, Courtney stated: *"At first he didn't have any frames of reference for understanding what I was doing"* (455).

### **Boundary and frame issues**

Therapists also outlined boundary and frame issues for both patient and therapist.

Theresa: *"With UIs there is a danger...I think generally, if you do unusual things it interrupts the consistency, the predictability, and I think clients need to have a sense of constancy, she [the therapist] isn't willy nilly, all over the place, today she feels like doing that, I don't think that is safe for a client"* (191-194).

Courtney: *"It was so raw [my own bereavement], but I think I allowed myself to say look, I'm taking a risk here in terms of stepping over boundaries" (308-310), "the risk is that I would cry and things would get out of control, as it becomes more of my agenda" (313).*

Alexander also reflected on the danger of UIs being for the therapist rather than the patient: *"I think the dangers of UIs are that we can justify them, I could use my kind of sense of connectedness to justify something that is not the client's experience...I'm getting the sense of connectedness, therefore the client is getting it, when they're not, actually it ends up being in my service" (379-383).*

On letting her patient stay in her house alone, Theresa stated: *"Yes, it could be shocking to a client to suddenly, maybe also feel burdened by the responsibility of guarding the therapist's house" (201-203), "did she feel I was sort of jumping out at her with some mad idea, or did she feel ambushed?" (197).*

Theresa also felt patient regression was a danger when using UIs: *"I guess in my experience it's regression...when something happens in the therapeutic relationship, or maybe the therapist intervention taps into something old, how clients can quickly go into a very young place, they can become very young, very little, very unthinking. Regression can be so powerful, and so I think UIs maybe can lead to those moments...once the client is 2, 3 years old and re-living something old there is a momentum that is then very powerful, different than having a talking therapy type session with a grown up client, so I think that could, if it isn't handled well it could be harmful" (256-263).*

### ***The teaching paradox***

Some of the therapists in this study teach and supervise trainees. The following quotations are relevant to therapists' perceptions of risk because of their reluctance to encourage UIs.

Joanne: *"I would be always urging my own trainees to stick to more straight forward interventions, because they might not, because they don't have the experience to be familiar with risk" (400-402).*

Theresa: *"[As a lecturer] I would say don't do those [UIs]" (159)*

David, a trainee, reflected: *"It's perhaps a risk on the supervisor's part to tell you their outlandish things. You might then use them and it blows up in your face" (526).*

## 3.2. Impact

- Positive impact
- Negative impact: Rupture and repair
- Mediators

'Impact' represents the first post-UI theme in this study and, naturally, is about the impact of the UI. It contains 3 sub-themes: Positive impact, Negative impact: Rupture and repair, and Mediators.

### 3.2.1. Positive impact

9 of the therapists in this study reported that their UIs had a positive therapeutic effect.

#### **Action**

5 therapists attributed their patients' positive behavioural changes to their UIs. Significantly, in 3 of these examples the patients provide direct feedback about their positive experience of the UI.

The stand out UI in terms of positive effect is that of Joanne. Remember, she had sung to her patient *"just say no"* (to drugs). Because of the nature of Joanne's service, her patient had been able to have intermittent therapy sessions. However, after her UI he did not come back for a number of years. But he then specifically returned to inform Joanne that he was clean, in a relationship, and now had a child. Joanne remembered: *"I asked how did you do that? He said 'it was what you said, the time you said about 'just say no'...'and he said 'do you remember? You said just say no (singing)'"* (197-201), *"it was really you and I wanted you to know that"* (208), *"I went away and I was really angry with you and thought you just didn't understand, and you came from a comfortable life and everything was so different for you, but it just stayed in my head, it wouldn't go away, and I started to think maybe it is that simple, maybe it's that easy"* (201). Joanne reflected: *"He'd come back in to say thanks very much that I'd helped him to change his life, and I was rather amazed by this"* (194).

David: *"He started doing things he had been putting off...interacting with people, things he'd been avoiding and not doing...he made quite a few changes and he was almost on a bit of a roll"* (204-

208). Further, *"He told me 'it [the UI] struck a chord...sometimes you hear stuff at the right time and it just seems to click'"* (200-202).

Sarah: *"She then started to engage in treatment and she did quite well [after the UI]"* (140).

After his planned CBT UI, Brian's patient stated: *"This is amazing, I've got to believe these people, particularly the women, I'm used to women, I watch them, and I was watching them and they didn't seem to flinch or do anything, it's amazing"* (106).

Annette: *"She's gone back to work...she's just passed an exam"* (80-82), *"she's undoubtedly made a lot of progress"* (90). Further, *"she said that she would never have thought she would have done as well as she has, and managed to get back to work"* (83-86).

### ***Internalising a good object***

Theresa: *"She actually said it was really important for her, she said she felt trusted and she said 'I actually slept'"* (90), *"that was after this session [the session of the UI], she said as a child she had a particular book, and there was a character in it [the fairy godmother] who could make life wonderful for children. She said 'I always dreamt of somebody actually making my life better'"* (116-119). Further, *"she writes an update every year, and she always says at the end, she refers to me as the character from the children's book"* (114-116). *"I think maybe she has internalised that she can be, she can listen to herself, so she can take care of herself, she doesn't have to drive herself relentlessly. I think she took something slightly magical away, I think she has internalised a bit of fairy godmother"* (121-124).

### ***The therapeutic relationship***

4 therapists stated that their UI strengthened the therapeutic relationship. In 2 instances this view was formed through client feedback.

Courtney, on self-disclosure: *"I think it deepened [the therapeutic relationship], the more I could connect with her on that intimate level, on that very personal level"* (141), *"that was very liberating for her and she said so several times and it did change our relationship"* (149).

Alexander: *"I think he probably did [feel connected]...the reason I think he did is because it seemed to go quite well after that [the UI], he seemed to be quite motivated and picked up"* (283), *"it felt a bit warmer"* (296).

At the end of his therapy, David's patient stated: *"It's a real shame sometimes how we meet people in life, and people you really connect with are sometimes not the ones you expect to connect with, and it's a shame you can't carry that on"* (467).

Sarah: *"It was the beginning of therapy so I think it [the UI] strengthened a little bit the therapeutic relationship at these early stages, because she learned that she needs to be honest to maintain the relationship"* (220-222).

### **Validation and acceptance**

Courtney, on her use of self-disclosure: *"She said 'that makes me feel a hell of a lot better, that you feel the same way I do, it's comforting for me to know that it's not just me'"* (146-148), *"I think it really helped boost her self-esteem and self-confidence because...it is a gradual thing of helping people to accept their own humanity, and the rightness, and themselves as they are"* (160-163), *"she felt much less terrified, more accepting of her emotions"* (60).

### **Insight**

Susan had advised her patient to seek out the support of his GP during her holiday break. She reflected that her potential enactment had enabled him to become more aware of the transference: *"In some ways it has [been a good thing]...I can kind of see it coming...so I can remind him and myself, here we are again, I'm about to leave you and you're angry with me about that...you're really feeling I won't be able to manage this and somebody with authority has to be brought in"* (172-176). *"When he's in better shape he can begin to understand that the transference is there, and that I become his mother who goes off and leaves him, or who is no good and can't do her job properly"* (179-181). Susan reflected: *"To some extent [it has been worked through], it still comes up"* (207).

### **3.2.2. Rupture and repair**

As outlined, 9 of the 10 therapists reported that their UIs had a positive impact. However, 3 of these UIs had an initial negative impact. This sub-theme charts out the process of a rupture in the therapeutic alliance following UIs, through repair to the subsequent positive effect. Melanie is the one therapist who did not report a positive UI effect. Her patient had taken her advice to seek medical opinion and, subsequently, had had surgery shortly before the interview. Melanie told me that her patient was still uncertain about how helpful her operation would be for her, and was angry as a result.

### ***Rupture: Evoking the negative transference***

When he returned to her service Joanne's patient told her: *"I went away and I was really angry with you and thought you just didn't understand [after your 'just say no' UI]"* (201). In terms of his reaction at the time, Joanne stated: *"He looked rather amazed and was rather fed up clearly, and felt that I wasn't understanding and sympathetic"* (152).

After she had told her patient *"you have a serious personality disorder"*, Annette stated: *"She was absolutely furious with me, terribly hurt"* (42), *"what was so difficult about her reaction was that I sort of lost her for quite a long time, because she was so hurt that she couldn't believe that I didn't mean to hurt her"* (174). Further, *"she berated me up hill and down dale"* (43), *"...accusing me of the cruelty"* (246), *"how terrible the label was, how destructive"* (50). *"From her point of view it was like saying you're beyond the pale"* (180).

Melanie, on advising her patient to get medical opinion: *"She's had the surgery"* (82), and *"I'm paying for it now"* (194). *"She made me feel quite bad yesterday actually, we'd had a break, she hates breaks, she isn't sure the surgery has worked, implicit criticism is look what you made me do, it's been embarrassing, it may not work... I feel just as depressed as I did before"* (87-91).

Melanie further: *"She was furious with me yesterday"* (204). *"She came actually yesterday and I think she's quite angry with me, it comes out in her saying that her mother thinks the therapy is not working, but I think it's her anger with me because I persuaded her to, I didn't persuade her but I suggested she went for opinion"* (82-85), *"I think I have evoked the negative transference by an UI"* (100).

On suggesting her patient see his GP whilst she was on holiday, Susan told me: *"[It] really mucked things up, in a way he was saying to me, well, you can't manage me, and I wondered actually if that was true...maybe I can't, or maybe I can't right now"* (137-138). Further, *"he then felt that I thought he was more ill than he thought he was"* (153-154), *"he watches me even more carefully now"* (405-406).

Finally, right at the end of her interview Melanie told me about a separate UI, which potentially had a solely negative effect: *"A patient once said what do you think of me? And I kind of more or less told her that I didn't like her, and that was awful"* (385-386), *"she walked out, I mean she walked out and never came back...I've never told anyone actually, never told anyone"* (392-393).

### ***Repair: Working through***

For Annette the rupture following her UI became a central part of the therapeutic work: *“It took us the best part of a year really to recover from this”* (42), *“it became very central”* (64), *“we’ve tried to talk and unpick why this incident, this surprising event [the UI] took place”* (107). Annette reflected: *“We’ve got into a more benign period, which I didn’t know if this was obviously ever going to happen”* (79).

Susan: *“We’ve been able to talk about that now, so that’s what I mean about bringing it [into the work]”* (166). *“In some ways it has [been a good thing]...I can kind of see it coming...so I can remind him and myself, here we are again, I’m about to leave you and you’re angry with me about that...you’re really feeling I won’t be able to manage this and somebody with authority has to be brought in”* (172-176). Susan reflected: *“To some extent [it has been worked through], it still comes up”* (207).

### ***3.2.3. Mediators***

This final sub-theme outlines the mediating factors, through which the therapists believed their UIs exerted a positive impact. A number of the outlined qualities of the UIs emerge as mediating variables in this sub-theme. Authenticity, which I have labelled ‘being real’ in this study, was the most salient, proposed mediating factor. It is noteworthy that this quality was evident in two further mediating variables, ‘taking a risk’ and ‘corrective emotional experience’.

#### ***Being ‘real’***

Annette: *“I think it was probably as effective as it was because it was spontaneous and genuine and not a kind of artificially planned thing”* (144).

Courtney reflected: *“If I am admitting my vulnerability, and showing myself and being transparent in that way, that helps them to validate their own complicated emotional responses”* (36-38).

On his planned CBT UI, Brian: *“The guy thought I was genuine, and I’d been truthful about other things”* (139). His patient confirmed this telling him *“I’ve noticed that, I thought at least the guy is being honest”* (66), and *“yes, I do believe you [that you’ll be honest]”* (77).

Susan: *“Yes, absolutely, and that’s very important [for the patient to see a human being]”* (426).

David: *"You're just being very congruent with the person, you're sharing, you're being transparent as well"* (622), *"they're [patients] not really being themselves, parts of themselves they've blocked off...if I start doing that then in a sense I'm full of shit, because I'm not actually being myself anymore either"* (680-682).

Alexander: *"It felt more human to collude with it a little bit I suppose...it felt less judgemental I guess"* (37-40).

### ***Taking a risk***

3 therapists felt it was important that they had taken a risk by making their UI, thereby modelling the risk inherent in self-expression and making behavioural changes, as well as conveying their care for the patient.

David: *"It's quite open, honest, I've probably slightly let my guard down to do that as well, there's a bit of risk in it for me"* (628). Further, *"I feel that I slightly modelled the message that I'm trying to get across to him...just do it, don't be so worried about the outcome"* (172), *"it's a bit like what I said to him, don't try, just do, and I just kind of did it"* (160).

Brian: *"It was important that I was willing to do this, he perceived this as rather extraordinary and a risk"* (304), and *"he gets the idea that I would risk something for him, doing the unusual"* (324).

Melanie: *"She can see that her therapist isn't just a kind of stereotype. I'm not going to be a stereotypical psychotherapist, I'm going to be intuitive and responsive, and take risks, that I think is of value to her"* (428).

### ***Good intentions***

2 therapists reflected on how their UIs potentially demonstrated their good intentions.

David: *"There was this thing of maybe he's trying to connect with me now, he's doing stuff I'm interested in"* (464).

Melanie: *"I think the person gets from it because, perhaps I feel that she knows that I'm really doing my best for her, at some level"* (423).

### ***Corrective emotional experience***

Theresa emphasised the opportunity her UI offered the patient for a corrective emotional experience: *"In terms of the developmentally needed relationship it was permission to look after herself... she knew she was tired and had voiced it and I thought it was important to encourage*

*her to then take that step further. You notice what you feel, you express what you feel and then you act on what you feel” (59-65).*

Further, *“to experience that 2 people can be close in a relationship and both can state their needs, and both can get what they want, so almost an experience of closeness where people can be close and yet separate” (350-352).*

Melanie: *“I think what my relationship with her demonstrates, I hope, is that I’m not concerned with how I appear, I will do things because I believe they are right and I don’t feel that I need to stick to, so her mother has always kind of hidden the father’s very disturbed nature, I don’t hide behind a theoretical stance, I don’t hide behind a particular persona, I try to be as real as I can be” (445-449), and “I think that’s what she gets, that’s very different from this internal object relationship with these parents who are not genuine, they are both extremely flakey” (457-458).*

Courtney: *“There was a real relationship between me disclosing, just not standing on the fence, me saying ‘look, I’ve felt mad too’...” (63-64), “her mother is someone who represses her feelings...so I was the sort of mother who could say, look, it’s alright, let’s go with it” (68-70).*

### ***Facilitating patient anger***

4 therapists’ UIs initially had a negative impact. 2 of them reflected on the opportunity this provided for the patient to be angry with them.

Annette: *“She was able to get really angry with me, she was able to tell me what a rubbish therapist I was and how she would never be so cruel” (100), “I think it maybe got her more in contact with this angrier part of herself, she was also furious with her parents” (102). “I think she is recognising herself as a more angry and aggressive person, and therefore a less passive victim, and therefore more able to change things” (111-113).*

Similarly, Melanie: *“I think the impact is that she’s clearly angry with the therapeutic work, I do think that is part of her fury with her internal objects, so I think in a way the impact of this intervention is to draw that out, so that’s not a bad thing” (200-202).*

### ***Therapist ‘survival’***

Building on the previous mediating variable of evoking patient anger through an UI, Annette reflected that her patient was able to experience her rage being survived: *“I was able to tolerate her attack, and I think she is very grateful to me for that” (251), “she has discovered that there is an object out there, in this case me, who can tolerate bearing the brunt of her fury without*

*crumbling, so perhaps that has helped her to feel less destructive about herself or something, I don't know..." (254-256).*

### ***Standing up to the patient***

Annette further hypothesised: *"I think it worked because it forced her to face the fact that she couldn't bully me, and that she couldn't get me to agree with her version of events" (244), "I had the freedom to think for myself about what was going on in the room, that's actually in the end freed her up from having to just go on being like this for the rest of her life. She was well set on a course of 'I'm too depressed to work'" (135), "I think she needed confrontation" (98).*

### ***A Shock***

Data from 5 interviews suggested that UIs may provide a type of 'shock', which functions as a mediating variable, precipitating change.

