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The power of the therapeutic relationship in Cognitive Behavioural Therapy

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Thesis submitted in fulfilment of the requirements for the degree of Doctor of Psychology

City University
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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 to me. This permission covers only single copies made for study purposes, subject to normal conditions of acknowledgment.

Abstract

As the Cognitive Behavioural Therapy (CBT) model has developed in recent years, so has the role of the therapeutic relationship within that model. This portfolio aims to uncover aspects of the therapeutic relationship in CBT as it is practiced nowadays. The first section presents an overview in which the different parts included in this portfolio are briefly described, and the way in which they are linked together is outlined. The second section, the research component, explores qualitatively Counselling Psychologists' experience of the therapeutic relationship while practicing CBT. This section aims to provide the reader with insights from the therapists' perspective, which has been a largely neglected variable in the literature. The third section represents the clinical component and gives a vivid account of CBT with a client with anger issues. Finally, the fourth section, the critical literature review, presents the role of empathy in the cognitive behavioural treatment of depression. As a whole, the portfolio provides a broad view of different perspectives of the therapeutic relationship in CBT, and aims to increase awareness among researchers and therapists of how the research findings can be of use for clinical practice.

SECTION A: INTRODUCTION TO PORTFOLIO

1.1 Overview

The main theme of each part of this portfolio is the importance of the therapeutic relationship, and the feelings evoked within it, in Cognitive Behavioural Therapy (CBT). Given that CBT is the treatment of choice for many mental health problems at the moment, is highly recommended by the National Institute for Clinical Excellence (NICE), and is widely used in the National Health Service (NHS) in the U.K., it is vital that we understand a significant aspect of it, which is the therapeutic relationship. Therefore, the overall aim of this portfolio is to enhance the understanding of the therapeutic relationship in CBT by providing a number of different perspectives on it.

In order to achieve this, three main components are presented. Firstly, the research component is a qualitative study of Counselling Psychologists' experience of the therapeutic relationship while practising CBT. Research into the therapists' experiences and feelings is scarce, and therefore this study aims to provide a very important point of view, which unfortunately is often neglected. Secondly, the case study presents cognitive behavioural therapy with a client who had anger problems. It illustrates how the therapeutic relationship can be the vehicle through which unhelpful behavioural patterns are broken, and long-held core beliefs are identified and disconfirmed. Thirdly, the literature review focuses on the cognitive behavioural model of another common mental health problem, depression, and examines the role of empathy for the treatment of this client group. It reveals that there is strong evidence for the significance of clients' perception of empathy in the reduction of their depressive symptomatology, and presents the implications for Counselling Psychology.

It is hoped that this portfolio will increase awareness among researchers and therapists of the need to ground our understanding of the therapeutic relationship in CBT in the participants' perspectives. That is, we need to focus on the point of

view of both therapists and clients, and not merely on theoretical models. In this way, new insights can be gained, and the research findings can be of use for clinical practice.

The following three sections will provide a few more details about each of the three components. Finally some reflective threads and the link with my personal experiences will be presented.

1.2 The Research

This study was undertaken because, in spite of the recognition that the therapeutic relationship is very significant in Cognitive Behavioural Therapy, there is a paucity of research on the therapists' experience of it. In depth accounts given by the participants highlight the centrality of a number of aspects of the therapeutic relationship, some of which are specific to the CBT model and some which are not. Therefore, it is hoped that the study will be of use to CBT therapists, Counselling Psychologists, as well as other mental health professionals who develop a therapeutic relationship with their clients. The findings indicate the need to move towards a wider definition of several concepts in therapy in order to incorporate the participants' perspectives. Other implications for Counselling Psychology concern the role of psychologists not just as practitioners, but as scientist-practitioners as well.

1.3 The Case Study

The case study aims to give a vivid account of my own experience of the therapeutic relationship when providing CBT to a client with anger problems. My work with this client illustrates helpful and unhelpful ways of resolving ruptures in the therapeutic relationship. It also highlights how the integration of empathy within the approach can promote a number of goals of Cognitive Behavioural Therapy. Contrary to common misconceptions about CBT, the centrality of feelings in the work with this client is emphasised. Therefore, it is hoped that this case study can further promote the recent trend in CBT of viewing the

therapeutic relationship not merely as a contextual factor, but as a vehicle of change per se.

1.4 The Literature Review

The impetus for the critical literature review of the role of empathy in CBT for depression came from my own questions when treating depressed clients. I frequently wondered whether empathy was therapeutic for clients who often felt worthless, desperate and suicidal. I feared that on some occasions empathy might be anti-therapeutic by reinforcing further the clients' depressive thinking. Beck and colleagues (1979) advise that the CBT therapist should not rely on empathy too much. However, how can one measure the amount of empathy displayed? Fuelled by these questions and dilemmas, I searched for an answer in the literature. However, the therapist's perspective is once more neglected. Furthermore, the lack of qualitative studies in this area makes it difficult to understand how empathy is experienced by depressed clients and their therapists. The literature review indicates that the clients' perception of their therapist as empathic contributes towards the success of therapy. The implications for Counselling Psychology are that therapists need to routinely seek feedback from the clients about their experience of empathy. It is also hoped that this literature review will encourage researchers to explore the meaning of empathy in CBT for depression through qualitative studies.

1.5 Reflective Threads and Personal Experiences

So far it has been shown that one of the threads that connect all the pieces in this portfolio is the therapeutic relationship in Cognitive Behavioural Therapy. I became particularly interested in the role of the therapeutic relationship after having psychodynamic psychotherapy myself. On both occasions, I had a rather intense relationship with my therapists, with lots of ups and downs. I actually identified therapy with the person of the therapist, whom I experienced as deeply empathic. What I valued most in the therapeutic relationship was speaking to someone who was striving to make sense of what I could not make sense of,

someone committed to help me. I hope that in whatever approach I practice, my clients will have a similar experience. Therefore, I undertook this research in order to deepen my understanding of the therapeutic relationship and enhance my clinical practice.

On another level, a different thread which connects all the pieces of this submission can also be identified: integration is a theme that runs through each part. Integration has many different meanings and can take place on many different levels, some of which are illustrated in the pieces of this portfolio.

Integration is a concept highlighted by the participants in the research study in relation to themselves and the clients as well. The concept of integration is also central in the case study and literature review, as both pieces explore the integration of empathy, which traditionally was considered a person-centred process, in the cognitive behavioural treatment of anger problems and depression, respectively.

Personally, I consider my practice as integrative, since I draw on a number of different approaches, even when practising mainly within the cognitive behavioural framework. Moreover, integration has a deeper meaning for me, having grown up as part of a minority. I was born Jewish in Greece, where the Greek nationality is interwoven with the religion of Christianity. Integrating my Greek and Jewish identities into one has not been easy; yet, it has shaped who I am. Inevitably, it has also shaped my research interests, and probably my interpretation or reading of the research findings.

This portfolio is concerned with the integration of two other identities, that of a Counselling Psychologist and a CBT therapist. In this way it is of relevance to other Counselling Psychologists practising CBT. It seems to me that the focus on the therapeutic relationship is a primary bridge between these two identities. In this way, I hope that the different perspectives provided in this portfolio will

become the impetus for others to reflect upon how they experience the therapeutic relationship, and how they integrate the two identities of being a Counselling Psychologist and a CBT therapist in their clinical practice.

Reference

Beck, A.T., Rush, A.J., Shaw, B.F., & Emery, G. (1979). *Cognitive therapy of depression.* New York: Guilford Press.

Foreword

The biggest part of the research component of the portfolio is written in the third person. However, throughout the thesis personal accounts of reflexivity are included. This will hopefully provide the reader with a better understanding of the experience of conducting this study, and the rationale behind some of the decisions made. In the reflective accounts I have used the first person and highlighted this by the use of italics.

SECTION B: RESEARCH COMPONENT

CBT from within: Counselling Psychologists' experience of the therapeutic relationship while practising Cognitive Behavioural Therapy

Abstract

In the early writings of Cognitive Behavioural Therapy (CBT), the therapeutic relationship was portrayed as a necessary but not a sufficient condition for therapeutic change. However, as the CBT model has developed in recent years, so has the role of the therapeutic relationship within that model, and the therapeutic relationship is now considered by many as a vehicle of change in CBT. A literature review revealed that, despite researchers' interest in the therapeutic relationship in CBT, there is a paucity of qualitative studies into the participants' experience of it. The therapists' perspective in particular is largely neglected. The present study aims to contribute towards the closing of that gap by exploring Counselling Psychologists' experience of the therapeutic relationship while practising CBT. Semi-structured interviews were conducted with eight Counselling Psychologists. The participants had varying levels of experience and theoretical orientations, and worked in diverse settings. The interview data was analysed using Interpretative Phenomenological Analysis (IPA). The analysis yielded rich insights into the participants' interpersonal processes with clients, some of which were specific to the CBT model and some which were not. Furthermore, themes focused on the participants' intrapsychic processes towards integration and on their experience of working within a setting. The findings of the present study provide evidence of the need to reconceptualise and move towards a wider definition of the therapeutic relationship in CBT, which will emphasise that techniques and relational factors are interwoven. This study also highlights the need for the qualitative paradigm to infiltrate organisational and policy levels. The implications of the findings for

Counselling Psychologists in their therapeutic practice and their role within organisations are also discussed, and suggestions for future research are made.

Keywords: therapeutic relationship; therapists' experience; Cognitive Behavioural Therapy; Counselling Psychology; Interpretative Phenomenological Analysis; qualitative methodology

Chapter 1

Introduction

1 Introduction

The examination of factors that lead to a positive outcome in psychotherapy is one of the oldest themes in the literature. In the search for these factors, the therapeutic relationship has emerged as one of the variables that most consistently contributes to the success of therapy (e.g. Martin et al., 2000; Horvath & Symonds, 1991). Therefore, research confirmed what was already known through clinical wisdom: the outcome of therapy depends on the quality of the relationship that the therapist and client establish (Sexton & Whiston, 1994). As a result of these findings, an increasing number of researchers have shown interest in the therapeutic relationship. In particular, a number of studies on the clients' perception or rating of the therapeutic relationship have been conducted.

But why study the therapist's experience of therapy (Orlinsky & Howard, 1977), or indeed the therapist's experience of the therapeutic relationship? As Garfield (1997 as cited in Skovholt & Ronnestad, 2003) observes, the therapist has been a neglected variable in therapy research. However, research on the therapists' experience of psychotherapy and the therapeutic relationship will shed some light on their reactions to clients, and thus on the therapeutic process. Therefore, the research findings could have significant clinical value. The present study aims to contribute towards the closing of the gap in the literature, by presenting Counselling Psychologists' experience of the therapeutic relationship while practising Cognitive Behavioural Therapy (CBT).

The focus on CBT in particular in the present study is guided by a rationale. Early theorists in CBT often assumed the development of a good therapeutic relationship, and therefore did not explore it in depth. Yet, the research findings

indicate that the quality of the therapeutic relationship leads to a positive outcome (e.g. Burns & Nolen-Hoeksema, 1992; Muran et al., 1995; Castonguay et al., 1996; Trepka et al., 2004). This has had a profound impact on the theory of the cognitive behavioural approach. The therapeutic relationship has recently been re-examined, and is now considered by many theorists not as a secondary, contextual factor but as a means of promoting understanding and therapeutic change that has primary importance (Waddington, 2002). Therapists' perspectives on this will capture the current prominence of the therapeutic relationship in the practice of cognitive behavioural therapy.

In the remainder of this chapter, an overview of the CBT model and the therapeutic relationship as part of this model are presented. This is followed by a literature review on the therapeutic relationship in CBT, with a focus on the methodological limitations of the studies and suggestions for overcoming them. At the end of this chapter, the aims of the current research are presented.

Chapter 2 is concerned with the methodology employed in the present study, while chapter 3 provides an overview of the findings. Chapters 4, 5, and 6 are divided into two sections. The first section of each of these chapters presents the findings of the study, while the second section contextualises the findings in relation to existing relevant research and theories. Finally, in chapter 7 some conclusions from this research are drawn.

2 Overview of Cognitive Behavioural Therapy

Cognitive Behavioural Therapy (CBT) is not a homogeneous theoretical approach but encompasses many different perspectives which share some common principles (MacLaren, 2008), since various forms of CBT have now been developed by many significant theorists (Dobson & Dozois, 2001). One of the difficulties that has persisted through the development of the different types of CBT has been the definition of their scope. Therefore, some definitional issues are addressed at the outset of this section.

Dobson and Dozois (2001) assert that all CBT approaches share the following three basic principles: cognitions affect behaviour, cognitions may be monitored and modified, and behavioural change may be accomplished through cognitive change. One of the main dimensions that differentiate the various types of CBT is their orientation towards different degrees of cognitive versus behavioural change. In the present study, the term 'Cognitive Behavioural Therapy (CBT)' is used to encompass all the therapeutic approaches that emphasise the interaction between the cognitive, behavioural, and physiological systems and target any of these systems in order to reach therapeutic change (Newell & Dryden, 1991).

Scott and Dryden (2003) suggest the categorisation of the different types of CBT under the following four main headings: coping skills therapies, problem-solving therapies, cognitive restructuring therapies, and structural cognitive therapy. Cognitive therapy, as developed by its founder Aaron Beck (Beck et al., 1979), falls within the domain of cognitive restructuring therapies. Cognitive therapy is defined as 'a system of psychotherapy based on a theory of psychopathology which maintains that how an individual perceives and structures his experiences determines how he feels and behaves' (Weishaar & Beck, 1986, pp.63). Therefore, cognitive therapy differs from other types of CBT in terms of its emphasis on the primacy of the unique and idiosyncratic cognitions of the client in addressing the client's difficulties (Weishaar & Beck, 1986).

It is beyond the scope of this section to present all the different orientations within CBT. This section will focus mainly on the theory of Aaron Beck (1976; Beck et al., 1979), as he is considered by many the founder of this approach (Dobson & Dozois, 2001), and on the theories of Young (1999), and Safran and Segal (1996), as they explored further the concept of schema, which seems to be particularly relevant to the therapeutic relationship.

2.1 The origins of Cognitive Behavioural Therapy

The philosophical roots of CBT can be traced back to Greek Stoic philosophy, and Epictetus, in particular, who observed that people are disturbed not so much by events but by the views which they take of them. Similar thoughts were also expressed within the realm of Eastern philosophies, such as Taoism and Buddhism, as they emphasised that people's emotions are based on ideas (Beck et al., 1979).

The founding father of cognitive therapy, Aaron Beck, maintains that the cognitive model was to some extent a derivative of and to some extent a reaction against psychoanalysis (Beck, 1991). While embracing the emphasis on meanings and generalised reaction patterns, Beck rejected the importance of the unconscious and psychosexual stages of human development. Therefore, Beck, as well as Ellis (1962 as cited in Gilbert & Leahy, 2007), asserted that people's thoughts regulated their emotions and behaviours.

The origins of behavioural therapy can be found in the work of Pavlov on animal learning, of Thorndike on the consequences of reinforcement and punishment, and of Watson on application of behavioural principles to create an anxiety response (Hawton et al., 1989; Gilbert & Leahy, 2007). Behaviourists rejected the utility of introspection, and aimed to examine only observable behaviour.

The integration of cognitive and behavioural approaches took place in the 1970s, as a result of Bandura's work on the contribution of cognitive factors in observational learning, and the increasing popularity of Beck's theory (Hawton et al., 1989). Some of the common principles underpinning the cognitive behavioural perspective on personality, psychological disturbance, and mechanism of change will be reviewed in the following sections.

2.2 Theory of Personality

In his early writings, Beck (1976) postulated a view of people as scientists, who, without recognising it, develop concepts and formulas to guide them based on their earlier observations and experiences. Even though the centrality of cognitions is emphasised, it is assumed that human experience also consists of emotions, behaviours, and physiological reactions. All these four elements constantly interact with one another. Change in cognition is thought to cause changes in all the other elements of human experience (Greenberger & Padesky, 1995).

Within the CBT model, the cognitions are presented as consisting of different levels (Scott & Dryden, 2003). At the deepest level lie the core beliefs, which are beliefs that people develop about themselves, others, and the world during childhood (Beck, 1995). Core beliefs influence the development of an intermediate class of beliefs, which consists of attitudes, rules, and assumptions. Both core and intermediate beliefs in turn influence how a person thinks about a specific situation he/she encounters. The thoughts and images that are generated involuntarily in a person's stream of consciousness are referred to as automatic thoughts (Beck & Greenberg, as cited in Curwen et al., 2000).

Within this model opinions of different theorists vary as to where the concept of schemas lies. In his early writings, Aaron Beck (1964, as cited in Beck, 1995) suggested that schemas are cognitive structures within the mind, the specific content of which are core beliefs. However, later on he used the term schema to refer to both core beliefs and assumptions, which is a type of intermediate beliefs. In the present study the term schema will be used only to describe core beliefs, as suggested by Padesky (1994).

Schemas develop as part of normal cognitive development so that people can organise into categories and understand the multitude of stimuli they encounter in the world. Schemas are related both to personal and impersonal categories

(Padesky, 1994). Beck and associates (2004) suggest that schemas have four qualities which determine the extent and the way in which they affect the person's cognitive processes. All these qualities exist on the following continua: broad to narrow, flexible to rigid, prominent to minor, and latent to hypervalent. All cognitive and emotional systems derive from the schemas, since schemas determine how we process and interpret information in a consistent manner.

2.3 Perspectives on psychological disturbance

According to the CBT model, psychological disturbance is a result of cognitive distortions, which lead to maladaptive interpretations of events in the person's life. These cognitive distortions or biases can occur on all the three levels of cognition described above (i.e. core beliefs/schemas, intermediate beliefs, automatic thoughts) and stem from negative childhood experiences and opinions of significant others (Beck et al., 1979).

On the level of automatic thoughts, the cognitive distortions are referred to as thinking errors. These are errors that the individual makes systematically, thus confirming their negative concepts despite the presence of contradictory evidence (Beck et al., 1979). Curwen and colleagues (2000) list the following most common thinking errors: all or nothing thinking, personalisation, catastrophising, emotional reasoning, should statements, selective abstraction, discounting the positive, overgeneralisation, magnification and minimisation, labelling, and jumping to conclusions.

On the deepest level of cognition, the cognitive distortions are commonly referred to as maladaptive schemas. Maladaptive schemas are developed in childhood due to ongoing negative experiences with significant others, and form the foundation of a person's concept of themselves, others, and the world (Young, 1999). They tend to be global, overgeneralised, and rigid, and have a self-perpetuating quality (Curwen et al., 2000). As a result, they lead to significant psychological distress in a recurring manner. Aaron Beck (as cited in Beck, 1995)

has suggested that there are two main categories of maladaptive schemas: those related to helplessness and those related to unlovability.

Young (1999) asserts that maladaptive schemas develop when the primary developmental needs of a child are not met. He lists eighteen maladaptive schemas that are categorised under the following five domains: a) disconnection and rejection, b) impaired autonomy and performance, c) impaired limits, d) other-directedness, and e) overvigilance and inhibition. Young maintains that even though these schemas may have been functional when the individual was a child, they are not adaptive for an adult, who most likely lives in a different environment. However, the schemas are perpetuated due to three processes. Schema maintenance refers to the cognitive process of exaggerating information that confirms the schema and minimising information that contradict it, and to self-defeating patterns of behaviour. In order to maintain the validity of maladaptive schemas, individuals also resort to schema avoidance, that is avoiding activating the schema by blocking related thoughts and feelings. Schema compensation involves developing cognitive and behavioural styles that seem the opposite of the actual schema held.

Similarly, Safran and Segal (1996) highlight the importance of schemas, and particularly of interpersonal schemas, in psychological disturbance. They explain that the interpersonal schemas represent goals and rules for self-other relationships. The individual develops these schemas very early in life in order to maintain interpersonal relatedness with the primary caregiver. Psychological disturbance occurs when a person, guided by early interpersonal schemas, repeatedly employs strategies which used to be adaptive in his environment as an infant, but are not functional in the current environment.

2.4 Therapeutic strategies and mechanisms of change

The goal of cognitive behavioural therapy was initially portrayed as mainly symptom reduction, which would come about through the modification of the

person's thinking and behaviour (Beck et al., 1979). However, more recently CBT is employed for more complex difficulties, such as personality disorders (Beck et al., 1990). Thus the aim of change now is presented as personality reorganisation, which can be achieved through the disconfirmation of dysfunctional schemas (Beck, 1991). The strategies that a therapist can use are numerous and depend upon the individual client's case conceptualisation. However, the mechanism which makes all these strategies effective is cognitive change.

Cognitive change can take place on any of the levels of cognition presented above. The deeper the cognitive construct, the more profound the change. At the level of negative automatic thoughts, the therapist can use an array of cognitive techniques, which will allow the client to monitor their cognitions, and if needed, modify them in order to represent more accurately all the evidence available. The principles of therapy that are postulated as particularly important are collaborative empiricism and guided discovery (Beck, 1991). Client and therapist collaborate in order to discover, through the use of empirical methods, any biases in the clients' thinking, and how these could be revised. Behavioural techniques are used in order to break the maladaptive pattern of cognition-emotion-behaviour, as well as to test any dysfunctional thoughts.

Padesky (1994) has elaborated on the mechanisms through which old maladaptive schemas can be weakened, while new ones are strengthened. These include using continuum charts from the maladaptive to the alternative schema, keeping a log of data that confirm the new schema, and using psychodrama and core belief worksheets. Young (1999) on the other hand underscored the importance of using a variety of techniques in order to trigger the maladaptive schemas. Change comes through cognitive techniques, which focus on the available evidence, experiential techniques, such as imagery, and behavioural techniques which will encourage the individual to behave in a way that is not consistent with the maladaptive schema.

Young (1999) and Safran and Segal (1996) have also emphasised the use of the therapeutic relationship as a powerful means through which schema change can be achieved. This will be elaborated further in the following section.

3. The role of the therapeutic relationship in Cognitive Behavioural Therapy

In the early writings of Cognitive Behavioural Therapy, the therapeutic relationship was portrayed as a necessary but not sufficient condition for therapeutic change. However, as the CBT model has developed in recent years, so has the role of the therapeutic relationship within that model. At the moment, there are a number of different discourses within the circles of CBT theorists about the client-therapist relationship, which emphasise different aspects and different functions of the relationship. Therefore, the principles underlying Clarkson's (2003) integrative psychotherapy framework of different relationship modalities seem useful in the conceptualisation of the therapeutic relationship in CBT. Similarly to Clarkson's model, the different types of therapeutic relationship in CBT presented here are not mutually exclusive. Nevertheless, at different times in therapy, one mode of therapeutic relationship might predominate, while others might be more in the background. Some of the types of therapeutic relationship that have been explored within the CBT literature will now be presented.

3.1 The therapeutic relationship as the necessary but not sufficient condition

This was one of the first types of conceptualisation of the therapeutic relationship in the CBT model. Within this framework, the therapeutic relationship is portrayed as a background factor, which will create a fertile environment so that the specific cognitive techniques can be applied most effectively (Beck et al., 1979). There is an understanding that without a good therapeutic relationship, CBT cannot be successful. However, the crux of CBT is cognitive change, and that change is not

perceived as feasible through the means of the therapist-client relationship. Influenced by Rogers' (1957) theory, and yet not embracing it fully, Beck described the attributes of a good CBT therapist as warm, empathic, and genuine, while stressing that these attributes are not enough for successful therapy. Furthermore, within this mode of therapeutic relationship in CBT, Rogers' core conditions are portrayed as potentially quantifiable constructs: too little warmth, empathy, and genuineness will obstruct the formation of a positive therapeutic relationship, while an increased dose of these conditions can also prove countertherapeutic (Beck et al., 1979; Persons, 1989). This conceptualisation of the therapeutic relationship in the CBT approach is increasingly becoming less popular, while most therapists focus on the modes of relating that are described below.

3.2 The therapeutic relationship as 'transference' and 'countertransference'

Influenced by the analytic literature, this mode of relationship includes all the negative and positive feelings that therapist and client have for one another which do not correspond to reality. Beck (Beck et al., 1979) used the actual terms 'transference' and 'countertransference' in quotations marks (p.58), and conceptualised them as problematic reactions which threaten the integrity of therapy. In particular, transference was perceived as stemming from the client's cognitive distortions, and countertransference as stemming from the therapist's complete identification with these distortions. The collaboration between therapist and client tends to dilute these 'problematic reactions' (Beck et al., 1979). Nevertheless, if they persist, therapists are advised to use cognitive techniques, such as the Dysfunctional Thought Record, in order to find alternative, more adaptive responses to the client (Beck et al., 2004). Lazarus (2003) argues that a focus on 'transference' and 'countertransference' when therapy is proceeding well might disrupt the process and prove countertherapeutic.

Layden and colleagues (1993) on the other hand, view countertransference as a potentially valuable means of gaining a deeper understanding of the client. They

define countertransference as representing 'the totality of the therapist's responses to the patient, including automatic thoughts, elicited beliefs or schemas, emotions, actions, intentions and so on' (p.117). Rudd and Joiner (1997) argue against the conceptualisation of the therapeutic relationship in CBT as transference and countertransference, because the psychodynamic roots of these concepts violate the principles of CBT. Instead, they propose the application of the therapeutic belief system (TBS) as a framework which is compatible with the underlying theory of CBT. According to the TBS both therapists' and clients' perceptions of the therapeutic relationship consist of material with varying degrees of accessibility. The therapist-client interaction is described as shifting along a continuum of the following three dyads: aggressor-helpless victim, collaborating partners, and savior-caretaker. Rudd and Joiner maintain that insight into both participants' perception of the therapeutic relationship could lead to productive cognitive restructuring, as long as this insight is conceptualised in cognitive terms and not by borrowing the psychodynamic constructs of transference and countertransference.

3.3 The therapeutic relationship as a teacher-student relationship

In this mode, the educative aspect of the therapeutic relationship is underscored. The therapist has the knowledge of the CBT model. However, the therapist does not hold on to the knowledge as a means of creating a power imbalance in the relationship. On the contrary, the therapist empowers clients by socialising them into the CBT model and teaching them skills and techniques to identify, evaluate, and modify unhelpful thoughts and beliefs (Beck, 1995). Like a good teacher, the therapist is not dogmatic and does not try to persuade clients of the correctness of the model; in contrast, the therapist uses guided discovery, thus leading the clients to discover the knowledge themselves.

3.4 The therapeutic relationship as a collaborative endeavour

Beck was one of the first within the field of CBT to emphasise the collaborative aspect of the therapeutic relationship. This mode of relating is similar to the

teacher-student view of the therapeutic relationship described above. However, the difference in this type of therapeutic relationship is the equality of the two participants. When the collaborative nature of the relationship is highlighted, the therapist is considered as the expert in the CBT model, and the client as the expert in their life. The therapist ensures that the client is actively participating in the process of therapy through the use of collaborative empiricism. Therapist and client form a team and put joint effort into the exploration of the client's difficulties and the ways these can be overcome (Beck et al, 1979). The end goal of this joining of forces is the self-responsibility and self-efficacy of the client (Overholser & Silverman, 1998).

3.5 The therapeutic relationship as a tool which promotes understanding and therapeutic change

Most contemporary theorists of CBT embrace the view of the therapeutic relationship as a vehicle of change. However, what often gets overlooked in the literature is that Aaron Beck was the first one to point out this role of the therapist-client interaction. In his seminal work *Cognitive therapy of depression* (Beck et al., 1979), he observed that the therapist's warmth 'may help to correct specific negative cognitive distortions' (p. 46) which the client often makes in relationships. Beck and colleagues (2004) further analysed this function of the relationship later on, and postulate that the feelings aroused in both therapist and client can illuminate the different meanings or subtleties of the client's difficulties. Another situation in which the therapeutic relationship is described as promoting change is when the therapist becomes the client's role model with regards to relating to others. Finally, Beck and colleagues (2004) assert that the therapeutic relationship can facilitate cognitive change through appropriate boundary setting. They explain that setting boundaries can be curative for the client, as this will help disconfirm any maladaptive beliefs they hold about limits.

According to the case formulation approach (Persons, 1989), the therapist-client interaction, as well as the feelings evoked, can yield important information about

the client's underlying beliefs, and the client's effect on other people. The therapeutic relationship is therefore seen as a means to deepen understanding of the client's difficulties. Furthermore, Persons argues that the therapeutic relationship can be a powerful tool for cognitive change during the session. Similarly, Jacobson (1989) suggests that if the therapist reinforces functional interpersonal behaviours that take place within the therapeutic relationship, therapeutic change takes place. Jacobson points to Safran for the specific mechanisms through which this change occurs.

Safran and Segal (1996) are well-known for their view of the therapeutic relationship as a vehicle for change in CBT. They posit that during therapy, the client's schemas lead him/her to interact with the therapist in a similar way to other relationships in the outside world. If these schemas are dysfunctional, the therapist may get pulled into a maladaptive interpersonal cycle. By being a participant-observer, the therapist can recognise the subtle processes through which the client instigates and maintains this interpersonal cycle, and unhook himself/herself. Therapeutic change comes about when therapist and client explore the feelings evoked in the interaction and relate them to the client's maladaptive schemas. The therapist uses the skill of metacommunication to disclose his/her subjective experience of the therapeutic relationship, and disconfirm the client's negative beliefs.

Young (1999) has also discussed the therapeutic relationship as a vehicle of change. Events during the session can trigger the client's schemas. Then therapist and client can use this as an opportunity to explore the aspects of the therapeutic relationship which the client found difficult, thus triggering the schemas. The therapist is advised to encourage the client to reality test these negative beliefs and use self-disclosure as a means of disconfirming them. Young goes even further in his view of the relationship as a therapeutic tool, and describes it as a form of reparenting. After finding out which needs of the client were not met during childhood, the therapist can provide a therapeutic

relationship which caters for these needs. In this way the client can re-learn more adaptive schemas.

3.6 The definition of the therapeutic relationship in the present study

Following the suggestions of Sexton and Whiston (1994), in the present study, the therapeutic relationship is defined as the 'aspects of the client and counsellor and their interaction that contribute to a therapeutic environment' (p.8). This definition is broad enough to encompass all the modes of the therapeutic relationship in CBT described above. Furthermore, this definition is suitable for an inquiry into the participants' perspectives and experiences, as it encourages the construction of multiple, equally valid meanings and interpretations of the therapeutic relationship.

4. Literature review on the therapeutic relationship in CBT

As will be discussed later, the studies in this area have been largely influenced by the postpositivist paradigm. Most of the studies reviewed have used quantitative methodology and examined whether there was a correlation between an aspect of the therapeutic relationship and outcome. Both therapeutic relationship and outcome are on most occasions operationally defined as a score in a questionnaire. First the quantitative studies are reviewed in this section, and then the findings of the few qualitative studies are also presented. In the end of this section the literature in the area is critically evaluated, and suggestions for the refinement of methodology are provided.