For example, Joanne stated: *"Maybe, suddenly it made him sit up and think differently about his situation, that instead of being stuck in the self-pity where he'd definitely been before, constantly ruminating, ruminating, ruminating about his situation, this provided a kick or sharp change that made him think, well maybe it doesn't have to be like this" (220-223), "yes, a CPR kind of thing" (225).*

David used the term 'ice-breaker': *"Maybe in some ways it was a bit of an ice-breaker as well, because before, when we were talking about motivation it may have been a bit more serious...he seemed to find it [the UI] quite humorous" (314-316).*

Sarah reflected: *"Yes, of course, it's something you don't expect from your therapist, because they come in and expect this caring, listening person, understanding..." (39-40), "it was quite shocking for her to hear that [her sarcastic 'you're cured' UI], surprising" (152).*

Annette described a *"sort of intended attempt to change the framework" (134), and Brian told me about his "intention to give this man [his patient] overwhelming evidence that would counter his delusion" (120).*

### ***Giving the patient responsibility***

Joanne also emphasised her 'rejecting responsibility' and dispelling unrealistic expectations her patients may have of her: *"I wanted them to see that I don't know all the answers, I'm not sitting there as a great guru...I often say to people, look, I'm like maybe the swimming instructor, you're in the pool, you're the one doing all the hard work" (279-282), "ultimately, if you give up drugs, or*

*if you take drugs, it's for you, not me, so don't use me as a teacher, mother, whatever, because I'm not really that interested"* (371).

Further, *"...him realising that I was fed up too because I didn't know what to do, I don't have the answers"* (288), *"maybe he saw at that point that I was slightly giving up on him and his drug stories, and so as I gave up he had to take responsibility"* (228).

### 3.3. The Unusual Intervention (UI) – reflections

Table 6: Important phenomenological qualities of the UIs, impact, and instances of unconscious decision-making processes from category 2.

| <i>Ps</i> | The UI: Quality |                  |                    |                  | The UI: Impact         |                        |                               | <i>Unconscious decision-making processes</i> |
|-----------|-----------------|------------------|--------------------|------------------|------------------------|------------------------|-------------------------------|----------------------------------------------|
|           | <i>Risky</i>    | <i>Automatic</i> | <i>Challenging</i> | <i>Authentic</i> | <i>Positive impact</i> | <i>Negative impact</i> | <i>Mediator: Authenticity</i> |                                              |
| David     | ✓               | ✓                | ✓                  | ✓                | ✓                      |                        | ✓                             | ✓                                            |
| Alexander | ✓               | ✓                |                    | ✓                | ✓                      |                        | ✓                             | ✓                                            |
| Sarah     | ✓               | ✓                | ✓                  |                  | ✓                      |                        |                               | ✓                                            |
| Theresa   | ✓               | ✓                |                    |                  | ✓                      |                        |                               | ✓                                            |
| Joanne    | ✓               | ✓                | ✓                  | ✓                | ✓                      | ✓                      |                               | ✓                                            |
| Annette   | ✓               | ✓                | ✓                  | ✓                | ✓                      | ✓                      | ✓                             | ✓                                            |
| Melanie   | ✓               | ✓                | ✓                  |                  |                        | ✓                      | ✓                             | ✓                                            |
| Brian     | ✓               |                  | ✓                  |                  | ✓                      |                        | ✓                             |                                              |
| Susan     | ✓               |                  | ✓                  |                  | ✓                      | ✓                      | ✓                             |                                              |
| Courtney  | ✓               |                  |                    | ✓                | ✓                      |                        | ✓                             |                                              |

'Automaticity' emerged as a stand out quality of the UIs in this study. 7 therapists described their UIs in terms consistent with unconscious, automatic processes, e.g., 'out of the blue', 'on the spur of the moment'. These 7 therapists also emphasised unconscious decision-making processes in the preceding section, as demonstrated in the final column of Table 6. Contrarily, the 3 therapists who only described conscious decision-making processes did not report 'automaticity' in terms of the quality of their UIs. As stated in the previous section, Brian may be distinguished from all the other participants in that his UI was planned. Similarly, Courtney's UI is different because, although she perceived her self-disclosure as unusual, she had integrated this form of intervention into her practice as standard technique. But what about Susan, whose intervention was both unplanned and unusual for her individual practice? Significantly, in this section she reflected that she may have become embroiled in a transference enactment, occupying the role of the

significant (m)other who could not handle her patient's distress and needed support (from the GP). This will be taken up further in the following section where other therapists also question whether their UI potentially represented therapeutic error.

7 therapists described their UIs as direct and challenging. As previously outlined, all of these therapists had also described their patients as treatment resistant and/or identified with a sense of victimhood. Thus, challenging interventions were made with challenging, treatment resistant patients in this study.

Authenticity emerged as an important quality of UIs. 5 therapists described their UIs as instances of 'being real'. Further, 7 therapists hypothesised that authenticity was potentially a mediator of positive UI effects, for example as an inherent quality of taking a risk as a therapist. Taken together, 8 therapists highlighted the importance of authenticity in UIs. 6 therapists perceived their UIs as unique to their individual patient. All of the therapists described their UIs as 'risky'.

9 of the 10 therapists stated that their UIs had a positive therapeutic effect, although the initial impact was negative in 3 instances, facilitating processes such as 'working through' and the 'expression of anger'. Melanie only reported a negative effect. Her patient was still angry about her UI, following an operation after she had taken Melanie's advice to seek medical counsel.

Before moving on I would like to highlight the paradox presented in the previous section, namely that 3 therapists described both conscious and unconscious decision-making processes in their UIs. This paradox is further underlined by the fact these therapists reported that their UIs were of the 'automatic', unconscious nature in this section. As previously outlined, I believe this captures a potential ambiguous quality regarding the level of consciousness/unconsciousness in UI related processes. Sarah reflected on this paradox eloquently: *"That's a very fine-tuning of therapy that you are investigating, and it does have a mysterious quality. Sometimes it [the UI] happens by accident, sometimes it's planned, sometimes it's somewhere in between so you can't really tell in a way"* (352-354). Further, these apparent contradictions may also point towards therapist self-conflict about the use of spontaneous, unplanned UIs. This will be taken up in the next category.

## 4. Self-Conflict: UI Propriety Continuum

This final category outlines the conflict that is engendered in therapists as a result of their UIs. At the core of this self-conflict is the question whether the UI was the right or wrong thing to do, and whether it represented therapeutic error or good practice. It is for this reason that I have labelled this theme 'Self-Conflict: UI Propriety Continuum'. Like the conscious to unconscious decision-making continuum this theme is also imbued with ambiguity and uncertainty, in this instance around the correctness of the UI. 8 of the 10 therapists contributed quotations to this theme.

### 4.1. Self-conflict: UI Propriety Continuum

- Initial UI anxiety
- Breaking the law
- 'Was it a mistake?'
- Holding the tension
- Learning process

#### 4.1.1. Initial UI anxiety

This sub-theme captures an anxiety around the topic of UIs for the therapists. It was the first manifestation of self-conflict in my interviews, and occurred before discussing the therapists' UIs.

#### **Resistance**

Despite having agreed to meet with me to discuss UIs a number of therapists demonstrated an initial resistance to the topic.

In the first 20 minutes of my interview with Sarah she told me about a planned UI, which had been agreed in supervision. I then enquired whether she had experiences of UIs that were not planned. Sarah, tentatively: *"Let me think, I'm not sure you'd consider that an intervention, but it comes down under the language that you use with the client in the room and what you say to them and how you verbalise, would that be considered an UI?"* (135-137), and then *"ok, yes I guess it would be [considered unusual]"* (140).

I felt that Sarah was initially testing the waters, discerning whether she was comfortable to talk about an unplanned UI with me.

In the first 15 minutes of her interview Melanie talked about a range of unusual aspects of her work with her patient, rather than an UI. She stated: *"It's more, in both cases [2 patients], it's more I tend to do things out of the ordinary with them, and so there isn't particularly one intervention, maybe, I haven't really thought about it a lot, but I have thought about it, ok"* (13-15).

Similarly, in the first 20 minutes of my interview with Susan she gave examples of unusual external events impinging on the therapy: *"They're more interruptions, doorbells going, which I wouldn't normally answer but now and again there's someone who is very insistent"* (64). A psychodynamic perspective may hypothesise that I was the current interruption, the doorbell she wouldn't normally answer, lest for its insistence.

Theresa immediately expressed that the audio recording be kept securely. Joanne partly constructed her agreeing to see me as a favour. Annette also agreed to meet with me as a favour. Further, when we met she asked to keep the interview to 30 minutes duration.

### ***Subjectivity***

2 therapists highlighted the subjective nature of UIs before telling me about their own interventions. I felt that this was potentially a defensive move, pre-empting negative judgement. The question of propriety emerges for the first time in the following quotations.

Melanie: *"There is a lot of debate that I have with colleagues about things like email contact with patients...a lot of people in the analytic world are still very resistant to the modern, patients text me for example, they also email me, but a lot of my colleagues don't think that is right"* (5-10).

Theresa: *"Something that might be unusual for a psychodynamic psychotherapist might not be unusual for a person-centred therapist"* (4).

### ***Initial reactions***

Some of the therapists' initial reactions to the descriptor UI were negative ones. The question of propriety is again evident in the following quotations.

Sarah: *"My first response was I don't do any unusual interventions, I do everything fine, and then you start thinking actually I do, I have done unusual stuff in therapy"* (4-6).

Alexander: *"I think of something extraordinary...I think breaking the rules slightly...maybe something that you wouldn't feel quite, feel a bit uncomfortable about...something that could be a mistake and raise a few eyebrows"* (365-369).

David: *"Probably when I read the email...I suppose I thought of things that might be considered a bit on the edge, maybe some people might think they're a bit inappropriate, not textbook, it's a bit risky"* (2-5).

#### **4.1.2. Breaking the law**

This sub-theme relates to conflict precipitated by the question of propriety in relation to various forms of internalised 'laws', including models of psychotherapy, training institutions, supervisors and ideas of what constitutes good practice. Evocative language in the following quotations powerfully highlights the capacity for UIs to engender self-conflict, e.g., "absolutely 'verboden'", "shot down in fire" and "in a confessional".

##### **Model and training conflict**

Sarah reflected: *"Especially in CBT...especially in primary care, you follow protocols and you think 'oh gosh', unusual means in your mind that you are deviating from the protocol. I'm not a very protocolised therapist myself, but you want to think that actually everything you are doing is according to the CBT principles"* (9-12).

Similarly, Melanie: *"The purists would say 'absolutely verboden'"* (181), *"if I was still a trainee at my training institute I would be, y'know, shot down in fire"* (186). Further: *"I think it is to do with one's relationship to one's therapeutic super ego, I see people now, because I train psychotherapists, who are very frightened to be themselves at the same time as being a therapist"* (466-468).

Joanne told me: *"I'm sure I wouldn't have done it [the UI] if it was a taped session"* (475).

##### **Supervision conflict**

Theresa was concerned about her supervisor's reaction to her UI: *"I think it [feeling anxious] probably started the day after...really as I was starting to think about supervision...fretting, will I be told off?"* (175). Further: *"I have a supervisor I can take anything to, I've also had supervisors where I probably wouldn't have taken it"* (182).

Significantly, supervisory conflict may be problematic if the therapist feels unable to discuss UIs. Both Melanie and Susan reflected on the importance of supervision to explore the potential role of the transference in their UIs. Susan: *"Not that the person [supervisor] is telling you off...it's more well ok, you did this but why...I believe the only thing you can do is come back to the position of where I'm sitting and analyse it again"* (197-202), *"...whether it's an enactment for example, whether there's something else going on or whether it was actually the right thing to do in the circumstances"* (4), *"supervision is of course essential to be able to have that other space to really talk about it [the transference]"* (181-182).

### ***'Good practice' conflict***

Reflecting on her 'you've got a serious personality disorder' UI, Annette stated: *"I think it had the kind of validity of being genuine, but on the other hand I feel like I'm in a confessional here, it's not how we're trained to behave is it"* (149-151).

David questioned his UI: *"I'm imitating a 2 foot green puppet, I was like: 'this is therapy?'"* (275). Further: *"There's probably a part of me that enjoyed the risk actually, woh-ho, I'm on the edge now, this could blow up, and probably going that's kind of fun, but thinking maybe that's not an appropriate buzz to be having in a therapy session"* (803-805), *"maybe that's the bit I was reluctant to reveal, maybe I shouldn't be getting a kick out of therapy...it's all about the client remember"* (809-812).

Similarly, Alexander: *"I was enjoying it with him in that moment, and I suppose almost like a guilty pleasure, almost like oh fuck, I shouldn't really be enjoying this shit, this guy's talking serious shit"* (51-53).

Joanne foregrounds a potential valorisation of 'being thought through' in the field: *"I wish I could say oh yeah I'd really thought it through, but it wasn't thought through at all"* (296).

Similarly, Sarah and Joanne's following quotations point towards a potential association between good practice and being 'empathic'.

Joanne: *"It would stand out in that it [the UI] would be perceived as quite rude and not very empathic"* (58). Sarah: *"Of course it's something you don't expect from your therapist because they come in and expect this caring, listening person, understanding..."* (39).

#### 4.1.3. 'Was it a mistake?'

Therapeutic self-conflict in relation to the 'UI propriety continuum' is best captured by the inevitable question: "Was my UI a mistake or not?" This sub-theme powerfully underlines the uncertainty and ambiguity surrounding this question for the therapists. The danger of UIs being more for the therapist than the patient, and representing enactment or collusion, is highlighted in this sub-theme.

Melanie powerfully demonstrates her uncertainty in the following sequence of quotations: *"Do I regret it? I guess that's the question really?"* (92). *"I think I have evoked the negative transference by an UI, I think on balance it's better to be like that than too slow..."* (100-101). *"I still don't know [if it was the right thing to do], I still feel unsure about that, hmmm, yeah (3 second pause), I do still feel unsure"* (148-149). *"I was frustrated with her so I do think it was an enactment, yes."* (225). However, in the final analysis she concluded: *"I don't regret it really"* (349), *"...on balance I think it was the right thing"* (381).

Similarly, Alexander sequentially reflected: *"I don't know, it's questionable, like is it my needs or something to feel that kind of buddiness with some clients on some level?"* (115). *"For me actually reflecting on it, I'd rather have had that moment and then said what I said afterwards than not have it at all, and just said I see that you're smiling about your drug taking"* (131-133), *"when I was thinking for you [pre-interview], I was thinking like that was more of a mistake and now I'm thinking maybe actually it wasn't really a mistake"* (184-186), *"if there's some tiny little moment of spark of connection I don't think that can be a bad thing"* (218).

Annette's following quotations are also rife with uncertainty: *"I got more and more frustrated and I think one day I sort of cracked and made the UI...I suppose you call it acting in, in a way"* (38), *"I'm sure it was undesirable in all sorts of ways...except, you see that she was able to get really, really angry with me"* (99-100). Further, *"I'm not sure, even now I think I regret it"* (144). *"I think it really was a mistake, but it's a mistake that seems to have had quite a good result, oddly enough...luckily enough"* (186-188). Annette reflected: *"Yes, [she made] huge changes, and of course the question that is pertinent to your research is: If I hadn't made the mistake..."* (94-95).

Similarly, Susan: *"I was handing him over in a way that perhaps wasn't absolutely necessary, but because I was under pressure, and maybe, in hindsight again, maybe it wasn't such a bad thing that he saw that, although he watches me even more carefully now, there's no answer to it"* (403-406).

Annette and Susan's aforementioned quotations highlight a potential conflict which may arise when what is perceived as a 'mistake' has a positive therapeutic effect.

Finally, Joanne: *"It [the UI] did help me to see that something extraordinary can come out of something quite sharp and rather brutal"* (227-228), *"I think we all do things that we might not like if they were exposed to outside authorities, but that doesn't mean to say that those interventions aren't useful or valid (pause accompanied with a marked sigh), I don't know what the answer is"* (479-481).

#### **4.1.4. Holding the tension**

This final sub-theme is about therapists' final reflections on UIs, which, I propose, represent a form of resolution in relation to the 'UI Propriety Continuum'. The data suggests this may be achieved through a commitment to authentic self-expression as a therapist, a willingness to take risks, embracing uncertainty, and holding mistakes lightly in the belief that therapeutic error can benefit the process.

Melanie: *"I think in this case, being confident in oneself but at the same time constantly challenging oneself, that paradox is there the whole time, you've got to say to yourself: Did I do the right thing there? At the same time you've got to, in the therapeutic hour, have confidence to be yourself, to take risks, and not constantly hide behind what you think you should be"* (470-475).

Theresa: *"So of course, it [the UI] could be arising from the therapist's need to do something glam or show off, or to be charismatic and so on, and I guess it's possible, I mean I don't think we are necessarily all 100 percent pure in our interventions"* (207-210).

Alexander: *"I don't think I have to maybe be so controlled, that I have to get it right all the time, and that it doesn't really, maybe they can be quite valuable those times when you do sort of make a mistake"* (139-141). Further, Alexander questioned: *"Do I really have to grade it as a mistake or good intervention, do I have to do that, or can I just fit it into, like well, this is what happens in therapy and you can still think about it psychologically?"* (328-330), *"what I mean is I don't mind making mistakes like that as long as I think about it afterwards"* (130).

David: *"How are we going to know if we never give it a go?"* (569), *"...is that maybe the attitude you take? You give it a go and if it doesn't work that's just, y'know, part of it"* (700-701). David reflected he had learned: *"You can take a chance, especially if you're stuck...you can just go for it, trusting your instincts"* (633-635).

#### 4.2. Self-Conflict: UI Propriety Continuum – reflections

Table 7 demonstrates that 8 of the 10 therapists described feeling conflicted in relation to the propriety of their UI, with contributions to at least 2 of the 3 sub-themes.

Table 7: Self-Conflict: UI Propriety Continuum

|                  | <b>Self-conflict: UI Propriety Continuum</b> |                                |                                 |
|------------------|----------------------------------------------|--------------------------------|---------------------------------|
| <b><i>Ps</i></b> | <b><i>Initial UI anxiety</i></b>             | <b><i>Breaking the law</i></b> | <b><i>Was it a mistake?</i></b> |
| David            | ✓                                            | ✓                              |                                 |
| Alexander        | ✓                                            | ✓                              | ✓                               |
| Sarah            | ✓                                            | ✓                              |                                 |
| Theresa          | ✓                                            | ✓                              |                                 |
| Joanne           | ✓                                            | ✓                              | ✓                               |
| Annette          | ✓                                            | ✓                              | ✓                               |
| Melanie          | ✓                                            | ✓                              | ✓                               |
| Brian            |                                              |                                |                                 |
| Susan            | ✓                                            |                                | ✓                               |
| Courtney         |                                              |                                |                                 |

It is once again stand out that Brian and Courtney did not make any contributions to the final category. This further highlights a clear distinction between unplanned interventions that are unusual in terms of the therapist's practice on the one hand, and both planned UIs (Brian) and UIs that, although potentially unusual, constitute standard, individual practice for the therapist (Courtney) on the other.

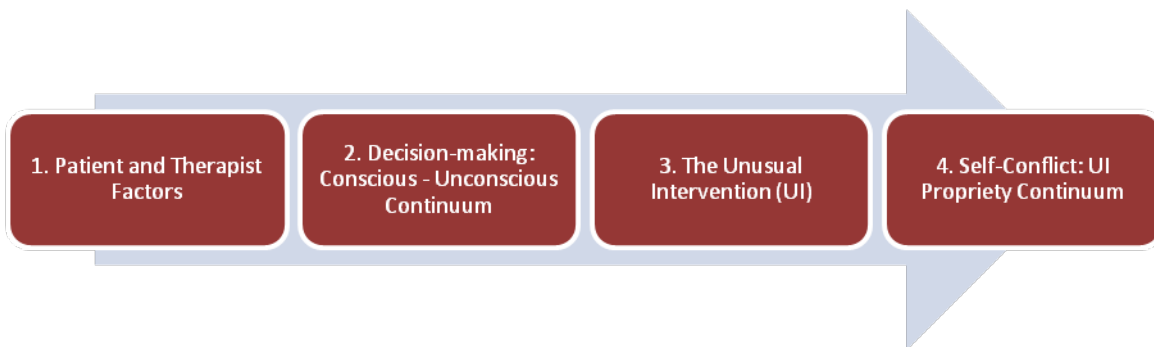
It is noteworthy that, although 7 participants described feeling conflicted, only the 2 trainees related conflict to their enjoyment/excitement. Significantly, in category 2, Theresa suggested that excitement was a cautionary emotion for her when using UIs. In this regard Sarah also told me: "*I did that [the UI] at a stage of my career where I knew why I was doing it, there wasn't much excitement coming out of it*" (97). Questions pertaining to therapist excitement in UIs will be taken up in the discussion section.

Finally, the data suggests that 'UI propriety conflict' may be mitigated by the therapist's commitment to authentic self-expression, a willingness to take risks, embracing uncertainty, and holding mistakes lightly in the belief that therapeutic error can benefit the process.

## Chapter 4: Discussion – The Grounded Theory

In this study I have generated a Grounded Theory (GT) of UIs, comprised of 21 proposals, derived from the 4 core, sequential categories outlined in the results section.

Figure 2: The 4 core, sequential categories.



I interviewed 10 clinicians who, taken together, represented a wide range of approaches to counselling and psychotherapy. They included counselling and clinical psychologists who, individually, specialised in person-centred, CBT, and integrative approaches. Further, I met with a CBT and person-centred practitioner, as well as 3 psychoanalytic psychotherapists. 2 of the counselling psychologists were trainees. The remaining 8 participants all had a minimum of 10 years post qualification clinical experience.

The discussion section of this study is structured around the 21 proposals. I explicate guidelines for clinical practice and ideas for future research throughout. I then present my concluding thoughts, followed by limitations of the present study and final points on reflexivity.

**Proposal 1: ‘There are 2 forms of UIs: Partial UIs and Full UIs’.**

*The primary type of UI, described by 8 of the 10 therapists, was unplanned and unusual in the context of the clinician’s individual practice. I have labelled it a Full UI. 2 further types of UI were outlined by 2 therapists respectively, and I have labelled them both as Partial UIs. The first (Brian) is a planned intervention, which is also unusual for the clinician’s individual practice. The second (Courtney) is an unplanned intervention, which, although perceived as unusual practice in general by the clinician, has been integrated into her individual practice as standard (usual) technique.*

The present distinction between Full and Partial UIs is largely consistent with the divergences found in Akhtar’s (2011) text, namely between planned and unplanned UIs. In this study the Partial UI label captures a greater complexity with the inclusion of Courtney’s UI, which, as stated, was unplanned but formed an aspect of her ‘usual’ practice.

**Proposal 2: UIs are more likely to occur with ‘challenging’ patients.**

*In the present study all UIs occurred with challenging patients, in terms of their presenting problems (e.g., a personality disorder diagnosis, childhood sexual abuse, history of substance abuse) and/or in terms of resistance to treatment.*

This trend can also be discerned in the limited clinical examples from the available literature. For example, Smolar (2011) reflected that most of her UIs seemed to occur with patients who had experienced significant childhood neglect. Ringstrom’s (2001) UIs were with a borderline patient. Frame deviation is a central characteristic of both UIs (Akhtar, 2011) and enactments (Bohleber et al., 2013). In light of this linkage it is important to note that the more unconscious a patient is of aspects of herself, the more likely it is that these will be projected into the therapist. Significantly, Clarkin, Yeomans and Kernberg (1999) stated that patients with a diagnosis of borderline personality disorder (BPD) are more likely to evoke enactments because of their predominant use of primitive defence mechanisms, e.g., splitting and projective identification.

***Clinical guideline 1***

UIs may occur more readily with patients with ‘challenging’ presentations.

**Proposal 3: A Full UI occurs in the context of the therapist feeling challenged in the work and/or identificatory processes.**

*6 of the therapists reported feeling stuck with, and/or under attack by their patients. 5 therapists thereof further stated they were frustrated, and 4 also felt threatened in terms of their identity as a therapist. 2 of the therapists did not feel challenged at all, but reported that they identified with aspects of their patient's experience related to their UIs.*

This third proposal shifts focus to the role of patient resistance to treatment in the occurrence of Full UIs. Therapists who felt 'stuck' in the work also described their patients as treatment resistant. The links in the present study between the 'challenging patient' and 'challenged therapist' are consistent with Bell's (2000) assertion that patients incur the therapist's greatest vulnerability when they thwart her reparative wishes.

In this regard, Joanne asserted: *"I have a huge desire to fix"* (304) and that *"I was up against the wall (160)...nothing was working"* (184).

Significantly, in terms of frustration, Reich (1951) noted that intense emotions may signify unconscious, therapist counter-transference reactions. Annette stated: *"I got more and more frustrated and I think one day I sort of cracked..."* (38). Thus, once again, the convergence between qualities of UIs and enactment/therapeutic 'error' is apparent.

The psychological theories of self (e.g., Rogers, 1961) presented in the introduction section highlighted the universal human need for positive regard and validation of the self. The data in the present study demonstrates that therapists' sense of individual worth may be closely linked to their ability to help the patient 'get better'. A picture emerged of therapists who were emotionally invested in positive therapeutic outcomes, affected by patients in a human relationship, rather than neutral or objective dispensers of model specific techniques. UIs were used to break through patient resistance to treatment. This is consistent with Deci and Ryan's (2000) proposal that, when necessary, individuals experiment with new pathways to achieve their goals in order to maintain a positive sense of self.

***Clinical guideline 2***

UIs may occur more readily when therapists feel frustrated by a lack of progress in the work.

As stated, 2 of the therapists who used Full UIs did not feel stuck or frustrated. However, they were 2 of the 6 therapists to report the presence of identificatory processes. This therapist factor subtheme included identification and non/anti-identification with the patient. The former denotes

aspects of the patient that the therapist could readily recognise in him-self, and which also felt pertinent to his own life. The latter is the reverse, i.e., aspects of the patient that felt alien to the therapist. For example, Annette stated vehemently that she could not identify with her patient's perverse attachment to being depressed. In this context, Reich (1951) proposed that 'counter-transference in the proper sense' is acute, and arises suddenly with certain patients because of their personality or presented material. Reich provides an example of a trainee who realised that he felt threatened by his patient's homosexuality, because of his own latent homosexuality. Similarly, in the present study, David, who urged his patient to 'just do it', stated that he could not allow himself to 'amble along' and not engage wholeheartedly. Again, a close link between UIs and transference enactment is evident. The paradox is that David's UI helped his patient to make significant changes in his therapy, although it was potentially a counter-transference response, derived from his own latent, negative judgement of not committing fully to endeavours.

Theresa felt that her UI provided trust, which she felt was important for her patient. In interview she made the link to her own, historical struggles with trust, which she had not thought of until then. I believe it is important to note that Theresa felt calm and "*grounded within herself*" (239) during her UI, and did not experience self-conflict until the following day when she began to prepare for supervision. This is particularly noteworthy, given just how unusual her intervention was (allowing her patient to have a rest in her home, post session, and going out during this period). As outlined, Bell (2000) proposed that therapists' unconscious desire to self-heal in the work may lead to negative psychological consequences in the face of treatment resistant patients. Theresa's experience demonstrates that therapists may feel particularly 'good' when they vicariously experience the fulfilment of their own needs through patients.

### ***Clinical guideline 3***

UIs may occur as a result of identificatory processes, both positive and negative. Thus, therapists should explore both positive and negative feelings that emerge when making UIs. This guideline resonates with Welling's (2005) intuition model, in which it is stated that intuition, with a concomitant sense of correctness ('feeling right'), is fallible.

### **Future research**

Literature about the 'wounded healer', e.g., Kirmayer (2003), explores the role of therapist identification with patient wounds in psychotherapy. I feel that a broader study of identificatory phenomena would be fascinating and informative. For example, how may our individual experiences and challenges predispose us to work with certain patient groups, or to produce

better work with certain patients? Are both our strengths and weaknesses inextricably linked to identificatory processes? In my counselling psychology training we had a group discussion about the most important drivers of positive change in psychotherapy. As might have been expected, different students emphasised different aspects of the work. Significantly, during further discussions with 3 of my peers, it emerged that what we felt was most important for our patients were the things we struggled with the most in our own lives. A year later I was particularly interested in what determined our favourite moments in the work, those moments that really stood out and that we most enjoyed. Again, these discussions also implicated our own 'challenges'.

**Proposal 4: Partial UIs occur in the 'absence' of identificatory processes or the therapist feeling challenged.**

*The 2 therapists who made Partial UIs in this study did not report potential, unconscious identificatory processes or feeling challenged.*

Proposal 4 represents a tentative hypothesis. It is important to note that I am referring to a relative absence of the aforementioned processes in Partial UIs. So, for example, Brian and Courtney did not state that they felt challenged in the work, although they described their patients as challenging. Further, although Courtney did not believe that identificatory processes were implicated in her UI, she had previously struggled to cope with the death of a parent, like her patient in the present.

**Proposal 5: Rebellious, risk-taking therapists may be more likely to make UIs.**

*6 of the 10 therapists in the present study described themselves as rebellious and/or having a greater propensity to take risks.*

This is potentially unsurprising given that all of the participants in this study described their UIs as 'risky' interventions. There is a large body of research, which demonstrates that individual difference variables are implied in risk-taking behaviour. For example, most adolescents take risks (Steinberg, 2004). However, those with impulsive-aggressive personality styles are more likely to do this to a higher degree (Romer, 2010). Guenther, Brust, Dersen and Trillmich (2013) outlined that personality traits such as boldness and exploration, which are related to risk-taking, are

commonly associated with risk-reward trade-offs. For example, bolder individuals may acquire greater resources in the short-term, but have decreased longevity.

### **Future research**

Future studies may explore the role of individual difference variables in psychotherapists. For example, research in this area may inform therapists about their strengths and weaknesses related to their willingness to take risks. I would also be interested to ascertain whether certain 'types' of therapists have a proclivity to work with certain patient groups and therapy models?

### ***Clinical guideline 4***

Therapists should reflect on their propensity to take risks as this individual difference variable may be implicated in the occurrence of UIs.

### **Proposal 6: Therapeutic intentionality/rationale and prior knowledge inform the decision-making process in UIs.**

*In this study therapeutic intentionality/rationale and prior knowledge emerged as the 2 main sources of information to inform decision-making processes in UIs.*

All the therapists in this study stated that their UIs were imbued with therapeutic intent. Various forms of intention emerged including the provision of a corrective emotional experience, modelling and building ego-strength. It is potentially unsurprising that 'breaking through resistance' represented the most frequent intention (4 therapists), given that 6 patients were described as resistant to treatment. UIs in the present study, which represented powerful attempts to break through the patient's resistance to treatment again foreground the close relationship between UIs and potential enactment/therapeutic 'error'. Consider McLaughlin's (1991) proposal that "*enactment is an act intended to strongly influence, persuade, or force another to react*" (p. 595).

### **Future research**

From a classical psychoanalytic perspective analysts are urged to maintain neutrality and not be moved by their patients (Reich, 1951). Does the present study suggest that analytic practitioners may be increasingly eschewing the endeavour to be impersonal, without anxiety or anger, embracing the notion that both participants' psychological structures are under pressure in the therapeutic relationship (Racker, 1957)? This would represent a shift to a relational psychoanalytic

stance, which views enactment as an inevitable facet of the therapeutic process which may benefit the treatment (e.g., Bohleber et al., 2013). Future research on UIs within the psychoanalytic community may address this question.