4.1 Quantitative studies

The working alliance has been consistently found to predict therapeutic change (Martin et al, 2000). However, despite its perceived significance within many treatment models, only few studies have examined the alliance both across and within different approaches. Two recent meta-analyses (Horvath and Symonds, 1991; Martin et. al., 2000) conclude that the relation of the therapeutic relationship and outcome is not influenced by the type of therapy. Contrary to this

finding, Raue et al (1993) found significantly higher total alliance scores in CBT than in interpersonal therapy. On the other hand, Krupnick et al (1994) found a significant relationship between alliance and outcome only for interpersonal therapy, but not for CBT. In another study examining alliance across different treatment modalities (Gaston et al, 1998), only some alliance dimensions predicted outcome in brief dynamic therapy, while all alliance dimensions were associated with a positive outcome in CBT. Consequently, it is premature to claim that the therapeutic relationship acts in the same way across all treatment modalities.

4.1.1 Core conditions and outcome in CBT

Rogers (1957) postulated that six conditions are necessary and sufficient for therapeutic change in any type of therapy. These refer to two people being in psychological contact, the therapist feeling empathy, congruence, and unconditional positive regard towards the client, and the client being in a state of incongruence, and experiencing the therapist as empathic, genuine, and acceptant. Rogers (1957) hypothesized that if these conditions are present, then constructive personality change takes place. Since Rogers (1957) developed this theory, several studies have been conducted in order to test it. The findings do not support the hypothesis when ratings from observers are used; however, they consistently demonstrate a positive relationship between clients' perception of the therapeutic relationship and outcome (Orlinsky, Grawe, and Parks, 1994; Gurman, 1977).

Within the CBT framework, empathy has been studied more than the other conditions, and has been found to have a medium effect size on outcome. Interestingly, this association was larger than that reported in other types of therapy (Bohart, Elliott, Greenberg, & Watson, 2002).

Beckham (1989) was one of the few researchers that did not find a positive relationship between core conditions and outcome. He used the Barrett-Lennard

Relationship Inventory (B-L RI; Barret-Lennard, 1962) in order to determine whether the clients' perception of their therapist as empathic, warm, and congruent predicted their rapid response to cognitive behavioural therapy of depression. The main methodological problem that suggests that this study may lack external validity is that the core conditions were assessed after the first session. Had measurement taken place a little later in therapy, the results may have been different.

Similarly, Blatt, Zuroff, Quinlan, and Pilkonis (1996) failed to find a relationship between clients' perception of the core conditions after the second session and post-treatment depressive symptoms. However, further analyses of the data revealed a complex interaction between perfectionism and the therapeutic relationship. The levels of experienced relationship conditions were strongly related (p<.001) to outcome for people with moderate levels of perfectionism; on the contrary, the quality of the therapeutic relationship was not predictive of therapeutic gain at low levels of perfectionism, where outcome was generally good, or at high levels of perfectionism, where outcome was generally poor. This study highlights the important role that clients' personality factors play in relationship between core conditions and outcome.

Burns and Nolen-Hoeksema (1992) used structural equation modelling in order to remove the causal effect of depression severity on clients' ratings and found that empathy was associated with a positive outcome (p<.01), while controlling for homework compliance. However, empathy was measured only after the 12th session. Even though the effect of depression severity was removed, client's ratings of empathy may have been influenced by other factors, such as feelings of trust that had developed during their course of therapy.

Therefore, it could be concluded that the relevant literature partially supports Rogers' hypothesis in CBT. Nevertheless, the fact that the core conditions were assessed only once in all the above studies limit the generalizability of their

results, and underline the need of a study measuring the relationship factors at several points during therapy.

4.1.2 Working alliance and outcome in CBT

The alliance is a concept that has been defined and redefined numerous times in the research literature and at the moment a universally accepted definition does not exist (Horvath, and Bedi, 2002). Despite its psychodynamic origins, it was later conceived as a pantheoretical factor (Horvath and Luborsky, 1993). Luborsky (1976) suggested that in the beginning of therapy, type I alliance develops, 'based on the patient's experiencing the therapist as supportive and helpful' (p.94); at a later stage, type II alliance becomes evident, based on the patient's 'sense of working together in a joint struggle against what is impeding the patient' (p.94). Bordin (1979) proposed a broader definition of the alliance, as consisting of three components: agreement on goals, agreement on tasks, and development of bonds. Even though he did not consider it curative as such, he postulated that it 'is one of the keys to the change process' (p.252).

Within the CBT orientation, the alliance has been viewed as necessary but not sufficient for therapeutic change to take place (Beck et al.,1979), and only recently did it start receiving attention. Since the relation of alliance and outcome appears to be influenced by the type of rater (Horvath and Symonds, 1991; Fenton et al., 2001), the studies reviewed will be presented according to the observational perspective they adopt.

Five studies that investigated the relationship between observer-rated working alliance and outcome in CBT were identified. Krupnick et al. (1994) examined the effect of the alliance on outcome in four types of therapy, and did not find a significant association for CBT. This result, however, could be attributed to the very small sample used (N=14). In a study conducted by the same team (Krupnick et al, 1996) on a bigger sample, a positive relationship was found. Similarly, Gaston and colleagues (1998), as well as Castonguay and colleagues

(1996), provided evidence that observer rated alliance predicts outcome in CBT. This was also confirmed by a study in which clients suffering from bulimia took part, and outcome was operationally defined as purging frequency (Loeb et al., 2005).

Startup and colleagues (2006) compared clients who dropped out of therapy prematurely to clients who completed CBT for psychosis. The two groups did not differ with regards to the bond aspect of the therapeutic alliance, as rated by trained judges. However, the observers reported that clients who ended therapy prematurely were less engaged in treatment, showed less agreement with their therapist, and had different recovery styles. The authors concluded that this provides evidence that premature endings were due to the clients' attitude towards their mental health problems and not due to the therapist. However, the reported different recovery style between the two groups does not exclude any other factors from contributing to the premature ending.

Client-rated working alliance has received more attention recently. Muran and his colleagues (1995) found that the clients' rating of the alliance was one of the strongest predictors of outcome in short-term CBT. Consistent with this finding are also the studies conducted by Safran and Wallner (1991), and more recently by Trepka and colleagues (2004), who confirmed that alliance ratings during therapy correlated significantly with the outcome.

Rector and colleagues (1999) examined the relationship among client rated alliance, change in cognitions, and outcome. They reported that agreement on goals and tasks predicted change in dysfunctional beliefs. Furthermore, reduction in depressogenic cognitions was associated with symptom change, only when the bond component of the working alliance was rated highly. Therefore, they provided evidence for the view of the helping alliance as necessary for therapeutic change.

In a study where people with personality disorders participated (Strauss et al, 2006), an interesting finding with regards to alliance ratings over time came forward. The authors claimed that apart from high early alliance ratings, episodes of alliance ruptures that were later repaired, were also positively related with improvement in symptoms. Finally, Klein et al, (2003) obtained ratings of the alliance in the beginning, middle and end of cognitive behavioural therapy. After controlling for early therapeutic gains and relevant patient characteristics, alliance still predicted reduction in depressive symptomatology. This study provides evidence against the theory that the positive relationship between alliance and outcome is due to early therapeutic improvement or patients' personality traits.

The findings from studies in which more than one observational perspective was adopted, seem controversial. Karver and colleagues (2008) found that the ratings of clients and judges correlated with each other; however, both types of ratings only predicted the client's involvement in therapy, and not outcome. According to Dunn and colleagues (2006), there was no significant agreement between therapists and clients on the quality of the alliance; both types of ratings predicted the client's homework compliance, but not outcome. In another study, only the client's reports of the alliance were associated with outcome and not the therapists' ones (Shirk et al., 2008). However, other researchers employing multiple observational perspectives maintain that only observer ratings predict outcome, and not the perceptions of clients and therapists (Langhoff et al., 2008; Fenton et al., 2001). Overall, it seems that the ratings from clients, therapists, and observers do not converge, and in different studies different types of ratings are found to predict outcome.

4.1.3 The relationship among the core conditions, working alliance and outcome in CBT

There has been considerable debate with regards to whether the core conditions and working alliance are distinguishable constructs or different measures of one

underlying variable. The empirical data in the field is insufficient to allow definite conclusions to be drawn (Horvath and Luborsky, 1993). In one study (Salvio, Beutler, Wood, and Engle, 1992) which used self-report measures of the core conditions and the working alliance, high correlations (.65 - .85) were reported among the subscales of the two instruments. Furthermore, all subscales loaded on the same factor. These results could be interpreted as indicating that the Barrett-Lennard Relationship Inventory (B-L RI) and the Working Alliance Inventory (WAI) measure the same construct. However, one of the limitations of this study is the fact that the core conditions were assessed only after the last session. The relationship between the facilitative conditions and helping alliance in the early and middle phase of therapy may have been different.

Two studies that explored the relationship between core conditions, alliance, and outcome in CBT, used an observer-rated scale in order to assess the facilitative conditions, and a self-report measure for the alliance. Both of them (DeRubeis, & Feeley, 1990; Feeley, DeRubeis, & Gelfand, 1999) found that neither the facilitative conditions nor the alliance predicted change in depressive symptomatology. However, there are serious limitations in these studies question the generalisability of their results. In both studies, the samples were too small to reveal a relationship of a medium, or even of a large size (Howell, 1997). Moreover, the raters were undergraduate students with no clinical experience. Finally, the fact that the psychometric properties of the scale used to assess the core conditions (Collaborative Study Psychotherapy Rating Scale) are not reported raises serious doubts about the validity of the instrument.

Zuroff and Blatt (2006) used the B-L RI (Barrett-Lennard, 1962) and the observer-rated Vanderbilt Therapeutic Alliance Scale in their study. The correlation between them was small, and the authors claim that the two instruments measure different dimensions of the therapeutic relationship. However, the different perspectives (client versus observer) and the different

times of assessments suggest that there may be alternative reasons for this result. With regards to outcome, only the B-L RI predicted symptom reduction.

The controversial results of the studies reviewed so far can be attributed to the different types of raters they use in order to assess the core conditions and the alliance. There seems to be a tendency for a relationship to be observed between clients' ratings and outcome, and not between observers' ratings and outcome. The only recent study which used only client ratings for both the relationship conditions and the working alliance is the one conducted by Watson and Geller (2005). They tested and confirmed the hypothesis that the working alliance mediates the relationship between the core conditions and outcome. The most serious limitation of this study is the late assessment of the facilitative conditions. The authors propose that in the future the possibility of a halo effect needs to be tested by several ratings of the core conditions during therapy. Furthermore, the review of the pervious studies has highlighted the need for simultaneous assessments of the relationship conditions and the alliance, using established scales rated by the same type of raters.

4.2 Qualitative studies

No qualitative studies exploring the experience of the therapeutic relationship in CBT either from the client's or from the therapist's perspective were identified. Nevertheless, there is literature on the clients' experience of cognitive behavioural therapy, within which some themes or categories concern the therapeutic relationship.

Two studies employing qualitative methodology explored the clients' experience of CBT for psychosis. The first one (Morberg Pain et al., 2008), used content analysis in order to assess mainly the client's experience of written case formulation within CBT. Few coding units in the analysis concerned the therapeutic relationship. The participants indicated that they had a positive relationship with their therapist, and the case formulation helped some of them

understand better the therapist's point of view. In an earlier study of CBT for psychosis (McGowan, et al., 2005), both therapists and clients were interviewed. Grounded theory methodology was used to identify the differences between clients who had progressed and clients who hadn't progressed in therapy. One of the differences reported concerned the therapeutic relationship, and the extent to which therapist and client felt that they were working towards shared goals and tasks. Furthermore, some of the clients who hadn't progressed reported having delusions about their therapist, as part of their delusional system in psychosis.

In the study by Nilsson and colleagues (2007) clients' accounts were compared depending on whether they judged the outcome of therapy as satisfactory or not. The participants who were satisfied with their CBT treatment seemed to perceive themselves and their therapist as motivated and involved in the whole process, and revealed that there was some type of chemistry between them. The therapeutic relationship was more commonly brought up by participants who were dissatisfied with therapy. They perceived their therapist as rigid, oppressive and mechanical. Moreover, the therapist was portrayed as someone who was interested to do their job and follow through predetermined tasks, rather than as someone genuinely interested in their problems.

Flexibility was a theme that also emerged in a qualitative study of clients' experience of CBT for adherence and depression in HIV (Berg et al., 2008). The participants generally reported having a positive relationship with their therapist, whom they perceived as supportive, understanding, and sympathetic. However, they suggested that more flexibility with regards to homework tasks would be helpful. Furthermore, the participants expressed the wish for more sessions.

The request for longer therapy was also brought up by clients who received group CBT for eating disorders (Laberg et al., 2001). The participants in this study placed a lot of significance on the therapeutic relationship, since they seemed to equate treatment with their therapist. The therapist was perceived as

a good role model, and as an efficient, straightforward and helpful person. However, many participants longed for more support from their therapist, which was expressed through their wish for longer therapy and more frequent appointments, and sometimes jealousy over the other members of the group. The authors understood the participants' expressed need for more structure in therapy as a reflection of their wish to be looked after.

Finally, some interesting themes about the therapeutic relationship in cognitive behavioural therapy emerged in a qualitative study of CBT for fear of flying (Borrill & Foreman, 1996). Clients were interviewed about their experience, and their responses were analysed using grounded theory methodology. One of the therapist's qualities that the participants appreciated greatly was their informality. The therapist's informality was associated with warmth and a relaxed feeling within the therapeutic relationship. Furthermore, the participants revealed that by being informal, the therapist communicated their wish for an equal relationship. Apart from informality, the therapist's confidence and optimism increased the participants' confidence in their ability to overcome their fear. Normalisation of feelings was another aspect of CBT which had a powerful impact on the therapeutic relationship, according to the participants. The therapist's acknowledgment of the validity of the clients' fears was contrasted with the approach of significant others who tired to dismiss their worries.

4.3 Methodological limitations of previous research

As was shown by the review of the literature, there are a number of studies examining the therapeutic relationship in CBT with quantitative methods. However, qualitative research into therapists' or clients' experience is scarce. Therefore, it could be concluded that the research in the therapeutic relationship in CBT has been dominated by the postpositivist paradigm and the quasi-experimental methods (Bachelor, 1995), as this has been the general trend in process and outcome research in Counselling Psychology (Hill & Corbett, 1993). Hill and Gronsky (1984, as cited in Hill & Corbett, 1993) noted that the following

underlying assumptions of the postpositivist worldview have been widely accepted by most researchers: there is one objective reality governed by universal laws, and the aim of scientists is to discover these laws through empirical methods, resembling those used in the physical sciences.

It therefore follows from these assumptions that there has been a heavy emphasis given to the quantitative assessment of constructs such as the core conditions and working alliance. Another implication of the assumption about the existence of one objective reality is the decision of researchers so far to study the process of CBT mainly from one perspective only. The finding that the client's observational perspective appears to be more highly correlated with outcome than therapists' ratings (Horvath & Symonds, 1991), seems to have supported the view that, even if multiple realities exist, they are not equal, and it's worth mainly studying the client's point of view.

Finally, the postpositivist paradigm has also resulted in the 'drug metaphor' (Stiles & Shapiro, 1989). Counselling is seen through the lenses of the medical model as consisting of 'active ingredients' offered to the client by the therapist, in the same way that drugs are prescribed to the patient by the doctor. Therefore, researchers have tried to 'weigh' how much of the core conditions the therapist offered, or how much alliance the therapist managed to achieve with the client. Moreover, there is a great emphasis placed on manualised treatments and randomised controlled trials as part of this medical model, and not enough attention is given on to whether and to what extent the findings are valid in real clinical contexts (Jarrett, 2008; Marzillier, 2004). As a result, the 'uniformity myth' is encouraged, according to which the timing of interventions and the individual differences of therapists and clients do not matter (Greenberg, 1986).

4.4 Suggestions for refinement of research

Howard (1983) was one of the first researchers to underscore the importance of methodological pluralism for the healthy development of the discipline of

Psychology. He argued that in order to enhance our understanding of complex phenomena in therapy, researchers should draw from a range of paradigms and methods, including those employed by the qualitative approach. More than 20 years later, his argument still remains of relevance. Silverstein and her colleagues (2006) explained further why the qualitative paradigm is particularly suitable to study clinical practice, by pointing at the similarities between the two. The aim to understand as fully as possible the subjective experience of the participant/client, as well as the emphasis on language and reflexivity, are two of the components that are shared by both the qualitative approach and Counselling Psychology. Therefore, it is important that the existing corpus of research in clinical practice is expanded and enriched by qualitative research.

If qualitative methodology should be employed to study clinical practice, the next question to arise is the following: 'What should be the topic of enquiry in order for the findings to be relevant to practitioners?'

More than two decades ago Windy Dryden (1985) observed that 'therapists rarely discuss their dilemmas in print' (p.1). It is still as if the therapists' dilemmas, or indeed the therapists' internal processes, are a taboo: everyone recognises that they are important, but they only get openly discussed within small circles of close friends, colleagues, and supervisors. So, we are faced with a paradox: there is an understanding that the therapist's emotions play a significant role in the process of therapy, yet it is one of the least researched areas in the literature of the therapeutic relationship (Beck et al., 2004). If the therapist's experience can help or hinder the relationship and, therefore, the process of therapy, then it needs to be explored. The present study aims to contribute towards the closing of that gap by presenting Counselling Psychologists' experiences of the therapeutic relationship while practising CBT.

5 Research aims

The aim of this study is to explore the subjective experiences of Counselling Psychologists of the therapeutic relationship when they practise CBT. It is hoped that in-depth interviews will reveal an 'insider's perspective' of the participants' world. Therefore, the study endeavours to enrich the existing corpus of research in the area of the therapeutic relationship by providing some insight into the therapists' perspective.

The central question of the research is:

- What is it like for a Counselling Psychologist to be in a therapeutic relationship with a client while practising CBT?

The study will also be guided by the following questions:

- How do Counselling Psychologists view the CBT that they practice?
- How do Counselling Psychologists view the role of the therapeutic relationship in the type of CBT that they practise?
- How do Counselling Psychologists experience themselves within the therapeutic relationship in CBT?

The next chapter will present in detail the methodology employed in this study in order to answer the above research questions.

Chapter 2

Methodology

1 Introduction

At the beginning of the Methodology chapter, some philosophical considerations are reviewed, and the philosophical assumptions made in this study are stated. In the next sections, the research design and the research procedures carried out are described. A great emphasis is placed on the validity of the data and the ethical conduction of the study.

Throughout the Methodology chapter, personal accounts of reflexivity have been included. This will hopefully provide the reader with a better understanding of the experience of conducting this study, and the rationale behind some of the decisions made. In the reflective accounts I have used the first person and highlighted this by the use of italics.

2 Philosophical considerations

One of the factors that has shaped the way in which research in Psychology has been conducted is the researchers' philosophical position. Epistemology is a branch of philosophy concerned with the nature of truth and knowledge. It attempts to provide answers to the questions 'What is there to know?' and 'How can we know it?' (Willig, 2001). Even though not always overtly expressed, researchers' decisions on their questions and methods are primarily influenced by the epistemological position they hold. Therefore, it is important to present very briefly the major paradigms used in the social and behavioral sciences.

The concept of paradigm refers to the 'shared belief systems that influence the kinds of knowledge researchers seek and how they interpret the evidence they collect' (Morgan, 2007, p. 49). As the concept of paradigm can be interpreted and defined in a number of different ways (Madill & Gough, 2008; Morgan, 2007), similarly there are many ways to classify social science research by paradigm. It is beyond the scope of this section to present all the different conceptualisations of paradigm and classifications of research. However, a brief overview of the paradigms of positivism, post-positivism, social constructionism and pragmatism may provide the appropriate context for locating the current study.

Positivism asserts a correspondence theory of truth, in which a 'real' world exists independent of our perception of it; this 'real' external world can be objectively known to us and accurately described (Gergen, 2001; Willig, 2001). Therefore, positivism adheres to a realist ontology, and portrays a reality that is characterised by causal relationships and immutable laws (Guba, 1990). Positivists subscribe to an objectivist epistemology, according to which knowledge can and must be totally separated from the individual knower (Guba, 1990). Objectivism contends that strict procedures and protocols allow the researcher to study the phenomenon under investigation reliably and without any bias (Ponterotto, 2005). In order to produce this objective, 'observer-free' knowledge, positivism uses experimental methodology, which is considered to be superior to all other ways of knowing (Gergen, 2001). It mainly focuses on the verification of clearly stated hypotheses through the use of tightly controlled experiments, and thus relies predominantly on quantitative methods of inquiry (Lincoln & Guba, 2000; Ponterotto, 2005). The ultimate aim of positivistic inquiry is to produce an objective explanation of phenomena, which will allow the researcher to predict and control them in the future (Lincoln and Guba, 2000).

Psychology has been dominated by the positivist paradigm for a very long time (Ponterotto, 2005). However, nowadays very few researchers subscribe to a pure form of positivism (Willig, 2001), as its basic principles have been criticised. This

criticism and dissatisfaction with positivism has led to the emergence of postpositivism.

Guba (1990) refers to postpositivism as a modified version of positivism, because both paradigms share a number of basic principles, such as the belief in a 'real' world, which is independent of our minds and our attempts at understanding it. Therefore, postpositivism is also rooted in a realist ontology. However, postpositivists accept that the way we perceive the world is constrained to some extent by the inherent imperfections of our intellectual mechanisms; consequently, our knowledge cannot be a totally objective representation of the world. This position has been termed critical realism (Madill et al., 2000). Postpositivism sees the fact that the inquirer cannot be fully separated from the world which he or she studies as a problem that needs to be overcome. The epistemology that is then employed is modified objectivism, as the scientists strive to reach objectivity, while admitting that this can never be fully achieved (Guba, 1990; Lincoln & Guba, 2000). In order to deal with this perceived problem, postpositivists try to build the 'true' picture of the world, by using as many sources of information as possible. The use of multiple researchers, research methods, and theories is considered a way of ensuring the reliability and accuracy of the findings. This type of methodology has been termed by Guba (1990) as critical multiplism. In summary, postpositivism subscribes to a modified version of the epistemology and methodology employed in positivism, and still aims at producing knowledge that leads to the prediction and control of phenomena (Lincoln & Guba, 2000; Ponterotto, 2005).

Social constructionism was born of opposition to the main beliefs of positivism and postpositivism, such as the existence of a world governed by causal laws, the feasibility of objective knowledge, and the dichotomy between the knower and the known (Halling & Lawrence, 1999). Before attempting to describe the basic principles of this paradigm, it is important to note two caveats. First, the terms social constructionism and constructivism are sometimes used

interchangeably (Burr, 1995). However, in the present thesis only the term social constructionism will be used in order to avoid confusion. This is consistent with Gergen's (1985) and Stam's (1990) recommendations, because the term constructivism is sometimes also used to refer to a theory of knowledge that underscores individuals' active role in the creation of their own representational model of the world (Mahoney, 1991; Mahoney & Lyddon, 1988). Second, there is no single social constructionist position (Burr, 1995; Cromby & Nightingale, 1999); writers referred to as social constructionists often disagree and debate the terminology and the epistemological boundaries of the field (Stam, 1990). Therefore, the principles reviewed in the next paragraph are to be viewed as areas of broad agreement rather than as unambiguous defining characteristics of social constructionism.

Gergen's (1985) description of the following basic qualities and principles of social constructionism have been embraced by a number of theorists in this field, such as Burr (1995) and Cromby and Nightingale (1999). One of these core principles is associated with a critical approach towards taken-for-granted knowledge, such as knowledge produced within the positivist and postpositivist paradigms. In this way, social constructionism invites people to suspend their beliefs about the world as unproblematically apprehendable through observation, and to consider the idea that the way we speak about the world does not mirror real structures in the world. The second principle follows from this and emphasises that the way we understand the world is dependent upon and a product of the historical and cultural circumstances that exist at the time. Thus it is the social processes within these historical and cultural contexts that determine whether a form of knowledge is sustained or abandoned. This third principle invites us to question the concepts of truth and objectivity, since what we regard as true and objective is that which is consistent with the rules within a given tradition of social practices (Gergen, 2001). This principle also points to the centrality of the role of language as constituting the world, by promoting certain forms of cultural practice and excluding others. Finally, since the concept of truth

is questioned, there are numerous possible and equally valid 'social constructions' of the world that arise from the interaction of members of the society. Therefore, according to the fourth principle, the different ways of understanding the world are an integral part of social activities, as they are developed within social activities and point to the direction of various forms of social action.

The above core principles of social constructionism suggest that our knowledge of the world is not a direct perception of reality; consequently the notions of truth and reality are problematic. Therefore, social constructionism traditionally subscribes to a relativist ontology, according to which there are multiple, equally valid realities constructed among members of a society (Guba, 1990; Ponterotto, 2005). Social constructionism takes a reflexive approach with regards to the relationship between the knower and the known, and acknowledges that we live in the same world as that we attempt to investigate; therefore, the separation of the two is not possible (Shotter, 1992). This subjectivist epistemology emphasises the researcher-participant interaction which enables the joint creation or co-construction of the research findings (Ponterotto, 2005). The hermeneutic methodology that social constructionists employ aims to identify the various ways of constructing social reality and their meaning. This process involves the interactive researcher-participant dialogue which facilitates reflection and uncovers deeper meanings and is based on qualitative modes of inquiry (Ponterotto, 2005).

The above description of positivism, postpositivism, and social constructionism is based on the most dominant interpretation of the term paradigm, as basic belief systems with regards to ontological, epistemological, and methodological issues (Madill & Gough, 2008; Guba, 1990). According to this definition, paradigms are incommensurable on a philosophical level, since their underlying assumptions are contradictory (Lincoln & Guba, 2000). However, Morgan (2007) has challenged the idea that paradigms need to be defined on an epistemological

basis, and that they are thus prima facie incommensurable. Morgan (2007) argues that by interpreting paradigms as shared beliefs among those in a research field, the paradigm of pragmatism can provide a basis for communication between research communities.

There are many versions of pragmatism, each of which emphasises different points (Cherryholmes, 1992). Nevertheless, it is important to note that pragmatism is first of all a method for doing philosophy, and not a collection of set beliefs or theories on specific topics (De Waal, 2005). Peirce's (1905, as cited in Cherryholmes, 1992) pragmatic maxim emphasises the importance of tracing the practical consequences of the various concepts, while James (1907, as citied in De Waal, 2005) and Dewey (1916, as cited in De Waal, 2005) shift their attention to the consequences that the intellectual concepts entail in the attitude of those who hold them. Ontologically, pragmatists agree that there is an external world independent of our minds (Cherryholmes, 1992). However, Rotry (1991) argues that there is no definite way of knowing how close or far we are from this real world. Dewey (1938 as cited in De Waal, 2005) suggests a probabilistic theory of truth, according to which we can never be certain that something is true, but within a specific context, we can be warranted for holding it for true. This 'warranted assertibility' of a certain belief is dependent upon the circumstances within which the inquiry arose, and the efficacy of the belief in resolving any prior conflict related to the inquiry (De Waal, 2005). Therefore, pragmatists accept that knowledge is a social and historical product, and consequently there are no context-free principles or beliefs about reality and causality (Cherryholmes, 1994). Since we cannot step outside of our historical and cultural systems, the idea of objectivity becomes obsolete, and the separation between the knower and the known untenable (Burr, 1998; De Waal, 2005). Keeping in mind what motivates the inquiry, how it is conducted, and what it is aimed at, the criterion of utility indicates whether a specific theory contributes to the purpose for which it was employed. In this way, science is portrayed as a form of human problem solving (Hoshmand, & Martin, 1994). The perception of science as a problem

solving activity can then explain the pragmatists' argument for methodological pluralism, which endorses both quantitative and qualitative modes of inquiry (Yardley & Bishop, 2008).

3 RESEARCH DESIGN

This study employed a qualitative methodology in order to explore Counselling Psychologists' experience of the therapeutic relationship in Cognitive Behavioural Therapy. The reasons for choosing qualitative methodology are inter-linked with the methodological limitations of previous studies, and have been explored in the first chapter. Therefore, the focus of this section is the specific method of Interpretative Phenomenological Analysis and its philosophical underpinnings.

3.1 Rationale for using Interpretative Phenomenological Analysis

The Interpretative Phenomenological Analysis (IPA) method examines the meaning individuals attach to their experiences and how they make sense of their world (Smith & Osborn, 2003). Therefore, IPA was the chosen method in the present study, because it could meet the complexity of inquiry into psychologists' experience of the therapeutic relationship while practising CBT. In particular, IPA seeks to gain an 'insider's perspective' (Conrad, 1987, as cited in Smith, 1996) of the participant's world. Hence, since IPA has been designed in order to gain insight into individuals' experiences (Willig, 2001), it seemed that this method would be best suited for the exploration of psychologists' processes within the context of the therapeutic relationship. Furthermore, IPA aims to develop an interpretative analysis of the participants' sense-making activities and allows the researcher to draw on a range of social and theoretical constructs during that process (Larkin, Watts, & Clifton, 2006). For this reason, it seemed that the use of IPA would allow the analysis of the psychologists' accounts to be informed and enriched by the existing theories about the therapeutic relationship.

Finally, Counselling Psychology is defined in the Guidelines for Professional Practice (Division of Counselling Psychology, 2005) as a branch of Psychology

which 'draws upon and seeks to develop phenomenological models of practice and enquiry in addition to that of traditional scientific psychology' (p.1). Therefore, it could be argued that the method of IPA with its phenomenological concern is consistent with the underlying principles of Counselling Psychology.

3.2 The theoretical foundations of IPA

Even though IPA is a relatively new and developing approach (Willig, 2001), it also has a long history, as it originates from phenomenology and symbolic interactionism (Smith, 1996). Phenomenology is concerned with the ways in which people experience and make sense of their world. There is no consensus on the exact definition of phenomenology, as it acts as an umbrella for different strands of thought (Willig, 2001). Husserl emphasised the role of consciousness in the process of perceiving reality, while Heidegger argued that thought should not be considered as a prerequisite of our experience (Larkin, et al., 2006). Instead, Heidegger suggested that people are always 'being-in-the-world' (Spinelli, 1989, as cited in Eatough & Smith, 2008), and therefore the separation or distinction between their thoughts and other elements of their experience is not applicable.

The phenomenological position employed in this study is more closely linked with that of Heidegger than of Husserl, as the former emphasised that when people are being-in-the-world, they are constantly trying to make some sense of it, to give meaning to it. Heidegger conceptualised phenomenological inquiry as an explicitly interpretative activity, and thus his approach is linked with the hermeneutic tradition (Smith et al., 2009). IPA is phenomenological, as it attempts to get as close as possible to the lived experience of the participant, and interpretative, as it recognises that this is from the outset an interpretative process both for the participant and the researcher. Participants try to make sense of events, and then the social scientist attempts to make sense of the participants' sense-making process. Thus, an interpretation process that takes

place in two stages, or a 'double hermeneutic' is required in IPA (Smith & Osborn, 2003).

Furthermore, IPA does not accept Husserl's claim that it is possible for the researcher to fully engage with the phenomenon under investigation, without being influenced by their previous assumptions about it. On the contrary, IPA is closer to the hermeneutic strand of phenomenology, and proposes that the researcher's assumptions are actually required in order to interpret the participants' accounts, and thus, are not seen as biases (Willig, 2001). Nevertheless, it is recognised that the researcher plays such an active role in the process, that the analysis of the participants' accounts is dependent to a certain extent upon the researcher's point of view. This is why the social scientist needs to be reflexive and critically examine their own preconceptions about the phenomenon under investigation. The process of bracketing any preconceptions about a phenomenon is a cyclical one and can only be partially achieved (Smith et al., 2009).

Symbolic interactionism is another important hallmark in the theoretical underpinnings of IPA (Smith, 1996). Symbolic interactionism has its roots in the early American pragmatists who rejected the positivist paradigm and argued for the interpretative, subjective study of the lived experience of interacting individuals (Denzin, 1995). Fundamental to symbolic interactionism is the view that the meanings individuals ascribe to events arise within their social interaction. The various communication systems in society convey messages which are symbolic and already interpreted. The self-reflections of individuals also play a role in the interpretation and modification of these messages. These messages, in turn, construct the culture of everyday life. Symbolic interactionism argues that societies and all their structures and practices (e.g. gender, doing work, religion) exist only in the interaction between individuals. In this way, symbolic interactionism 'is both a theory of experience and a theory of social structure' (Denzin, 1995, pp.51). IPA endorses symbolic interactionism's concern

for how subjective meanings are constructed by individuals and its emphasis on individuals' self-reflections (Eatough & Smith, 2008).

3.3 Locating the study within a research paradigm

The aim of this study was to explore and describe Counselling Psychologists' subjective experiences of the therapeutic relationship while practising CBT. The chosen method of analysis was IPA for the reasons described above. However, apart from clearly stating the method employed, researchers also need to explain their anchoring paradigm, as this has implications for the evaluation of the quality of the research (Ponterotto, 2005; Elliott et al., 1999). Nevertheless, it is important to note that the process of locating a study within one specific paradigm is complex, as it is not always possible to identify unambiguous epistemological perspectives (Willig, 2001).

This aim of this study fits with the philosophy and intentions of the paradigm of social constructionism. With regards to ontology, IPA is concerned solely with the participants' subjective experience of the world rather than with the objective nature of the external world (Willig, 2001). According to IPA, people can ascribe different meanings to the same event; therefore IPA assumes that people construct multiple, equally valid realities through the process of interpretation (Brocki & Wearden, 2006). In this way, IPA subscribes to a relativist ontology (Willig, 2001), which allows for multiple interpretations and realities, and can therefore be classified as consistent with social constructionism in ontology. In reference to epistemology, IPA asserts that the research findings are a function of the relationship between the researcher and the subject of inquiry (Larkin et al., 2006). Therefore, IPA recognises that the knowledge it produces is necessarily dependent upon the researcher's own assumptions and conceptions, since these are required for the process of interpretation (Smith, 1996). In this way, IPA involves a reflexive attitude from the researcher (Willig, 2001) and can thus be classified epistemologically under social constructionism. Finally, on a methodological level, IPA employs qualitative methodology and typically uses

semi-structured interviews, as it is a flexible data collection instrument (Smith & Osborn, 2003). IPA's concern with how participants construct the meaning of their experiences is consistent with the hermeneutic emphasis of social constructionism.

In conclusion, the present study employs the method of IPA, and draws on social constructionism as its anchoring paradigm.

4 THE PROCESS OF THE RESEARCH

4.1 Constructing the interview schedule

Smith and Osborn (2003) recommend the use of semi-structured interview as a way to collect data for an IPA study, because it allows the researcher to engage with what the participant is saying, and explore further any interesting areas that arise. Therefore, a semi-structured interview allows entering as far as possible into the participants' individual world.

The questions in the interview schedule were derived from personal experiences and reflections on the therapeutic relationship in CBT, discussions with colleagues, and influential theories in the area. In particular, some questions were influenced by Bordin's (1979) conceptualisation of the working alliance as consisting of agreement on goals, agreement on tasks, and an emotional bond. This conceptualisation seemed congruent with the CBT framework.

Rogers' (1957) core conditions, that is empathy, congruence, and unconditional positive regard, were also included as part of the interview schedule. The use of specific words within the interview schedule was an area to which a lot of thought was given. It was assumed that the word 'empathy' is part of most people's everyday vocabulary, and so its use in the interview could facilitate psychologists to communicate their potential experience of it in Cognitive Behavioural Therapy. On the contrary, the words 'congruence' and 'unconditional positive regard' are more closely associated with Rogers' theory and could even be considered as

jargon. It was expected that the Counselling Psychologists participating in the study would have heard of these concepts; however it was decided to not use them in the interview, unless used by the participants themselves. There were two reasons for this decision. First, their use would impose the researcher's vocabulary onto the participant's language, and thus would limit the exploration of the participants' subjective experience. Furthermore, for any interview to produce rich data, it is necessary that the participants feel at ease. It was assumed that the use of Rogers' terminology on this occasion could potentially make participants feel as if their knowledge or competence as therapist is being assessed. The danger would then be that psychologists might try to give what they think is the 'correct answer', rather than an account of their subjective experience. It was thought that a way to handle this difficulty was to phrase the questions without the use of the words 'congruence' and 'unconditional positive regard'. Instead, the questions incorporated concepts, such as the therapists expressing their 'feelings and thoughts to clients', and their 'ability to accept clients as they are'. It is recognised though that this represents only one way, among many others, to understand Rogers' terms, and therefore an effort was made to use participants' vocabulary and related concepts whenever possible.

4.2 Piloting the interview schedule

An initial draft of the interview schedule was devised and used during the first pilot interview with a fellow Counselling Psychologist in training. After long discussions with the research supervisor, the questions were revised, and a new interview schedule was developed. Consistent with Smith and Osborn's (2003) recommendations, the second draft contained questions that were gentler and less suggestive. The new interview schedule was then used as guidance during the second pilot interview with another fellow Counselling Psychologist in training. Both participants in the pilot interviews agreed that the questions were clear and relevant and did not make them feel uncomfortable. A copy of the interview schedule can be found in appendix 1.

4.3 Sampling and participants

The selection of participants that took part in the present study is criterion based, or more commonly referred to as purposive (Ritchie, Lewis, & Elam, 2003). Purposive sampling is frequently used in IPA, as it allows the researcher to identify a relatively homogeneous group of people for whom the research question is relevant (Smith & Osborn, 2003).

4.3.1 Inclusion criteria

For the purposes of the present study, it was decided that participants need to fulfil the following criteria:

(a) be chartered Counselling Psychologists (or eligible for chartership) with the British Psychological Society

(b) use Cognitive Behavioural Therapy as part of their practice

(c) have at least one year of experience working with clients post qualification

The rationale behind the first criterion was that the aim of the study was to explore how Counselling Psychologists experience the therapeutic relationship in CBT, given that they are trained in other therapeutic approaches apart from CBT, and might draw on a range of theoretical perspectives. Since the phenomenon under investigation is the therapeutic relationship in CBT, it is obvious that participants needed to use this approach as part of their practise; this is the reason for the second criterion. Finally, it was decided that at least one year of experience working with clients was needed for the participants to have an understanding of the phenomenon.

4.3.2 Sample size

The samples in qualitative research are normally small in size (Ritchie, et al, 2003). The same applies to studies using IPA. An optimum number of participants is not predefined; nevertheless, the requirement for IPA is that the data that participants provide is rich enough to allow the researcher to explore in

detail the phenomenon under investigation (Smith & Osborn, 2003). In the present study eight participants were recruited, so that the richness of the individual cases would be maintained, and at the same time the amount of data would not be overwhelming.

4.3.3 Recruitment procedure

Participants were recruited in a number of ways. A list of all chartered Counselling Psychologists practising in the area of London was obtained through the website of the British Psychological Society. From this list, the psychologists who stated that they used CBT in their practice were contacted via phone or e-mail. The research purposes were explained to them, and a copy of the Information Sheet (see appendix 2) and the Consent Form (see appendix 3) was also sent to them prior to the interview. Participants were also recruited through the NHS. Psychologists working in the two NHS trusts for which ethical approval had been granted were approached and informed about the study.

4.3.4 Demographic information of participants

Ritchie and her colleagues (2003) advise that the sample in qualitative research should be as diverse as possible, as long as it falls within the defined inclusion criteria. They argue that diversity facilitates the identification of many different aspects of the phenomenon. In order to ensure diversity in the sample of the present study, it was decided to include psychologists who have different levels of experience, and who work in diverse settings. Furthermore, psychologists who use CBT as their only approach, as well as those who use other approaches apart from CBT were also included. All the above information about the participants is provided, so that the sample is situated (Elliott, Fischer, & Rennie, 1999) and the transferability of the findings is evaluated.

It is common practice to present all the demographic information for each participant in one summary table. This allows not only the situating of the sample, but also a deeper understanding of each individual participant. However, in the

present study, for confidentiality purposes the demographic information is presented for the whole group and no reference is made to any individual participant. It was assumed that, since all participants are Counselling Psychologists, giving a combination of specific personal details, e.g. their age, ethnic background, and years of experience, might lead the reader to identify some of them, and thus risk breaking confidentiality.

All the participants were women, which does not fully correspond with the demographic characteristics of the Division of Counselling Psychology, and thus constitutes one of the limitations for the transferability of the findings. The age of the participants varied from 30 to 65 (see table 1) and their ethnic backgrounds were White British, White European, and Asian British (see table 2). For some participants, the years of experience post qualification were the same as the years of experience post chartership. Several other participants had considerable experience working as therapists prior to gaining eligibility for chartership. Therefore, it seemed that years of experience post qualification is a more accurate indicator of participants' clinical experience. These varied greatly, with one participant having 2 years and another 20 years of experience (see table 3). The participants worked in the NHS, private practice and a Counselling Centre (see table 4). The types of services where the participants worked included Primary Care (adults' service), Secondary Care Psychology Department (adults' service), Older Adults Service, and a Student Counselling Service (see table 5). In their private practice, the participants mainly worked with adult clients, and sometimes with older adults. One of the participants also offered therapy to children in her private practice.

Table 1: Age of participants

Age	Number of participants
30 - 40	3
40 - 50	2
50 - 60	2
60 - 65	1

Table 2: Ethnic background of participants

Ethnic background	Number of participants
White British	4
White Other	3
Asian British	1

Table 3: Years of experience (post qualification) of participants

Years of experience	Number of participants
2-5	4
6-10	2
11-15	1
16-20	1

Table 4: Work setting(s) of participants

Work setting	Number of participants
Private practice only	2
NHS only	1
NHS and private practice	4
NHS and private practice and Counselling Centre	1

Table 5: Type of service(s) of participants

Type of service	**Number of participants**
Primary Care (NHS)	5
Secondary Care (NHS)	1
Older Adults Service	1
Student Counselling Service	1

With regards to theoretical approach, six out of the eight Counselling Psychologists who participated in this study practised mainly within a CBT framework. One of the participants used CBT and the psychodynamic/integrative approach as her main models, and one used CBT and the systemic orientation as her main models. However, this categorisation is a rather arbitrary one, and more information about the participants' clinical practice will be provided in the following chapters where the findings are presented. Four of the participants had undertaken additional post-qualification training in CBT (i.e. postgraduate certificate in CBT, postgraduate diploma in CBT) apart from that provided as part of the Counselling Psychology course. One of the participants was accredited with the British Association for Behavioural and Cognitive Psychotherapies (BABCP).

CBT is a rapidly expanding field, and various forms of CBT have now been developed (Dobson & Dozois, 2001). Therefore, consideration was given as to whether the participants should be asked which particular form of CBT they practised. This information could potentially help to situate the sample more accurately, and to better evaluate the transferability of the findings. It was decided not to ask the participants what type of CBT they practised, because this would possibly lead to an intellectual discussion about CBT, its various forms, and the overlap between them. Furthermore, such a question might have made some of the participants feel as if their knowledge or competence as a therapist was being assessed. The aim of IPA research studies is to explore in detail the

participants' subjective experience of their world, and not to obtain an objective account of that experience (Smith & Osborn, 2003). It was assumed that asking participants about the type of CBT they use might obstruct the pursuit of this aim. Nevertheless, it is recognised that the lack of this information about the Psychologists who took part is one of the limitations of the study, as it impacts on the transferability of the findings.

4.4 Interviews

The interviews lasted for about an hour and were audio-taped on a digital tape recorder. Great emphasis was placed on ethical considerations, such as obtaining informed consent, explaining to the participants that they could withdraw their consent at any time, and providing debriefing information at the end of each interview (see appendix 4). The ethical considerations will be further analysed later on in this chapter.

During the interviews, the schedule was used only as rough guidance in the process, while the focus was on engaging as much as possible with the participants' concerns. As a result, the order and wording of many questions varied. This was not perceived as a limitation of the study, but rather as a way to enhance the aim of IPA to gain an insider's perspective in the participants' world. This flexibility frequently led the interviews to particularly interesting and novel paths.

During the debriefing, most participants commented that they had found the interview a reflective exercise, which allowed them to put their clinical practice into words. Some participants revealed that this was a bit difficult, and yet rewarding, because they rarely reflected upon their own experience of the therapeutic relationship.

After the end of the interviews, field notes were also kept to capture observations, reflections, and the general 'flavour' of the interview.

Conducting the interviews was one of the most interesting and rewarding parts of the research process. I was impressed by the frankness and openness of the participants, and found many of their stories fascinating. As is natural, I identified with some of the dilemmas and conflicts that the participants revealed more than others. This, in turn, provided me with more material to reflect upon.

4.5 Transcription

All interviews were transcribed verbatim, and paralinguistic features, such as pauses, laughs, and false starts were included in the transcripts. However, IPA does not require the inclusion of prosodic features of talk (Smith, & Osborn 2003).

The transcripts are not included as part of this thesis, as they contain sensitive information which could potentially render the participants identifiable. Furthermore, consent to publish the full transcript of each interview was not sought, and therefore not obtained from the participants. For this reason, the transcripts are only available to the research supervisor and the examiners.

4.6 Data analysis

The aim of the analysis in IPA is to understand the complex meanings in the participants' psychological world. Smith and Osborn (2003) suggest a number of steps that they have found helpful in this process, but emphasise that each researcher may adapt them according to their individual way of working. These stages are summarised below.

In order to develop an understanding of the participants, the researcher needs to read and re-read their account several times. The first stage of the analysis involves writing down in the left hand margins any comments that one has in response to the text, such as observations, links with other themes, summaries and reflections. Once this is complete for the whole transcript, then the

researcher re-reads the transcript and identifies themes that emerge at a slightly higher level of abstraction and can even include psychological terms. These are noted on the right hand margin. During this process, a lot of emphasis is placed on grounding well every theme title into the participants' actual words. During the third stage of the analysis, the researcher first lists the themes and then tries to find connections among them, and group them under different categories or labels. In this stage, the analyst's interpretative ability plays a vital role. Finally, the different themes and their grouping are summarised in a table. Once this process is completed for the first transcript, the researcher continues with the analysis of the next transcript, with the aim of identifying the similar patterns, as well as the new ones that emerge from each participant's account. Once a summary table is generated for each participant, the next stage involves the identification of themes that are reflecting shared aspects of the experience of all or most participants. Finally, a summary table for all the interviews is prepared, from which a narrative account is generated, which explains all the shared themes among the participants and illustrates them with representative quotes.

In the present study, the above steps were followed during the analysis of the transcripts. As IPA is not a prescriptive methodology (Smith & Osborn, 2003), a few adaptations were made to fit in with the researcher's personal way of working. These are described below, so that the transparency of the analytic method is enhanced.

During the first stages of the analysis, any initial comments in response to the text were noted on the left-hand margin of the transcript. Some of these comments were getting increasingly long and complex, including reflections about the interview process, current themes, and how these may be linked with other parts of the interview and other participants' accounts. Therefore, apart from the comments on the left-hand margin, a separate document was also created for each participant. In this document, preliminary narratives about aspects of the participants' accounts were included, as well as other any

thoughts and observations that were easier to express in a narrative format. No rules were followed about what was commented upon in these documents, and thus they included some observations which were grounded in the data, and some which were not. The value of these 'messy' documents was that they facilitated immersion in the data and gave rise to further reflections. An extract from one of these documents is provided in Appendix 6.

As outlined above, after the themes are identified and noted in the right-hand margin, a chronological list of themes is generated, based on the order in which the themes emerged in the text. This list of themes provides the basis for the grouping of themes under different clusters (Smith & Osborn, 2003). In the present study, a list of themes together with a representative quote for each theme was prepared. An example of a list of themes and quotes is presented in Appendix 7. Once this list was printed, each theme with the corresponding quote was cut onto a single strip of paper. Subsequently, these strips were grouped together under different clusters, and a few of them were dropped out of the analysis. In this way, it was ensured that the clustering of themes into master themes was also grounded in the participants' words. An example of a summary table of the themes and quotes grouped under different clusters is provided in Appendix 8. It should be noted that later on in the analysis, these themes were reviewed again, in light of the new themes that emerged from the other interviews. Furthermore, most of these summary tables were reviewed by the research supervisor, and discussions about the integration of cases and the final emergent themes followed. Therefore, the final table developed through an iterative process of reviewing earlier transcripts in light of new themes that emerged. The final summary table of the master themes and the constituent themes used for the final analysis is presented in Appendix 9.

5 Quality checks in the study

5.1 Keeping close to the data

Henwood and Pidgeon (1992) emphasise that the themes in qualitative research should emerge from the data, and therefore fit the data well. In the present study, a great effort is placed on grounding the themes in the participants' words, and presenting illustrative examples throughout the analysis (Elliott, et. al, 1999). Furthermore, part of the analysis of the data was reviewed by the research supervisor and peers, so that alternative meanings were considered and a good fit with the data was ensured.

5.2 Documentation

A comprehensive account of all the decisions made throughout the study and the rationale behind them was filed in a paper trail, as recommended by Henwood and Pidgeon (1992). Components of these documents are presented throughout the thesis, so that the reader can follow the process of the research from beginning to end. The documentation thus enhances the transparency of the research process.

5.3 Situating the sample

In accordance with good practice in qualitative research, descriptive details about the participants were provided in this chapter (Elliott et al. 1999). These included demographic information (sex, age, ethnicity), as well as information that is particularly relevant to the participants' clinical practice (years of experience, setting(s) where they practise, main orientation, further training). In this way, the reader will be able to evaluate the transferability of the findings.

5.4 Negative case analysis

Since the identification of 'negative cases' encourages the researcher to refine the existing themes in order to include all cases (Henwood & Pidgeon, 1992; Willig, 2001), an effort was made to include such cases in the analyses. For this purpose, diversity in the sample was promoted, by including participants with

different orientations, and levels of experience. The analysis of the data examined how the experiences of the participants converged and diverged from one another.

5.5 Reflexivity

The emphasis placed on reflexivity is one major difference between the quantitative and qualitative approaches. In the latter, it has a central role, as it is assumed that the researcher in many ways shapes both the study and the analysis. Therefore, it is important that the researcher maintains an open attitude towards the values and assumptions that may have influenced the conduct of the research (Henwood & Pidgeon, 1992). Finlay (2003a) defines reflexivity as 'the process of continually reflecting upon our interpretations of both our experience and the phenomena being studied so as to move beyond the partiality of our previous understandings and our investment in particular research outcomes' (p.108). In this way, reflexivity involves the continuing active participation of the researcher who employs it in an immediate and dynamic way, and can be contrasted with the concept of reflection, which involves thinking about something after, and not during the event (Finlay, 2003b).

There is a variety of types of reflexivity that a researcher can employ. For example, Finlay (2003b) identifies the following five variants of reflexivity: introspection, intersubjective reflection, mutual collaboration, social critique, and ironic deconstruction. In the present study, Willig's (2001) definition of reflexivity was employed, as it incorporates the concepts of 'personal reflexivity' and 'epistemological reflexivity'. Personal reflexivity involves the researchers' critical self-awareness of their own values, interests, experiences and assumptions, and constant evaluation of how these influence the research process. At the same time, personal reflexivity invites social scientists to think about how the research has shaped their own identities as people and as researchers. Epistemological reflexivity involves a critical evaluation of how the different decisions made throughout the study (e.g. with regards to the research question, research design

and methodology) have constructed the findings of the research and perhaps closed down avenues of understanding.

In the present study, a diary provided a space in which to reflect upon all the issues related to personal and epistemological reflexivity. Extracts and summaries of the entries are presented throughout the thesis, so that the reader can develop an 'insider's perspective' of the research process.

6 Ethical considerations

The main ethical considerations within the study are informed consent, confidentiality, and data storage and security.

Informed consent was obtained from all participants, as outlined in the guidance for the design of information sheets for "competent" adults by the Central Office for Research Ethics Committee (2005), and the British Psychological Society (BPS; 2005) guidelines. All participants were given the Participant Information Sheet and the Participant Consent Form (see appendices 2 and 3) at least two days prior to the interview, and on most occasions a week in advance. In this way, all participants were given enough time to think about their participation and make a decision. On the day of the interview, all participants were encouraged to read the information sheet once again, before giving their informed consent. All participants were supplied with a copy of the information sheet and of the signed consent form. Furthermore, the participants were informed orally, as well as by the Consent Form, that they are free to withdraw their consent and/or to stop the taping at any time, without needing to give any reason.

All reasonable steps were taken to ensure confidentiality and security of data. This was achieved by safeguarding the security of records which contained personally identifying information, and by rendering anonymous all records that did not need to be personally identifiable, as outlined by the BPS Code of Conduct (2005). The only documents containing personally identifiable

information were the consent forms. The participants' consent forms were stored separately from all data in a locked filing cabinet. While conducting the interviews, all the participants were asked to not mention the name or any other identifying information either of themselves or of any of their clients.

The tapes of the interviews were kept in a locked filing cabinet separately from the consent forms. As soon as the interviews were transcribed, the research supervisor listened to the tapes and authenticated the transcripts by signing a relevant form (see appendix 5). As soon as authentication was completed, all tapes were destroyed. All computerised data were password protected. After a period of five years, all transcripts and computerised data will be completely destroyed. All the above procedures are outlined in the Participant Information Sheet, so that the participants are ensured of the confidentiality of the information they provide.

The interview was not expected to involve any risks of harm any greater than those involved in daily life. In case, however, a participant found some of the questions upsetting, they were able to cease the taping and withdraw their participation in the study. During this study, none of the participants said that they had felt upset by any aspect of the research process, and no one seemed to show distress during the interviews. At the end of the interview, some time was dedicated to debriefing and giving the participants the opportunity to express how they had found the experience. In addition, after the end of the interview a list of help lines was provided to all participants (appendix 4).

7 A personal note on reflexivity

Since in qualitative research there is an acknowledgment that the researcher influences the findings to some extent, it is important that one is aware of their own preconceptions and tries to bracket them out. Of course, it is never possible to bracket out all our preconceived ideas, as some of these are needed in order to make sense of the data in front of us. Therefore, it is important to state

explicitly any implicit assumptions one has about the area of the research, and thus allow the reader to decide about the transferability of the findings to different contexts.

Therefore, I need to recognise that I brought a lot of 'baggage' with me before embarking on this qualitative research. My original research design involved the extensive use of quantitative methods in order to study the same phenomenon, the therapeutic relationship in CBT. I now realise that that research design was based more on my confidence levels in the different research methods rather than on the suitability of such methods. I moved away from the original research design for various reasons, including practical problems and a growing understanding that the findings would not tell me anything I did not already know. The process of drastically changing the research design was a particularly stressful one, with lots of ups and downs. A summary of my reflections on the previous research design and the decision to move away from it is included in Appendix 10.

Regarding my views on CBT at the beginning of the study, I thought that CBT was a very useful approach, and I used it routinely with my clients. However, I never adhered to a strict CBT protocol, and was constantly informed by the person-centred and the psychodynamic approaches. In particular with regard to the therapeutic relationship, I did not feel that the CBT model could offer me any guidance. When addressing problems in the therapeutic relationship, I drew on other theoretical models. I was however often faced with conflicts and dilemmas, such as the following one: How can I show unconditional positive regard to clients, while practising CBT? Even by asking them to complete a homework task, I am placing a condition upon them. Providing reinforcement for finding an 'adaptive' way of thinking is yet another proof of my conditionality.

I expected that the research participants would have similar dilemmas as me and would find it difficult to maintain a focus on the therapeutic relationship when

using the cognitive behavioural framework. I assumed that the participants would then draw on different theoretical models in exploring aspects of their relationship with their clients.

Chapter 3

Overview of the findings

1 Themes identified

The analysis yielded 11 themes, which are presented in table 5 along with the number of participants who displayed each of them. These themes were subsequently grouped into the following three master themes: 1) 'Intrapsychic processes towards integration', 2) 'Interpersonal processes with client: perceiving and responding to client's reality', and 3) 'Working within a setting'.

Table 6: Master themes with constituent themes

Master themes and themes	**Number of participants with theme**
1 Intrapsychic processes towards integration	
1.1 Relationship with inner self: self-acceptance and integration	7
1.2 Relationship with CBT model and other theoretical approaches: integration or conflict?	8
1.3 Reflexivity	7
2 Interpersonal processes with client: perceiving and responding to client's reality	
2.1 Promoting the values of honesty, equality, and respect through the practice of CBT	8
2.2 Personalising and tailoring CBT to clients	8
2.3 The permeable boundary between self and client	8
2.4 Therapeutic impasses and failure	8
2.5 Using the therapeutic relationship as a tool	6
2.6 Non-verbal communication in the therapeutic relationship	5
3 Working within a setting	
3.1 Time pressure and the therapeutic relationship	6
3.2 The decision to use CBT: free choice versus mandatory	6

2 The conceptualisation of the therapeutic relationship in the present study

During the analysis of the interviews, the therapeutic relationship was conceptualised as comprising different subsystems, and at the same time as being part of a bigger system. Therefore, the three master themes illustrate some of the systems / subsystems that the therapeutic relationship is interrelated with. It is beyond the scope of this study to present all the systems connected with the phenomenon of the therapeutic relationship. The aim of the following three chapters is to present the 'systems' that the participants of this study discussed in their accounts. Since all the systems are interconnected and constantly interact with one another, the three master themes do not represent totally discrete categories; there is overlap between them.

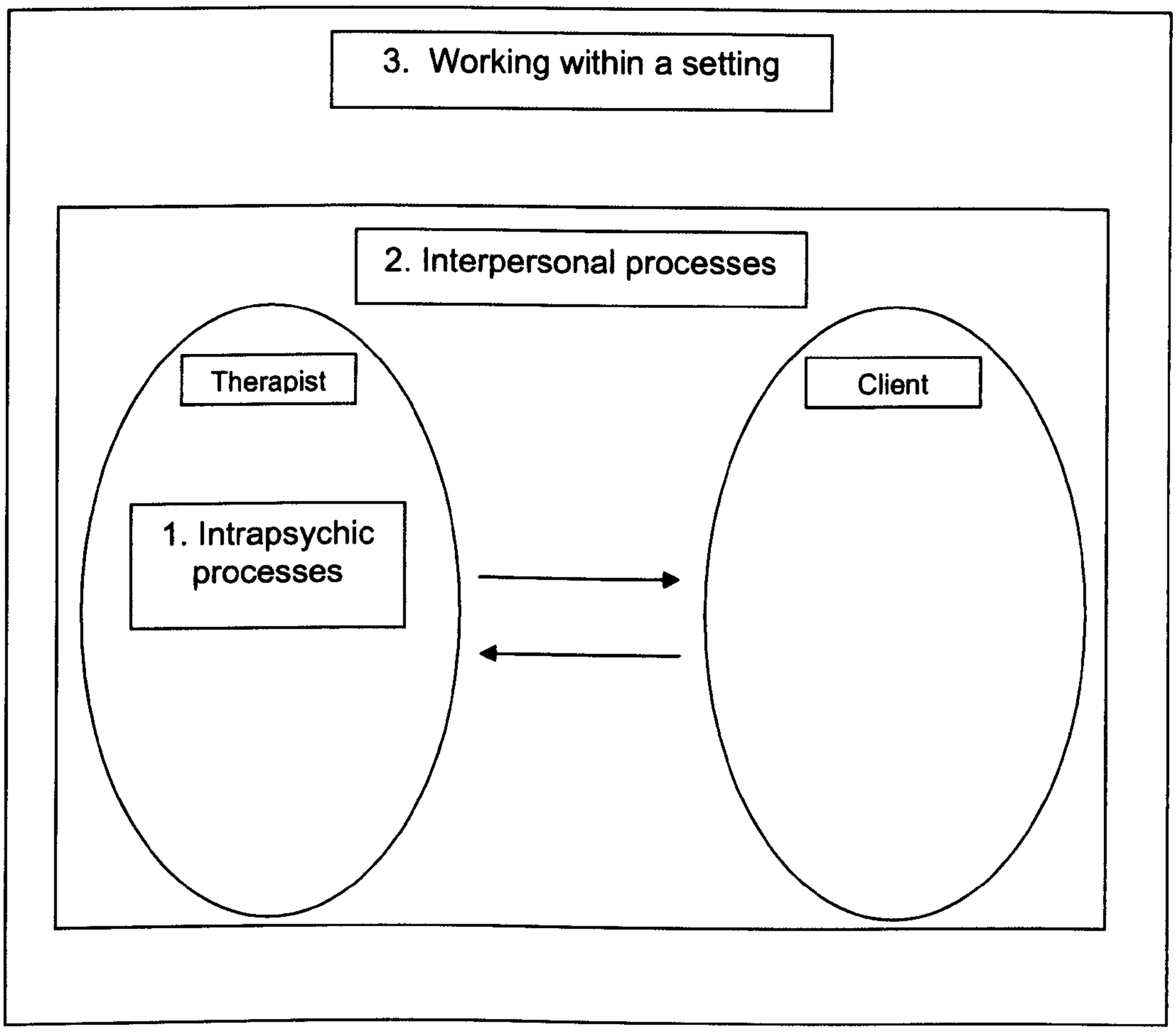
The following three chapters will focus on each of the three master themes. In the first section of each chapter the findings of the current study will be presented. In the second section, the findings will be reviewed and reconceptualised in light of theories and empirical investigations on the topic concerned. It should be noted that there is a multitude of theories from a number of different models that could potentially be used to conceptualise the findings of the present study. However, it is not feasible to present all of them as part of this thesis. The criteria used to choose the literature to present were the applicability of the theory to explain the findings, and the perceived value of the theory to guide clinical practice. Undoubtedly, these are subjective criteria, and different researchers would potentially have made different choices.

In order to convey the essence of the phenomenon under investigation, verbatim excerpts from the interviews which displayed each theme will be presented. The source of each excerpt is indicated by page and line reference number. In the interest of confidentiality of the participants, all names and identifying information

have been changed or omitted. Ellipses (...) indicate omitted material and brackets [ ] indicate material that has been added by the researcher to increase the readability of the excerpts.

The reader may find it helpful to visualise a video camera shooting the phenomenon of the therapeutic relationship in CBT while reading the following three chapters. The 'video camera' will first zoom in to one of the subsystems that the phenomenon of the therapeutic relationship encompasses, which is the internal processes of the therapists. Next the 'video camera' will be set to 'normal mode' to capture the therapeutic dyad, therapist and client together. Finally, the 'video camera' will zoom out to portray the therapeutic relationship as part of a bigger system, the setting in which it takes place. Figure 1 illustrates the three different modes of the 'video camera' which will capture the three master themes in this study: intrapsychic processes, interpersonal processes, and working within a setting.