All of the therapists also stated that prior knowledge influenced the UI decision-making process. Level of experience emerged as an important facet of prior knowledge. In turn, self-trust, which subsumed confidence and trust in intuition and feeling, emerged as the most salient aspect of experience level, noted by 8 of the 10 practitioners. 2 therapists emphasised the importance of extensive personal therapy to increase self-awareness and, thereby, to facilitate self-trust.

Annette reflected: *"If you have had a lot of analysis yourself and you know about your own capacity for cruelty or sadism, then hopefully something you do spontaneously isn't going to go beyond some kind of...it's not going to come out of some part of yourself that you're not aware of"* (198-204). This is consistent with Rea's (2001) clinical guideline to increase self-understanding (of strengths, weaknesses, tendencies, vulnerabilities), to safeguard against the danger of intuition being contaminated by personal biases. In this regard, Winnicott (1954) proposed that *"...the answer to many obscure problems of psycho-analytic practice lies in further analysis of the analyst."* (p. 196).

### **Future research**

This emergent emphasis on the importance of self-knowledge in UIs is pertinent for the fields of counselling and clinical psychology. Personal therapy is not mandated on a large number of clinical psychology programmes. The course requirement for personal therapy on my counselling psychology training programme was 40 sessions, which pales in comparison to the volume on a psychoanalytic training. I believe that future research should contribute to an ongoing debate about personal therapy in the fields of counselling and clinical psychology.

Clinicians also linked self-trust with the duration of their clinical experience, noting they wouldn't have made their UIs at earlier stages of their careers. The question emerges here of how much clinical experience is enough experience? David, a second year counselling psychology trainee felt he could trust himself to be spontaneous at this point in his development. In this regard, 2 experienced clinicians stated that a lack of excitement left them feeling secure in the propriety of their UIs. I noted in the results section that, contrarily, the 2 trainees had felt excited. But we should question a potential preoccupation with excitement. Remember, Theresa felt calm when making her UI. However, she recognised, in interview, the potential presence of unconscious, identificatory processes with her patient around 'trust'. I argued that her feeling of peace may

have resulted from this identification. As stated, even a feeling of correctness does not mean an intuitive intervention is appropriate (Welling, 2005). It is for this reason that clinical guideline 3 highlights the importance of exploring all feelings associated with the use of UIs.

### **Future research**

Nevertheless, I believe the fact that both trainees felt excited and the experienced clinicians didn't (or at least didn't report it) warrants attention, and could be explored in more detail in future research.

### ***Clinical guideline 5***

Clinicians with less experience should look out for, and reflect on feelings of 'excitement' when using UIs.

This fifth clinical guideline is tentative and, as stated, this concern needs more detailed focus. For example, it is potentially the novelty of stepping outside of prescribed technique for the first time that evokes excitement. Further, in spontaneous UIs the data suggests that the presence of excitement is recognised post hoc, and is evoked as a result of making the UI, rather than preceding it. Significantly, the presence of excitement did not result in negative UI effects, and the trainees' reports were otherwise indistinguishable (in general terms) from those of the highly experienced practitioners. Further, the experienced clinicians learned from their experiences of making UIs at early stages of their careers. In turn, this learning informed their later UIs described in this study.

Another key aspect of prior knowledge is knowledge of the patient, which 7 therapists highlighted. The data suggests it is vital for clinicians to 'know their patients' when using UIs. The question here is: Will this UI work with this patient? For example, Sarah felt that her sarcastic proposal that her young patient was cured may have been considered rude by an older adult. 3 therapists stated that a sensitivity to the therapeutic relationship is also important. In this regard, Melanie reflected: *"I don't think I would have done that [the UI] if I felt the therapeutic relationship was fragile in any way"* (424). This emergent emphasis on knowing the patient is consistent with Ringstrom's (2001) reflection that his UIs would probably not have occurred with a new patient.

### ***Clinical guideline 6***

The use of UIs should be informed by the clinician's knowledge of the patient and the strength of the therapeutic relationship. This is consistent with Bonitz's (2008) clinical guidelines for the use

of touch in psychotherapy. She emphasised the importance of a strong therapeutic alliance and an appraisal of client characteristics (e.g., sexual abuse history) to ascertain if they would benefit from being touched. A paradox here is that UIs may strengthen the therapeutic relationship. However, the relationship may have to be strong enough in the first instance for any potential benefit to take hold.

**Proposal 7: In Full UIs the decision-making process is largely unconscious or a combination of conscious and unconscious processes.**

*7 of the 8 participants' decision-making in Full UIs was informed by unconscious processes. 3 therapists displayed a combination of conscious and unconscious processes. Susan is the one exception. She made a Full UI but emphasised conscious decision-making processes only. This anomaly will be explored in further detail, later in this discussion section.*

Proposal 7 brings focus to a central question in this study: What is the role of unconscious processes in psychotherapy? Is the unconscious superior, or potentially dangerous and the primary source of enactments and therapeutic error? This question will be taken up, with different emphases, in a number of the following proposals.

The apparent role of unconscious decision-making processes in UIs is potentially unsurprising. Cognitive psychology asserts that mental processes in general are performed both consciously and unconsciously (Kihlstrom, 1987). More specifically, there is a body of research, which demonstrates that unconscious decision-making may be superior, e.g., Dijksterhuis (2004), de Vries et al. (2010). The superior storage capacity of the unconscious may be implicated in these findings (Miller, 1956). In regard to the role of prior knowledge in UIs, Bargh (1997) argued that automatic, unconscious responses have greater recourse to learned experiences. Fonagy and Bateman (2006) asserted that decision-making about clinical interventions in general is commonly unconscious, and that this is a good thing. However, they highlight that general guidelines should be adhered to.

By contrast, Casement's (1985) concepts of the 'internal supervisor' and 'trial identification' seem to promulgate conscious thought processes, e.g., imagining how an intervention may be experienced by the patient. Casement (1985) stated that analysts should "*learn to watch themselves*" (p. 32), which Fink (2007) described as "*a sort of self-policing function*" (p. 162). I have heard the anecdotal account of an analytic supervisor's advice to 'think before making an

intervention, and then think again'! Advice to be thought through is not surprising given that unconscious, automatic processes are implicated in enactment and therapeutic error

**Proposal 8: In Full UIs the extent to which the decision-making process is conscious/unconscious may be ambiguous and even unclear to the practitioner.**

*This proposal pertains to the 'conscious to unconscious decision-making continuum'. The simultaneous presence of both conscious and unconscious processes for 3 therapists (David, Sarah, Annette) highlights the ambiguity and uncertainty in regard to decision-making.*

In the introduction section I proposed that Smolar (2011) and Jacobs (2011) overemphasised the level of conscious thought processes in their UIs. Further, Smolar provided contradictory clinical guidelines, urging practitioners to be both intuitive and thought through simultaneously. In the present study Joanne realised that she had not consciously made a risk appraisal, and that it was very intuitive. She subsequently also provided clinical guidelines, which emphasised conscious processes: For example, that UIs were imbued with codicils and that the practitioner should always hold risk in mind. Other participants lamented the lack of 'conscious thinking' in their UIs. Given the outlined research on decision-making, the question is raised why psychotherapists may have a tendency to eschew unconscious processes and, further, valorise being 'thought through'.

Are we, primarily, anxious not to enact, i.e., to not impinge our own unconscious needs and fears onto our patients? Classical analytic theory certainly eschews enactment (e.g., Reich, 1951). The person-centred practitioners Mearns and Thorne (2007) describe enactment as a potential 'abuse' of the patient. Significantly, Bohleber et al. (2013) describe enactments as automatic and unconscious, qualities that are prevalent in UIs in the present study. Similarly, Mearns and Thorne (2007) propose that spontaneous responses are risky because these are more likely to be distorted by the counsellor's own fears and needs. Rea (2001) stated that intuition may readily be imbued with our own prejudices because of its unconscious nature. In addition, I would argue that the field also emphasises the deleterious effects of the unconscious in general. For example, defended against impulses, which may lead to ill physiological health (Westen, 1999), or the unconscious repetition of pathological, internalised object relations to the detriment of current social interactions (Clarkin et al., 1999).

## **Future research**

A question on my mind is whether UIs are actually more unconscious, or spontaneous, than prescribed 'bread and butter' technique? If being 'thought through' is valorised in psychotherapy, then therapists may not only overestimate conscious processes in UIs, but also in more model specific interventions. Future research may further explore the role of unconscious processes in UIs and 'usual' practice in psychotherapy. Is it in fact only when we deviate from the frame and clinical guidelines, or when things go wrong, that we become more aware of unconscious processes, e.g., when our unconscious has potentially tripped us up?

### **Proposal 9: The decision-making process is predominantly 'conscious' in Partial UIs.**

*Brian and Courtney only reported conscious decision-making processes in their Partial UIs.*

### **Proposal 10: Full UIs represent a predominantly 'automatic, unconscious process'.**

*7 of the 8 therapists who made Full UIs described these in terms, which point towards an automatic, unconscious process, e.g., spontaneous, intuitive and 'not thought through'. Significantly, these 7 practitioners also reported unconscious decision-making processes. As outlined, Susan was an exception and did not describe her UI as automatic. This will be taken up in further detail, later in this section.*

These findings are consistent with UIs described in the available literature, for example Ringstrom's (2001) improvisational interventions and Smolar's (2011) spontaneous use of touch. Sarah stated that the overall work of psychotherapy becomes more automatised with increased experience. She proposed the novice's mind was between both the client and books, and that, therefore, beginners were much more thought through.

### **Proposal 11: Partial UIs do not represent a significant 'automatic, unconscious process'.**

*Consistent with their emphasis on conscious decision-making processes, Brian and Courtney did not describe their Partial UIs as 'automatic'.*

### **Proposal 12: UIs are high-risk interventions.**

*All of the therapists described their UIs as risky interventions, which could go wrong and potentially have an extremely negative impact on the patient.*

Proposal 12 resonates with Ringstrom's (2001) description of his UIs as 'high-risk, high-gain'. As stated, spontaneous and intuitive responses are risky because unconscious processes are more likely to be coloured by the clinician's own fears and needs (Mearns & Thorne, 2007). However, it is noteworthy that the Partial UIs in this study were also perceived as risky interventions. This is important because it informs us that there may be an inherent risk in UIs that is independent of potential therapist enactments.

### ***Clinical guideline 7***

It is vital that clinicians are aware that all forms of UIs may represent 'high-risk' interventions.

### **Proposal 13: A stand out quality of UIs is that they are frequently 'direct and challenging'.**

*7 therapists described their UIs as 'direct and challenging' in the present study. This is potentially unsurprising given that 6 of these therapists were working with treatment resistant patients.*

'Boom!', punchy, attacking, brutal, confrontational, 'like a CPR' and 'no bullshit' were some of the evocative descriptors used by participants to capture the phenomenological quality of their UIs. In terms of theory I discern a certain degree of semblance here to the Lacanian technique of session scansion (Fink, 1997). In scansion the analyst ends a session prematurely. The aim is to accentuate the material at a given moment and, thereby, to highlight its perceived importance. I believe an important question is why such a large proportion of the UIs in the present study (7 of the 8 Full UIs) were 'direct and challenging'? Or, more specifically, why does it represent unusual practice so frequently when clinicians are challenging?

Mearns and Thorne (2007) proposed that congruence is the most difficult of the person-centred core conditions for beginning therapists, because they are prone to censor their negative responses. The data in this study suggests that being challenging is challenging for a large proportion of therapists, independent of experience level. For example, reflecting on a perceived lack of empathy in her UI, Annette reflected: *"It's not how we're trained to behave"* (150).

Akhtar (2011) stated that the function of listening has become institutionalised and achieved exalted status in psychoanalysis. I propose that 'being empathic' may also have garnered a special

place in the 'therapist super-ego/ego-ideal', to the detriment of challenge. This is potentially an important contribution of the present study. Implications of a therapist's reluctance to be challenging will be taken up in further detail in later proposals. For now it will suffice to warn that a stereotypically nice counsellor may not provide patients with sufficient challenge and encounter (Mearns & Cooper, 2005).

### **Future research**

I feel fortunate to have had a training placement with an experienced psychodynamic psychotherapist, who frequently used challenging interventions in his work at a personality disorder service. The question on my mind as I analysed the data in the present study was, 'would he have reached the point of frustration that a number of the therapists in this study described, and which was implicated in the occurrence of their UIs? Or might he have been challenging sooner, in a way that was imbued with less risk?' Challenging interventions are central in Clarkin et al.'s (1999) Transference Focused Psychotherapy and in Davanloo's (1980) Intensive Short-Term Dynamic Psychotherapy. I propose that future research is needed to increase our understanding of the present status of 'challenge' in the field, and the implications thereof.

### **Proposal 14: A stand out quality of UIs is that they are 'authentic'.**

*8 of the 10 therapists described their UIs as a form of authentic self-expression.*

The authentic quality of the UIs in this study is consistent with the notion that spontaneous interventions represent the most authentic form of therapist engagement with patients (e.g., Stern et al., 1998). Ringstrom (2001) described improvisational UIs as the purest form of authenticity on the part of the therapist.

The potential importance of therapist authenticity is unsurprising, given the significant role ascribed to this quality in human development by a large number of psychological theories of self. Consider that an inauthentic self is safe and unequivocal (Jung, 1970), inhibited and characterised by an ardent, conscious control of actions and expressions (Laing, 1960). Contrarily, authentic self-expression is unpredictable (Jung, 1954), spontaneous, intuitive and creative (Rogers, 1961). The link between the properties of authentic self-expression and the qualities of the UIs outlined in the present study is clearly evident: Spontaneous, intuitive, unpredictable and therefore risky. Like Ringstrom (2001), a number of the therapists stated that their UI represented a 'corrective emotional experience' for their patients, because it stood in stark contrast to their expectations of

inauthentic, significant others. Further, it was proposed that authentic UIs were a powerful means to gain the patient's trust. Finally, clinicians experienced their UIs as a form of modelling. This proposal is consistent with Jung's (1966) challenging question: *"How can the patient learn to abandon his neurotic subterfuges when he sees the doctor playing hide-and-seek with his own personality?"* (p. 137).

### ***Clinical guideline 8***

Given the emphasis that significant psychological theories of self place on the importance of authentic functioning in human development, I propose that practitioners should reflect on their propensity to be spontaneous, unplanned, and to make UIs.

### **Proposal 15: UIs may represent a highly tailored intervention, unique to the individual patient.**

*6 therapists in the present study stated that their UI was highly tailored and, therefore, unique to their individual patient.*

In this regard, the findings are consistent with the notion that authentic responses may be unique responses that could not be readily used with a different patient (Stern et al., 1998). This is powerfully demonstrated by Theresa: *"I think it was this person, this point in time, I couldn't imagine that happening with anyone else, or certainly none of the clients I have worked with..."* (297-299).

Salo (2011) once again foregrounds the apparent, blurry boundary between UIs and enactment. He argues that in enactment the therapist is being a real object in a transference relationship and that, therefore, the patient may experience the intervention as uniquely tailored to her.

### **Proposal 16: UIs can have a significant, positive therapeutic effect.**

*9 therapists in the present study stated that their UI had a positive therapeutic effect. 6 of these therapists described a significant positive impact.*

The potential for UIs to have a significant, positive therapeutic effect is evident in the present study. For example, Joanne's patient told her that her singing to him 'just say no' to drugs was the catalyst for the remarkable changes he made in his life. This is consistent with Lichtenberg et al.'s

(1992) assertion that stand out interventions have a special capacity to penetrate defences and, thereby, to facilitate highly therapeutic moments.

Proposal 16 brings my focus back to the most salient question to emerge from this study: What is the role of unconscious processing in psychotherapy, given its link to positive therapeutic effects on the one hand, and enactment and therapeutic error on the other? It is important to note that this is a 2-throged question. It is not only contingent on views of the unconscious, but also on perspectives on therapeutic 'error'. At this point my focus is on the former. Therapeutic 'error' will be taken up later in this discussion.