Figure 1: The three master themes as captured by the 'video camera'



While looking at figure 1, the reader might be intrigued by the fact that none of the client's intrapsychic processes are depicted. Of course, the figure does not mean to imply that the client's internal processes are not present or important during therapy. On the contrary, there is an understanding that the internal worlds of both the therapist and the client are part of the therapeutic relationship. However, in the present study only therapists were interviewed about their experience of the therapeutic relationship in CBT. Therefore, there were no first person accounts of the client's intrapsychic processes. What is evident in the interviews, is the participants' (who are therapists) perceptions of the clients, and their internal worlds. In this study it was decided to include the therapists' perceptions of their clients as part of the constituent themes under the master

theme 'Interpersonal processes with client: perceiving and responding to client's reality'. However, it needs to be recognised that this was the way in which the data were conceptualised in the present study, and that other researchers might have conceptualised and depicted the same data differently. It is up to the reader to decide the extent to which the present conceptualisation resonates with them (Elliott et al., 1999).

After reading the literature for the discussion sections, I was tempted to change the labels of some themes into some more widely used terminology, so that they correspond more clearly with relevant theories and they are more easily understood by the reader. However, I decided to remain faithful to the participants' interviews and present the labels of the themes as they emerged out of my immersion in the research data, rather than out of reading the literature. As a result, some of the terms I use might correspond to different terms in the existing literature. Some other terms used in the present study might have a different meaning in other studies or theories. I hope that those different meanings will be illuminated more clearly in the discussion sections of the following three chapters.

Chapter 4

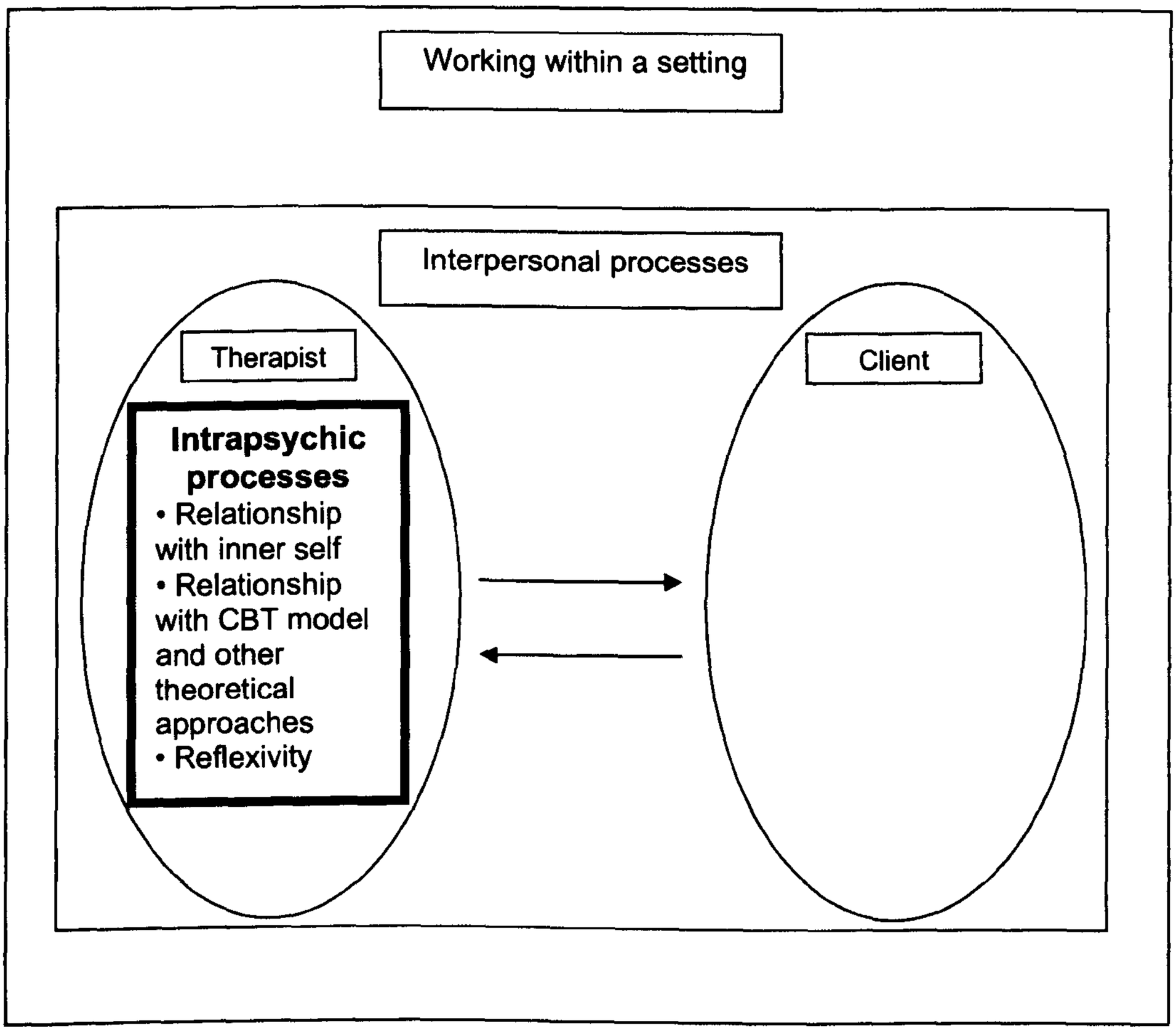
'Zooming in mode': Intrapsychic processes towards integration

Introduction

All the participants in this study strived to reach an internal state of integration while being in a therapeutic relationship with their clients, to whom they provided CBT. This master theme concerns all the intrapsychic processes of the therapists in order to integrate harmoniously all the parts within themselves. Naturally, these processes include dealing with inner conflicts, as well. In particular, the therapists talked about different aspects of their inner self and their effort to develop an integrated sense of self. Furthermore, the therapists tried to integrate their knowledge of different models of therapy within their clinical practice. At the same time, therapists aimed to make sense of and integrate as much as they could about what was going on between themselves and their clients through reflexivity.

The reader may now visualise the 'video camera' zooming in to the therapists, thus gaining an insider's perspective of the therapists' experience of themselves, as illustrated in figure 2. In this chapter, the focus will be on the therapists, and how their internal processes may affect their way of being with the client.

Figure 2: 'Zooming in' mode: The themes of the master theme 'Intrapsychic processes towards integration', as captured by the 'video camera'



Theme 1: Relationship with inner self: self-acceptance and integration

Participants described having developed an integrated sense of self, in which there is a very big overlap between their personal self and their professional self. Central to the process of reaching a state of integration, is the participants' ability to accept the different parts within themselves, both their strengths and limitations. Subsequently, the participants' personal congruence allows them to also be congruent within the therapeutic relationship with their clients.

Lea and Mary seem to accept their limitations, and the fact that they will occasionally have negative feelings towards clients, as normal, without trying to place any blame on themselves or the clients. In the excerpt below, Lea describes an incident in therapy, during which she had some negative thoughts towards her client, which is against the notion of the 'perfect' therapist. Lea's self-acceptance is evident, as she does not judge herself for it, does not feel bad about it, and does not try to attribute it to any other reason other than being human.

> 'They are saying, 'Oh I'm so boring', and you are like, mmm, you are a bit (laughs), and sometimes those things go through your mind. So it's never...100 percent unconditional...you might be a therapist but I'm still a human' (Lea, 15:2-30)

Mary on the other hand, goes to the extent to consider the fact that she occasionally reacts negatively towards her clients as a positive sign. Mary embraces those instances of having negative feelings towards her clients as evidence that she has not become complacent and ingenuine. The fact that she allows herself to be affected by the client shows to her that she is still in touch both with her personal and professional self whilst in the therapy room.

> 'how can you not respond? I would argue that you're not really there, in that relationship, in the core conditions...if you don't occasionally find people that say or do [things that] are objectionable to you or you react negatively to... If you're being authentic, and you're being really there, as opposed to this professional persona, then yes, you will react' (Mary, 25:24-31)

For Mary it is very important to be able to bring in the therapeutic relationship both her personal and professional notions of herself. In the excerpt below, she explains that there is a very big overlap between those two aspects of herself,

with only few details differentiating the two. She also emphasises that the crux of the job of a therapist is actually the ability to integrate their personal and professional self.

> 'it is kind of an area where the professional and interpersonal mingle inevitably. I wouldn't do this, unless I could put something of myself into it, but it's not me, this side of me that you'd see at a pub or anywhere else, obviously it's a professional...thing, but it's a personal thing too, yeah, it has to be, isn't it, otherwise it would be inauthentic and how can we do the work that we do if we're not genuine really' (Mary, 28:30-29:5)

Annette conceptualises this integrated sense of self as simultaneously 'having two minds, the professional mind, but the human, personal, empathetic side' (Annette, 17:30-31). On the other hand, what is important for Sandra for this process of integration is to be able to use humour in therapy when appropriate, rather than hide behind the seriousness of a professional façade.

'I'm not a therapist in here and somebody else outside. What they get here is me' (Lea, 23:21-22). With these powerful words, Lea illustrates what this state of integration means for her; it means not splitting between herself in the therapy room and herself outside, between the part of herself that is a therapist and the other parts of herself. Interestingly enough, what allows Lea to be confident to be herself in the therapeutic relationship, is her ability to be aware of and accept her limitations, as illustrated in the excerpt below.

> 'I think now I've become far more confident in myself, and I cant know everything, I don't know everything, I know a pin, the top of a pin, compared to what there is to know in therapy, and I'm well aware of that...generally I'm far more comfortable with myself in this work.' (Lea, 22:29-23:4)

It seems that there is a strong link between the participants' way of relating to aspects of themselves and their way of relating to their clients. Reaching a state of integration and congruence internally seems to be a prerequisite of being congruent with the clients in the therapy room. In her account, Barbara portrays congruence as having those two interrelated levels, the internal and the interpersonal one.

> 'I think that for me it's really about being genuine with yourself and the client...it's about facing up to how you feel... and being very congruent with the client as well' (Barbara, 28:9-14)

Barbara, as many other participants, describes the integrated sense of self with simple language, as just 'being myself' (5:14). Integration of the different aspects of the self seems to be coming naturally and effortlessly, as the therapists gradually become aware of and accept more and more parts of themselves.

On the whole, participants seem to have developed an integrated sense of self, in which generally speaking there are no conflicts between their personal and professional identities. Acceptance of their limitations as people and as therapists seems to be playing a key role in that process. This sense of wholeness allows the participants to actually be themselves during the therapeutic encounter with their clients, and thus to be real within the therapeutic relationship.

Theme 2: Relationship with CBT model and other theoretical approaches: integration or conflict?

Whilst achieving an integrated sense of self seemed to be a rather natural process for most of the therapists participating in the study, achieving integration of the knowledge from the different psychological models of therapy does not appear as straightforward. As mentioned earlier, all the participants in this study are Counselling Psychologists, which means that they have been exposed to a number of theoretical models apart from CBT throughout their training. This

theme has been developed to encapsulate the challenge of the participants to integrate their knowledge of CBT and other approaches within their clinical practice. At the same time, the participants talked about reaching a state of integration, so that there is no conflict between their personality and the cognitive behavioural approach. It seems that the way that each participant understands CBT is quite individual. Therefore, the relationship that each participant has with psychological theory, and with the CBT model in particular, is unique. For some participants this relationship is a smooth one, while for others it fraught with conflicts. The excerpts that will be presented will help illuminate the implications that this might have on the therapeutic relationship that the participants establish with their clients, while practicing CBT.

The terminology that the participants use when talking about the therapeutic relationship may shed some light on the way they relate to the different psychological models. The participants seemed to be using a lot of concepts that originate from the psychodynamic and person-centred approaches while discussing their experience of the therapeutic relationship in CBT. However, what differentiated the participants was their reaction to the realisation that they were using those terms. For example, Barbara, Joy, and Rachel thought that the therapeutic relationship goes beyond the specific theoretical approaches, and their ability to conceptualise the therapeutic relationship using a number of models was perceived by them as an asset. In the excerpt below, Rachel uses the CBT and the systemic approach to conceptualise the same problem. Those two different conceptualisations of the same problem are not mutually exclusive; she uses both in developing a treatment plan. This might be an indication of Rachel's perception of the complimentary nature between CBT and the other models.

> 'So you could look at that in a CBT model and say...that you're mind reading or you're jumping to conclusions... but also you can look at their

> relationship between them [the client and his wife], and their particular system and how…the system has been altered' (Rachel, 5:16-23)

On the other hand, Annette and Mary seem quite concerned during the interview about using CBT terminology about the therapeutic relationship; in a way, they impose some type of censoring on to themselves every time they don't. Annette makes a remark about the lack of aptitude of person-centred terms to be used within the CBT framework, without being able to find a more appropriate for her term. In contrast, Mary will correct herself many times when she uses a psychodynamic term, by 'translating' it into the CBT equivalent. This might indicate different levels of integration of psychological theory. However, one needs to note that these participants may have been trying to please the researcher by using terms consistent with the CBT framework, as the topic of the study was explained to them from the beginning.

> 'Empathising is perhaps not exactly the right label because this terms is taken from Rogers, and again theoretically, it doesn't really apply' (Annette, 11:4-6)

> 'I see individuals where there are transference issues, there are issues that, putting it in CBT terms it's not the actual relationship, it's something from the past, you know, reflecting that individual's interpersonal schemata if you like' (Mary, 7:7-11)

Lea and Rachel said that they use psychodynamic theory for the case conceptualisation, while they use CBT techniques when they are in the therapy room with the client. This experience though has a different meaning for each one of them. Rachel attributes it not only to the limitations of the CBT model, but also to her own difficulty to be a purist, and to use only one theoretical approach in the case conceptualisation.

'[CBT] doesn't work for everybody, not just in the techniques but in how you think about the case, I find it difficult to always think in a particular way' (Rachel, 2:22-24)

Lea gives a very interesting account of how and when she will use the psychodynamic theory, while practising CBT. It is important to note that Lea describes her approach as 'gentle CBT', and does not generally use other models with her clients. However, she uses the psychodynamic theory for her own benefit. It seems that when she conceptualises the case and reflects on her own after the session, the psychodynamic theory enhances her CBT clinical practice. Yet, during the session, she seems to be trying to monitor the amount of analytic thoughts, in order to maintain her focus in CBT.

'Sometimes I might sort of take this analytical think..., certainly if they start...bringing up their past in the session. But obviously in a CBT way, you use that very differently... and sort of explain that, how their core beliefs have maybe made them feel how they feel now...But I may be thinking, 'Oh, I see where this is coming from', but I wouldn't necessarily share that in an analytical way. I wouldn't analyse how they, what they are doing in the session, how they are being in the session, I don't go into that depth, because it's impossible to stay CBT focused if your mind is sort of somewhere else. So...I do make some notes about it myself, maybe after a session, possibly how I felt within the session, use some of that process for myself, in a personal way.' (Lea, 3:21-4:6)

What was also evident in many of the participants' accounts was the definition of CBT by its stark contrast to the psychodynamic approach. The two approaches were polarised and in some ways CBT was defined by what it isn't. The comparison between the two models had a strong evaluative element. All the participants except for Annette perceived CBT on the whole as 'better' than the psychodynamic approach. The advantages of CBT mainly had to do with its

practicality, as well as with the promotion of an equal, collaborative, and transparent therapeutic relationship. What was also remarkable was the participants' perception of a match or a mismatch between the different theoretical models and their own personality. For example, Joy felt that the flexibility of the CBT model allowed her to develop 'something which I feel suits me and my clients…it suits my personality' (2:2-4). On the contrary, talking of the psychodynamic approach, she says, 'I couldn't do it for all the money in the world, cause it's not me' (27:18-19).

Similarly, in Mary's account one can see that CBT resonates with a part of herself. The CBT model allows her to express and use therapeutically her tendency to solve other people's problems.

> 'So CBT is…something that I like, something that I'm comfortable with, something I'm familiar with, it fits in with me, the way I am, and that's important too…I think there's a certain 'Mrs. Fix it' in me, which likes…the fact that CBT is quite directive compared to other forms of therapy' (Mary, 2:21-3:3)

The positive relationship that Mary has with CBT theory helps her to use parts of her personality constructively, and not allow them to become barriers in therapy. In particular, Mary turns to the CBT model for guidance when encountering problems in the therapeutic relationship. She feels that the ways of overcoming these problems are 'built into the model', and therefore the CBT framework offers her some type of quality control.

> 'that's when an approach like CBT is so helpful, because…it's built into the model the ways of getting round those things, so you don't start to tell people what to do, and…it's built into the whole approach that you work together with them to try and come up with their solution…so I think…the model helps one keep on track' (Mary, 11:10-19)

In contrast to Mary, Annette's relationship with the CBT model involves a number of conflicts. One example is the conflict between CBT theory and her belief system. Actually, Annette's beliefs about the unconscious are so strong, that they constitute her reality.

> 'And the other thing that I have great difficulty from a philosophical point of view is that CBT doesn't absolutely recognise the unconscious. And this for me is a big limitation, because...[this is] part of our psyche that we don't access, and that I am convinced that exist...And CBT doesn't recognise that at all.' (Annette, 4:14-19)

Within that conflicting relationship with the CBT model, Annette struggles to come to a decision about how to use her own feelings as a tool in therapy. She says, 'it means also a judgement on what do I do with that information. Do I feed back, do I use in a cognitive way?' (10:17-21). Whilst in that dilemma, Annette seems to be on her own, unable to get any guidance from the CBT model, where she feels 'there is very little conceptualisation in CBT how you define those feelings, when really, from a theoretical point of view there is no definition as such' (9:8-10). The lack of guidance from the model, as well as other factors, leads Annette to decide not to use her feelings as a tool when practising CBT. It should be noted though that Annette later on in the interview gives a very vivid account of how she uses herself as a tool, when practising within a different approach. Therefore, that decision does not reflect her skills as a therapist, but rather her challenging relationship with the CBT model.

Overall, the participants of this study talked about their effort to integrate their knowledge of CBT and other models within their clinical practice. That process involved resolving conflicts on two levels: a) between CBT and the other approaches and b) between CBT and the participants' personality. The level of

integration that each participant managed to reach varied, and that linked in with the participants' experience of the therapeutic relationship while practising CBT.

Theme 3: Reflexivity

The final theme of the 'Intrapsychic processes towards integration' is reflexivity. The participants spoke about developing a reflective aspect of themselves which would allow them to integrate all the fragmented pieces of information about the client into one meaningful picture. These pieces of information came from the client's direct communication to them, but mainly from the client's unvoiced communication, and the participants' own reaction towards the client. For many participants, reflexivity was facilitated through supervision, as well as through Continuous Professional Development (CPD).

For Carla reflexivity is particularly important. She emphasises that therapy is 'not just the 50 minutes, not as simple as that' (11:7). For her the therapeutic relationship is developed by everything that goes on in therapy, thus making the distinction between techniques and the relationship fade away. In the excerpt below, she gives an insider's perspective of all her internal processes in order to gain a deeper understanding of the client. Carla's reflexivity involves looking inside her, looking at the client, and at the same time looking at her interaction with the client. Implicit here is the idea that the questions for the therapist to consider are innumerable, and the role of the therapist is to be aware of them, without getting overwhelmed.

> 'You keep an eye on everything that's happening with this person. Are they arriving late all the time? You know, do they keep looking at the clock? Are they, sort of, trying to keep me happy? Are they the sort of people that want to please others? Are they trying to be the good client for me? Why...do we kind of lapse into chit chat a lot? ...Why am I so happy to see this client? Is it because they're keeping me that way? Are they protecting? You know, the dynamics are so great, I mean there are so

> many, and the effort is to keep on top of them, and really be aware of what's going on' (Carla, 22:27-23:8)

CPD plays a central role for Carla's reflexivity. She describes how reading can facilitate insight, leading to the 'Aha!' moment about her clients.

> 'CPD really, constant reading...and I find that I'm often reminded of a patient I may be working with, or I may have worked with, and that provokes certain reflection and sometimes understanding of something that you may have looked at in a slightly different way. You suddenly think, oh yes, that's a good way of perhaps thinking about it' (Carla, 13:5-11)

The participants explained that reflexivity served a number of functions for them. Joy said that reflexivity and supervision facilitated self-care, since it would help her process all the distressing material that her clients disclosed to her. Mary and Rachel felt that reflecting upon their own feelings allowed them to understand the client's parallel process. Furthermore, Rachel and Barbara revealed how reflexivity helped them to make sense of their negative emotions towards their clients within the therapeutic relationship. Rachel talks about her effort to unpick a difficult situation and find where her feelings of anger stemmed from.

> 'I think some of the more challenging emotions, like anger or irritation, where you're not quite sure where it's coming from, then those are the ones you have to keep more in check and think about why am I feeling this, is this an empathy reaction or is this something else?' (Rachel, 10:19-23)

On the whole, reflexivity appeared as the way in which the participants tried to make sense of the clients, and all of what they communicated directly and indirectly. Reflexivity facilitates the integration of all the different threads into one. As it will be discussed further in the next chapter, it is this deeper understanding

that allows the therapists to respond to the clients appropriately within the therapeutic relationship in CBT.

Discussion of themes

The discussion section attempts to locate the findings in the context of the existing research literature and psychological theories. For reasons of coherence, all the themes within the master theme 'Intrapsychic processes towards integration' are grouped and presented together in the discussion section. Since all the themes in this domain are connected so closely to each other, there are a number of theories that seem apt to interpret all of them. Therefore, it made sense to present those theories once, rather than repeat them for each theme. It is also important to note that there is a dearth of research on the therapist's experience of psychotherapy; consequently, only few empirical studies were found to relate the therapist's intrapsychic processes with the therapeutic relationship.

All the participants in this study emphasised the importance of developing an integrated sense of self. Within that state of wholeness, all the parts in themselves were recognised and accepted. Strengths and limitations, positive and negative feelings, were all valued equally as a true expression of who they are. The different identities or roles were all compatible with each other and there was a sense of inner harmony. Several participants described that state as congruence, and highlighted how this internal state allowed them to be real within the therapeutic relationship.

One of the most prominent figures in psychotherapy who illuminated the importance of the concept of congruence in therapy was Carl Rogers. In his seminal paper 'The necessary and sufficient conditions of therapeutic personality change' in 1957, Rogers postulated that the therapist's congruence is one of the six conditions required to lead to the client's personality change within any type of therapeutic approach. He described the therapist's genuineness as 'the

opposite of presenting a façade' (p. 97). This concept lends itself for the interpretation of the finding of the present study that the participants integrated their personal and professional self. Therefore, instead of presenting a façade, the participants brought their authentic self into the therapeutic relationship. Within the concept of congruence, Rogers also emphasised that a therapist needs to not deny any feelings to the awareness that might be opposed to the notion of the 'perfect' therapist, such as negative feelings towards clients. Similarly, the participants in the study talked about being aware of such feelings, and accepting them as a sign of being authentic, or as a normal characteristic of any human being. This finding is also consistent with Rogers' (1951) theory of personality, according to which psychological adjustment occurs when all the experiences of the organism are perceived, accepted, and accurately symbolised in awareness, while being internally consistent with the structure of the self. Empirical data also verify the significance of the therapist's genuineness in the therapeutic relationship. Klein and her colleagues (2001) conducted a review of the studies documenting the relationship between congruence and outcome, and found that 34% of the studies showed a positive relationship. It should be noted that the absence of the positive outcome in the rest of the studies may be related to a number of methodological limitations, such as low reliability of the measuring instruments and different rating perspectives.

Virginia Satir's model (Satir, 1987; Satir et. al., 1991) also presents a particularly useful framework to understand the participants' accounts of their internal processes. For Satir, the therapist's intrapsychic experiences are of primary importance, since 'the person of the therapist is the center point around which successful therapy revolves' (Satir, 1987, p. 24). Congruence is considered as one of the four goals of therapy; however, this does not only apply to the clients, but to the development of the self of the therapist, as well (Lum, 2002). Congruence is conceptualised as consisting of the following three levels: the intrapsychic, the interpersonal, and the spiritual (Wong and Ng, 2008). The intrapsychic and interpersonal levels are most relevant to the findings of this

study. Satir uses the eight iceberg layers to represent the person's internal systems (i.e. behaviour, coping, feelings, feelings about feelings, perceptions, expectations, longings, and life force). Therefore, the participants' accounts of congruence and integration between their personal and professional self, could be conceptualised as the harmonious interaction of the above eight layers within them. Furthermore, Satir makes reference to self care, as necessary to promote a sense of wholeness. Within that framework, she encourages therapists to maintain a balance in their personal and professional life, thus providing further evidence for the importance of integration between the therapist's personal and professional self. The participants of the present study revealed that self-acceptance, and in particular acceptance of their limitations, was necessary in order to reach a state of congruence. This ties in with Satir's proposition to therapists to increase their self-esteem, by accepting who they are, and by being gentle, kind and non-judgemental to themselves. Furthermore, the phenomenological analysis of therapist's lived experience of congruence presents self-acceptance as a main theme (Wong and Ng, 2008). Once aware of their own internal processes, therapists can be fully present with their client, and foster the development of a congruent and harmonious therapeutic relationship. The significant relationship between intrapsychic congruence and interpersonal congruence is also confirmed by empirical quantitative data (Wong and Ng, 2008).

Collier (2000) also places great emphasis on the presence of self in the therapeutic work. She postulates that during the therapeutic encounter, the therapists need to be fully aware of who they are, by bearing in mind that their past, present, and future are present at that moment. She conceptualises the therapist's integrated self as comprising differing selves, and concludes with several questions: 'Can our profession be enriched by paying more attention to the existence of different voices and selves? Can we balance the presence of the selves in the therapeutic process? What are the lessons we will learn when we hear their symphony?' (p.103)

A tentative answer to these questions could be found in Bakhtin's dialogical view of the self. Bakhtin (as cited in Rober, 2005) describes the self as a multiplicity of inner voices. These voices are constantly conversing with one another, as well as with voices coming from the external world. These voices represent different points of view and frequently oppose each other. Then, the individual's lifelong responsibility is to constantly work towards the creation of an integral self. Within this framework, the participants' effort to integrate the different aspects of their self in the therapeutic relationship, could be seen as the task of allowing all their inner voices to be present and to be heard within their inner dialogue, as well as within their dialogue with the client.

Qualitative data provide further support on Bakhtin's dialogical view of the self. Family therapists refer to the therapist's inner dialogue as the therapist's inner conversation (Rober, 2005). It has been found that this inner conversation concerns mainly four areas of therapy: perceiving the here and now of the client, processing the client's past, perceiving the here and now of the therapist's own experience, and actively managing the therapeutic encounter (Rober et al, 2008). The first three themes seem to correspond closely with the experience of the participants in the present study.

On a different level of integration, the participants of this study talked about integrating their knowledge from different psychological models of therapy into their own style of practising CBT. Theory itself has been sometimes described in negative terms in the literature, such as a 'straight jacket' (Wosket, 1999) or just a tool for reassurance (Mann, 1994). Therefore, practising psychologists need to negotiate their relationship first with Theory, as a body of knowledge, and then with the specific theory of the CBT approach, and decide to what extent it will inform their practice. During that negotiation process, the participants of the present study were aware of a number of theoretical models that they were trained in or read about. Or, to use Bakhtin's conceptualisation of the dialogical

self, they could hear the different voices coming from the different models of therapy. The challenge facing the participants was quite a tough one: reach integration between CBT and the other approaches they may have been interested in, and at the same time reach integration between their own personality and CBT. The participants revealed their struggles and conflicts in that process and the varied level of integration achieved.

The participants' tendency to integrate elements from other approaches within their CBT practice is consistent with empirical data which suggest that psychologists favour the integrative approach (Norcross et al., 2006, 1992). This might be partially because therapists feel that the client's complex needs cannot be met by one orientation only (Beitman, Goldfried, & Norcross, 1989), and perceive their role as a psychologist as someone who needs to adapt their approach to suit their individual client. This view was also expressed by all the participants in this study, as well.

However, despite the growing interest in psychotherapy integration, there is a dearth of research on the therapists' experience of it. A notable exception is Petruska Clarkson (2003) who designed an integrative psychotherapy training based on her lifelong clinical experience and research in the therapeutic relationship. She conceptualised the cyclic nature of learning as an integrative process. Within that process, assimilation is one of the phases during which the clinician makes their skills and knowledge an integral part of their system. Clarkson contrasts personal integration with one 'correct' model of integration, and encourages the therapists to develop their own style of integration, drawing on their knowledge so far. However, what is distinctive about Clarkson's model is the emphasis on the integration of all aspects of the self within the personal integration of psychological theory.

This seems to be particularly significant for the experience of some participants in this study, as they revealed a conflict between CBT and their personality,

values, and / or belief system. On the contrary, for other participants, CBT, or the type of integrative CBT that they practised, seemed to be in harmony with their philosophical position in life. This, however, should not be viewed as a sign of each participant's competence as a CBT therapist, but rather as a temporary phase within the constantly moving cycle of learning. It is the thesis of the present paper that therapists need to be aware of their current position within the process of personal integration in order to be able to use the therapeutic relationship constructively in CBT.

Empirical data further confirms the significance of congruence between theory and the therapist's personality. CBT therapists have been found to select that orientation, because it facilitates the achievement of what they perceive as the goal of therapy (Richardson, 2007). Furthermore, they revise their selected orientation in practice if needed, in order to achieve resonance between the CBT model and their personality, philosophy, and values (Vesco et al 1993, as cited in Arthur, 2001). This resonance was documented in the participants' accounts, who expressed the idea that the CBT framework allowed them to be themselves or to develop their own personal style of working, in contrast to other approaches, which they found somewhat 'oppressive'.

Similar findings were reported by Skovholt and Ronnestad's (1992) qualitative study into the development of therapists. Furthermore, the themes that emerged from their study provide a particularly useful framework to understand how the therapists' intrapsychic processes in the present study are linked with one another. Therapists with varying levels of experience indicated that they gradually integrate the different parts within themselves in order to form a therapeutic self that consists of a blend of their personal and professional self. During that process of 'professional individuation' (p.507), therapists choose to practice within a model that is compatible with their personality and cognitive schema, rather than on the basis of research evidence. Data from their study also indicate that the method through which therapists reach congruence

between the different parts of themselves, as well as between their personality and their practising model, is continuous reflection.

The significance of the therapist's reflexivity has been highlighted by a number of theorists. Schon (1983) made the distinction between reflecting-on-action, which is reflecting after the session, and reflecting-in-action, which refers to the ability to reflect during the session, and exemplified the importance of the latter in psychotherapy. In order to do that, a person needs to have the capacity to be centred on the here and now. Through self- and relational observation, an individual manages to be in touch with the lived experience of themselves and the other in the relationship, while observing that process at the same time (Horowitz, 2002; Wolfe, 2002). Within the cognitive behavioural framework a similar concept of the therapist being a participant – observer has been described (Safran and Segal, 1996). The findings of the present study are consistent with the above theories. Reflecting upon their client's material, as well as upon their own response to that material, helped the participants achieve a deeper understanding of their client. Therefore, the theme reflexivity in the present study could also be conceptualised as the participants' ability to observe themselves and their clients within the therapeutic relationship, and use those observations in order to enhance the process of therapy.

Reflexivity is emphasised in contemporary theory and research in cognitive behavioural therapy. The recent developments in CBT have led to a greater emphasis on the interpersonal processes within therapy, and on the therapist's contribution to the therapeutic alliance (e.g. Beck et al, 2004, Waddington, 2002). Within that framework, theory and research have focused on the person of the therapist, and on ways of enhancing the reflexivity of CBT trainees. It has been argued that identifying the schemas of the therapist with the use of relevant questionnaires is one of the ways used to encourage self-reflection (Haarhoff, 2006). Another way to support reflexivity that has been suggested is the reflective learning journal (Sutton et. al, 2007). However, the main trend in CBT

currently is to enhance the trainees' ability to reflect through self-practice and self-reflection (Bennett-Levy et al., 2001, 2003).

In an overview of studies in self-reflection and self-practice in CBT trainees, which included publications from German-speaking countries, it is reported that there are four models through which reflexivity can be promoted (Laireiter & Willutzki, 2003). The 'person-centred' models focus on the person of the trainee and their self-schemas, the 'practice-centred' models focus on the trainees' responses and experiences while providing CBT to clients, the 'self-practice' models concentrate on trainees using CBT techniques on themselves, and finally the 'training therapy' models use a combination of CBT and other techniques to promote self-reflection. The findings of the present study are consistent with some of these models, while at the same time showing important differences. The participants' efforts to reach an internal state of integration could be paralleled to the 'person-centred' models, since they concern the therapist's experience of themselves as a person. The participants' reflections upon the client's direct and indirect communications and their meanings could echo elements from the 'practice-centred' models, which are concerned with the therapist's responses and reflections on the client's materials. However, the main difference between the present study and the findings of the overview, is that the participants did not report using methods of reflection that are unique to the CBT approach, but were informed by several therapeutic models, and the reflexivity developed during their training as Counselling Psychologists. On the other hand, in the studies reported in the overview, the emphasis is placed on incorporating methods that are consistent with the CBT model to encourage self-reflection. Such methods would include completing thought records and identifying self-schemas. This difference could be attributed to the fact that the participants of the current study had core training not just in CBT, but in other approaches, as well. What was captured in the interviews was the participants' spontaneous way of reflecting upon process issues, rather than the requirements of a CBT training course.

One of the leading CBT therapists who has been advocating for the importance of reflective practice in CBT is Bennett-Levy. Bennett-Levy and his colleagues (2001, 2003) have devised a training component called 'self-practice/self-reflection' (SP/SR) in order to promote the reflexivity of CBT trainees. In SP/SR trainees either receive cognitive therapy from a peer or practise cognitive techniques on themselves. Subsequently, they reflect upon their experience of being a client, and how this experience can inform their own practice of CBT. Qualitative data demonstrate several benefits that this type of experiential training offers for the participants; among others, it was reported that it enhanced the trainees' cognitive therapy skills, as well as their interpersonal skills concerning empathy and the therapeutic relationship, increased the trainees' reflexivity, and promoted the perception of themselves as a good therapist. It is particularly interesting that in a later study (Bennett-Levy & Beedie, 2007) the role of self-reflection as central in the process of developing a positive self-concept as a therapist was highlighted. The data from these studies led to a new model of the development of cognitive therapy skills, which consists of a declarative, a procedural, and a reflective system (Bennett-Levy, 2006). Within that model, the therapist's ability to perceive the client's direct and indirect communications is underscored (Bennett-Levy, 2006; Bennett-Levy & Thwaites, 2007). This concept is similar to the accounts of the participants who tried to integrate all the information they have about the clients (e.g. biographical details, content of sessions, own feelings towards clients) into one meaningful picture through reflexivity. Furthermore, Bennett-Levy's model emphasises the significance of the individual's self-schemas, which concern the 'person of the therapist', and their self-as-therapist schemas, which refer to their skills and beliefs about themselves as therapists. This distinction seems particularly useful to understand the findings of the present study. The participants talked about integrating their personal and professional self into a harmonious structure of the self. Using Bennett-Levy's model, this could be conceptualised as finding a

balance, rather than a conflict, between their self-schemas and their self-as-therapist schemas.

The aim of the discussion section was to place the findings of the present study in the context of the literature with regards to the therapist's experience of themselves within the therapeutic relationship. It was demonstrated that the findings are consistent with a number of other studies and theories that derive from a variety of theoretical approaches. In particular, the themes of 'Intrapsychic processes towards integration' correspond with contemporary cognitive behavioural literature, where there is an emphasis on the therapist's internal processes, and particularly on reflection. What seems to differentiate the findings from other studies is the fact that the participants used a variety of strategies and techniques to reach intrapsychic integration, while other studies focus mainly on CBT techniques.

Chapter 5

'Normal mode': Interpersonal processes with client: Perceiving and responding to client's reality

Introduction

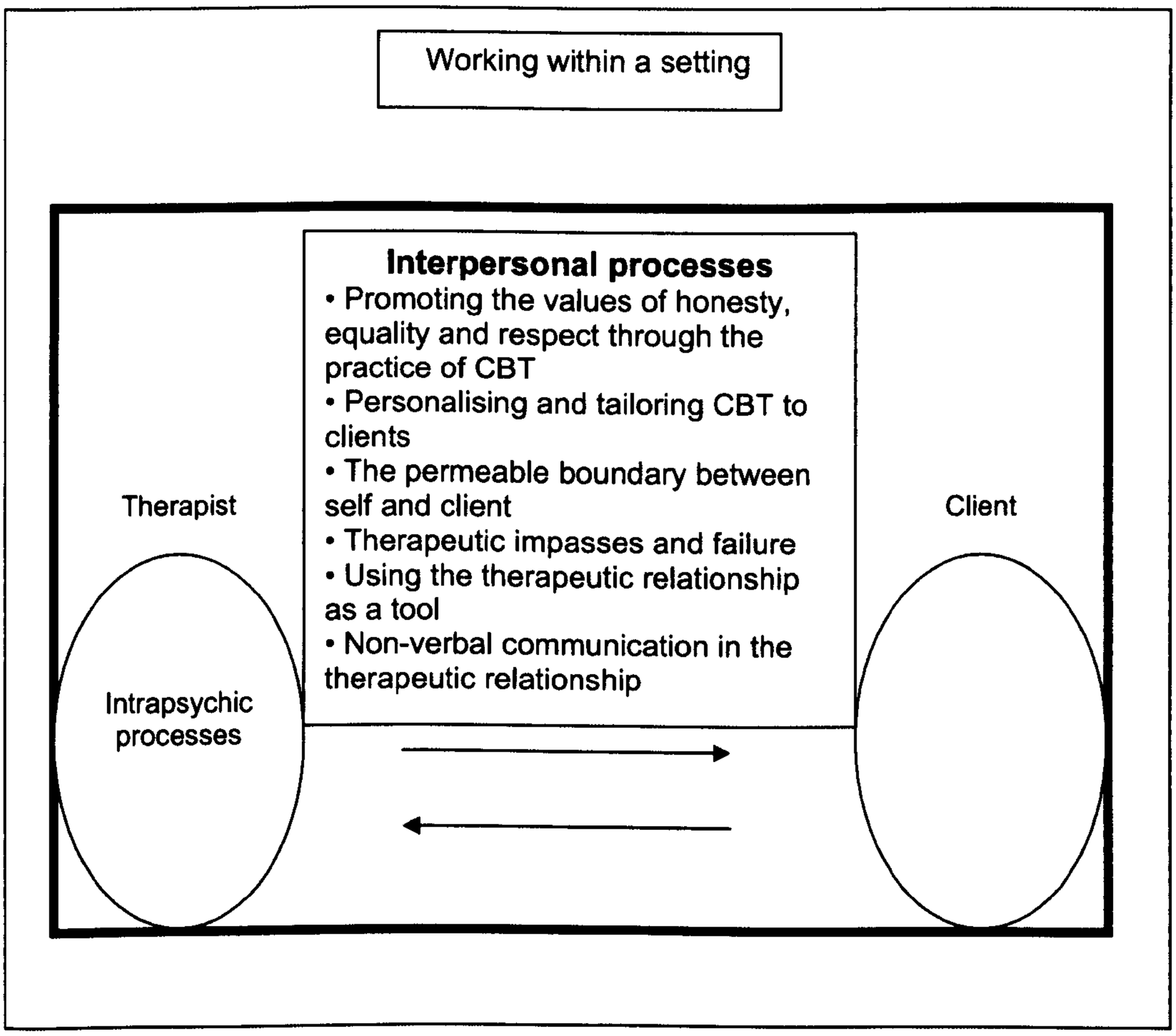
> 'that's where I think the relationship is important, that you have to be very aware of your client's response and deal with it in a kind of phenomenological way, what is actually facing you rather than what you read in the manual' (Carla, 8:9-12)

The master theme 'Interpersonal processes with client: perceiving and responding to client's reality' was developed to capture the participants' experience of their interaction with their client. Similarly to Carla, all the participants emphasised the importance of perceiving as accurately as possible their client's experience of the world, the therapy, and the therapeutic relationship. Once the therapists took in and processed their clients' reality, they formulated their response towards the clients. Therefore, even though internal activities are required for this to happen, this chapter will focus more on the interactional nature of the process, the give and take between therapist and client. This give and take involved the therapists being affected in some way by the clients, and then transforming their experience into a therapeutic intervention. Naturally, these interventions were informed by and had an impact on the therapeutic relationship.

The reader may find it helpful to now visualise the 'video camera' switching to 'normal mode', as illustrated in figure 3. Even though such a label may not exist

in real cameras, the word 'normal' was selected to reflect the more traditional definition of the phenomenon of the therapeutic relationship; typically, the therapeutic relationship is described as the interaction between therapist and client. Thus, the video camera will now focus on the verbal and nonverbal communication between therapist and client.

Figure 3: 'Normal' mode: the themes of the master theme 'Interpersonal processes with client', as captured by the 'video camera'



Theme 1: Promoting the values of honesty, equality, and respect through the practice of CBT

Underlying all the participants' accounts was the integration of values into their clinical practice. The values of honesty, equality, and respect permeated their theoretical understanding of the role of the psychologist, as well as their practical use of therapeutic interventions with their clients. Therefore, a strong moral aspect of therapy was conveyed in the interviews. The choice and the way of applying seemingly simple CBT techniques, was informed by the therapists' value system. In this way, these therapeutic interventions served as a vehicle to promote an honest, equal, and respectful therapeutic relationship.

Barbara articulates some of the values that guide her clinical practice. She conceptualises her role as a psychologist to respect and accept every person for being a person. The shared humanity between therapist and client seem quite significant here.

> 'My job is to be there for them...accepting who they are and what they're bringing, cause they're human, you know, and they deserve the same treatment as the next person' (Barbara, 11:24-12:20)

Respect is a value particularly important for Sandra, too, who goes to the extent to consider respect as curative. Maybe it is the value of respect that influences Sandra's response to clients who do not do their homework tasks in CBT. Unlike other therapists who perceive this as non-compliance, Sandra respects her client's decision as valid and adapts her clinical practice accordingly, as illustrated from the excerpt below.

'some people don't want to be bothered while they're not in session, other people are quite keen to get involved, and they want to get better as fast as they can...We just do it when they come in, I mean that's OK, if they

> don't want to, they don't have to, that's my perspective...my goal is to get them better' (Sandra, 8:29-9:13)

Joy also accepts her clients even if they don't do their homework. For Barbara, on the other hand, respecting the client is particularly important when she challenges their thoughts or behaviours.

> 'when you're teaching them something, or telling them well, have you thought about this,...having that respect for them, because [if] they feel they're being respected, when you do make the suggestions, they're not seeing it as negative criticism, they see it as something being helpful given to them' (Barbara, 4:21-30)

Equality is another value that the participants spoke about. Sandra tries to promote equality by having the same chairs for her and the client. Lea promotes equality through the arrangement for the fees.

> 'if they [i.e. clients] cancel within 24 hours I ask to charge, but if I cancel with less than 24 hours, I don't charge them for the next session' (Lea, 26:13-15).

One of the most prevalent ways of promoting equality through the practice of CBT is by explaining CBT and sharing expertise with the clients. The participants spoke about the importance of establishing an equal and collaborative relationship with their clients. Socialising clients to the CBT model empowers them and promotes equality in the therapeutic relationship, as Carla explains below. Lea's account also illustrates how equality and collaboration are established by sharing expertise with the client.

> 'it's very important... this kind of socialising the client to the treatment... you make them, from the very beginning, part of it, so that they don't get

the impression that you, the professional, are doing something, you know, to them, and they 're in the position of helplessness, because they're not the expert' (Carla, 3:2-8)

'Their [i.e. the clients'] life obviously is very important, I know the CBT so lets put the two together. The work is 100% collaborative' (Lea, 9:13-15)

Finally, honesty seems to be characterising the participants' practice of CBT. Both Joy and Mary perceive the CBT model as actively promoting collaboration through the therapist's honesty and transparency. Therefore, a therapeutic relationship where the therapist is true and open is portrayed. Mary encompasses the value of honesty in her practice and is transparent in front of her client:

'I don't have my rules, agenda, that, you know, is separate or not spelt out or secret or anything like that, I'm being open' (Mary, 28:27-29)

The values described above may not always be clearly articulated to the clients, or may not even be consciously thought of by the therapists themselves. However, these ethical principles seem to be permeating therapists' practice of CBT and the establishment of the therapeutic relationship.

Theme 2: Personalising and tailoring CBT to clients

All of the participants emphasised the importance of tailoring the CBT techniques to each individual client, and applying them in a way that is personalised to the client. The participants contrasted their way of using CBT principles to the stereotype of CBT, which involves mechanical application of techniques. The participants reported that it is essential in that process to first perceive the client's reality fully, so that subsequently the CBT techniques can be adapted to that reality. This, in turn, would allow therapist and client to have an individual and smooth therapeutic relationship.

For example, Sandra places a lot of emphasis on listening carefully to the client, particularly in the first few sessions, so that she can really understand them, and know what they want from therapy. That awareness then allows her to tailor her style of therapy according to the clients' expectations. Therefore, she will emphasise the research evidence behind CBT to clients who like the structure of the model. In the excerpt below she describes how different her approach would be with clients who do not like structured therapy sessions. She uses a standard CBT technique of looking for evidence against a negative thought; however, she applies it in such a way that it is totally personalised to the particular client and is integrated in their conversation. In this way, the client does not perceive Sandra and their relationship as impersonal.

> 'You wouldn't say this is CBT (laughs), you would say lets try asking some questions about that, well you wouldn't even say lets try asking some questions, you would say, that's interesting, what do you think, by then you know someone around them who's pretty level-headed, your sister would think if that happened to her? And so that they don't realise that this is a kind of standard CBT technique, it's personalised to them and it's introduced in the conversation at a point where it's relevant... to have these kind of approaches in your mind, and then introduce them to the person in a natural way, so that they don't feel like it's, you know, one size fits all kind of approach, yeah, personalise it for them' (Sandra, 12:30-13:12)

Almost all the participants (Sandra, Lea, Barbara, Joy, Mary and Carla) contrasted their clinical practice to the standard CBT therapy that is described in manuals. Carla said:

> 'I don't follow a manualised approach, so I don't go through prescribed stages, I sort of go with the client. You know, some people are ready to

...jump into the, sort of graded exposure, and some people are not...they don't want to do that necessarily, so I just use what CBT offers and adapt it to the client, rather than follow the manualised step by step, stage by stage' (Carla, 3:27-4:3)

Implied in Carla's account is the idea of power and control. This idea emerges in relation to the therapist's attitude towards the CBT theory. Carla might be implying that it is her and the client who are the experts, not the theory. Therefore, Carla is in control of the theory, actively adapts it to the client, instead of passively following what the manual prescribes. In this way she manages to provide CBT that is tailored to the client's individual needs.

Like Carla, Joy emphasises that the therapist needs to use their clinical judgement in formulating a treatment plan using CBT principles, rather than follow passively the CBT protocol. Throughout the interview she gives several examples of other professionals who 'apply CBT techniques blindly' and either harm the client or fail to help them to get better. One example of how CBT therapists can miss out the obvious by not tailoring therapy to the client follows.

> 'I've got another new case of a boy who got hit by a car, he still at the age of 13 wets his bed, he went to the Bed-wetting Clinic, they did a lot of CBT with him, nobody processed the accident!' (Joy, 14:25-29)

Several participants also mentioned the role of creativity and the ability to 'think out of the box' in personalising CBT to the individual needs of each client, and enhancing the therapeutic relationship. Barbara said she is open to what the clients bring in the session, including poetry and photographs. Rachel offered therapy sessions to a client in a pub, in order to encourage him to get back to his old routine. Lea describes below how she used a non-conventional intervention to tailor CBT to her client.

'I've worked with people who thought that they are going to have an anxiety attack, and crash the car. I would be the passenger. I said to a client the other day, she is doing really well with her driving, but she said it's really hard for me to think about having a passenger in the car. I said, well I ll be your passenger.' (Lea, 11:15-19)

Looking at this excerpt in a little more detail, one can see a number of underlying messages about the therapeutic relationship Lea develops with this client. Lea offers her client strong evidence that she trusts her ability to drive the car, thus disconfirming her client's belief and fear of crashing the car and harming the passenger. By placing herself in the 'passenger' position, Lea also gives the lead to the client; she follows her in her journey, rather than shows her the way.

On the whole, the common denominator in all the participants' accounts is the following idea: it is the therapist's ability to tailor the techniques to the clients that makes CBT what it is: therapy. And a good therapeutic relationship is developed when the clients feel that they are treated as individuals through the personalising of the CBT techniques.

Theme 3: The permeable boundary between self and client

This was one of the most prevalent themes in the interviews and concerns the psychological boundary between the participants and their clients. The participants talked about the significance of boundaries in therapy in order to protect the professional therapeutic relationship, and to help them preserve some mental space and independent thinking during the sessions. However, what was presented as particularly important about the boundary, was finding the right balance about it. Implied in the participants' accounts was the idea that the boundary shouldn't be too rigid or stiff and thus separate them from the clients, nor too permeable, so that it gets lost, and client and therapist become one. The participants expressed the idea that the boundary should be permeable to an extent, so that they can be connected to the client and perceive their reality. The

participants also discussed their difficulties in placing a boundary between what was attributable to them and what was attributable to their clients. At the same time, they faced the challenge of deciding when to maintain the boundaries with their clients, and when it would be more appropriate to break some of them.

Going through all the transcripts, Mary, Joy, Sandra, Lea, Annette, and Carla underscored the importance of balancing the distance between themselves and the client, in order to avoid being too close or too far away. Carla is very articulate in describing the paradox of how 'too much' empathy could become a barrier in the therapeutic relationship.

> 'Empathy could separate you almost...it's like the thing of not jumping in the same hole as the client is in, but keeping enough distance to sort of be able to help them, but not too much distance so that you are in a completely different psychological space... it's something that you need to be aware, how is this client affecting you, how is their predicament making you feel, are you being overwhelmed by their sadness or their problems, or are you managing to keep enough distance to work with them, but are you distancing yourself too much, because it's just too painful... Trying to find a balance to be in a position to work well with the client. Um, because sometimes, sometimes you're confronted with a great deal of suffering, and then you have to keep, a position where you're not, either swept away with it and overwhelmed, or so, distressed that you need to put yourself away and distance yourself from, from the client' (Carla, 11:28-12:19)

Looking at this excerpt in a bit more detail, it seems that Carla may imply that she needs to set the boundaries from the beginning of therapy; in this way, she will avoid the risk of getting overwhelmed by the intensity of the feelings, or indeed collapsed, and the risk of using the coping mechanism of distancing herself. It seems that for Carla the absence of boundaries would mean getting too close to

the client, which in turn would lead to going too far away from them in order to cope.

Joy seems to share the above view, as well. She balances the distance between herself and the clients by creating something almost like a shield. In this way, she manages to protect herself and avoid burn-out.

> 'Obviously you've got to connect with them, but at the same time you need to protect yourself as well, cause you're going to get all these horrible stories all the time, you might feel burnt-out too, so it's connecting with the client, but creating a little bit kind of something to protect myself as well ...not allowing all of this stress to hit me' (Joy, 3:14-20)

Mary and Lea perceive compassion and sympathy as harmful for the therapeutic relationship. Therefore the psychological boundary for them lies in the distinction between empathy and sympathy.

> 'One has to be aware of when the feelings are spilling over from empathy to sympathy or compassion, although one has undoubtedly compassion for certain people,...one has to be careful not to, for it not to interfere with the therapy, so if one is focusing on one's own feelings, rather than on ... what's the client's feelings in that situation, [it can] be disruptive of the relationship' (Mary, 8:10-21)

The participants also talked about their difficulty in placing a clear boundary between their own issues and the client's ones. For example, Carla talks about her effort to distinguish whether the thoughts and feelings she experiences during a session belong to her or to her client. She concludes that she cannot put aside completely her own stuff, implying that the boundary can never be set clearly, as there is a grey zone of issues that belong to both herself and the client. Therefore, she perceives her task as a therapist to ascertain whether her

emotional reaction has to do only with her own issues, or with some sort of interaction between her own and her client's issues.

> 'If a client brings up a certain response in me, I want to see what that's about, whether it's my stuff or something that the client has triggered...You think about yourself, am I responding because of my own circumstances, of my own emotional make-up, or is that, plus the fact that...this is the way that the client interacts with others, and the wider world' (Carla, 9:8-22)

As the word 'permeable' in the name of this theme implies, the boundaries that the participants talked about were not too rigid. On the contrary, the participants allowed themselves to be affected by the clients and their material, since this is part of therapy. However, at times the impact of the client issues on them was so great, that certain boundaries in the therapeutic relationship began to fade away. For example, Sandra found herself crying in front of the clients

> 'People say things that do in fact make me cry, and that's something I cant stop' (Sandra, 16:10-11)

Joy talked about being distressed by the client's horrific experiences, while Rachel reported feeling empathic both for her client's happiness and sadness. The situations in which participants shared common experiences with the clients were the most challenging ones in terms of the boundaries in the therapeutic relationship. Barbara and Mary experienced this situation in a very different way. Barbara describes below her reaction towards a client whose issues closely paralleled her own.

> 'My assessment came in...And it was all kind of like, ooh, you know, these are the two things...that... are really in my mind today, it kind of felt a little bit like, ooh, you know, a bit difficult, a bit tough...It was kind of almost

comical, cause I was like, I don't believe that out of all, anything could have come through the door, but it had to be this kind of issue...I guess in an awful kind of way I was glad I was not where she was, with grief, you know, I could kind of see where she was and I knew that I wasn't at that place any more. But also I guess it put it in perspective for me, as well, that I kind of moved on' (Barbara, 7:14-8:6)

Looking at this excerpt closely, it seems as if Barbara's contact with the client initially stirred up her own issues. It may have felt so difficult for her then, because the boundary between the client's and her own issues started to fade away. The words 'I don't believe' may denote the sense of a surreal experience. However, after the initial shock, it seems that this encounter had some redeeming qualities for her, since it helped her gain insight into her own issues. This realisation may have been quite disturbing for Barbara, hence the use of the word 'awful'.

In contrast to Barbara's experience, Mary reveals that she finds it too difficult to work with people that share similar experiences or problems with her. When the client's issues do not resonate with her though, the boundary is easier to establish, and the impact on her is more tolerable.

'I've been in situations with people who...experienced things that I've experienced in relationships...and that's made it difficult for me, you know, to work with' (Mary, 8:15-19)

'People that I find I struggle is people that have repeated profound depression...I do find it very heavy going, you know, for my own reasons I find it very difficult, which is, I don't know why, maybe because I have a tendency towards depression myself, I certainly have been depressed, whereas for instance I can work quite easily with people who had terrible experiences with PTSD for some reason, you know, not necessarily that

I've been there, cause I haven't... but I can tolerate that degree of emotional, you know,...depth or negativity, or intensity, but not with depression, and that's just me' (Mary, 24:19-25:4)

The participants also discussed the theme of boundaries in relation to harming the therapeutic relationship. They talked about difficult dilemmas concerning maintaining or breaking the boundaries, and the implications that this would have on their relationship with the clients. Lea, for example, faced such a dilemma when she was diagnosed with a serious illness, and had to be off work for a substantial amount of time. Normally, Lea was very clear about her principles with regards to self-disclosure and boundaries. However, this was an out of the ordinary situation, and therefore the normal rules did not necessarily apply. She was in conflict, as she felt that either decision (to disclose or not) could potentially harm the therapeutic relationship in different ways. In the excerpt below, she describes her dilemma, and her perception of self-disclosure as breaking the boundaries, and thus damaging the therapeutic relationship.

> 'While working... that is something, do you bring it into the sessions? Do you not? It's not a normal situation so it was a quite difficult one to handle... It's, you know, crossing that line between this is client - therapist relationship, not client, this isn't a friend...I cannot tell them, and 'I'm this, I got this', I cant do that ...it's not therapeutic, it's not ethical, and, so it's quite a difficult one to handle' (Lea, 27:19-23, 29:25-31)

Therefore, Lea perceived breaking the boundaries in that specific situation as harmful for the therapeutic relationship. Joy and Barbara, on the other hand, thought that sometimes maintaining the boundaries quite strictly could damage their relationship with their client. Joy decided not to address openly the issue of boundaries in the therapist – client relationship, as she was concerned that this would wipe out the client's progress so far. Barbara also thinks that sometimes

it's important to break some boundaries, in order to avoid damaging the therapeutic relationship.

> 'People giving you gifts or things, you have to be careful not to make them feel rejected, and kind of sometimes humbly accept it, because otherwise that's going to give the wrong message...you need to be really careful, cause it can damage the relationship that you have, and it can be very critical for the client' (Barbara, 17:3-17)

Overall, the theme of 'The permeable boundary between self and client' appeared to be very important in all the participants' accounts. The participants implied that the boundary needs to be permeable, so that they are connected to the clients and affected by their material. At the same time, they underscored the importance of having a boundary in place, in order to protect themselves and the therapeutic relationship. It was apparent though that no preconceived rules could be used on all occasions; the therapists had to make decisions about maintaining or breaking the boundaries according to the relationship they had with each individual client.

Theme 4: Therapeutic impasses and failure

All the participants in this study spoke in great detail about their experience of failure and therapeutic impasses while using the CBT framework. An interesting observation was that the types of relationships that were considered most challenging varied among the participants. However, several participants had common reactions to these relationships, such as feeling frustrated, hopeless and deskilled. The participants encountered different problems within these challenging relationships, and subsequently identified a number of ways to deal with them. The most common one was addressing the problems openly with the client during the session. Many therapists also seemed to use defence mechanisms, such as splitting and rationalisation, in order to deal with the

intensity of the emotions evoked, as well as with the threat that these relationships presented for their perception of themselves as a good therapist.

For Barbara, Joy and Carla dealing with therapeutic impasses is particularly difficult. This type of therapeutic relationship is characterised by stagnation and lack of progress, a feeling of being stuck. Barbara says that in these situations both her and the clients feel frustrated and hopeless. Joy also feels frustrated, but underlines the importance of the therapist's ability to contain the frustration and 'stay with that' (26:26). Carla reports feeling frustrated as well. Furthermore, Carla describes a number of powerful feelings when encountering an impasse in the therapeutic relationship. It is important to note that Carla considers the therapeutic impasses as her responsibility fully, as it is evident from the excerpts below.

> 'If something I'm doing doesn't work,...that's my problem, it's not the client's fault...But in more often than not, if something doesn't work, I find it's my responsibility, it's not the client's failure, I haven't been able to...work with this person,... you know, I don't really buy into the resistance concept' (Carla, 4:24-25, 20:27-30)

Therefore, it is not surprising that when Carla encounters an impasse in the therapeutic relationship, she doubts her ability to be a good therapist, since she considers it as her fault. Naturally she feels anxious and puts herself under a lot of pressure to find some type of resolution. This experience seems to constitute a big threat for Carla's perception of herself as a good therapist.

> 'Sometimes I find [it] can be quite difficult to engage, and, and there's very little progress, and sometimes you can get quite frustrated, I guess my limitation is that, you know, I'm not really good at dealing with, um, stagnation, you know when nothing's happening,... you know, you wonder, is this working? And that's when that anxiety comes over me, I

find I can slightly, um, lose my cool, as it were. When I think, well, this is not going anywhere, you know, this person is not making any progress, what to do now? You know, this sense of, am I doing the right things, and putting yourself under lot of pressure.' (Carla, 13:22-14:5)

Annette, Lea, and Mary experience similar feelings when they encounter failure. Annette describes feeling shattered and powerless when she could not establish a therapeutic relationship with any of the clients in a particular service.

> 'There has been a particular surgery that I've been working for four months, with, extremely deprived population area. And I tell you, I was absolutely shattered. And no matter my personality, my presence,...my enthusiasm, my professionality, my belief system, my feelings, my acceptance, no matter what, it's simply nothing works there' (Annette, 21:10-18)

In contrast to Carla, who takes full responsibility for the impasses, Annette, Lea, and Marry attribute the client's decision to discontinue therapy to reasons other than their clinical practice. It seems that the clients' decision to drop out of therapy is quite a big threat for the therapist's self-esteem. Therefore, therapists need to use a range of mechanisms to cope with that threat and continue to perceive themselves as competent therapists. One way of making sense of this, is to attribute it to the client's problems. For example, Annette attributes the failure to establish a therapeutic relationship with clients, to the severity of their pathology. Lea, as well uses the conceptualisation of the client's problems to understand challenging therapeutic relationships, as described below.

> 'I had maybe one or two people that were slightly BPD [i.e. borderline personality disorder], but they generally... either don't come to therapy or they ll come for one or two sessions, and then decide that you re not good enough, you are not the right person for them. And you know that's part of

the problem...so I don't take that as being, you know, a personal thing.' (Lea, 16:10-24)

Annette, Lea, and Mary also seem to be using rationalisation as a defence that will help them maintain their self-esteem intact despite their client's decision to end therapy prematurely. Whilst trying to make sense of the fact that some clients decided not to come back to therapy, Lea gives a number of possible explanations. However, she only mentions quickly her way of practising CBT as a potential reason, without going into it in any depth. She quickly goes on to talk about reasons that are completely unrelated to her clinical practice, and thus out of her control. This might help Lea to remain a confident therapist in the face of challenging therapeutic relationships, and not doubt her abilities like Carla did.

'I had some clients...who have decided that they didn't want to come back for whatever reasons, that's fine. Some people might not like my approach, some people might not like me, some people may have a thing with people with my hair colour, I don't know, or I may be, you know, they are going through a bad divorce with somebody who I might remind them of, they will not want to come back into the sessions...or maybe cant afford to see me, or maybe I charge too much, or you know' (Lea, 10:7-16, 32:8-10)

Barbara and Joy also seem to be using defence mechanisms to cope with challenging therapeutic relationships and failure. However, for them it is not the client's decision to discontinue therapy that is perceived as particularly difficult. Barbara and Joy talk about their occasional failure to show empathy and unconditional positive regard to clients that have committed an action which was against their value system. Barbara in particular talks about her therapeutic encounter with a client who committed a crime. During the session, Barbara seems to have been caught up in a conflict of values between: a) her personal value system, which the client violated with the criminal action and b) the value

that a counselling psychologist needs to be empathic and non-judgemental with every single client. In the excerpts below Barbara describes experiencing a conflict between 'herself and the counsellor'. She then talks about detaching the judgemental part of her during the session, and thus using the defence mechanism of splitting in order to deal with the conflict.