Rea (2000) argues that the unconscious has been marginalised in psychology. For example, clinical psychology has aligned itself with the medical model in order to achieve the status of a hard science (Albee, 2000). Through the subsequent emphasis on the quantification of symptoms and operationalisation of interventions (Goldfried & Wolfe, 1998), a division has emerged between reason and intuition, with the latter regarded as 'unscientific' (Welling, 2005).

The writings of C. G. Jung on this schism are profound and may potentially inform a re-addressing of this apparent imbalance. Jung (1967) argues that, in its development, a primitive, polytheistic Western world was prematurely liberated from impulsivity and irrationality at the expense of the wholeness of the individual. In this process the Western psyche became synonymous with consciousness, and man became disciplined, rational and organised. Further, a concomitant fear of the unconscious manifests in the endeavour to control and master the external world. In this process Jung (1967) proposes we have lost touch with our inner roots and man has become wrong and 'at fault', repentant and diminished in the face of a perfect God for whom the 'one mind' and 'symbols of eternity' (the unconscious) are reserved. The Eastern equivalent of the Western obsession with complete objectivity is a total introversion, where the individual is in a permanent state of oneness (with the 'one mind'/God/supreme consciousness) and, therefore, in control of unconscious processes.

What is important is Jung's recognition of the potential one-sidedness of both extreme positions (1970). He argues that psychological health is contingent on ascribing an equal value to both the conscious mind and instinctive, unconscious processes. Just as the East makes use of Western science and technology we need to develop aspects of the psyche that have their roots in the unconscious, e.g., intuition.

In this regard, Rea (2001) states that the question is not about the need for conscious processes but the extent to which this system represents our full potential. It is proposed that clinicians

must find an appropriate balance between intuition (the unconscious) and reason (consciousness) to best serve their patients. Similarly, Rustin (2013) speaks of her personal interest in unconscious, intuitive processes to expand her clinical repertoire.

Modern attachment theorists, e.g., McGilchrist (2009) also propound a balance perspective. In this approach there is an emphasis on a distinction between the right and left brain hemispheres, which account for unconscious and conscious processes respectively. McGilchrist posited that mental health is contingent on the right balance between the 2 hemispheres. Further, it is argued that great cultural achievements are contingent on their harmonious functioning. However, they are at conflict, and since the Enlightenment the left brain has gained ascendancy in Western society. The result is a one-sided and mechanical world, which dismisses right brain processes as imprecise.

### **Future research**

I believe the field will benefit from a lively debate about the role of conscious and unconscious processes in psychotherapy and the balance between these 2 systems. Fonagy and Bateman (2006) argue it is good that clinical decision-making is generally unconscious, but that guidelines should be adhered to. However, the present study demonstrates that the 'unconscious' may sometimes have other ideas and benefit patients through frame deviations in the form of UIs.

### **Proposal 17: UIs may exert a positive therapeutic effect through the pathway of an initial negative impact.**

*3 of the therapists told me that their UI initially had a negative effect on the therapeutic relationship. Through a process of 'working through' or, in one instance, simply the passing of time, the UI was ultimately described as positive for the patient.*

Proposal 17 shifts focus to the second central question to emerge from this study: Are potential 'mistakes' and therapist enactments to be avoided at all costs, or to be embraced as therapeutic opportunity? In the present study clinicians emphasised the fruitful evocation of the negative transference as a mediator between the UI and positive impact. They described their patient's fury, feeling terribly hurt, sense of not being taken seriously, and subsequent attacks on them. This is consistent with psychoanalytic theory, which proposes that it may be vital for patients to use their therapist to express their anger. Winnicott (1971) highlights the infant's need to experience her mother, who the therapist may stand in for in the transference, as surviving her

rage. Fink (1997) states that conflicts, e.g., aggression towards a parental figure, can only be worked through when they come alive in the relationship with the therapist. The data in this study suggests that UIs may unearth the patient's latent aggression, and facilitate its expression.

This proposal also brings focus back to the potentially important capacity of the therapist to be challenging. Elkind (1992) proposed that most therapists are too invested in maintaining harmonious relationships with their patients at all times. The danger here is that the patient's expression of anger may be inhibited by a therapist who is insufficiently challenging, for example because of a latent need to be liked by the patient.

Ehrenberg's (1974) concept of the 'intimate edge' is a compelling theoretical perspective on how the actual process of 'working through' stand out moments in psychotherapy can be curative. Ehrenberg argues that the therapist attains maximum self-expression through acknowledging the moment (for example an UI) and then exploring it with the patient. Thereby, he conveys to the patient what it is like to be in a relationship with her, validating her impact and foregrounding her agency. It is stated that the patient may become aware of her responsibility as a result, and move away from a position of victimhood. This account is particularly germane to Annette's 'you have a serious personality disorder' UI, which became the central focus of the therapeutic work for months and precipitated the patient's shift from her 'intractable' depression.

### ***Clinical guideline 9***

Given that UIs may have a positive therapeutic effect through evoking the negative transference, e.g., the patient's aggressive and hostile impulses, I propose it is important for clinicians to reflect on potential fears of conflict with their patients in general, and on their relationship to therapeutic 'error'.

### **Proposal 18: UIs can have a significant, negative therapeutic effect.**

*Melanie had made her UI one week prior to meeting with me for the interview. It had a negative initial impact and, although she felt she had done the right thing, she was unsure what the long-term effect would be. Further, right at the end of the interview Melanie also told me that a patient of hers had never returned after an UI, which she felt certain had represented therapeutic error.*

In light of Proposal 18 it might be argued that the unconscious is linked to both the best and worst manifestations of therapeutic practice, vis a vis UIs and enactment/therapeutic error. But data in this study also compels us to ask: What exactly represents therapeutic error? For example, in

terms of Melanie's UI, what conclusion can be drawn from the fact that it had an initial negative impact? As outlined, Annette's patient was furious about her UI, and a potential positive effect only emerged months later. Similarly, what conclusion can be drawn from the fact that a patient of Melanie's did not return to therapy after she had told her 'I don't like you'? After her 'just say no' UI, Joanne's patient also did not return. Yet months later he came back to thank her for making him aware that positive change may be that simple.

Melanie concluded that her 'I don't like you' UI was a bona fide 'mistake', and I find myself agreeing with this conclusion. Yet, without speaking to this patient we simply cannot know the impact thereof. Annette reflected that her UI may also have represented a genuine 'mistake'. I find myself also agreeing with her tentative conclusion, yet, as Annette reflected, her UI precipitated a remarkable positive shift in a lady who had suffered from a severe, apparently intractable depression for years. Previous therapies and psychotropic medication had not helped her during this period. Annette questioned whether her patient would have made those changes without the UI.

### **Future research**

In the present study participants explored UIs which, in the final analysis, had a positive therapeutic effect and/or which they at least felt may have represented the right thing to do. Towards the end of her interview Melanie disclosed an UI, which she felt was a bona fide 'mistake'. Further UI research should explore UIs with negative therapeutic effects, which were perceived as therapeutic 'error'. This may help clinicians to distinguish between genuine, unethical mistakes and both 'inevitable' clinical 'error' (Murphy, 2012) and UIs.

### ***Clinical guideline 10***

Given that UIs may have a negative therapeutic impact it is vital that clinicians reflect on their willingness to use UIs and, therefore, are prepared to deal with this potentiality. In this regard, Akhtar (2011) stated that the therapist's holding functions have to be in place, so that any negative effect can be worked through if necessary. This guideline is consistent with Bonitz (2008) who stated that therapists using touch need to be aware of issues that may become salient as a result.

**Proposal 19: Full UIs evoke self-conflict in psychotherapists about the propriety of their intervention, but Partial UIs do not.**

*More specifically, in the present study UI propriety self-conflict is evoked in relation to training and model guidelines, personal notions of 'good practice' and the fantasised positions of others, e.g., supervisors. Partial UIs did not precipitate self-conflict in this study.*

*"I do still feel unsure" (Melanie, 149), "There's no answer to it" (Susan, 406), "I don't know what the answer is" (Joanne, 481).*

Proposal 19 does not come as a surprise given the inextricable links that have emerged in this study between UIs and therapeutic enactment. The data suggests that Full UIs are spontaneous, and less 'thought through' than classical technique (and Partial UIs). Similarly, Bohleber et al. (2013) describe enactments as automatic and unconscious. They also stated that enactments represent a deviation from normative, technical processes, as do UIs. Further, Mearns and Thorne (2007) and Rea (2000) both propose that spontaneous and intuitive responses are risky, because these are more likely to be distorted by the counsellor's own fears and needs. Taken together, these points underline an inherent and potentially unavoidable uncertainty around the propriety of UIs.

**Proposal 20: UI propriety self-conflict is greater when the UI has an initial negative impact, and in the absence of a clear positive effect.**

*3 of the 4 therapists who explicitly questioned whether their UI represented therapeutic error, and were unable to reach a definitive conclusion, reported UIs that had an initial negative therapeutic impact. The fourth therapist could not state with certainty that his UI had a positive effect.*

I have noted throughout this report that Susan was, in part, an anomaly amongst the 8 clinicians who made Full UIs. She was the only Full UI clinician who did not report unconscious decision-making processes and phenomenological qualities. It is noteworthy that she was also the clinician who felt most assured that her UI represented an enactment (therapeutic 'error').

***Clinical guideline 11 + future research***

A very tentative hypothesis is that Full UIs, which are relatively void of spontaneity and imbued with conscious decision-making processes, are potentially more likely to represent 'bona fide'

therapist enactment/therapeutic 'error'. This should be taken into consideration in future UI research.

**Proposal 21: Therapists may find a resolution to self-conflict precipitated by Full UIs, through a commitment to their inherent properties, e.g., spontaneity, authenticity, risk and uncertainty.**

*This proposed commitment to the properties of UIs may manifest, for example, as a 'holding mistakes lightly', and as a confidence to be one-self.*

This final proposal returns focus to the question of propriety. Should potential 'mistakes'/enactments, in the form of UIs, be avoided or accepted as the inevitable consequence of therapists' humanness, and as potentially fruitful moments in psychotherapy. In the present study resolution to conflict was found through a commitment to the inherent qualities of UIs, e.g., authenticity, spontaneity, risk, and a concomitant acceptance of the inevitable uncertainty surrounding propriety.

I am not suggesting that self-conflict should be eschewed. By contrast, its absence would be concerning. However, contemporary psychoanalytic theories provide a 'way out' of sorts, because of their relationship to enactment. It is argued that enactments are inevitable and that, when subjected to analysis, these can be fruitful (Bohleber et al., 2013). For example, enactments of early relational dynamics may render these conscious and amenable to analysis. It follows that therapists are not urged to avoid 'transference – counter-transference enactments' (T-CT-Es) at all costs (Jacobs, 2011). For example, in the present study Susan stated her UI may have represented an enactment of an early object relations dyad, which she was then able to work through with her patient in the present. In this regard, Bohleber et al. (2013) note the paradoxical task of integrating enactment into an event that represents both the breaking of technical rules, and as inevitable aspect of therapy which can have a positive effect.

Hoffman (1994) provides a compelling, relational theoretical perspective, which is germane to UIs: Even if a spontaneous intervention represents enactment, the therapist's willingness to respond immediately to his patient, to take a risk and potentially inhabit the role of 'bad object', may transform him into a 'good object'. As outlined, Hoffman (1994) argues that uncertainty is a central feature of the 'good object'.

The data suggests that it is vital for clinicians to bear uncertainty around UI propriety in order to manage self-conflict. This is unsurprising given the close ties between UIs and

enactment/therapeutic ‘error’, which I have presented throughout this discussion section. These concepts are unified by frame deviation, unconsciousness (spontaneity, automaticity, identificatory processes), strong affect (both negative and positive), risk, therapist intentionality and negative and positive therapeutic effects. Regarding positive effects, it is proposed that both relational enactments (Jacobs, 2011) and spontaneous responses (Stern et al., 1998) can break through impasses in the work, and move the therapy forward through crisis points and stalemates.

Renik (1993) argues there are times when the correctness of an intervention may never be clear. In terms of UIs, there may be times when definitive answers may be impossible to attain and unnecessary.

### ***Clinical guideline 12***

Although definitive answers regarding propriety may remain elusive, clinicians should explore UIs in personal therapy and in supervision to maximise their learning. In this regard, clinical supervisors should demonstrate an acceptance of potential therapeutic ‘error’ and a willingness to make use of it (Mazetti, 2012).

### **Final thoughts**

#### ***Can UIs represent technique?***

Hoffman (1994) proposed that highly authentic, spontaneous engagement is void of intentionality and, therefore, cannot become technique. Similarly, Watzlawick, Weakland and Fisch (1974) stated that if improvisation were a technique it would no longer be improvisation. Given that I have expounded an initial Grounded Theory of UIs, with guidelines for clinical practice, it is potentially unsurprising that I disagree with the aforementioned assertions.

I believe the present study demonstrates that Hoffman’s (1994) separation of the spontaneous and intentional is overly simplistic. I argue that, paradoxically, as Hoffman is a psychoanalyst, he jettisons the unconscious. The interview data suggests that highly spontaneous UIs may well be imbued with intention, even if the therapist is unaware of it at the time. Ringstrom’s (2001) “...sooo understandable” (p. 728), improvisational UI, also seems to be intentional. That is, to compel his patient to be more accepting of, and kind to himself.

Further, is it really possible for 'relational psychoanalysis' (e.g., Stern et al., 1998) to theorise that therapist spontaneity is integral to positive change, and for this theory to not be transformed to technique? The person-centred approach also valorises authentic, spontaneous therapist responses but its proponents are not concerned that both 'congruence' and 'use of self' represent core techniques. According to Hoffman (1994) this could be problematic, and mitigate the 'truly' improvisational and spontaneous.

In my opinion Mirvis (1998) points to something more complex in her reflections on the improvisational in psychotherapy. She urges psychotherapists to "think about what you are doing, and don't think about it as you're doing it" (p. 2). To 'try' and be spontaneous may be antithetical to the goal. However, cultivating an 'openness' to be spontaneous may represent a more subtle form of technique. I tentatively propose that this is what the person-centred approach emphasises. Similarly, Welling (2005) reflects that intuition is contingent on the clinician's willingness to acknowledge it. Eisengart and Favier (1996) argue that intuition is facilitated by an open attitude and playfulness, and Rea (2001) foregrounds the importance of the clinician's readiness to act on intuition in its usage.

I believe that the role of 'willingness' in the occurrence of UIs is significant, and I urged practitioners to reflect on it in clinical guideline 8. I would like to provide 2 clinical examples to highlight the potential importance of reflections on 'willingness to use UIs'. The first is from David in the present study. He told his patient to 'not try, but do', impersonating Yoda from the film Star Wars. He knew this message from the film, but he had also heard a clinician use it in a group therapy session previously. Significantly, he had liked this message, which he had perceived as direct and somewhat unusual. Thus, one might say the seeds were sown for him to try something similar in his own practice, even if he did not experience this burgeoning 'willingness' consciously. He then did use a similar intervention, and it had a positive therapeutic effect as his patient became increasingly engaged in his therapy. In this example we might say that all has gone well.

The second clinical example is from my own practice. I had previously experienced my own therapist using humour and, like David, without thinking about it, took this into my work with a patient. In this instance the outcome was less positive. I undoubtedly became embroiled in a transference enactment and my patient asked to change therapists within the service. I propose that I had unconsciously developed a 'willingness' to use an UI in my practice. Significantly, because it was unconscious I did not reflect on the appropriateness of using humour with this individual patient, and I was also unprepared to manage a potential negative therapeutic effect.

### ***Should clinicians cultivate a willingness to use UIs?***

It is inevitable that different clinicians will have different perspectives on these interventions, for example based on their training backgrounds, theoretical orientations and individual difference variables. My view is that, yes, clinicians should cultivate a willingness to use UIs, to be spontaneous and unrehearsed. I have presented literature in this study which, taken together, I perceive as a compelling argument for this endeavour. For example, I find the overlap between proposed qualities of the self in optimal human development and UIs quite astounding: Spontaneity, creativity, interpersonal risk-taking, unpredictability, uncertainty, authenticity, intuitive, and trusting. Further, significant positive therapeutic effects of UIs have been demonstrated in the present study, and can be found in the available literature. These examples support assertions that spontaneous interventions can break through stalemates in the work (Stern et al., 1998) and defences, facilitating highly curative moments (Lichtenberg et al., 1992).