'It feels kind of almost like, um, a conflict between me and the counsellor...Half of me was like, 'Oh my God! It was you who did that kind of thing', but again, I was there for that client, that was my role, so that's what I had to make sure that I did, that I empathise with them, that I was there listening to their needs and putting all my stuff away...You have to detach yourself, you know. As much as there might be a part of me saying, well, hold on a minute, this person had done this, I'm not, I'm not in the room as that person, I'm there as their counselling psychologist or their counsellor' (Barbara, 13:10-11, 12:11-13:7)

Later on in the interview, Barbara emphasised how important it was for her to get in touch with the judgemental part of her after the end of the session, and process her feelings through personal reflection and supervision.

Rachel, Mary, Joy, Barbara, and Lea underscored the importance of addressing the problems openly with the client during an impasse. Rachel said that it is vital to address openly any underlying problems in the relationship, thus making the implicit explicit.

'It was very clear from the beginning that there was a power struggle going on in the room, in terms of who held the power him or me....And then he would try to give me a kiss on the cheek at the end of the session, and so, you know, those things needed to be brought out in the open, needed to be made explicit as to what's going on here, and, you know, what's behind what you're doing' (Rachel, 3:13-21)

Later on in the interview, Rachel came back to this client and revealed how difficult and anxiety provoking it was for her to actually address these issues openly during the session. She explained that she managed to overcome these difficulties by bracketing out her own anxiety.

'If there is a difficulty you need to address it, and I think that's probably one of the hard things about being a therapist, because it is, it can be confrontational and it can be anxiety provoking to do that, or to think, oh, you know, I need to talk to this person about his boundaries and that, you know, he cant give me a kiss on the cheek at the end of therapy and why is he doing that and what's this all about... It's quite anxiety provoking, um, but then you need to, I guess, to put that part aside and say that's my own stuff, you know, but it's really about addressing it in the room' (Rachel, 19:30-20:14)

Finally, it is important to note that Barbara was the only participant who, after overcoming the problems of initial failure, found challenging therapeutic relationships as enriching for herself later on.

> 'But as the sessions have gone, the relationship has improved and I've actually really enjoyed working with them, I've got a lot out of it.' (Barbara13:29-31)

Theme 5: Using the therapeutic relationship as a tool

All the participants in this study emphasised the central role that the therapeutic relationship plays in CBT; some characterised it as the 'key to therapy', while others thought of it as the 'foundation'. However, apart from the overall importance of the therapist - client relationship, the participants also talked about using the therapeutic relationship as a tool in CBT. In order to do that, the participants had to perceive, to take in what was happening between them and

the client, and then sometimes feed that back to the client with a therapeutic intervention. The therapeutic relationship was then seen as a means through which some goals of therapy could be achieved. The functions that the therapeutic relationship has in the practice of CBT vary among the participants. Some therapists talked about using their own feelings about the relationship as a tool, some emphasised the reparative aspects of the therapeutic relationship, while others underscored the role of the therapeutic relationship in promoting client change.

Rachel, Sandra, and Lea use the here and now of the therapeutic relationship in CBT. Sandra in particular uses problems in the relationship as an opportunity to explore the client's cognitions and possible mental mistakes in relationships in general. Lea in the excerpt below uses the here and now to express empathy and explore the client's thoughts and feelings.

> 'I would say, when we spoke about that, I could see it made you unhappy, I could see the tears in your eyes. Can we talk about that again, what was it that made you so unhappy, I mean, when we were talking? What was it that made you cry when we talked just now? So, you can get that empathy in there... which is very much CBT, very much about what's happening in the room now, you know, what's going on through your mind' (Lea, 14:5-16)

Mary, Barbara, Sandra, and Carla use their self, and in particular their own feelings towards a client, as a way of gaining a better understanding of the client's internal world, and the client's contribution to relationships outside the therapy room. In the excerpts below, Barbara uses relational self-disclosure in order to promote the client's self-awareness, while Carla uses her own feelings as a clue to the client's problems in relationships with others.

'I might actually say to someone, like, 'Oh I'm feeling quite frustrated with what you're saying', or, you know, 'it feels very sad, it makes me feel now there's a real sense of sadness now in the room'...you put it on the table, and name it, and recognise it' (Barbara, 3:4-10)

'If I'm responding like this, and I'm a kind of, in a way, representative of the wider world, is this the sort of response that the client, um, provokes in others?' (Carla, 9:11-14)

On the contrary, Annette maintains that in CBT the therapist shall not use their own feelings as a tool. It may be important to note that, as discussed earlier, Annette seems to be having a conflicting relationship with CBT. However, she does use herself as a tool whilst practising in different approaches.

'[In CBT] you wouldn't use that tool, this is another thing. You again, you tend to concentrate on the cognition and the behaviour, so um, the information that you get at another level, for example, at the level of countertransference, is not used' (Annette, 9:10-14)

Despite this view, Annette does perceive the therapeutic relationship in CBT as potentially reparative of the client's relationship with their parents. Therefore, while practicing CBT, she offers her clients a corrective experience, during which she is like a parent who cares and at the same time challenges them.

'I am um... a good mother, sort of able to care for them... they are able to feel my concern, and my interest, my genuine interest in them and acceptance, but at the same time I'm tough. At the same time I maintain the boundaries, I say no, I, I challenge them, I stretch them when possible. And, of course, again, this is a sign of care. A lot of patients haven't had at all an experience of care from their parents, either positive or negative.

So… they blossom in therapy when they experience that' (Annette, 20:10-22)

Carla as well assumes a parental role for her clients to replenish what they missed out in their childhood.

'You've taken on a role of,… it's almost….parallel to parental roles, you know, you've been modelling…the sort of nourishing relationship that perhaps they didn't have, and so there's a lot more intensity there' (Carla, 7:25-29)

Lea's reference to the parental role is much more subtle in her account below.

'People have um blood phobias or needle phobias, you know, I ll hold the needle, I ll stick it in my own finger, you know,… it's modeling in a way, that they ll do this, lets do this together, you know, it's sort of childlike in a way, but, lets do this together, then what does that mean if I say we are going to do this together, it sort of gives them a different message, rather than I'm being made to do this, but she is not, why?' (Lea, 11:4-13)

Looking at this excerpt in a bit more detail, it seems as if Lea encourages the client to take the risk of behavioural exposure in the same way that a good parent would do with a child. The use of the word 'childlike' supports further this interpretation of her account. Lea acts as a role model for the client and sticks the needle in her own finger, as if she was showing a small child that there is nothing to be afraid of. At the same time though, like a good parent, she does not just observe from the outside the client taking the risk, but participates fully in the whole process, so that they do everything together.

Lea uses the therapeutic relationship in order to facilitate the client's change, and in particular the client's behavioural exposure. Joy also perceives the therapeutic

relationship as a tool that supports the client's change. However, for Joy the necessary condition for change is the client's self-acceptance. Therefore, Joy accepts her clients within the therapeutic relationship in CBT, which in turn promotes the client's self-acceptance, and which then leads to change.

> 'You've got to accept them exactly as they are. Especially to help them to change, Rogers said, 'Paradoxically when I accept myself as I am, I can change myself'. So if you want to help them to change, the position of change is actually self-acceptance...Just stay with them emotionally. Not technically, but emotionally, stay with them on their journey with you, whether they do CBT assignments or they don't do them, they are much more likely to get the change, the cognitive change, if you stay with them and don't judge them' (Joy, 14:15-18, 21:21-25)

In summary, all the participants did not only consider the therapeutic relationship as necessary condition for successful therapy. They gave specific examples of how they used the therapeutic relationship itself as a tool to promote the aims of CBT and facilitate client change.

Theme 6: Non-verbal communication in the therapeutic relationship

Several participants talked about the importance of non-verbal communication in the therapeutic relationship. Non-verbal communication was perceived as having a dual function. First, it offers the participants a way into the client's internal world; it offers some insight into the client's negative automatic thoughts and their internal conflicts. In this way, the participants conceptualised the body language as helping them to perceive the client fully, as a whole person, and not just as a 'talking head'. The second function of non-verbal communication was that it allowed the participants to respond to the client's reality they had just perceived. The participants described their own body language as a powerful means of communicating to clients what they may have not been able to communicate with words.

Annette and Barbara use the client's behavioural cues to gain a better understanding of the client's thoughts that are particularly important. In both their accounts, it is evident that the client's non-verbal communication is perceived as a sign of underlying difficulties that the client may even not be aware of.

'What is used, for example, observation of the patient in the room, their behaviour, the way they look, the way they use the body, um, the tone of voice, the pace, some movement. All this are information that are used, of course, to have a better formulation of the presenting problem...and they are useful to, um, flag up certain emotions or certain thoughts that the patient might have automatically, they are not able to understand what's going on. But, for example, the therapist might be able to guess quite clearly. So, it's around shame and guilt, um, you would observe them from behavioural clues.' (Annette, 9:14-27)

> 'You try your best to pick up on the things that really are important, you know, not just with words but maybe their body language, so a client might be saying something to me,...when they're saying it they might be welling up with tears...really notice their, kind of, body posture, or their shifting around and their movement, and what they indicate, you know, they might be feeling uncomfortable, or something's difficult to talk about, you know, just be really mindful of those kind of things, as well, the nonverbal communication that goes on' (Barbara, 6:3-15)

Similarly, Joy observes any contradictory messages between the client's verbal and non-verbal communication, and tries to understand what that means for the particular client.

> 'There are certain things that I think every therapist should be very good at, reading what the client does not tell you, OK? They may say one thing,

but their body can tell you something completely different, and trying to respond to the things between the sentences...So very much understanding the client and responding to what they're communicating, whether it's verbally or non-verbally.' (Joy, 2:24-3:2)

At the same time, she responds to the client's reality through her own body language, which she regards as more powerful than words.

> In some ways non-verbal communication can be more powerful than verbal communication...Sometimes I do tell them [the clients], I'm saying this because I really want to help you...but most of the time I think you can communicate all of this without words, which is more powerful, when you look at them, the body language, if you are wrapped up like this, looking a bit bored or whatever, so there are many ways of communicating.' (Joy, 19:1-10)

Rachel reveals that 'I talk a lot with my hands'. For her, reflecting the client's body language has the underlying function of strengthening the working alliance and enhancing the holistic approach that CBT promotes.

> 'Make sure that you use...nonverbal language... to reflect someone's body language to them, so I think part of a good working alliance is that the person knows that you understand them not just by what they're saying, but also by what they're not saying,... I suppose they need to know that you're aware of them as a whole person and that you're trying to understand them' (Rachel, 7:3-11)

Sandra, as well reflects the client's body language. In the excerpt below she emphasises that this is a natural process for her, which facilitates the client's perception of her as empathic and similar to them.

'I do find that I quite naturally mirror other people and I think that's very helpful...if you sit like this, I tend to sit like this, if you do this, I tend to do this, and I don't try to do it, but I just find that I do it (laughs) and I think that helps...they feel that you are listening to them, and they feel that you are like them, you're similar to them, and I think that is helpful... they feel that you're empathising with them' (Sandra, 14:9-20)

Therefore, non-verbal communication between therapist and client appears to be taking place in parallel to the verbal communication. Thus, the therapeutic relationship in CBT encompasses what therapist and client say to each other, as well as what they convey through their body language.

Discussion of themes

For reasons of coherence, the themes within the master theme 'Interpersonal processes with client: perceiving and responding to client's reality' are presented separately in the discussion section. The following six subsections aim to illuminate how each of the themes that emerged in the present study is related to the existing literature.

Discussion of theme 1: Promoting the values of honesty, equality, and respect through the practice of CBT

Consistent with the humanistic roots of Counselling Psychology (Woolfe, 1997), the values of honesty, equality, and respect have a central role in the participants' therapeutic practice.

Clients tend to adopt their therapists' values, as shown by a review of empirical studies in psychotherapy (Kelly, 1990), as well as by studies in CBT in particular (Hamblin et al., 1993). Therefore, since we can not avoid imposing our values on our clients, we need to at least be aware of that influence (Clarkson, 2003), and reflect carefully upon the type of values that we hold and upon which of these values it is best for clients to adopt (Tjeltveit, 1999). For this reason, Tjeltveit

views the therapist as an 'ethicist', and the therapeutic relationship as containing by definition ethical qualities.

The participants' values permeated their role as a psychologist both in theory and in practice. Many participants conceptualised their role as a therapist to be honest, to respect their clients and their individual decisions, and to try to empower clients within the therapeutic relationship. Consistent with these values, the participants were open to clients to the extent that this did not undermine the goals of therapy, respected their clients' decisions within therapy (e.g. to do or not behavioural exposure, to do or not homework tasks), and used the clients' expertise in their life to guide therapy. Therefore, for the participants in this study, the values of honesty, equality, and respect seemed to not just be avowed, but enacted as well (Clarkson, 2003).

A useful framework for the role of ethics in the practice of Counselling Psychologists is presented by Jordan and Meara (1990). They argue that, whilst there is a difference between principle ethics and virtue ethics, they are complimentary to each other and need to be integrated within psychologists' practice. Principles guide therapists on what to do when encountering an ethical dilemma, while virtues guide them on who to be. Among the six principles that Meara and her colleagues (1996) propose as central within therapy, three seem to correspond most closely to the participants' accounts in the present study: being truthful, creating a trustful and loyal therapeutic relationship within which no abuse of power occurs, and respecting the client's right to make their own decisions. Among the four virtues suggested as particularly important for Counselling Psychologists, the ones of integrity and respectfulness seem to be reflected in the participants' accounts.

Within the theory of CBT, the concept of values has not been discussed explicitly. The literature is restricted to a quick mention of the therapist's desirable qualities of warmth, empathy, genuineness, and acceptance (Beck et al, 1979;

Beck, 1976, 1995). However, what is emphasised in CBT theory is the concept of collaborative empiricism: therapist and client create a team and make a joint effort to overcome the client's problems, by coming to an agreement about the goals and tasks of therapy (Beck et al, 1979; Beck, 1976, 1995; Curwen et al., 2000). Implicit within the concept of collaborative empiricism are the values of equality and respect. Therefore, the participants' efforts to empower clients, to rebut the expert position, by explicitly acknowledging that the clients are experts in their life, and to respect the client's wishes about the therapeutic process, are in line with the notion of collaboration, as it is portrayed within cognitive behavioural theory.

Notable exceptions to the overlooking of values within CBT are Evans, Safran and Segal. Evans (1997) advocates for the need to state explicitly the social and professional values guiding our practice, in order to enhance the integrity and reflexivity of behaviour therapy. At the same time, Safran and Segal (1996) are aware of the convergence of the client's values towards those of their therapist. Therefore, they propose that therapists need to accept fully their clients. This will allow clients to feel secure enough within the relationship to assess their therapist's value system, and integrate only those values that resonate most closely to their personality and philosophy. The idea of accepting all aspects of clients was expressed by several participants in this study.

The research findings on the therapists' values are related to the findings of the present study. Fisher-Smith (1999) reported that all the psychotherapists participating in her qualitative study promoted the values of authenticity and autonomy, which correspond closely to the theme of honesty, equality, and respect that emerged in the present study. Williams and Levitt (2007) interviewed expert therapists from different orientations about their use of values within therapy. One of their main clusters was labelled 'Who is the expert? Using moral relativity as a guide when negotiating clients' values and belief in science as a guide when applying theory'. With this particularly interesting conceptualisation,

the authors expressed the therapist's tendency to seek clients' expertise in their own life experiences to guide therapy, while at the same time acknowledging that they were equipped with psychological theory and practical experience of the process of therapy. A very similar idea was described by participants of the present study who promoted equality in the therapeutic relationship by sharing expertise with their clients: the participants viewed themselves as experts in CBT, and the clients as experts in their own life. Finally, the fact that therapists' values influence their decision as to whether and how to use the research evidence to inform their practice (Corrie & Callanan, 2001) provides further support for the significance of values within the therapeutic relationship.

The research findings on the clients' experience of therapy and the therapeutic relationship also underscore the importance of the therapist's values. It is not reported that clients talk about values explicitly; however, it has been found that clients appreciate and perceive as therapeutic a relationship with a therapist who is honest (Bedi, 2006; Borrill & Foreman, 1996), non-judgemental (Shattell et al, 2007), respectful of the client (Wright & Davis, 1994; Heppner, 1992; Lilliengren & Werbart, 2005) and of the pace they wish to maintain in therapy (Levitt, et al., 2006). Furthermore, the fact that clients defer to their therapist's authority (Rennie, 1994a), together with the finding that this deference is interwoven with the experience of resistance in counselling (Rennie, 1994b) make the participants' effort to restore as much as possible the equality in the therapeutic relationship particularly important. Therefore, going back to Jordan and Meara's (1990) conceptualisation of principles and virtues, it seems that the values and ethics behind what the therapists do, as well as who they are, are salient within the therapeutic relationship.

Discussion of theme 2: Personalising and tailoring CBT to clients

One of the most common misconceptions about CBT is that it involves the mechanical application of techniques (Gluhoski, 1994). Perhaps the dramatic increase of treatment manuals in cognitive behavioural therapy has contributed

to the misunderstanding that CBT is easily applied by following step-by-step guides. Therefore, Beck and his colleagues (2004) warn therapists to not consider this type of therapy as a 'cookbook' approach (p.102). There is a big gap between adhering to the treatment manual and being a competent CBT therapist (Dobson & Shaw, 1988). What lies within this gap is professional artistry (Beck et al., 2004).

So how does one develop professional artistry? One answer to this question could be found in Little's (1986 as cited in Clarkson, 2003) words: 'the same thing can be both bad and good, that what is most valuable can also be dangerous and useless...The great need is for flexibility...and a willingness to use whatever resources are available' (p.134).

The participants of this study explicitly positioned themselves against following manualised treatment, and emphasised the use of flexibility and creativity within their practice of CBT. Perhaps staying close to the phenomenological roots of Counselling Psychology, and the focus on the subjective experience of each person (Division of Counselling Psychology, 2005), the participants valued the 'person' in front of them, and tailored any interventions according to their individual client.

The participants' flexibility is in line with contemporary CBT. Castonguay and his colleagues (1996) have warned against rigidity, as it can affect negatively the therapeutic relationship in CBT. Therefore, there is a current emphasis on flexibility and spontaneity in CBT, not only in the case conceptualisation, but in the therapy process and structure, as well (Howes & Parrott, 1991). Overholser and Silverman (1998) suggest that in order to achieve that, a therapist needs to understand the structural underpinnings of CBT, and then weave them together with events that the clients consider important and raise in the sessions. This holds true for several participants, who integrated CBT techniques naturally into their conversation of the client's problems.

The participants of this study also emphasised that in order to be able to use the CBT model in a way that is personalised and tailored to the individual client, they first need to see reality from the client's point of view. During this process, the therapist's perceptual skills are of particular importance. Bennett-Levy (2006) has developed a CBT model of therapist skill development called the declarative-procedural-reflective (DPR) model, in which the therapist's perceptual skills are highlighted. The therapist's interpersonal perceptual skill is part of the procedural system in this model, and allows the therapist to tune in with the client and empathise with them. Over the time, the therapist combines the interpersonal skills with the CBT-specific skills into an implicit set of when-then rules, which allow the therapist to be flexible and adapt to the client's individual presentation (Bennett-Levy & Thwaites, 2007). Bennett-Levy (2005, as cited in Bennett-Levy & Thwaites, 2007) argues that when the interpersonal skills are enhanced, they infuse the CBT-specific skills that the therapist uses with more interpersonal sensitivity. This results in professional artistry. The DPR model seems like a useful framework to understand how the participants in this study managed to use the CBT techniques in a way that was personalised to each client, and thus enhancing the therapeutic relationship.

Within the research literature, the therapists' effort to tailor therapy to their clients is evident. Williams and Levitt (2007) report that eminent therapists of different orientations are frequently caught up in the following dilemma: use their theoretical and empirical knowledge to guide their practice or 'bend their rules' in order to accommodate for the subjectivity of each client. The way that this conflict of values was solved was individual to each therapist. In another study (Binder et al., 2008), the therapists personalised the treatment offered to adolescents by using the same language and framework as them when giving meaning to their problem. The tendency to use the same framework as the client was also evident in the accounts of the participants in the present study.

The clients' perspective in therapy provides further support for the need of flexibility in CBT. The therapist's ability to enter the client's world and reassure the client that she was justified in her views in a friendly manner, was perceived by a client receiving CBT as a particularly important event, which led to insight (Elliott et al, 1994). One the other hand, therapists can learn useful lessons from clients who are not completely satisfied with their therapy. Depressed clients diagnosed with HIV requested for greater flexibility in terms of the homework set in CBT (Berg et al., 2008). In a study of clients' experience of change (Nilsson et al., 2007), what was prevalent among the dissatisfied CBT clients was the idea that the therapist was applying a rigid predetermined therapy design, which felt more like a lesson, rather than as a reflective activity. These clients felt oppressed by their therapists' fixed ideas; they felt as if their therapists viewed them as a passive thing rather than as an active, thinking person. These findings illustrate the detrimental effects of the therapist's lack of flexibility and spontaneity on the therapeutic relationship and therapy in general. These studies also highlight that the views from the participants of the present study converge with those of clients receiving CBT.

Therefore, it can be concluded that the CBT techniques are interwoven with the therapeutic relationship. The therapist's ability to tailor the use of theory to the individual client enhances the therapeutic relationship, as he/she values the person of the client. At the same time, the therapist's lack of flexibility weakens the therapeutic alliance, as it conveys that the model is more important than the client's immediate concerns.

Discussion of theme 3: The permeable boundary between self and client

The participants in this study emphasised the importance of boundaries in their practice. They gave vivid accounts of their struggles to determine what type of boundaries and how to place them in their work with their clients. The participants felt that the repercussions for the therapeutic relationship would be very significant, and were concerned not to damage the relationship with their

decision to maintain or break the boundaries. The therapists' difficulties on this issue have been documented by other studies, as well. Therapists seem to perceive self-disclosure and breaking other boundaries as a risk-taking activity (Knox, 2007), which poses significant dilemmas (Dryden, 1985).

Can an answer to the boundary dilemmas be found in the theory of the cognitive behavioural model? Boundaries have generally been overlooked by the authors of the early books in CBT, as there was an understanding that the practitioners' code of conduct would serve as a guide on how to resolve boundary dilemmas in an ethical manner. However, as CBT began to be applied with clients who had more complex presentations than anxiety and depression, the need to discuss boundaries more elaborately as part of therapy became compelling. In their book on personality disorders, Beck and his colleagues (2004) stress the importance of maintaining boundaries when working with this client group, as otherwise there is a risk of reinforcing the clients' maladaptive beliefs that they can live 'outside the rules'. Furthermore, the boundaries are presented as containing curative qualities, since they can allow the client to test their negative beliefs about setting boundaries, which stem from the lack of parenting in their childhood. However, it is important to note that the participants in the present study did not conceptualise boundaries as means through which to alter the clients' maladaptive beliefs.

The steps that the therapist needs to follow when a client breaks the boundaries are described very clearly in the same book (Beck et al, 2004). The first of these steps is for the therapist to explain to the client the rationale behind the boundary, instead of resorting to justifications based on institutional or professional rules. Clarity and consistency in setting boundaries seems particularly important, as clients have revealed that they felt angry, not at the existence of boundaries per se, but at the fact that they thought that the boundaries were arbitrary, inadequately explained, or shifted suddenly to accommodate the therapist's needs (Dalenberg, 2004).

The participants in the present study expressed the need to not cross the boundary between empathy and sympathy. Whilst empathy meant they could see the world from the client's point of view, as if they were in the same position like them, sympathy meant that the 'as if ' quality was lost (Rogers, 1957), and the boundaries between self and client faded away. The distinction between empathy and sympathy has also been highlighted by Beck and his colleagues (1979). A similar idea is presented by Overholser and Silverman (1998), who advocate for a balance between empathy and objectivity in CBT, which allows the therapist to stay close to the client, and at the same time to be able to challenge their maladaptive beliefs. On the other hand, Fish (2000, as cited in Lum, 2002) and Yardley (1990) place the significance of psychological boundaries in their function of protecting the therapist from getting too emotionally involved with the client, and subsequently burnt-out. The idea that boundaries promote self-care and protect the therapist from burn out was also expressed by one of the participants in the present study.

One situation in which some participants found it particularly difficult to balance their distance from the client, was when they shared common experiences with them. In those instances the boundaries began to fade away, and the participants got significantly affected by the clients' material. This is coherent with Saakvitne's (2002) observation that when both therapist and client share a traumatic event, the therapist is vulnerable to get traumatised through their empathic engagement with the client.

The therapist development throughout their career sheds some light on the issue of boundaries. Bischoff (1997) has found that novice therapists begin with very permeable boundaries. However, in their attempt to be as helpful as possible, they become anxious and overwhelmed by the client's material. This encourages them to re-evaluate the existing boundaries, and define them more clearly in a way that they are less permeable. Similarly, Skovholt and Ronnestad (1992)

report that therapists tend to get more skilled at regulating their involvement with their clients, as they get more experienced. They observe that by mid-career, the therapists prioritise self-care, by adhering more strictly to clear boundaries. Skovholt and Ronnestand argue that it is the development of these boundaries that allows the practitioners 'to be involved but not depleted' (p.513) by the continuous contact with the clients' intense pain.

So do the above findings mean that it is wise to always set and maintain clear boundaries with clients? As the participants' accounts demonstrate, the issue of boundaries is particularly complex, and no 'rule of thumb' can be applied. Some participants felt that on some occasions, breaking some boundaries would be beneficial for the therapeutic relationship. Support to the participants' views provide studies into therapists' and clients' experience of boundaries in therapy. Therapists reveal that the fading of boundaries is not necessarily a negative sign of getting overwhelmed by the client's material. On the contrary, during moments of relational depth (Cooper, 2005) and moments of client change (Williams & Levitt, 2007), the therapists immerse in the client's world in a way that psychological boundaries between them and their clients disappear.

The clients' perception of the boundaries seem to be quite complex as well. On the whole, clients seem to value boundaries in the therapeutic relationship, as they foster an atmosphere of security. However, instances in which the therapist breaks those boundaries in order to accommodate the client, are perceived as particularly positive by the clients (Bedi et al., 2005), as they provide strong evidence that the therapist truly cares for them (Levitt et al., 2006). Therefore, Levitt and her colleagues conclude to the following principle: 'Structure in the relationship provides safety and empowerment. Transgressions of structure, however, can improve the alliance when they illustrate care but weaken the alliance when they lead to client discomfort' (p.319). Following that principle, the participants in this study maintained the boundaries on most occasions, and only broke them if they felt that this would preserve the therapeutic relationship.

Some participants in the present study perceived self-disclosure as an act of breaking the boundaries which required thoughtful consideration. Within the cognitive behavioural framework, self-disclosure has received attention recently. MacLaren (2008) argues that self-disclosure is one powerful way that a CBT therapist can use their self in therapy. Goldfried and his colleagues (2003) explain that self-disclosure is consistent with the CBT model, and the principles of modelling pioneered by Bandura. They advocate that when a therapist discloses some relevant personal information (e.g. how they coped with a similar difficulty), a number of therapeutic tasks are achieved: it enhances clients' positive expectations and motivation, strengthens the therapeutic bond, normalises the clients' feelings, reduces the clients' fears, and provides a model of an effective way of functioning. Contrary to this view, the participants in the present study did not report disclosing any personal information to the client.

The findings from qualitative studies into the clients' experiences seem to support the view that self-disclosure can enhance the therapeutic relationship. Clients report that a relevant self-disclosure by a therapist can facilitate relating with them (Shattell et al., 2007), provide them with insight, and a role model, normalise their feelings, and improve the therapeutic relationship by making it more equal or real (Knox et al., 1997). However, the study by Hill and her colleagues (1989) reveals that it is not the act of self-disclosure per se that is important, but rather the function it plays within therapy. Both clients and therapists consider self-disclosure helpful when it reassures the client, and unhelpful when it challenges the client's way of thinking or behaving. Therefore, therapists need to reflect upon the function and the meaning of self-disclosure within the specific therapeutic relationship they have with a client, before deciding whether this is an appropriate boundary to break. This is consistent with the participants' reflections upon the potential impact of boundaries and self-disclosure on the therapeutic relationship, before deciding which route to follow.

Since, as the participants in this study explained, no universal rule can be applied to all clients, Clarkson (2003) advises that the therapist needs to 'experiment' with self-disclosure. The client's initial reaction to self-disclosure will provide insight into that client's needs within the therapeutic relationship, and reveal whether self-disclosure can be used to meet those needs.

Discussion of theme 4: Therapeutic impasses and failure

'We are all incompetent some of the time. We just cannot get through to some people because of our deficiencies and limitations' (p.59). With those words Kottler (1986) emphasises the inescapability of facing failure, when one works as a therapist. However, traditionally, the issues of impasses and failure have been shrouded in shame and silence. This silence though does not signify the absence of problems. As Crowly and Avdi (1999 as cited in Hannigan et al., 2004) reveal, the psychologists who took part in their study felt 'stuck' in therapy with over half of their clients. Therefore, the need to bring this hidden topic out into the open becomes evident. The participants in the present study responded to this need, by discussing openly their experiences of being in a challenging therapeutic relationship, which was characterised by a distinct lack of progress and/or a premature ending.

The participants in this study revealed that, when faced with therapeutic impasses or failure, they experienced a number of powerful feelings; they felt frustrated, anxious, deskilled, powerless, and hopeless. Similar feelings have been reported in the few other studies identified on this subject. Davis and his colleagues (1987) report that one of the frequent difficulties therapists face is feeling stuck, incompetent, thwarted or threatened in the therapeutic relationship with their client. Similarly, the therapists in the study by Hill and her colleagues (1996) explain that during therapeutic impasses they feel frustrated or angry with their client, disappointed, confused and anxious. The counsellors in Mearns' (1990) study experience failure when the client doesn't trust them, disappears or uses therapy as a place to dump powerful feelings. In response, the counsellors

feel impotent, unable to help the client overcome their problems, belittled, frustrated and angry. Furthermore, premature endings can also leave the therapists feeling a burden from the unfinished business. This might explain why several participants brought up this issue during the interview.

One implication of failure that is evident in the present study, as well as in the studies presented above, is that it leads to self-doubt. If then therapists perceive their therapeutic abilities as a complete evaluation of the self (Eckler-Hart, 1987), those feelings tend to be intensified. The participants in the present study did not base their self-esteem only on being a competent therapist. Nevertheless, therapeutic impasses and failure posed a significant threat to their perception of themselves as a good therapist. One of the mechanisms they used to cope with such feelings was rationalisation: they attributed failure to factors outside of their control, and in fact irrelevant to their therapeutic practice. A similar process of rationalisation to deal with failure was documented in Mearns' study (1990). Furthermore, the therapists in that study used the thinking strategy of focusing on their successes with other clients they treated. Similarly, in another study (Hill et al., 1996), the therapists used positive self-talk and reframing of the situation, in order to cope with their perceived negative self-efficacy and self-doubt.

Despite the powerful negative feelings that therapists experience during impasses or failures, Schon (1983) suggests that these instances can be a 'source of discovery rather than an occasion for self-defence' (p.299). However, what do we need to do in order to make use of this opportunity for breakthrough (Safran, 1993; Clarkson, 2003)? The answer might be to look into ourselves, since the type of difficulties in the therapeutic relationship reported, show consistent idiosyncratic features *of the therapist* (Davis et al., 1987).