### ***Open clinical reporting***

What is potentially most important at this juncture is that even if clinicians are against the use of UIs, they should be prepared for their occurrence. Like mistakes, UIs may inevitably occur regardless of how welcome they are. Thus, it is important for the field to enhance its understanding of UIs. Such knowledge may exert a positive effect on unconscious decision-making processes and mitigate the inherent risk in the use of UIs.

Open clinical reporting is vital to increase our understanding of UIs. The present study demonstrated that this will represent a challenge for clinicians. First, it was comparatively difficult to recruit participants. For every 25-30 emails I sent, one therapist agreed to meet with me. By contrast, my colleague recruited one participant per 5 emails for his study on the role of hope in psychotherapy. In interview a CBT therapist initially told me about a planned UI, which had been discussed in supervision and represented technique (the 5-minute session; Waller et al., 2009). After 20 minutes I asked if she could think of an UI that had not been planned. She tentatively replied that she did not know, before recalling an example, and then another. I believe that she remembered these instances of unplanned UIs well, but that she was unsure of, and ambivalent about disclosing them to me. 2 of the participants couched their participation in terms of doing me a favour, with one stating she was concerned that she did not do anything unusual. It transpired that she had quite a few examples to choose from. Melanie disclosed an UI that had gone wrong, and which she had never shared with anybody. Similarly, Annette stated: *"I feel like I'm in a confessional"* (151).

According to Murphy (2012) ‘mistakes’ have become stigmatised in psychotherapy, imbued with shame and rarely disclosed. The data in the present suggests that the same can be said of UIs. Murphy argues that open clinical reporting is essential to normalise therapeutic ‘errors’ and, importantly, to facilitate distinctions between the inevitable and the unethical. Mazetti (2012) proposed that therapists can only make use of ‘mistakes’ if these are not defended against. In his work as a supervisor he endeavours to share them, thereby modelling an acceptance of his own humanness and his belief that ‘mistakes’ can be dealt with. These same principles should be applied to the further study, and utilisation of UIs. One potential method to better research both UIs and therapeutic ‘error’ may be anonymous clinical reporting.

***“When pendulums begin to swing, they commonly swing too far”*** (Bonitz, 2008, p. 394).

The Lacanian psychoanalyst B. Fink (2007) calls for caution in the current shift in contemporary psychoanalysis, which emphasises the importance of the therapeutic relationship. This is the notion that *“the analyst cures not so much by what he says and does, but as by what he is”* (p. 51). Outside of the analytic domain this perspective is seen most evidently in the ‘common factors’ literature (e.g., Wampold, 2010).

Fink (2007) distinguishes between the symbolic and imaginary registers. The former is the register of language, and is valorised by Fink in clinical work. Thus, he endeavours to help the patient verbalise that which, hitherto, has remained unspoken. In this process he pays special attention to the manifestation of the patient’s unconscious in language, for example through slips of the tongue, mispronunciations and cut-off sentences. The primary goal is an articulation, as full as is possible, of the ‘pathogenic nucleus’. The imaginery is the register of relationship, in therapy between the ego of the clinician and the ego of the patient. According to Fink the danger of working in this domain is that attention becomes overly focused on the transference and counter-transference, and there is an emphasis on insight and understanding, which may not lead to change. He proposes that the depths of a patient’s complex desires and pleasure are best reached by following her unconscious, manifest through language. Significantly, he argues that the personality of the therapist takes centre stage in the imaginary register, and that he is more likely to feel the type of pressure that was described by a number of clinicians in this study. Further, Fink proposes that the more of the personality of the analyst is involved in the work the less sure he becomes of his action, as was also evident in the present study.

I have drawn strongly on relational psychoanalytic literature to argue that practitioners should cultivate an openness to use UIs. Fink’s main focus on language provides an important

counterpoint to relational psychoanalysis and may inform future debate and theoretical conjecture related to UIs.

### **Final points on reflexivity and limitations**

I recently visited an exhibition of the British artist Sarah Lucas, at the Whitechapel gallery in London. One piece was a pair of stockings hanging from a clothes-hanger, with a quarter of a cigarette attached to the seam in the crotch area. One of my friends saw anal sex, the other a shrivelled penis as a result of excessive smoking, and I saw a vagina smoking a cigarette. Make of these associations what you will. The important point is we all saw the same objects, stockings and a cigarette, but our interpretations were very different. As psychologists and psychotherapists we are naturally aware of the phenomenon of projection. Yet, it still amazes me when I re-experience it in action so vividly. I propose that the principle limitation of my study is my humanness. I cannot be objective, and it is likely that different researchers would have reached different conclusions. Further, it is possible that I would reach different conclusions if I re-visited this area of research in the future. Roulsten (2001) reported that she came to an alternative interpretation of her data when she re-analysed it.

As stated in the method section, qualitative research methods are anchored in the constructivist-interpretivist paradigm. This epistemological stance posits the existence of multiple realities (Charmaz, 2006), and that reality is constructed by the individual perceiving it (Hamilton, 1994). Research findings are viewed as a co-creation between the researcher and participants. For example, I will undoubtedly have influenced my participants' responses through the types of questions that I asked, and nonverbal communications (Sollund, 2008). I question whether I should even speak of limitation, when subjectivity is ubiquitous in all forms of research, and objectivity is such an obvious fallacy. Consider that up to a third of the conclusions derived from so-called 'scientific' research trials in medicine are later overturned (Carey, 2006). Fink (2013) urges his readers to remain sceptical about the scientific method, and to remember that theoretical models are not truths for time immemorial.

### ***The sample***

I am reluctant to view my sample size of 10 as a limitation in the present study. In GT research theoretical saturation may be achieved when no new properties of a given pattern emerge (Charmaz, 2006). However, Dey (1999) argues that Grounded Theories are always provisional, because new perspectives can emerge at any time. Thus, there is not a 'final word'. Consequently,

Dey (1999) proposes that researchers should aim for theoretical sufficiency. Sufficiency pertains to the adequacy of data and the depth or fullness of the subsequent analysis (Charmaz, 2006). I believe that this was attained in the present study. It represents a novel line of enquiry and, therefore, future research may unearth further, more nuanced facets of UIs. However, the data was analysed in depth, and significant processes were discerned. The sample size of 10 provided a manageable volume of data and enabled me to achieve these aims within the allotted time frame. Further, the types of UIs that emerged in the literature review were all represented in this study, labelled as Partial and Full UIs. Similarly, no new fundamental processes emerged in the latter stages of data collection. In essence I believe I have conducted a thorough and sound study of UIs, cognisant that it does not represent a 'final word'.

A clear, sample related limitation is that I was not able to recruit more men. Only three of my participants were male, of which two were trainees. Further, the qualified male therapist discussed a planned CBT intervention. As demonstrated Partial UIs are less likely to engender self-conflict, related to uncertainty around potential therapeutic error, than spontaneous, unplanned Full UIs. Future research is needed with a more gender balanced sample.

### ***The last word***

I felt privileged to speak with highly experienced practitioners about UIs, to see their uncertainty and struggles. I hope that this study may represent a first step in the development of a comprehensive theory and debate around this topic, which captures such fascinating facets of what it means to be both a clinician and human being.

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## **Appendices**

### **Appendix 1: Recruitment email**

Dear X

I am in the final year of the counselling psychology programme at City University London. For my doctoral thesis I am hoping to interview an experienced [type of practitioner] about 'unusual interventions', as defined by Salman Akhtar (2011): Clinical surprises from the side of the practitioner – stand out moments where s/he radically departs from the set and familiar rules of technique, and does something unusual.

It would be great to meet with you for 45-60 minutes if you have experience of unusual interventions. I would come to a location convenient to you for the interview.

Kind regards,

John Moulder-Brown

Trainee Counselling Psychologist  
City University London

## Appendix 2: Information sheet



Department of Psychology  
City University  
Northampton Square  
London EC1V 0HB

Mobile: [REDACTED]  
Email: [REDACTED]

### INFORMATION SHEET

**Study Title: 'Unusual' interventions in counselling and psychotherapy: A grounded theory analysis.**

This study forms part of a Professional Doctorate in Counselling Psychology at City University, London.

**Researcher:** John Moulder-Brown

**Research Supervisor:** Professor Marina Gulina

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

Akhtar (2011) describes 'unusual interventions' as clinical surprises from the side of the practitioner – stand out moments where s/he radically departs from the set and familiar rules of technique and does something unusual.

Akhtar (2011) states that 'unusual interventions' largely remain unreported. Through interviewing experienced practitioners this study aims to increase our understanding and encourage more open clinical reporting.

#### **What happens next?**

If you agree to participate we will arrange to meet for a semi-structured interview, approximately 45-60 minutes in duration, at a time and place convenient to you. I will also ask participants to have 2 relevant clinical examples to hand so as to allow more time for discussion and reflection. Interviews will be audio recorded and I will ask participants to sign a consent form before beginning.

#### **What happens with your data?**

Strict confidentiality is assured. The audio-recording and all other data will be kept in a safe place and separate from any identifying details. You will be given a pseudonym in your transcript. Audio recordings will be destroyed once the research has been concluded. The results of this study will be submitted for publication to scientific journals and may be presented at conferences. Next to the general findings, relevant excerpts may be re-produced if the study is published. Great care will be taken that participants are not identifiable in any published transcripts.

**Your protection**

This study has been granted full ethical approval from the Senate Research Ethics Committee at City University, London. It fully conforms to the ethics guidelines of the British Psychological Society of which I am a graduate member. You are free to withdraw from participation at any time during this study. As outlined, strict anonymity is assured. Only the researcher will have access to your data and know your identity.

**Contact for further information**

If you have any questions you can contact me by phone: [REDACTED] or email: [REDACTED]  
[REDACTED]

For an independent party please contact my research supervisor, Professor Marina Gulina by phone: [REDACTED] or email: [REDACTED]

### **Appendix 3: Consent form and debrief information**

Consent form for participants in the psychological research study: 'Unusual' Interventions in counselling and psychotherapy: A grounded theory analysis.

Researcher: John Moulder-Brown

This study forms part of a professional doctorate in counselling psychology at City University, London.

The researcher has to receive your written consent to take part in the research. Please read the consent form and print your name, date, and sign if you happy with the requirements for this study.

I agree to take part in this study conducted at City University London by John Moulder-Brown. I have received an information sheet that outlined the purpose of the study. I am satisfied with what is required of me to participate. I am aware that my data will be treated as confidential and anonymous. I understand that I am able to withdraw from this study at any time and to request that my data be destroyed. I also understand that this study is being conducted within the British Psychological Society's guidelines and that ethical approval has been granted by the Senate Research Ethics Committee at City University. I have been encouraged to contact the researcher or his supervisor should I have any questions or concerns. I hereby agree to participate in this study.

Name:

Signature:

Date:

I, the researcher, agree to comply with the above statements and sign for both myself and my research supervisor.

Name:

Signature:

Date:

Please keep a copy of the consent form for your records. My research supervisor, Professor Marina Gulina, can be contacted via email: [REDACTED]

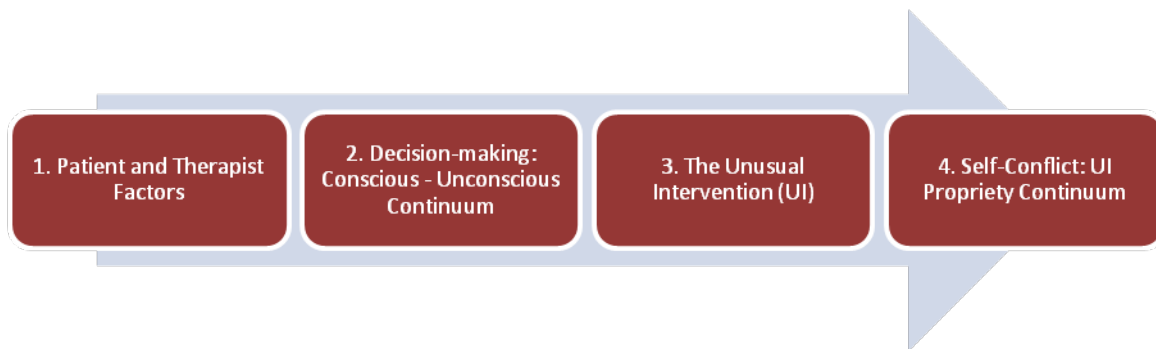
#### Debrief information

Thank you for taking part in my study. As stated in the information sheet you may have your audio recording and the transcript if you wish. I expect to complete my study in October, 2013. Upon completion I will send you a summary of the findings. Please contact me if you would like to receive the full study. I will also keep you informed regarding the publication of this study. As outlined in the consent form you are free to withdraw from the study at any point and to request that your data be destroyed. Please contact me if you have any further questions or concerns.

#### **Appendix 4: Interview schedule**

- 1.) What were the first things that came to your mind when you read my email?
- 2.) What was your UI?
- 3.) What was your (qualitative) experience of making your UI?
- 4.) What happened after the UI?
- 5.) Why do you think it had that impact?
- 6.) What was happening leading up to the UI (backdrop)?
- 7.) Why did it happen, in that moment, with that patient?
- 8.) What was your intention/why did you make the UI?
- 9.) Do you have a theoretical rationale/does it fit your model?
- 10.) What have you learned from this UI?
- 11.) What are the dangers?
- 12.) Are there factors that influenced you making the UI, e.g., theory, past experiences, supervisors?
- 13.) Has your experience of making UIs changed over time?
- 14.) Stigma: Have you shared UIs with peers or supervisors?
- 15.) Did anything occur to you that you hadn't thought about prior to this interview?
- 16.) Was there anything you were reluctant to disclose, or didn't feel able to?

## Appendix 5: 'The Grounded Theory: 21 proposals derived from 4 core, sequential categories'



Proposal 1: 'There are 2 forms of UIs: Partial UIs and Full UIs'.

Proposal 2: UIs are more likely to occur with 'challenging' patients.

Proposal 3: A Full UI occurs in the context of the therapist feeling challenged in the work and/or identificatory processes.

Proposal 4: Partial UIs occur in the 'absence' of identificatory processes or the therapist feeling challenged.

Proposal 5: Rebellious, risk-taking therapists may be more likely to make UIs.

Proposal 6: Therapeutic intentionality/rationale and prior knowledge inform the decision-making process in UIs.

Proposal 7: In Full UIs the decision-making process is largely 'unconscious' or a combination of conscious and unconscious processes.

Proposal 8: In Full UIs the extent to which the decision-making process is conscious/unconscious may be ambiguous and even unclear to the practitioner.

Proposal 9: The decision-making process is predominantly 'conscious' in Partial UIs.

Proposal 10: Full UIs represent a predominantly 'automatic, unconscious process'.

Proposal 11: Partial UIs do not represent a significant 'automatic, unconscious process'.

Proposal 12: UIs are high-risk interventions.

Proposal 13: A stand out quality of UIs is that they are frequently 'direct and challenging'.

Proposal 14: A stand-out quality of UIs is that they are 'authentic'.

Proposal 15: UIs may represent a highly tailored intervention, unique to the individual patient.

Proposal 16: UIs can have a significant, positive therapeutic effect.

Proposal 17: UIs may exert a positive therapeutic effect through the pathway of an initial negative impact.

Proposal 18: UIs can have a significant, negative therapeutic effect.

Proposal 19: Full UIs evoke self-conflict in psychotherapists about the propriety of their intervention, but Partial UIs do not.

Proposal 20: UI propriety self-conflict is greater when the UI has an initial negative impact, and in the absence of a clear positive effect.

Proposal 21: Therapists may find a resolution to self-conflict precipitated by Full UIs through a commitment to their inherent properties, e.g., spontaneity, authenticity, risk and uncertainty.

## **Part D: Critical literature review**

### **The role of client factors in psychotherapy treatment outcomes**

#### **Introduction**

Interest in the client factors that impact on psychotherapy treatment outcomes has its roots in the common factors models of psychotherapy (e.g., Garfield, 1995; Rosenzweig, 1936). The common factors models have been defined as the second strand of the development of psychotherapy, embedded in a humanistic tradition that emphasises the importance of the interaction between therapist and client (Wampold, 2010). These models stand in contrast to the first strand in the development of psychotherapy: The medical model, which emphasises the importance of technique and model specific factors in counselling (Wampold, 2010).

Hubble, Duncan and Miller's (1999) 4 factor "common factor" model includes: 1.) client and extra-therapeutic factors, 2.) relationship factors, 3.) expectancy and placebo effects and 4.) technique and model specific factors. Bohart and Tallman (2010) described the client as the neglected common factor in the current literature. Significantly, client characteristics are potentially the most important of the common factors. In their review Asay and Lambert (1999) attributed 40% of the variance in treatment outcome to client factors.

The aim of this review is to 1.) identify and evaluate the research of client factors that impact on treatment outcomes in psychotherapy and 2.) identify the implications for counselling psychology from this available research. A brief history of common factors research and an overview of the common factors are presented. This review then identifies and evaluates the available client factors research including: Client expectations, treatment allegiance and preference, client motivation and participation, ecological circumstances, client capacity for spontaneous change, attachment style, perfectionism, and ideas about psychotherapy. Subsequently, the implications for counselling psychology are explored. This review argues that it is vital for counselling psychologists to understand the client factors that have an impact on therapeutic outcomes, so they are able to tailor their work to the individual needs of their clients. Further, it is proposed that counselling psychologists, through exposure to a variety of treatment modalities and training in the scientific method, are ideally placed to lead the field in this area.

## **The common factors model: A historical perspective**

In 1995 the Society of Clinical Psychology (a division of the American Psychological Association) set up the Task Force on Promotion and Dissemination of Psychological Procedures to develop criteria to establish empirically supported treatments or ESTs (Wampold, 2010). The taskforce adopted a medical model of psychotherapy, which prioritises the importance of treatment ingredients. Barlow (2004) stated that an EST has to contain specific psychological procedures, which added something above and beyond the client-therapist interaction effects, i.e., the effects produced through the therapeutic alliance or client factors including expectation and motivation. Contrarily, the common factors models propose that client-therapist interaction effects are the most significant determinants of therapeutic change; it is argued that treatment specific techniques are primarily important because they provide a context in which the common factors are manifested (Bohart & Tallman, 2010).

### ***Common factors vs. treatment ingredients: The available research***

The medical model of psychotherapy predicts that a treatment with more potent ingredients will lead to better treatment outcomes (Wampold, 2010). Component designs have been used in an attempt to isolate the specific ingredients of psychotherapeutic approaches; it is hypothesised that if a treatment ingredient is added or taken away therapeutic outcome will be affected, either positively or negatively (Wampold, 2010).

There are a number of studies, which demonstrate that some forms of treatment are better than others. However, on closer inspection these are blighted by the effects of confounding variables (Wampold, 2010). For example, Robinson, Berman and Neimeyer (1990) reported that cognitive-behavioural therapy (CBT) was superior to behavioural therapy alone in the treatment of depression and that both these approaches were better than general talking therapies. In this study the allegiance of the researcher accounted for the differences, i.e., the researcher was a proponent of the approach being studied (Wampold, 2010).

In other studies that support the specificity paradigm (e.g., Foa, Rothbaum, Riggs & Murdock, 1991; Gloaguen, Cottraux, Cucherat, & Blackburn, 1998) cognitive therapies are compared to a “supportive therapy”, administered by the researcher, which is intended to mimic the common factors, i.e., client and therapist interaction effects. However, it is problematic when the supportive therapy is not intended to be therapeutic, a critical component of the common factors model. Consider the supportive therapy in Foa et al.’s (1991) study: Patients who had experienced

posttraumatic stress disorder (PTSD) as a result of sexual abuse were not allowed to talk about their assault as this would have constituted exposure, a therapeutic technique.

Wampold et al.'s (1997) meta-analysis only included studies, which compared treatments intended to be therapeutic, and found that the differences between these treatments were statistically non-significant. Ahn and Wampold's (2001) meta-analysis of 27 component studies found that effect sizes were not significantly different from zero for a treatment package with more or less of the specified critical components.

### ***What are the common factors?***

Hubble et al. (1999) outlined a 4 factor "common factors" model, which includes: 1.) client and extratherapeutic factors, 2.) relationship factors, 3.) expectancy and placebo effects and 4.) technique and model specific factors.

*Client factors* are both internal, e.g., personality, motivation, and self-worth, and external, e.g., social support and ecological circumstances (Hubble et al., 1999). Lambert and Bergin (1994) hypothesised that client factors were the single largest determinant of therapy outcome accounting for 40% of the variance.

*Relationship factors* focus on the warmth, empathy and acceptance of the therapist and, according to Lambert and Bergin (1992), account for 30% of the variance in treatment outcome. Some therapists are more effective than others irrespective of the therapy administered (e.g., Crits-Christoph et al., 1991; Kim, Wampold, & Bolt, 2006; Lutz, Leon, Martinovich, Lyons, & Stiles, 2007; Wampold & Brown, 2005). Significantly, the client is implicated in this common factor: It is the client's perception of the therapeutic relationship that is of primary importance (Bohart and Tallman, 2010).

*Expectancy and placebo effects* account for 15% of the outcome variance and refer to the client's and therapist's belief that therapy, and the techniques used, will beget positive change (Lambert and Bergin, 1994).

*Technique and model specific factors.* Lambert and Bergin (1994) stated that only 15% of the change variance can be accounted for by specific therapeutic techniques. It is proposed that the primary role of treatment specific ingredients is to provide a context in which the common factors are manifested; for example, in order for there to be agreement about tasks and goals in therapy there needs to be a treatment plan, rationale and agenda (Wampold, 2010).

## **Client factors**

Bohart and Tallman (2010) described the client as the neglected common factor in psychotherapy. In their review of the available literature Asay and Lambert (1999) attributed 40% of the variance in treatment outcome to client factors. In Wampold et al.'s (1997) meta-analysis only 13% of the outcome variance was accounted for by treatment variables; the authors proposed that a large proportion of the remaining 87% is client variability. Proponents of common factors models draw on an amalgamation of research from unrelated areas to highlight the importance of the client in therapeutic outcomes (Bohart & Tallman, 2010).

## ***Expectations***

Bohart and Tallman (2010) proposed that placebo effect studies demonstrate the importance of client expectations that a treatment will be beneficial. In The Treatment of Depression Collaborative Research Project, one of the largest randomized clinical trials, Elkin (1994) found that a placebo group achieved similar increases in mental well being to those who received psychotherapeutic input. Grissom's (1996) review of 46 meta-analytic studies reported an effect size of .44 for placebo conditions in comparison to control groups without a treatment component.

Kirsch et al. (2008) conducted an extensive review of selective serotonin reuptake inhibitors (SSRIs) studies; they reported non-significant differences in outcome between participants who had received a placebo and SSRIs. It is argued that clients are endowed with self-healing capacities, which are activated through an expectation of change (Bohart & Tallman, 2010). Stosky, Glass, Shea and Pilkonis (1991) examined the impact of client expectations on participants receiving a 16 week course of CBT or interpersonal therapy for a major depressive disorder. Client expectations of the efficacy of the therapy were significantly related to outcome (Greenberg, Constantino, & Bruce, 2006; Kirsch et al., 2008).

## ***Allegiance***

Wampold (2007) stated that the client's allegiance to a therapeutic intervention is vital as it is likely to change the individual's expectations of the therapeutic outcome. Further, client allegiance is also important to establish a strong therapeutic alliance; a good working alliance involves the client accepting the formulation of his problems and the rationale for the treatment process (Wampold, 2010). Successful therapy is a collaborative process; therefore, it is important for the therapist and client to be in agreement about the treatment tasks and goals. Both agreement and acceptance are likely to be enhanced by client allegiance (Wampold, 2010).

In Fennell and Teasdale's (1987) study 34 patients received CBT for depression and responses were examined over the first 2 weeks of treatment. Some individuals were rapid responders to the therapy. Significantly, these individuals endorsed the cognitive model of depression more strongly than those who responded less well to treatment. From this perspective it is important that the treatment is acceptable to clients, compatible with their values, expectations, and characteristics (Wampold, 2010). High drop-out rates in therapy are, at least in some cases, due to the fact that the client does not like the form of treatment (Westen & Morrison (2001). Iacoviello et al. (2007) found that the clients' initial engagement in treatment was largely determined by the extent to which they found the treatment agreeable. Swift and Callahan (2011) reported that when treatment was matched to clients' preferences they were between 30 and 50 percent less likely to drop out of therapy prematurely.

Bevan, Oldfield and Salkovskis (2010) reported individual differences in patient's acceptability of different formats of treatment for obsessive compulsive disorder. In this study 6 individuals chose to receive a course of 5 CBT sessions either once a week or in an intensive treatment format (5 consecutive days in one week). Those in the weekly treatment group felt that the intensive format would have been too brief and potentially too intense; contrarily those in the intensive group valued the intensity and felt that it had increased their motivation and willingness to engage in treatment. The intense week suited the work or study commitments of some clients, whereas for others it was easier to complete sessions on a weekly basis.

### ***Participation***

Orlinsky, Ronnestad and Willutzki (2004) conducted a review of the therapeutic process and treatment outcome literature. They found that the client's participation in the therapeutic process was the decisive factor in determining treatment outcome in most studies. Client participation includes the client's co-operative involvement in the therapeutic work, an openness and willingness to engage in the therapeutic process and a collaborative attitude (Orlinsky et al., 2004).

Bachelor, Laverdiere, Gamache and Borderleau (2007) found that 76% of clients believed that treatment outcomes were primarily determined by their own or joint efforts of themselves and the therapist. Similarly, in Hoerner's (2007) study client's perceived themselves as active agents in the therapy and felt that their own participation was a significant determinant of treatment outcome. Levitt & Rennie (2004) found that clients have an idea of what they need from therapy (see also Philips, Werbart, Wennberg, & Schubert, 2007) and actively manipulate the therapy to

meet their perceived needs (see also Rennie, 2000). Clients receiving a course of CBT for depression only used the tools offered to them that they found useful (Kuhnlein, 1999).

Levitt and Rennie (2004) reported that clients are able to use therapeutic blunders positively, and to their benefit. Clients construe therapist empathy as supportive or insightful dependent on whether they want support or insight (Bohart & Tallman, 2010). Selby (2004) reported that 50% of clients creatively directed the course of therapy, thereby facilitating positive treatment outcome. Levitt, Butler and Hill (2006) found that clients reflected on dialogue with the therapist, prepared for sessions, both before and after, and took initiative steps of their own accord to enhance the therapeutic process, e.g., reading self-help books. Clients also reflect on their experiences in therapy with friends and family (Moertl, 2007).

The person-centred paradigm (Rogers, 1957) emphasises the importance of the client-therapist relationship in psychotherapy. In Knox and Cooper's (2011) study clients stated they had made a conscious decision to show themselves at their most vulnerable and to enter into a relationally deep meeting with their therapist. Other client factors, which facilitated a meeting at relational depth included: Desire and willingness, being in touch with difficult emotions, and taking a risk (Knox & Cooper, 2011).

### ***Motivation***

Allumbaugh and Hoyt's (1999) meta-analysis of 35 bereavement studies found that individuals who seek treatment for bereavement voluntarily benefit more than individuals who are recruited for research purposes. The authors suggested that clients who self-select are more motivated. These findings could be explained in terms of distress levels, i.e., individuals seeking therapy to cope with grief are more distressed than those who do not (Allumbaugh & Hoyt, 1999). In this context Brown, Burlingame, Lamber, Jones and Vaccaro (2001) found that the best predictor of change in therapy was the client's level of distress, with higher levels related to superior treatment outcomes. Brown et al. (2001) suggested that clients became more motivated to engage and actively participate in therapy as their distress increased. It is important to note that this research is contraindicated by findings that individuals with personality disorders, with greater levels of impairment, and more destructive early relationships with significant others are more resistant to and less likely to benefit from treatment (Casotonguay & Beutler, 2006).

### ***Attachment style, perfectionism, ideas about therapy and spontaneous change***

Levy, Ellison, Scott and Bernecker (2011) found that adult attachment styles affect the quality of the therapeutic relationship: Adult attachment avoidance was negatively related to the

therapeutic relationship. Contrarily, adult attachment anxiety was uncorrelated. Zuroff et al. (2000) found that perfectionist patients were less able to develop strong therapeutic alliances and less able to increase the strength of the alliance over the course of treatment; significantly, there was a negative relation between perfectionism and outcome. Individuals who were more perfectionist did not feel less valued by their therapists but were less able to become fully involved in the therapy (Zuroff et al., 2000).

Phillips et al.'s (2007) study demonstrated that clients have different ideas of what they need when they enter therapy, which can have both a positive and negative impact on treatment outcomes. Some patients held ideas that are beneficial to treatment, e.g., that therapy is a means to process and understand problems (approaching). Others held detrimental ideas of cure around wanting to distance themselves from their difficulties (distancing).

Levitt, Butler and Hill (2006) reported individual differences in readiness to engage in the therapeutic process. Clients who had experienced therapy positively participated actively, read self-help literature in their own time, prepared for sessions and reflected on their therapy. Those clients who had not been helped by therapy stated that they weren't ready, that they were uninterested and resistant to the process.

Proponents of client factors (e.g., Bohart and Tallman, 2010) invoke a body of research around self-generated and spontaneous change to highlight the human potential for self-healing and the importance of the client. For example, Gurin (1990) reported that 90% of individuals questioned in a poll had overcome a significant emotional, health or addiction problem in the last year, without the benefit of professional help. Lambert, Shapiro and Bergin (1986) found that 40% of individuals recover from a mental health problem without seeking professional treatment. In Zanarini, Frankenburg, Hennen, Reich and Silk's (2006) study 88% of individuals with a diagnosis of borderline personality disorder achieved remission over a 10 year period.

### **Critique of the client factors research**

An amalgamation of unrelated research findings is used to highlight the importance of client factors. It is important to recognise the methodological limitations in this body of research. Bohart and Tallman (2010) noted that most studies are non-experimental (either correlational or qualitative) and retrospective, subject to ex post facto analysis. It is not possible to conduct experimental designs with individual difference variables, e.g., attachment style, trait resistance, treatment preference and motivation, as these cannot be randomly assigned (Swift & Callahan,

2011). Therefore, it is impossible to guarantee that participants are otherwise comparative (Norcross & Wampold, 2011). In a large number of studies client factors, e.g., preference, motivation, expectancy, are measured as an aside, post hoc, as the primary research aim is to measure treatment outcomes (Norcross & Wampold, 2011).

### ***Placebo effects***

As outlined proponents of client factors (e.g., Bohart & Tallman, 2010) have argued that placebo effects demonstrate that client expectations of treatment efficacy are an important determinant of outcome. Wampold, Minami, Tierney, Baskin, and Bhati (2005) stated that the placebo effect was large and robust. However, there are a number of methodological shortcomings in this study: It consisted of 11 trials, which is low and, therefore, an issue in terms of statistical power (Hrobjartsson & Gotzsche, 2007). Further, Wampold et al. (2005) intimate that the placebo effect was large as it did not differ significantly from that of the treatment. This implies that the treatment effect was large. However, as noted by Hrobjartsson and Gotzsche (2007) a sample of 11 trials does not provide sufficient statistical power to exclude relevant differences between trials. In their meta-analysis of 132 trials, which compared placebo with no treatment, Hrobjartsson and Gotzsche (2007) found that the placebo effect was not strong; further, even with 132 trials there was a clear indication of funnel plot symmetry in their data, which points towards small-sample bias. It is noteworthy that Wampold et al.'s (2005) and Hrobjartsson and Gotzsche's (2007) meta-analyses both yielded small placebo effect sizes, 0.29 and 0.28 respectively. Subsequently, Hrobjartsson and Gotzsche (2007) speculated that Wampold et al. (2005) were biased by their own core beliefs in interpreting their data.