Strong (2002) suggests that therapists need to develop their ability in 'generous listening' and discursive flexibility, in order to overcome therapeutic impasses. 'Generous listening' refers to the therapist's ability to hear beyond the familiarities

of their own forms of discourse, by trying to learn and appreciate the client's culture. This allows discursive flexibility, that is the ability to negotiate a shared agenda with a client, by drawing on a number of discourses or ways of talking. According to Strong and narrative therapy, therapeutic impasses occur because of the dominance of inflexible discourses which do not engage both therapist and client. The problem lies in the discourse, rather than in the person of the therapist or the client. Therefore, Strong argues that it is the therapist's task to disentangle themselves from the rules of their own discourse, improvise, and talk in forms of discourse accessible to clients. Perhaps, in the present study, the participants' open discussions with the clients about the problems could be understood as an invitation to notice a problematic discourse and then negotiate a more appropriate one.

The concept of flexibility and pluralism is central also in Omer's (2000) model of therapeutic impasses. According to this model, there are three interrelated conditions that can lead to therapy being stuck: a hopeless narrative about the client's difficulties, inflexible therapeutic strategies, and a pattern of negative interaction between therapist and client. Omer, like Strong, advocates for flexibility and modification of the above conditions, in order to come out of the vicious circle. However, he believes that the therapist may be too immersed in this circle to manage to break through it on his own. An external consultation will help the therapist analyse the situation and develop a critical intervention which will move therapy forward. In this study, supervision was portrayed as playing the role of this external consultation.

A different way of resolving therapeutic impasses has been put forward by Klagsbrun and Brown (1984). They describe a method of imagery which the therapist can use with the help of their supervisor or by themselves while reflecting on a difficult client. The method involves a set of questions which will help reveal latent qualities of the therapeutic relationship and ways that these can be used differently in therapy. During this form of imagery, the therapist

imagines meeting the client in a metaphoric place, and notices the roles, activities, and body sensations present in this image. This different way of looking at the therapeutic relationship helps the therapist discover new ways of being with their client.

Buie (1981, as cited in Tempel, 2007) also considers the therapist's imagination as a central mechanism to deal with failures of empathy. He suggested that when a therapist faces difficulties in their empathic engagement with a client, they need to imitate both in action and in fantasy what it would be like to be that client. The therapists in Tempel's (2007) study seem to be resorting to their imagination to help them experience empathy towards mothers who physically abuse their children. Therefore, they envisioned the mother as a frightened child herself, imagined what it would be like to be a mother of a difficult child, and how, in the mother's eyes, physical aggression could be used as a way to protect their children from the dangers of the real world. Imagination may provide a useful framework to understand one of the participants' effort to detach herself and focus on the client's experience.

All the reflective activities described above seem to be particularly important for therapists who want to overcome impasses and deal with failures in therapy. However, one of the most common ways of overcoming these problems is to address them openly with the client. This was evident in the participants' accounts in the present study, who made the implicit problems in the therapeutic relationship explicit. Consistent with Ungar's (2005) view that silence perpetuates the impasse, while openness leads to growth, clients report greater satisfaction with therapists who discussed openly any ruptures in the alliance (Dalenberg, 2004).

Discussion of theme 5: Using the therapeutic relationship as a tool

In the early period of cognitive behavioural therapy, the therapeutic relationship was seen as important in creating a fertile environment where the cognitive or behavioural techniques could be used most effectively (Beck et al., 1979). Therefore, the therapeutic relationship per se was not considered as a tool of CBT. Several contemporary writers in CBT have challenged this view the past two decades. The participants in the present study remained faithful to Counselling Psychology's 'value base grounded in the primacy of the counselling or psychotherapeutic relationship' (p.2 Division of Counselling Psychology, 2005). In line also with the contemporary view of the therapeutic relationship in CBT, the participants talked about using the therapeutic relationship as a means through which to understand the clients better and promote change.

One of the key functions of the therapeutic relationship emphasised by the participants was to facilitate exploration of the clients' problem areas in their life. Through the discussion of the clients' experience of the relationship, as well as through observation of their own emotional responses towards the client, the participants managed to gain insight into the client's difficulties. In fact, Beck and his colleagues (2004) consider the client's reactions towards the therapist as 'open windows into the patient's private world' (p.108). This is why they encourage therapists to be vigilant for any signs of the client's emotions, as well as of their own emotions, as they can both suggest the presence of automatic thoughts that need to be identified. The idea that the therapeutic relationship may mirror the client's underlying problems in their life, has also been put forward by Wright and Davis (1994) and MacLaren (2008). Curwen and his colleagues (2000) have suggested that the therapeutic relationship in the first session, and in particular the client's ability to form an alliance with the therapist, can help the clinician assess the client's suitability for CBT.

The therapeutic relationship also plays a central role in Persons' (1989) case formulation approach. Persons argues that the interaction between the client and

the therapist can shed light on the client's problems outside the therapy. Furthermore, the therapist's emotions in the relationship can yield important information about the type of responses the client arouses in others. This view was also expressed by the participants in this study. However, Persons does not just consider the therapeutic relationship as a tool that enhances understanding, but also as a tool for change. Providing a therapeutic relationship that is consistent with the formulation can prove as a powerful intervention, since in vivo work is normally highly emotionally charged. Research into the client's experience of receiving a written formulation in CBT supports this view, as the formulation was found to evoke both negative and positive emotions (Morberg Pain et al., 2008). The clients perceived the formulation as valuable, since it helped them understand themselves, their problems, and the coping mechanisms they could use. Moreover, both clients and therapists thought that the case formulation enhanced the therapeutic relationship. The participants in the present study revealed that they would use the therapeutic relationship to aid the case conceptualisation, but they did not talk about providing a written formulation to their clients.

The therapeutic relationship has been considered as a tool for change by other clinicians as well. Padesky (1996) describes how the relationship can be used as a safe place to experiment and test beliefs, while Safran and Segal (Safran, 1990; Safran & Segal, 1996) explain how the relationship can disconfirm the client's dysfunctional interpersonal schemas. Safran and Segal suggest that the therapist initially should allow themselves to respond to the client's interpersonal pull like other people. By observing and monitoring their reaction, the therapist understands the client on a deeper level. This type of understanding helps the therapist to subsequently unhook themselves from the interpersonal pull, and display a different behaviour to the ones that the client is used to. This experience is powerful for the client, who, in turn, begins to display new interpersonal behaviours. Those behaviours are gradually generalised outside of the therapy room to the client's relationship with significant others. Another

intervention with which Safran and Segal (1996) use the therapeutic relationship is metacommunication. They advocate that the therapist can facilitate the exploration of the client's thoughts and feelings, and enhance the client's understanding of their contribution to their interactions with others. In order to do that, the therapists can disclose their own feelings within the therapeutic relationship, and point out to the client any covert communications they make, which influence the relationship. In this way, the therapeutic relationship is used as a powerful tool which disconfirms the client's maladaptive schemas. The participants in the present study also used metacommunication in similar ways to those described by Safran and Segal. However, the participants did not aim explicitly at schema change, but at facilitating the client's exploration and self-awareness.

Young (1999) also considers the therapeutic relationship as important in schema change. He encourages therapists to be alert for instances in the sessions during which the client's schemas are triggered. When this happens, the therapist can explore the event further and disclose their own feelings, in order to provide for evidence that disconfirms the client's schema. Moreover, Young goes to the extent to describe the process of counteracting early maladaptive schemas as reparenting. He advocates that the therapist should find out which needs of the client were not met during their childhood, and provide a therapeutic relationship which caters for these needs.

The idea of assuming a parental role and providing a corrective experience to clients was evident is several accounts in the present study. However, the participants did not explicitly link this with challenging schemas. Therefore, the participants' view of the role of the therapeutic relationship in CBT corresponds more closely to Clarkson's (2003) conceptualisation of the reparative/developmentally needed relationship. This refers to the intentional provision of a replenishing relationship to clients who had experienced deficient parenting. In this way, the participants in this study used the therapeutic

relationship as a means to provide a new, nurturing, re-parenting experience to their clients.

Discussion of theme 6: Non-verbal communication in the therapeutic relationship

The participants in this study viewed body language as a powerful way of communication between themselves and their clients. Several participants expressed the view that the clients perceived their genuine care mainly through their non-verbal communication. However, it is important to note that the participants did not use their body language consciously as a technique that would enhance the therapeutic relationship. On the contrary, they described it as a natural and spontaneous process, parallel to the verbal communication. Perhaps it was the participants' congruence in the therapeutic relationship which allowed them to connect with clients through the verbal, as well as the non-verbal channels.

In the realm of cognitive behavioural therapy, there is an understanding that the therapist's non-verbal behaviour towards the client carries powerful messages (Persons, 1989). Aaron Beck (Beck et al., 1979) points to the therapist's general manner and tone of voice as conveying his/her acceptance and warmth. Judith Beck (1995) goes to the extent to consider the therapist's non-verbal behaviour, such as tone of voice, facial expressions and body language, as more commonly used than direct statements to demonstrate the therapist's commitment towards the client. Not surprisingly clients' experience of the therapeutic relationship seems to converge with the above views, since they consider the therapist's body language as an important aspect of the development of the alliance early in therapy (Bedi, 2006). Furthermore, physical contact with mental health professionals through hug or touch helps clients feel connected with them (Shattell et al., 2007). After all, relational depth is not necessarily conveyed through words; sometimes, eye-contact is powerful enough (Cooper, 2005).

Non-verbal communication was not perceived by the participants as a one-way process. Apart from their own body language, the participants focused on the client's body language during the sessions; they considered the client's non-verbal behaviour as a path to their internal world. Even though the participants in this study did not explicitly use CBT theory to guide them in this, their views are in line with contemporary writers in cognitive behavioural therapy, who recognise that a big part of interpersonal communication takes place at a non-verbal level (Sanders & Wills, 1999). Marcus (1985) was perhaps one of the first CBT therapists to emphasise the intentional use of the client's non-verbal behaviour in order to identify and modify their maladaptive thoughts and beliefs. He proposed a five-step model derived from Beck's principles. When a therapist would observe the client displaying some type of non-verbal behaviour which they were probably unaware of, the therapist would point it out to them. Next, therapist and client would try to identify any latent feelings and automatic thoughts, in order to come up with a more adaptive way of viewing the situation. According to Marcus, this structured approach would allow the CBT therapist to address not just the client's rational side, but their unconscious too. Similar views have been proposed more recently by Safran and Segal (Safran, 1990; Safran & Segal, 1996). In their model of disconfirmation of the client's schemas, the therapist needs to first identify any subtle paralinguistic and non-verbal communications of the client that create an emotional response in them. After reflecting upon it, the therapist may decide that there is a therapeutic value in feeding that back to the client, so that they increase their self-awareness. Both Marcus and Safran and Segal's views are reflected in the participants' accounts of how they use the client's non-verbal behaviour to understand any underlying difficulties.

A different way of conceptualising the client's non-verbal behaviour has been proposed by family therapist Peter Rober (2002). Rober advocates that some of the client's nonverbal communication during therapy may indicate their hesitation to tell their story. While respecting the client's decision, the therapist can use these nonverbal utterances as a starting point for further exploration of the

client's dilemma to disclose or not their story at that particular point in therapy to that particular therapist. Using silence as an example of non-verbal behaviour in therapy, Rober argues that silence does not signify an absence, a lack of words. On the contrary he describes silence as 'full of unspoken stories and reasons why they are kept unspoken' (p.193). It is then up to the therapist how to respond to the presence of non-verbal cues: by simply bypassing them and leaving them in obscurity or by attempting to create their meaning together with the client. The present group seems to have chosen the latter approach.

But what if therapist and client are not from the same culture? Can a shared meaning of non-verbal communication still be negotiated? A number of researchers (Herring, 1990; Singh et al., 1998) advocate that in order to understand a client, the clinician needs to be aware of the meaning of non-verbal behaviours in different cultures, and interpret the client's communication within their cultural context. The role of non-verbal communication in different cultures was not discussed by the participants in this study. However, this aspect of non-verbal behaviour is included here in the discussion section, as it seems that it has important implications for practice.

Even though in today's multicultural society, people are frequently part of more than one culture, and the degree of identifying with each of these cultures varies for every individual, there are a number of considerations that might prove helpful for therapists. With regards to physical contact, Hall (1966 as cited in Herring, 1990) asserts that cultures from the south tend to interact using frequent gesturing, physical closeness and occasional touching, while cultures from the north would tend to interact from greater distance. Hall (1990 as cited in Singh et al., 1998) also maintains that in western society people tend to convey their message through their verbal communication, while in eastern cultures a big part of the message is non-verbal and needs to be interpreted through the speaker's body language. Obviously, these categorisations of cultures are not be used as ways to stereotype, but rather as a reminder of the multitude of cultural nuances

in the therapeutic relationship. And since, as Strong (2002) observes, therapy is a context where client and therapist practise culture, the meaning of non-verbal communication needs to be negotiated within 'therapy's borderzone' (p.251), rather than in the clinician's conventional territory.

Chapter 6

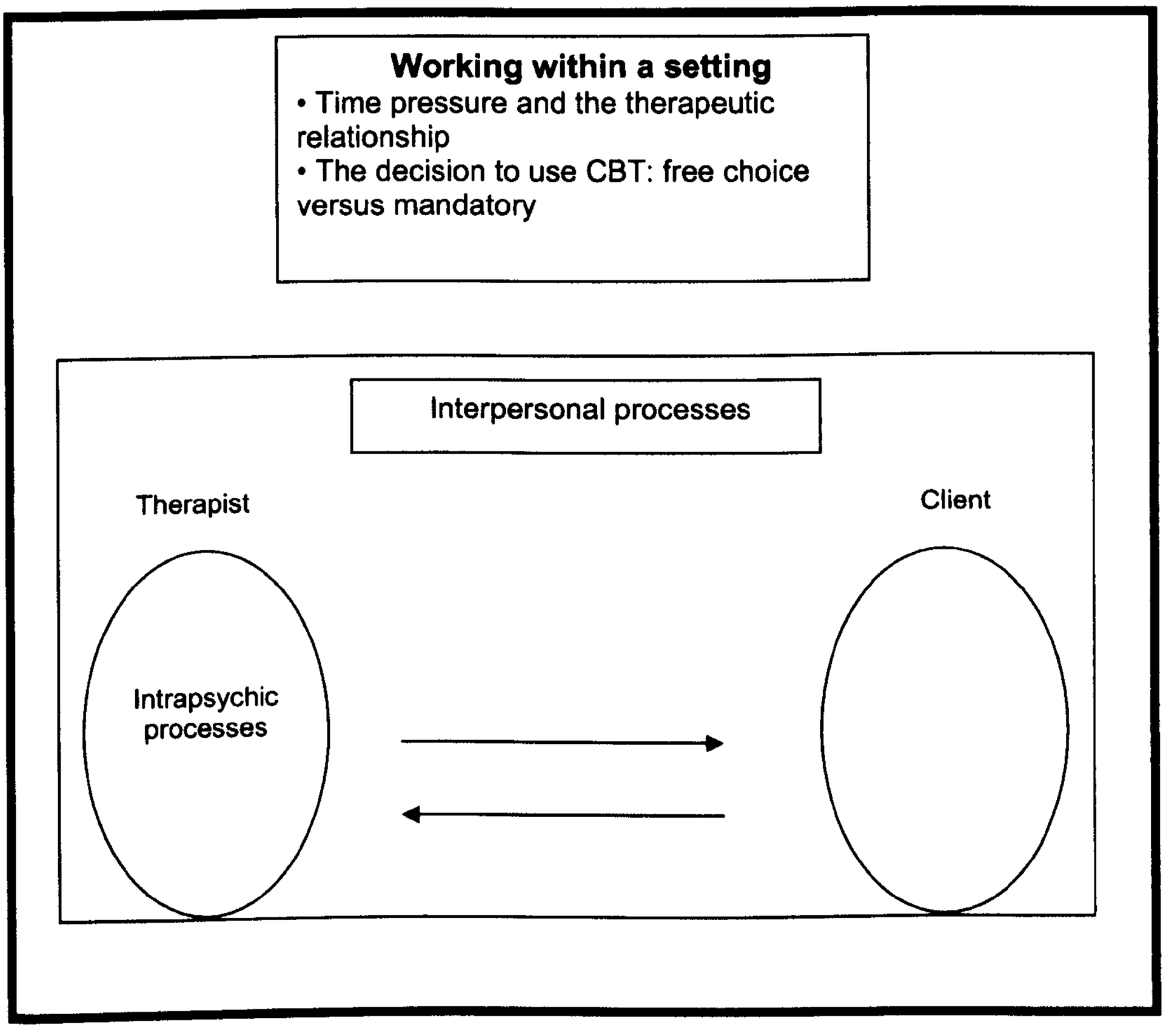
'Zooming out mode': Working within a setting

Introduction

Many participants talked about the therapeutic relationship in relation to their experience of working within a particular setting. The settings in which the participants worked included NHS services, counselling centers, and private practice. Some participants also got referrals from insurance companies in their private practice. The participants themselves had a relationship with the organisation in which they were working, and this, in turn, had important implications for the participants' relationship with their clients. The participants talked about how the time pressure in their setting affected different aspects of the therapeutic relationship. In addition, many participants discussed whether they chose freely to use CBT or whether there was pressure from the setting to use the cognitive behavioural approach. Overall, the themes under the heading of the master theme 'Working within a setting' were considered as the most unexpected, as well as the most interesting ones.

The reader may now find it helpful to visualise the 'video camera' zooming out, as it is illustrated in figure 4. In this way the 'video camera' captures the bigger system that the therapeutic relationship is part of: the setting in which it takes place. The setting is no more just the background, but an important part of the whole scene. Looking at the setting will shed some more light on the complexities of the interaction between therapist and client.

Figure 4: 'Zooming out' mode: the themes of the master theme 'Working within a setting' as captured by the 'video camera'



Theme 1: Time pressure and the therapeutic relationship

Many participants discussed how the time pressure from the setting where they work affected their relationship with their clients. They reported feeling pressurised and frustrated by the time limits. The participants also attributed a number of decisions about the therapeutic relationship to the setting's time constraints. In addition, several participants experienced a conflict between their

personal values and the requirements of the setting to work within strict time-limits. This led to an ethical dilemma. They tried to resolve this dilemma in different ways; however, this had important repercussions for the therapeutic relationship.

Barbara and Mary described feeling frustrated in the instances when they ended therapy with clients, who could benefit more from CBT. In Barbara's account below there is almost a sense of incompleteness in the therapy that she is able to provide.

> 'It can be frustrating, especially if you know that there's so much more you can do with them, or you know that you're kind of, on a good path, and you know that it could really get resolved, but then it's annoying cause you feel that you have to end when you have to end, because of the constraints or resources...And it can be quite frustrating as a therapist...you've seen them making progress, or you know if they have more time they would start to make a lot of improvement, but unfortunately you're not able to offer them that time' (Barbara, 19:21-20:12)

Mary, as well as other participants, also reports feeling pressurised by time. The emphasis on the extent of that pressure is prominent in the interviews. Lea refers to it as a 'big pressure', while Joy experiences it as 'a huge pressure just to keep the waiting list down'. Annette conveys the breadth of the pressure by repeating the same words: 'I don't have time, I don't have time, enough time'. The fact that Annette believes that 'change comes with time', poses significant questions about her perception of herself as able to help the client change through brief CBT.

Annette also experiences the time pressure as having very important implications on the therapeutic relationship. In the excerpt below, she explains that

sometimes, even though she perceives some problems in the therapeutic relationship, she does not address them due to the lack of time.

> 'There are times when the therapeutic relationship doesn't work, when I don't understand the patient, I don't feel close to him or her…this is again, in a way a shame, or a limitation of the NHS, because if this happens in the NHS I don't have…enough time to do something about it…I know that there are some things at a different level that wouldn't be addressed' (Annette, 12:29-13:7)

A bit later, she adds that she also chooses not to use the therapeutic relationship as a tool with clients who have relationship difficulties for exactly the same reason: lack of time.

> 'With this particular population, part of the work is around their difficulties in relating to other people. But then, I choose not to go there, because I don't have enough time. And I could very well use the therapeutic relationship to address that, I'm aware that it's happening, but I have to ignore it.' (Annette, 13:24-31)

Other participants emphasised the effect of the time pressure on the goals of therapy. In particular, when negotiating with clients about the therapeutic goals, one of the main factors that guided their decisions was the time constraint, as Mary explains.

> 'One of the…things in the relationship … that I do have to wrestle with often is what to focus on and what to exclude… So, for instance, a lot of the therapeutic decision-making about what to prioritise has to be, is this feasible in the time that we have?' (Mary, 30:5-10)

Lea, Barbara, and Joy described experiencing a conflict between the requirements of the setting to offer brief CBT, and the client's needs for longer therapy; they were caught up in a difficult ethical dilemma. All three of them resolved the dilemma in a different way, which in turn had different implications for the therapeutic relationship.

Lea said that the insurance companies that refer clients to her have a very simplistic view of CBT. She attributes the time pressure that they impose on her to their lack of understanding of the complex process of therapy.

> 'Because the people who are referring, the insurance companies, the solicitors, etc, don't generally understand what happens in therapy. So they sort of think: well we ll send them off, we read about CBT... those people get it done in six sessions, which is fine, if they are coming about their driving problem, but suddenly when they sit in here, they come up, you know, they were abused when they were 6 years old!' (Lea, 5:28-6:6)

During that incident, Lea experienced a conflict between the setting's directions to offer CBT for the driving problem, and her own perception of the client as needing therapy for their childhood abuse.

> 'There is part of me as a therapist that is wanting to help them with that bit of information, but it's also they've got six sessions because they've got a driving phobia and you have to balance that. So I don't like that part of it, to be honest' (Lea, 6:13-20)

Later on in the interview, Lea explained that she resolved that ethical dilemma by offering CBT for the driving problem, and then referring the client on to the NHS for therapy focusing on the abuse. During the interview, Lea also described another similar conflict between the directions of the insurance company for short-term CBT and her own clinical judgement to offer longer therapy. In that

situation, she appealed to the insurance company for more sessions, and this was accepted.

Contrary to Lea, who follows more or less the setting's directions, Joy reveals that she breaks the rules of the setting in order to meet the client's needs. For Joy, the setting does not just lack understanding, but it is deceitful, mechanical, and impersonal.

> They're trying to cheat the waiting list. It's like NHS is like a sausage machine, putting them in one end and get them through the other, you know somebody said it's like chewing gum, you chew it up and you spit it up' (Joy, 6:28, 9:9-12)

For this reason, it seems that Joy has no guilty feelings for 'deceiving' the setting herself, and offering the client more sessions than she is supposed to. It seems that Joy's personal values of offering therapy according to the client's needs are more important than the rules of the organisation where she works. Furthermore, one could think that Joy's relationship with the client is much stronger than her relationship with the organisation. However, by breaking the rules of the organisation, the therapeutic relationship might become a relationship of collusion between her and the client. In the excerpt below, Joy refers to a client who had three very significant traumatic experiences, which, for confidentiality purposes, are omitted.

> 'Sometimes I put the patient before the system anyway, so I'm doing things which I'm not supposed to be doing (laughs)... There are some patients...I feel they really need it...Or for a woman, she had [three serious traumas]. So what to do in 6-8 sessions? (laughs). So she got, I gave her I think about 17.' (Joy, 12:12-24)

Barbara also experiences a conflict between her personal values of offering to the client as much as she can, and the directions of the setting to only offer rapid assessment and then refer the client on to other organisations. In the excerpt below she explains how the time constraints turn the therapeutic relationship to an impersonal and mechanical relationship. It is particularly interesting that the loss of individuality characterises both the client's and her experience of the therapeutic relationship.

> 'Sometimes for a client it may feel like they are getting pushed away or kind of like, you know, churned out, like, next one please, you know, I think it can be difficult for the client...And you just end up like you're churning through them, you know, and they lose the meaning that you'd like to give to each person, you know, individually' (Barbara, 20:1-21:3)

However, what is even more important in Barbara's experience is that she feels that not only does she not help the clients, but she even harms them. In this way, the therapeutic relationship ceases to be therapeutic, and, according to Barbara, becomes rather damaging.

> 'And that's a horrible feeling, when you've gone into the job to be helping people, but sometimes it feels as if you're doing more damage than good, if you're in a situation where they're ripping the heart out of you, and then you say, 'sorry, we haven't got any resources here..., here's the name of the voluntary organisations, go and wait for another three months on their list', yeah, it's a really shit feeling...So you feel that you fail them, you know, or you feel that you are not able to do enough for them, and again that's not a nice feeling.' (Barbara, 21:3-29)

Looking at this excerpt more closely, it seems as if Barbara feels guilty, maybe because she is violating her own principle 'give as much of yourself as you can'. It seems as if Barbara does not feel as just the messenger of the organisation's

orders, but takes upon herself the responsibility of not offering help to clients. One could also hypothesise that she might be experiencing herself as the setting's 'partner in crime'. Later on in the interview, Barbara revealed that she is resolving that powerful ethical conflict by leaving that job.

In contrast to Barbara, who chooses to distance herself from the setting's time constraints, Annette and Mary say that they have gradually accepted the time limits and learnt to adapt their practice to them, and still offer high quality CBT.

> 'So I think that's something one has to live with if one's working in a setting where one is constrained to be brief. But on the other hand, one learns to adapt to it, and to do very useful, beneficial, short-term, very focused work within those constraints, so it works both ways' (Mary, 30:21-25)

Overall, it seems that the time pressure has a very powerful impact on the participants' experience of the therapeutic relationship. Even though the time pressure is perceived as stemming from the setting rather than the CBT model itself, nevertheless CBT is never practiced in a void, but always within a setting. Therefore, this theme is salient in the study of the therapeutic relationship in CBT.

Theme 2: The decision to use CBT: free choice versus mandatory

This is the final theme identified, and is related to the participants' decision to use CBT. It was prominent in the interviews that the setting where the participants worked played an important role in that decision. For the participants who worked privately, CBT was more or less a free choice. However, for some of those working within an organisation, there was certain pressure to use CBT and not other approaches. This had important implications on how the participants related to CBT, and how they experienced the therapeutic relationship within that approach.

Sandra and Lea have a private practice, where they use CBT. Both of them adapt CBT to suit their own clinical judgement and their clients' needs, and use the therapeutic relationship as part of the cognitive behavioural approach. Their free choice of CBT is based on its effectiveness, which they have witnessed in their practice.

> 'I specialise in people who are depressed, or who have relationship problems...And I find that the CBT approach usually is very good with them...[CBT] has a big part [in my practice], because most of my patients are depressed and CBT is in my experience very effective for people who are depressed' (Sandra, 1:6-27)

For Annette, things are quite different. She uses CBT in the organisation where she works, because it is a time-effective approach. Therefore, the choice of CBT is based on the time constraints, which is a limitation of her organisation. CBT is then perceived as an approach which can compensate for this limitation.

> 'The other advantage of CBT is that [it] is very goal oriented, so you are very clear from the beginning of the contract, what is the purpose of the session, is limited sessions in the NHS, I am only able to offer six sessions in total. And this is very limited amount of time. So... it's more useful to have a practical approach...I wouldn't like to practise in any other way because of how the therapy is structured there,... the amount of time... gives very limited space to integrate any other techniques' (Annette, 2:30-5:23)

As presented earlier, Annette does not use much the therapeutic relationship within CBT. On the contrary, in her private practice, where she decides independently on the approach to use, Annette uses an integrative framework, in which the therapeutic relationship plays a central role.

Joy uses CBT both in the NHS and her private practice. The choice of CBT is based, among other reasons, on its time and cost-effectiveness.

> 'In the private sector they want CBT, so I use, and in the NHS as well, it's short-term, nobody's got the time and money at the moment for other things' (Joy, 2:5-7)

Mary believes strongly in the effectiveness of CBT. However, she reveals that in her organisation, there is also some pressure to use CBT and follow the NICE (National Institute for Clinical Excellence) guidelines.

> 'Increasingly I find in the work context that I have that there is a certain amount of pressure to use CBT, so, for instance, the NICE guidelines being applied in the NHS of course widely' (Mary, 2:11-14)

Barbara says that using CBT was a requirement of her fist job. It is important to note that until then Barbara had never used that approach, and had a negative view of it. The obligation to use cognitive behavioural therapy in her organisation helped her break the stereotype, and correct her previous misconception about the therapeutic relationship in CBT.

> 'I actually was quite anti CBT... I had this kind of false perception there is no real therapeutic relationship in CBT, that you just told the client what to do, and it's very rigid, but then my first paid job happened to be where I had to do CBT, and now I've seen the results, I've seen how effective it is, I really believe in it.' (Barbara, 25:15:21)

Therefore, it appears from the interviews that the free or mandatory use of CBT in the participants' settings, affects the way they perceive and experience the cognitive behavioural approach, and the therapeutic relationship within that

approach. However, the nature of that influence is rather complex and unique for each participant.

Discussion of themes

'Practitioners must consider the context in which they work and the impact such a context is likely to have on the client's therapeutic experience' (p.7). This is one of our responsibilities towards our self and society, according to the professional practice guidelines published by the Division of Counselling Psychology (2005). However, how often do we take the time to reflect upon the impact that the setting in which we work has on the therapeutic relationship? The participants in the present study did reflect upon such issues during the interviews. It is important to note that the discussion of the setting where the participants work occurred spontaneously. It was not preconceived as an important aspect of the therapeutic relationship by the researcher, and was not part of the questions on the interview schedule (see appendix 1).

Most participants emphasised how the time pressure induced by the setting where they worked affected their experience of the therapeutic relationship in CBT. The time pressure was not perceived as stemming from the cognitive behavioural model itself, but rather of the contexts where CBT is practised. In the literature of managed care, the time constraints have a central role. Perhaps this is why Feldman (1992) has concluded that in the modern mental health organisations where clients do not pay fees, time has become the new currency. She goes on to say that therapists and clients use the term 'time' to describe issues of commitment and caring. This seems to ring true for most participants, who, during the interviews, repeated the lack of time they experienced in their setting. Related to this was the participants' frustration and disappointment that they could not offer more sessions to the clients. Therefore, for some of the participants maybe this lack of time meant that they could not commit themselves and care for their clients as much as they wanted to, or as much as they felt it was necessary to.

The impact of the time constraints and the culture of the organisation on the therapists' interpretation of the scientist-practitioner model, and thus their clinical practice, has also been documented by Corrie and Callanan (2001). Psychotherapists have also expressed the concern that the pressures within their organisation might undermine the quality of care offered to clients (Neill, 2001). Perhaps this is one of the reasons behind the particularly high levels of stress reported by clinical psychologists in the U.K. (Hannigan et al., 2004). In Cushway and Tyler's study (1994 as cited in Hannigan et al., 2004) the psychologists attributed their stress partially to the lack of resources within their organisation. Therefore the participants in the present study who reported feeling pressurised, frustrated, and losing their job satisfaction due to the lack of time in their organisation, might in fact have been experiencing work related stress. In their systematic review of stress in clinical psychology, Hannigan and his colleagues (2004) highlight that organisational factors are significant sources of work related stress. This, in turn, has important implications about the possibility of burn-out among psychologists.