Maltzman (2001) reported a number of factors, which limit the generaliseability of Wampold et al.'s (1997) and Ahn and Wampold's (2001) meta-analyses: Participants were predominantly white across the studies included; socio-economic status was addressed adequately in only two of the studies; therapist ethnicity was ignored completely and therapist gender was specified in 2 studies only; only 3 studies addressed client x treatment interactions and 4 studies examined therapist x treatment interactions.

### ***Spontaneous recovery***

Spontaneous recovery research is used to underline the importance of client factors (e.g., Bohart & Tallman, 2010). However, a closer inspection of Zanarini et al.'s (2006) borderline personality disorder (bpd) remission study reveals significant methodological shortcomings. Zanarini et al. (2006) noted that a large number of the no-treatment controls received help in some form, in

some cases even psychotherapy, outside of the parameters of the study. Others felt they had benefited from the assessment interview pre-study. Further, only 40% achieved remission within two years and it took 10 years for 3.7% to achieve remission.

Lambert et al. (1986) stated that their 40% spontaneous recovery estimation is a ballpark figure, which fails to capture wide variation in change rates contingent on the type of disorder. They concluded that, at present, there is not a reliable figure of spontaneous change in untreated individuals. Even if the 40% figure is correct 60% of individuals with mental health difficulties do not get better without treatment. In their review of the spontaneous recovery literature Lambert et al. (1986) concluded that results are significantly influenced by the subjective stance of the researcher; further, they argue that although individuals who recover spontaneously may not have psychotherapy it is likely that many seek support from friends, family, teachers, spouses and clergymen.

### ***Selective use of the literature***

When reading the client factor literature it is important to be aware that proponents use the available studies selectively to highlight the strengths of clients, which facilitate treatment outcomes. For example, Bohart & Tallman (2010) concluded from Zuroff et al.'s (2000) study that clients take from therapy what they need to get better. It would be more appropriate to state that successful clients take from therapy what they need to get better. In this study 162 out of the 239 clients dropped out of therapy before completion. Drop-out, otherwise known as premature termination is viewed as a major problem in psychotherapy (Swift & Callahan, 2011). Clarkin & Levy (2004) estimated that premature termination rates are between 30% and 60%.

Paradoxically a researcher bias towards client factors that facilitate therapeutic change does not detract from the importance of client factors. From the available research, presented in the previous section, a picture emerges of individual differences in characteristics and behaviour that can have either a positive or negative effect on treatment outcomes.

### ***Specificity – treatment ingredients***

Wampold et al.'s (1997) meta-analysis, which demonstrated that all psychotherapies intended to be therapeutic are equally effective is a seminal piece of common factors research. It is argued that 1.) the function of techniques is to provide a context in which the common factors are manifested and 2.) techniques are only of utility when embedded within the common factors (Wampold et al., 1997). In response to this argument Chwalisz (2001) calls for caution and warns that we should not “cut off our discipline’s nose to spite its face” (p. 262); although technique is

but one feature of psychotherapy it remains an important one. She imagines a worst case scenario of the lived common factors model where therapists do as they please with their clients, disregarding systematic treatment selection models.

There are two important points to be made in this regard. In terms of ingredients Chwalisz (2001) states that therapies may be achieving the same results through different mediating processes. Secondly, psychotherapies are potentially more similar than they are different. In administering brief psychodynamic psychotherapy therapists applied strategies typically described as psychodynamic as well as other interventions typically viewed as belonging to CBT, i.e., exploring irrational beliefs (Ablon and Jones, 1998). Goldfried, Raue and Costanguay (1998) reported extensive overlap in the workings of master therapists using the psychodynamic and CBT approaches. Leichenring, Salzer et al. (2009) demonstrated that both CBT and psychodynamic therapy for anxiety supported clients to face feared situations, although the approaches have different rationales for why this is important. In sessions where patients were encouraged to approach the feared stimulus raters were unable to distinguish between the two approaches (less than 75% agreement).

Ablon and Marci (2004) propose that the main divergence between therapies is how psychological constructs are conceptualised and that the processes are quite similar. They argue that unless the workings of the therapists are controlled for in randomised control trials comparing psychotherapies then results are not valid. Even when treatment protocols are strictly adhered to a minimal presence of ingredients that are affiliated with a different approach can predict positive outcome; this has been demonstrated for psychodynamic (Ablon and Jones, 1998) and interpersonal (Ablon and Marci, 2004) elements in CBT.

The most encouraging research in support of specificity can be found in the area of “sudden gains” (Tang, DeRubeis et al., 2007). Sudden gains occur when a client’s symptoms change significantly (in a positive direction) from one session to the next. Significantly sudden gains were preceded by dramatic changes in cognitions in prior sessions (Tang, DeRubeis, Hollon, Amsterdam, & Shelton 2007). Further, individuals who experienced sudden gains had better treatment outcomes and fewer relapses.

### **Implications for counselling psychology**

Despite methodological shortcomings in the available research, this review argues there is sufficient evidence to suggest that the client plays a significant role in psychotherapy treatment

outcomes. A number of common factors protagonists (e.g., Bohart & Tallman, 1999) have called for a new paradigm, which views client factors as the most important determinant of therapeutic outcome: Client motivation, openness and willingness to engage in treatment, active participation, commitment to integrate therapy into everyday lives, and creativity in utilising and taking what is needed from the therapy provided. This position is not intended to de-value the role of counsellors and model specific techniques but to highlight that client factors are of primary importance (Bohart & Tallman, 2010). It is the therapist's prerogative to provide the fertile ground where the client can activate her self-healing potential; techniques may be suggested, but the client will take from the therapy what best meets her needs (Bohart & Tallman, 2010). Taking a more conciliatory stance Wampold (2010) concluded that it is a matter of preference whether one emphasises the primary importance of common factors or model specific techniques; however, it is imperative to recognise the importance of the common factors.

### ***Adaptation***

This review proposes that the main implication for counselling psychology to emerge from the client factors research is that treatments should be tailored to meet client's individual and unique needs (Maltzman, 2001; Norcross & Wampold, 2011). For example, although CBT is highly effective for the treatment of a wide range of mental health disorders not all individuals get better or respond to treatment (Norcross & Wampold, 2011). Otto, Jasper, & Hannah (2004) found that the response rate of clients to CBT for social anxiety disorder was only 50%. Elkin (1994) reported a dropout rate of 33% in the CBT treatment of depression; further, 35% of those treated for a mental health problem do not resolve their difficulties to the extent that they no longer need to access services for that same problem.

Wampold (2010) stated that an understanding of the differences between treatment responders and non-responders is a vital factor in the continued development of psychotherapy. The 1995 APA task force aligned EBP with the medical model based on randomized clinical trials, the use of treatment manuals and a focus on the application of specific treatments for specific disorders (Wampold, 2010). In 2006 the American Psychological Association (APA) task force revised its definition of evidence based practice (EBP). Adopting a client focused approach the 2006 taskforce defined EBP as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p.273). Empirically based approaches are one of the required considerations of practitioners but are not requisite in the new EBP (Norcross, Beutler, & Levant, 2006).

Counselling psychologists are ideally placed to increase understanding of how treatments are best tailored to the client's individual needs. Consider a number of Norcross' (2002) training recommendations for psychotherapists to best enable them to achieve this goal: Therapists should be exposed to a number of the major models of psychotherapy; training should follow an apprenticeship model with trainees working closely with and being supervised by expert clinicians; training in the scientific method with an emphasis on critical thinking skills; substantial practices with a wide range of populations.

In 2011 the Journal of Clinical Psychology devoted an entire volume [67(2)] to increase understanding of how therapists can adapt psychotherapy to the client's individual characteristics. Paul's (1967, p. 127) question lay at the heart of their endeavour: "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, and under which specific circumstances?" What follows here are a number of recommendations, from the available research, for therapists to adapt their approaches to the client's individual needs.

Beutler's (2011) meta-analysis demonstrated that the client's level of resistance to treatment determines how well she responds to directive interventions. Therefore, therapists are recommended to match directiveness to patient resistance. Suggestions for high-resistance clients include fewer therapist instructions, more client talk-time and less rigid homework assignments. In their (2002) review Beutler, Moleiro, and Talebi (2002) found that unstructured, talking-based treatments were better for resistant clients, whereas more structured approaches, e.g., CBT, were better for clients who were less resistant.

Westra and Phoenix (2003) proposed that motivational interviewing (Miller and Rollnick, 2002) could be integrated into the other protocols, e.g., CBT, to reduce client ambivalence and resistance to treatment; they outlined the case of a client suffering from panic disorder, who was resistant to the traditional CBT protocol. She made statements such as "I can't" and "yes, but...". The client reflected that the therapy wasn't working and agreed with her therapist to adopt a new approach to treatment, motivational interviewing. Her resistance was acknowledged and the client was encouraged not to try and change her current difficulties. The focus of the therapy moved to a contemplation of change. In one exercise the client wrote 2 letters in which she imagined what life would be like in one year's time with and without change. She looked back over the content of the letters in the following session: The images of change made her feel happy and at peace whilst a maintained state of anxiety seemed unbearable. She was also asked to advise a hypothetical client on what steps to take to reduce her worry. She created her own interventions that, according to Westra and Phoenix (2003), were a match for any CBT

recommended course of treatment. In this period she reflected on the impact of her behaviours on her interpersonal relationships and began to listen to others' perceptions of her. After 3 sessions using the motivational interviewing approach this lady's anxiety score had reduced to the normal range (Westra & Phoenix, 2003). Prochaska and Norcross (2002) also found that ambivalent and resistant clients benefited from treatments, which focused on motivation and did not exert any pressure on them to take action.

Swift and Tallahan (2011) reported that when treatment was matched to clients' preferences they were between 30 and 50 percent less likely to drop out of therapy prematurely. Meyer and Garcia-Roberts (2007) found that clients were specifically motivated to use therapy to work on those factors that they perceived to be causal of their depression, e.g., early childhood relationships. Participants in Whalley and Hyland's (2009) study believed that therapies will be more effective if they are in line with their values; they read formulations of depression, which were informed by either CBT, person-centred therapy, psychodynamic therapy, or medical treatment and rated their belief in the effectiveness of each approach. It is important to note that the participants did not have therapy in this study. Therefore, it did not demonstrate a relationship between matching values to treatment and treatment outcomes. However, Kirsch (2005) found that clients' perceptions of the effectiveness of a therapy are an important predictor of treatment outcome. Bohart & Tallman (2010) stated that clients' perspectives on their problems should be valued and taken seriously; it is important for the therapist to relinquish control by including clients in the process of finding solutions, valuing the client's motivations even if these differ from those of the therapist.

Constantino, Arnkoff, Glass, Ametrano, and Smith (2011) found that client expectations of the efficacy of therapy impact on treatment outcomes; therapists are recommended to explicitly address these at the beginning of treatment and to carry out regular checks throughout. Levy, Ellison, Scott and Bernecker (2011) found that the client's attachment style is a significant correlate of treatment outcome; assessing client attachment style can provide information about how the treatment may progress. Hill et al. (2007) conducted a study of dream work with clients of East Asian origin. Clients with greater levels of attachment anxiety benefited from less therapist input regarding the content of their dreams, preferring to come to their own conclusions and interpretations. In contrast, clients with less attachment anxiety benefited more from an active therapist who provided more inputs. These findings resonate with Hardy, Stiles, Barkham and Startup's (1998) study, which demonstrated that therapists intuitively provide clients with less

attachment anxiety with more interpretations; they adopt a more supportive and reflective approach with clients with greater levels of attachment anxiety.

### ***Focus on client strengths***

Bohart and Tallman (2010) state proposed that an implication for treatment from the client factors research is that therapists need to place greater focus on client strengths and personal agency. This notion is supported by Gassman and Grawe's (2006) detailed analysis of 120 sessions of 30 clients; they found that successful therapists focused on client strengths, whereas unsuccessful therapist placed greater emphasis on client problems. Further, the successful therapist emphasised client strengths from the beginning of sessions, whereas their less successful counterparts tended to do this at the end of sessions. Gassman and Grawe (2006) conclude that it is vital for therapists to perceive clients as well functioning, resourceful, and resilient; if this was the case client's were more likely to begin work on their problems.

### **Discussion**

This review outlined and evaluated research of client factors that impact on treatment outcomes in psychotherapy. As Bohart and Tallman (2010) noted, most client factors studies are non-experimental (either correlational or qualitative) and retrospective, subject to ex post facto analysis; further, an amalgamation of unrelated research findings is used to highlight the importance of client factors. Proponents of client factors use "spontaneous change" findings selectively to demonstrate that client's are endowed with self-healing capacities that facilitate positive treatment outcomes. However, client characteristics, e.g., resistance, can also undermine therapeutic change (Swift & Tallahan, 2011). Despite these methodological shortcomings and theoretical biases this review argues that client factors play a significant role in treatment outcomes.

Clients are more likely to benefit from therapy if they expect positive outcomes (Wampold et al., 2005), are motivated (Allumbaugh & Hoyt, 1999), engage and actively participate in the therapeutic process (Hoerner, 2007), want to use therapy to understand and process their difficulties (Levitt et al., 2006), like the form of treatment (Swift & Tallahan, 2011), accept the therapist's formulation of their difficulties and agree with the therapist about treatment tasks and goals (Iacoviello et al., 2007). Treatment outcomes are also affected by client individual difference variables including attachment style (Levy et al., 2011) and perfectionism (Zuroff et al., 2000). Client variables such as attachment style, trait resistance, treatment preference and motivation,

cannot be randomly assigned; it follows that this line of research will rely heavily on correlational designs and qualitative studies (Norcross and Wampold, 2010). Nevertheless, more robust studies of this nature are needed in the future to underline the importance of client factors.

From a theoretical perspective this review endorses Wampold's (2010) impartial view that it is a matter of preference whether one emphasises the primary importance of common factors or model specific techniques; however, it is vital that the importance of both common factors and model specific techniques are recognised. Chwalisz (2001) imagined a worst case scenario of the lived common factors model where therapists do as they please with their clients, disregarding systematic treatment selection models. This review aligns itself with Ablon and Marci's (2004) proposal that the main divergence between the major psychotherapies is how psychological constructs are conceptualised and that the processes are quite similar. It is potentially for this reason that Wampold's meta-analyses (e.g., 1997) have reported zero differences in treatment outcomes between therapies that are intended to be therapeutic, and not because techniques are unimportant. This review seconds Wampold's (2011) proposal that further research is needed to understand how psychotherapies work.

The major implication for counselling psychology to emerge from this review is that we need to have an understanding of the client factors that impact on therapeutic outcomes in order to be able to adapt our work to the individual needs of our clients (Norcross & Wampold, 2011).

Recommendations included matching therapist directiveness to client resistance (Beutler, 2011), matching treatment to client preferences (Swift & Tallahan, 2011), evaluating client expectations throughout the course of therapy (Constantino et al., 2011), using motivational interviewing strategies with ambivalent and resistant clients (Westra & Phoenix, 2003), and focusing more on client strengths (Bohart & Tallman, 2010). It is argued that counselling psychologists, because of their training in the major psychotherapies and the scientific method, are ideally placed to lead the field in this area. Qualitative studies with counselling psychologists who adapt their work to the needs of their clients are a potential fruitful avenue for future research.

## **Conclusion**

Despite methodological shortcomings in the available literature this review has argued that client factors play a significant role in psychotherapy treatment outcomes. However, the role of model specific techniques should not be de-valued. Counselling psychologists need to understand the

role of client factors in order to tailor their work to the individual needs of their clients: We are ideally placed to lead the field in this area.

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