However, the impact of the time pressure was not only the stress experienced by the participants. In the present group, the lack of time made therapy look a bit like 'unfinished business'. The participants expressed the view that they did not help the clients as much as they could have done if they had more time. Therefore, the therapeutic relationship was characterised by pressure, and was even considered as a 'no win situation', since no matter how hard therapist and client tried, the limited time would not allow them to reach the desired outcome. The views from the participants in this study correspond closely with findings from studies on the clients' experience of therapy. The study by Leroux and her colleagues (2007) highlighted that clients need time in order to build up trust within the therapeutic relationships, and tend to feel more vulnerable in the beginning stage of therapy. The fact that mental health professionals took time to listen to them, and did not look rushed, was particularly important in the

experience of the therapeutic relationship by the participants in another study (Shattell et al., 2007). However, clients who received individual CBT for depression in HIV (Berg et al., 2008) and group CBT for eating disorders (Laberg et al., 2001), reported being dissatisfied with the short duration of therapy. In particular, they requested more sessions, in order to deal with a number of outstanding problems in the end of treatment. They resented the lack of time, as they felt it obstructed them from progressing. These views are largely similar to those of the participants in this study, and highlight that the time pressure in organisations affects therapists and clients in similar ways.

However, a number of theorists are concerned that the impact of the time pressure on the therapist and the therapeutic relationship is much more profound than it initially appears. Mitchell (1999) argues that managed care stops therapists from using their authentic voice, and forces them into business talk. She continues to say that this loss of language leads to numbing of the therapist's feelings, and thus to distant therapeutic relationships, which protect therapists from the experience of any conflict. It is important to note that the participants in the present study did not report any numbness of feelings or avoidance to feel. However, what Mitchell describes is a subtle and gradual process that takes place throughout someone's career as a therapist.

Similar arguments have been put forward by other theorists, too. Cushman and Gilford (2000) assert that nowadays in organisations there is little time for the examination of the therapeutic relationship and any problems that might arise. This seems to resonate with some of the participants' experience, who revealed that they tended to ignore problems in the relationship, because there was not enough time to address them. Cushman and Gilford explain that in managed care there is a pressure on therapist and client to reach an agreement too quickly; the result, they argue, is not therapeutic alliance, but compliance. In order to deal with such pressures, therapists might use defence mechanisms in the therapeutic relationship (Loula, 1999). In the present study, the participants

did not indicate using dissociation, intellectualization or identification with the aggressor. However, some participants seemed to disavow their knowledge and their clinical judgement to address certain problems in therapy, in order to maintain equilibrium within the pressurising and challenging environment of the setting. Loula (1999) is concerned that the intrapsychic change that takes place as a result undermines the therapist's therapeutic abilities. Therefore, she wonders, 'Is the treater still a therapist?' (p.53). That doubt in the clinician's ability to provide therapy, and in fact in the clinician's professional identity, is voiced by some participants in the present study, who are worried that they do more damage than good. For them, working under such tight time constraints, takes away the therapeutic qualities of their relationship with clients, and renders it into a relationship that is potentially damaging.

The other theme that emerged from the participants' accounts in relation to the setting concerned whether they decided freely to use CBT or there was pressure to choose that approach over others. Stern (1993) argues that, even though brief therapy can be useful, when it is mandated by a third party, and in this case by the organisation, it violates the fundamental integrity of the therapeutic relationship. Given the need of any therapeutic model to be compatible with the therapist's personality and epistemology (Arthur, 2001), the fact that some participants were coerced in their settings to use CBT poses questions about the extent of that compatibility. MacLaren (2008) warns that for therapists who are obliged to use CBT due to managed care, it is unlikely to have real faith in the model. This in turn compromises the use of the therapist's self as part of CBT. This might be a possible explanation why one of the participants in this study used her self and the therapeutic relationship as a tool in therapy only in her private practice where she used an integrative framework, and not in her organisation, where she used CBT. Furthermore, MacLaren's observation has important implications also for the participants who have faith in the cognitive behavioural model. Due to the pressure to use CBT, some participants may have attributed their choice of model to external factors, such as time and cost-

effectiveness, rather than to their own faith in the model. Therefore, the need for an open, supportive work environment, where multiple points of view are encouraged, rather than only a narrow, prescriptive theory, becomes evident (Skovholt & Ronnestad, 1992).

From the discussion of the themes so far it transpires that the organisation where the participants work plays a fundamental role in their experience of the therapeutic relationship. Lane and Corrie (2006a) suggest that we need to adopt a systems framework, and consider the effects of the system, and our activity as part of it, on our clients' life. It seems that the participants in the present study did reflect upon this issue, and, as a result, were caught up in powerful conflicts and ethical dilemmas. Of course, this does not imply that clinicians should refrain from adopting a systems framework, but rather it helps explain why many therapists are reluctant to do so.

In particular, several participants in this study described being forced between the dual demands of their client and the organisation's policies, which they experienced as a compromise of their unilateral dedication to their clients. They were caught up in ethical dilemmas, such as the following one: meet the client's needs and offer them more sessions than is permitted by the setting, or follow the setting's directions knowing that the client's needs will not be met? The ethical challenge of dual allegiances has been discussed extensively by Bilynsky and Vernaglia (1998). They explain that the actual challenge occurs when the responsibility to the organisation is in direct conflict with the responsibility to the client. This corresponds to several accounts in the present study.

Therefore, it could be argued that the therapeutic relationship is no longer a dyad, but a triad, consisting of the client, the therapist and the organisation (Feldman, 1992). Using concepts from general systems theory, Feldman describes the following four different types of alliances that can be developed: a) alliance of the therapist and the client 'against' the organisation, b) alliance of the

client and the organisation 'against' the therapist, c) alliance of the organisation and the therapist 'against' the client and d) no alliances at all – distance and animosity between and among all three parties. This seems like a particularly useful framework to understand the conflicts that the participants of this study experienced. The first type of alliance of the therapist and client 'against' the organisation helps clarify one of the participant's decision to break the rules of the organisation and offer more sessions than those allowed to the client. Another participant, who followed the directions of the setting, felt particularly guilty for not offering more sessions, and thus more help to clients. In her mind, it may have seemed as if she had developed an alliance with the organisation 'against' the client, and this created intense distress in her.

So how can a therapist resolve such powerful conflicts? Anderson and his colleagues (2000) suggest that in order to preserve their alliance, therapist and client should recognise the existence of the organisation, and discuss openly how it affects their relationship. Similarly, Bilynsky and Vernaglia (1998) propose that the therapist needs to review the policies of the organisation and discuss its impact on the therapeutic relationship as part of the informed consent process when the therapeutic contract is being negotiated. This is similar to the strategy that many participants in this study employed: they included the time constraints as part of the negotiation process to reach an agreement on goals, and collaborated with the clients to set goals that would be feasible within the given time limits. Furthermore, Bilynsky and Vernaglia suggest that the therapists need to understand thoroughly the policies and procedures of their organisation prior to being faced with an ethical dilemma, so that they can anticipate rather than react to the dilemma. This seems to hold true with the account of one participant, who used her knowledge of the appeal and referral processes in order to ensure that her clients were offered the amount of sessions that they needed.

Nevertheless, if the therapeutic relationship is more like a family triad within an organisation (Feldman, 1992), then maybe we need to go back to systems theory

to discover how to form and maintain the different alliances simultaneously. Within the realm of family therapy, multipartiality represents both a technique and an aspect of the therapeutic relationship (Sutherland, 2005). Multipartiality reflects the therapist's ability to consider all the different sides and work within all views simultaneously (Anderson & Goolishian, 1988). Therefore, one could argue that multipartiality will allow the therapist to consider the points of view of the client, the organisation, as well as their own point of view. This will lead to positive alliances to be developed among all the three parts of the system. However, it is important to note that Sutherland (2005) places a caveat on the term multipartiality. She emphasises that multipartiality is not a stance of the individual therapist, but a joint activity between the participants involved. So what are the implications for the therapeutic relationship in CBT? Since the organisation where the therapist works plays such a fundamental role, therapist, client, and organisation need to cooperate and jointly accomplish multipartiality towards their different perspectives. This will include a number of discussions and negotiations among the three participants. Multipartiality is then likely to allow for a shared understanding of the therapeutic relationship and the factors which impinge upon it to be negotiated among the therapist, client, and the organisation.

Chapter 7

Conclusions

1 Introduction

In this final chapter, the summary of the main findings of the study, as well some reflections about the broader significance of the findings for the conceptualisation of the therapeutic relationship in CBT are presented. The methodology of the study is evaluated, and some avenues for future research are highlighted. A final reflective statement is included, and subsequently the implications of the findings for the practice of Counselling Psychology are illustrated.

2 Summary and implications of the main findings

The current study aimed to explore Counselling Psychologists' experience of the therapeutic relationship while practising CBT. The participants highlighted a number of issues that are specific to the cognitive behavioural approach. The study confirmed Arthur's (2001) assertion that therapists normally practice within models that are consonant with their personality and philosophy in life. For most participants, CBT was an approach that allowed them to be themselves. Implicit in the accounts were also the values of honesty, equality, and respect, which were perceived as compatible with the CBT model, and were thus promoted through the practice of cognitive behavioural therapy. The participants explicitly positioned themselves against following manualised treatment, and emphasised the importance of flexibility and creativity within their practice of CBT. They explained that for this to happen, they needed to perceive the client's reality in a 'phenomenological' way, and adapt their interventions accordingly. In this way, a personal and individual therapeutic relationship could develop. Finally, and most unexpectedly, the participants underscored the influence of the setting where CBT is practised on the therapeutic relationship. Private practice and public

organisations were contrasted, and the association of CBT with strict time constraints and guidelines to follow was portrayed.

At the same time, the participants in this study talked about issues that are not specific to the CBT model. These aspects of the therapeutic relationship have been highlighted by a number of theorists in the past, and concern the boundaries, failure and therapeutic impasses, using the therapeutic relationship as a tool for exploration and change, and the non-verbal communication between therapist and client. Even though all these dimensions of the therapeutic relationship are recognised as important in the realm of cognitive behavioural therapy, only the use of the therapeutic relationship as a tool has been explored thoroughly in contemporary writings.

The participants did not only use CBT theory to conceptualise the therapeutic relationship. They sometimes used concepts that originate from the psychodynamic and person-centred approaches when discussing their experience of the therapeutic relationship in CBT. One possible explanation for this may be the participants' view that no single theory or approach is adequate for all clients and therapeutic processes (Norcross, 2005; Prochaska & Norcross, 2010). Another possible reason behind the participants' use of concepts from other approaches may be related to CBT theory itself and the extent of its aptitude for the conceptualisation of the therapeutic relationship. In the early writings of CBT, the therapeutic relationship was seen as an important contextual factor, but not as a core mechanism of change (Waddington, 2002). The recent increased interest in the therapeutic relationship in CBT has led to the development of CBT theories which emphasise the use of the therapeutic relationship as a means to modify the client's cognitive and emotional problems (Leahy, 2008; Kanter et al., 2009). However, the fact that these theories only developed recently might mean that not all therapists practising CBT are familiar with them and able to use them to guide their thinking about the therapeutic relationship. Contrary to CBT, the psychodynamic approach for example, has a

longer history of conceptualising the therapeutic relationship as a mechanism of change (Milton, 2001; Raue et al., 1997). Therefore, it is likely that the participants of this study were more competent at using constructs from approaches other than CBT as these may have been available and accessible for a longer period of time.

The finding of the present study that psychologists practising CBT did not use CBT theory to a great extent to guide their thinking about their relationship with their clients is consistent with findings from other studies. Kanter and colleagues (2009) found that CBT practitioners in research trials using traditional 'Beckian' cognitive therapy for depression rarely focused on the therapeutic relationship. On the few occasions that they did touch upon the present interaction between therapist and client, this was limited to a brief comment, which lacked any in-depth exploration or use of specific CBT techniques addressing the therapeutic relationship. The researchers concluded that well-trained and adherent CBT therapists rarely engaged in present-focused work. The participants of the present study may have tried to compensate for this potential limitation by using theoretical constructs from other approaches to guide their thinking about the therapeutic relationship. This might pose some questions about the participants' adherence to a CBT protocol. However, findings from other research studies suggest that in real therapeutic settings fidelity to CBT is not as unproblematic as it appears in theory (Milne, 2008), and the participants' accounts may be reflective of this. Besides, Norcross (2005), after reviewing studies in a number of countries, including Great Britain, suggests that only very few therapists adhere to one therapeutic approach exclusively. It seems that the participants of the present study may have used what Norcross (2005) calls assimilative integration. This type of integration involves a firm grounding in one therapeutic approach with a willingness to incorporate some techniques and views from other modalities. In the present study, the participants seemed to anchor the therapy they offered within the CBT model, while incorporating some compatible theoretical concepts about the therapeutic relationship from other approaches.

Another possible reason that contributed to the participants' tendency to draw on a number of approaches and not CBT alone may be related to their training. In particular, the participants did not report using methods of reflection about their clients and their relationship with them that are unique to the CBT approach. The participants seemed to use the reflective awareness of their own thoughts, behaviours and emotional reactions towards their clients as a way to understand better the processes that took place in therapy, and the clients' difficulties outside the therapy room. This is consistent with contemporary writings in CBT in which the therapist's self-awareness is underlined (e.g. Bennett-Levy et al., 2001, 2003; Dobson & Dobson, 2009; Kuyken et al., 2009). However, the above contemporary CBT theorists also emphasise the need for the therapists to conceptualise their reflections in CBT terms, and to use traditional CBT techniques, such as a dysfunctional thoughts record, to evaluate the relevance of these observations to the case conceptualisation. Kuyken and colleagues (2009) suggest that personal CBT therapy can help the clinicians to develop this skill, while Bennett-Levy and Thwaites (2007) highlight the value of personal experiential work, which they call self-practice/self-reflection, as an essential part of therapists' training in CBT. Even though the participants' training included personal therapy and experiential work as a requirement, this did not necessarily need to be conducted within a CBT framework, and could potentially follow a different approach, such as the psychodynamic or the person-centred one. Therefore, it seems likely that the participants learned to conceptualise their own issues and emotional reactions using the language and constructs of a different approach, and not CBT. This, in turn, may have had an impact on their thinking about the therapeutic relationship while practising CBT with their clients. Further support for the link between clinicians' training and their tendency for an integrative attitude is provided by Prochaska and Norcross (2010). These theorists argue that therapists whose training does not pressurise them to adopt one orientation only, and who have opportunities to observe and experiment with different approaches, are likely to develop an integrative stance in their practice.

These conditions have probably been met in the participants' training as Counselling Psychologists, which required competence in more than one therapeutic approach.

Apart from the participants' training, it is likely that their way of thinking about the nature of truth and the diverse therapeutic models may have contributed to their conceptualisation of the therapeutic relationship in CBT. In particular, Perry (1970 as cited in Prochaska & Norcross, 2010) derived a model of intellectual and ethical development in relation to the nature of knowledge. According to this model, students move from the dualistic stage, in which the world is seen in polar terms of right and wrong, towards more complex ways of looking at the world, which acknowledge the inevitable diversity and uncertainty that exists. The final stage within that model is referred to as 'committed'. The practitioners within the committed stage recognise that the nature of knowledge is contextual and relative, and yet make a commitment to a theoretical approach based on their values and what fits best with them. It may be hypothesised that the participants in the present study have been operating from the perspective of the committed stage. Within that stage, they may have made a commitment to the CBT model, while acknowledging that other therapeutic systems are equally valid. The open and flexible attitude towards other models of therapy may have encouraged the participants to incorporate compatible ideas from neighbouring approaches within their CBT practice. Furthermore, it may have been this attitude towards the nature of knowledge and the various therapeutic approaches which contributed towards the participants' choice to train as Counselling Psychologists and not as CBT therapists.

The way the participants talked about the therapeutic relationship in CBT may have been related to the way that the research study was conducted. Therefore, it seems important to follow Willig's (2001) recommendation about using epistemological and personal reflexivity in order to explore how the researcher's involvement may have influenced the research findings. With regards to

epistemological reflexivity, the research method and the questions in the interview schedule may have 'constructed' to some extent the findings of the study. In particular, the present study employed the method of IPA, which aims to explore in detail the participants' individual experience of the phenomenon under investigation (Eatough & Smith, 2008; Willig, 2001). Therefore, the present study did not focus on participants' intellectual activities and the theories they used in order to guide their practice. On the contrary, it aimed to examine how the participants actually experienced the relationship they had with their clients while practising CBT. In order to avoid having an intellectual discussion, the participants were not asked about any specific CBT theories or CBT constructs (e.g. schema). Therefore, it seems possible that the participants may have tended to use CBT concepts to guide their thinking about the therapeutic relationship, but not talked about this during the research interview, as they were not specifically asked for it. The research questions included the concept of empathy, since it was assumed that it is part of most people's everyday vocabulary and thus it would not necessarily lead to an intellectual discussion. Nevertheless, empathy is associated with Rogers' (1957) theory, and it is possible that the use of this word within the research questions may have shaped to some extent the findings of the present study. Regarding personal reflexivity, the researcher's own struggle to use CBT theory in order to conceptualise the therapeutic relationship may have contributed towards what was attended to and explored further during the research interview and what was not followed-up.

Thus far the participants' tendency to draw on a number of approaches and not CBT alone in their conceptualisation of the therapeutic relationship in CBT has been discussed, and the possible reasons behind this have been explored. It also seems worth considering whether using elements from other orientations is actually compatible with the principles of the CBT model. Alford and Norcross (1991) argue that it is, as historically CBT grew out of the incorporation of theoretical concepts from a number of therapeutic approaches. Moreover, various techniques from diverse schools of psychotherapy are routinely used in

CBT (Alford & Norcross, 1991; Beck, 1991). For the above reasons, Aaron Beck (1991) refers to it as '*the* integrative therapy' (pp.191), and recommends that CBT therapists can use therapeutic methods from any theoretical orientation, as long as these are not incompatible with the CBT model. The participants' accounts in the present study indicated that, on most occasions, using concepts with regard to the therapeutic relationship from other approaches enhanced rather than undermined their CBT practice. In this way, it could be said that the participants used theoretical constructs that were compatible with the CBT model. In addition, the participants tended to use ordinary language rather than jargon to describe their experience of the therapeutic relationship in CBT. For example, they used their own emotions evoked within therapy as a tool to understand how the client's interactional style might contribute towards some of their interpersonal difficulties outside of therapy. This intervention seems consistent with the concept of participant-observer (Safran & Segal, 1996) and the identification and use of schemas as a way of enhancing the therapeutic relationship and the outcome of therapy in CBT (Leahy, 2008), despite the fact that these terms were not explicitly used by the participants. Besides, it has been suggested that therapists' ability to be fluent in more than one 'psychotherapy language', as well as their ability to use ordinary language to describe therapeutic processes, can actually facilitate the communication amongst clinicians from different therapeutic modalities (Messer, 1987). For this reason, the participants' tendency to draw on a number of theoretical models in their conceptualisation of the therapeutic relationship rather than CBT alone and to use ordinary language could be considered as an asset rather than as an obstacle in the practice of CBT.

The findings of the present study provide evidence of the need to reconceptualise and move towards a wider definition of the therapeutic relationship and the CBT model. Contrary to researchers who still distinguish therapy in specific and common factors (e.g. Tracey et al., 2003), and consider the therapeutic relationship as one of the common factors among all types of

therapy, the participants emphasised the interdependency of techniques and the therapeutic relationship in CBT (Wright & Davis, 1994; Safran & Segal, 1996). The participants showed how the use of CBT techniques in a flexible manner that is personalised to each individual client can in fact enhance the therapeutic relationship. At the same time, the therapeutic relationship in CBT was not perceived as playing a secondary, background role. The therapeutic relationship was indeed one of the tools or techniques that the participants used in order to explore the clients' difficulties, understand them better, and promote change. These findings are consistent with the clients' view of the therapeutic interventions and the alliance as interconnected (Bedi et al., 2005). Therefore, the present study supports further Butler and Strupp (1986) and Stiles and Shapiro's (1989) position that the dichotomisation of specific and non-specific factors in therapy is problematic. The current study calls for a wider definition of the therapeutic relationship to encompass all the aspects of the interaction between therapist and client. Following Butler and Strupp's (1986) definition of therapy as 'the systematic use of a human relationship for therapeutic purposes' (p.36), the therapeutic relationship could be conceptualised not just as an aspect of therapy, but as comprising everything that goes on in therapy.

The wider definition of the therapeutic relationship that is proposed in the present study does not only include the interpersonal processes between therapist and client. The participants underscored the importance of their intrapsychic processes. The therapist's values and way of being affect their relationship with their clients. Furthermore, the context of the therapeutic relationship should not be viewed narrowly or literally as the room where therapy takes place. As discussed in the previous chapter, the setting, whether that is an organisation or private practice, has important implications for the therapeutic relationship, rendering it sometimes from a dyad into a triad (Feldman, 1992).

The findings of the present study also suggest the need for a reconceptualisation of the CBT model to encompass the principles of social constructionism (Lyddon, 1995). The participants in the present study, even though they did not explicitly state so, seemed to be informed by the epistemology of social constructionism, and viewed the therapeutic relationship in CBT through that perspective. The fact that the participants strove to perceive the client's reality and appreciate it as valid, is consistent with the essence of social constructionism that our understanding of the world is socially constructed (Gergen, 1985), and thus multiple, equally valid versions of reality can exist (Burr, 1995). In a similar vein, the participants did not perceive themselves as holding the true or correct way of looking at the world, and therefore respected the client's decisions within therapy (e.g. to do or not homework, behavioural exposure). This seems to be consonant with the social constructionist idea that there are no superior or inferior forms of rationality, only different, since the definition of rationality is dependent upon the dominant rules of the culture within which it is evaluated (Gergen, 2001). Lyddon (1995) argues that social constructionism can potentially inform the CBT model by encouraging the inclusion of the concept of empowerment as a therapeutic strategy. The present group endorsed the concept of empowerment in CBT, since they rejected the expert position, and emphasised that the clients are experts in their own life. Finally, the CBT model can be enriched by social constructionism's emphasis on the context within which people live and experience their problems. The participants in the present study took into account a wide range of phenomena, since they tried to perceive various aspects of the clients' reality and life experiences, and not only their cognitive processes. Above all, the participants placed emphasis on the context in which the therapeutic relationship existed. This is evident in the participants' concern with the implications of the setting where they worked on their relationship with their clients. Therefore, the findings of the present study provide support for the need to move towards a wider definition of the cognitive behavioural model, to encompass the principles of social constructionism.

3 Critical evaluation of the research

3.1 Strengths

This study has drawn attention to a neglected area in research, the therapists' experience of the therapeutic relationship in CBT. Therapists rarely discuss their dilemmas in print (Dryden, 1985), and researchers rarely explore therapists' emotions (Beck et al., 2004). Therefore the present study has addressed a significant gap in the literature. It is hoped that the findings have stimulated reflection upon how the therapeutic relationship is defined, and how the therapists' experience of it might relate to that of the clients.

The qualitative methodology has enabled participants to reveal rich details of their experience of the therapeutic relationship, and the ethical dilemmas they occasionally encounter. The interviews were conducted in a flexible manner, which allowed the exploration of novel areas that the participants introduced (Smith & Osborn, 2003). Evidence of that are the unexpected themes that emerged, such as those concerning therapeutic techniques, issues that are not specific to the CBT model, and mainly issues about the setting. In particular, the themes about the setting where the participants worked were illuminating, as they highlighted the potential dilemmas practitioners face due to their dual allegiances to the organisation and the client. The research has thus provided a framework to redefine concepts such as the therapeutic relationship, the CBT model, and most importantly the role of the psychologists within the organisations where they practise.

The coherence of the analysis of the data (Stiles, 1993) was ensured through multiple discussions with the research supervisor and peers. These discussions did not serve as credibility checks, since a number of different interpretations of the same data are possible in IPA. Rather, they ensured the fit between the themes and the excerpts (Henwood & Pidgeon, 1992) and facilitated further reflection and interpretation of the data.

Transparency of the analytic process was maintained, as the choices made at different stages of the research were highlighted. The description of the internal processes of the investigation (Stiles, 1993) was enhanced through the inclusion of extracts of the reflective diary at different points within this thesis. In this way it is hoped that the reader can gain an insider's perspective of the research process.

3.2 Limitations and avenues for future research

Since qualitative methodology was employed in this study, generalisability of the findings was not sought. This is not a limitation, but a characteristic of qualitative research. The reader will decide whether the findings of the present study correspond to their own experiences, and whether they are transferable to other contexts and professionals.

IPA, like all research methods, has some intrinsic limitations. Willig (2001) maintains that IPA does not necessarily provide direct access to the participants' immediate experience, but rather to the way that they talk about that experience. However, IPA is concerned with the way in which participants are trying to make sense of the world (Smith & Osborn, 2003), and therefore their accounts provide insight into their sense-making activities, even if they rely on language.

Another aspect of the present study that could be considered as a limitation is the fact that no member validation was sought. Since an integral part of IPA methodology is the interpretation by the researcher, agreement between the participants and the researcher on the interpretation of the data is not necessarily expected (Stiles, 1993). This is particularly true when the interpretation concerns defences or other aspects of the participants' experience that are on the margin of consciousness. Furthermore, there is an understanding that multiple, equally valid readings and interpretations of the data are possible, given the central role of the researcher in the whole process.

Nevertheless, the above limitations that concern the constructive role of language, and the significance of member validation, could be addressed through future studies, which use different types of qualitative methods, such as grounded theory and discourse analysis. It would be useful to compare the findings from these studies, and get a deeper understanding of the experience of the therapeutic relationship in CBT, that would not be restricted by the limitations of each one of the methods.

Another weakness of the present study is the fact that only female Counselling Psychologists participated, something that is not consistent with the demographic characteristics of the Division. Furthermore, the fact that the practitioners decided whether to participate or not knowing that the research topic was the therapeutic relationship in CBT, may have introduced a systematic bias of some kind. A different sample of Counselling Psychologists may have highlighted different aspects of their experience. Therefore, further qualitative work in the area is suggested. Moreover, exploring the experiences of the therapeutic relationship in CBT of therapists with different training would provide further insight. In particular, it would be useful to look at the experiences of clinical psychologists, whose core training does not emphasise the therapeutic relationship as much, and of CBT therapists, who do not practise within other approaches. Identifying divergences and convergences among the different groups would provide a deeper understanding of the phenomenon.

The analysis of the data highlighted the centrality of values in the experience of the therapeutic relationship. Therefore, it would be useful to conduct qualitative studies in the future exploring how values are incorporated within CBT and other models. Furthermore, research in the ethical dilemmas that therapists face would address the gap in the literature.

Adopting a systemic framework, it would be useful to examine therapists' values in relation to the values of the organisations where they practise. It would also be

interesting to identify the similarities and differences in the experiences of therapists working in private practice and as part of an organisation.

Finally, it seems interesting to pursue the question of the mechanisms through which therapists achieve integration. This could include integration of different models, integrating the different parts within themselves, and integrating all the fragmented pieces of information about the client into one meaningful picture.

4 Reflections on doing the research

Clandinin and Connelly (1994 as cited in Clarkson, 1996) view research itself as about relationship, conducted in relationship and through relationship. At the heart of qualitative methodology lies the relationship between the researcher and the participant; therefore this methodology lends itself to the study of another type of relationship, the therapeutic one.

Ironically, I had initially planned to use quantitative methodology. It was the difficulty to recruit enough participants, together with a growing understanding that quantitative methods would not answer my questions, that led me to move away from the initial research design and consider IPA. However, this experience before embarking on the qualitative study, to a certain extent shaped the research process. A part of me felt particularly stressed and insecure about using a methodology that was new to me. On the other hand, I felt a strange familiarity with it, as the principles underpinning Counselling Psychology and the qualitative methods are largely similar. Not knowing what would emerge out of my data made me feel anxious, and yet excited about discovering an unexpected thread. The themes emerged out of my immersion in the data, indeed out of my relationship with the data. I made decisions about which parts of the interviews contained interesting themes, about which themes to include and which to drop, about how the themes are linked together, about which theories to explain my data to present. I now embrace the subjectivity of the process that I once feared.

Above all, what shaped the present research was my relationship with the participants. Ponterotto (2005) maintains that the interactive researcher-participant dialogue stimulates reflection and brings to the surface hidden meanings. I tried to enter that dialogue as open-mindedly as possible, so that the otherness of the participants' views was respected, valued, and explored. Unexpected themes, such as those concerning the setting, may provide some support to the fact that I tried to follow the participants' track of thought, rather than impose my own preconceived constructs. Nevertheless, a totally naïve or neutral position can never be assumed. A reminder of this came from one of the participants, who, in the middle of the interview, revealed her surprise to be talking about certain aspects of the therapeutic relationship. Even though she perceived them as relevant, she had not expected that the interview would take that route. No matter how open the questions were, the choice of specific questions over others undoubtedly shaped the findings. Therefore, the findings reflect a co-creation between the participants and myself. In some ways, the interview itself could be considered as a co-creation. During that process, the participants tried to make sense of their experiences of the therapeutic relationship in CBT. Even though that is a topic that is commonly talked about, it is rarely reflected upon. The participants expressed this view during the debrief and revealed their surprise at how difficult it was at times to explain with words what they do in their clinical practice. Some of them described the interview as a 'useful exercise', which helped them put their thoughts and reflections together, and which reminded them why they really love being a Counselling Psychologist.

My position as a trainee Counselling Psychologist is also likely to have shaped the research process. Talking to someone from the same discipline may have encouraged the participants to elaborate more on issues relevant to Counselling Psychology and disregard others. At the same time, I may have also been perceived as an 'other', who cannot understand, since I was still a trainee.

Furthermore, events in my life during the research process may have shaped the findings. One event that had a powerful impact was failing a CBT process report on the course. This led me to re-examine what CBT means to me, and how I interpret the CBT principles in my clinical practice. Another significant event that may have influenced my interpretation of the data was finding a job as a Psychologist in the NHS. The emphasis on the setting and its influence on the therapeutic relationship may reflect some of my own fears about my job.

Reflexivity in qualitative research also involves thinking about how the research has affected us (Willig, 2001). Before conducting this study, I thought that the therapeutic relationship had a secondary role within CBT, thus aligning myself with common misconceptions about this approach. Influenced by my own struggles, I thought that all therapists find that an in session focus on the therapeutic relationship is incompatible with the cognitive behavioural framework. However, reading about CBT and interviewing the participants helped me resolve this misconception, and view CBT and the therapeutic relationship in broader terms. Furthermore, the research process has rendered the concept of the scientist-practitioner from a model that 'others' talk about, to something that I personally relate to. I reflected upon how the postpositivist paradigm has at times influenced my practice and encouraged me to reduce my clients' suffering to the presence and absence of symptoms. Above all, the participants stimulated a lot of reflections upon how I practice and experience the therapeutic relationship in CBT. I am left feeling deeply impressed by the participants and proud of my identity as a Counselling Psychologist.

5 Implications for Counselling Psychology

In this section of the conclusions, the implications of the present study for Counselling Psychology as a field, and for Counselling Psychologists as individual practitioners will be explored.

Hill and Corbett (1993) suggest that over the last few years, a paradigmatic shift has taken place, and qualitative methods have become increasingly popular in the study of process and outcome in Counselling Psychology. One of the reasons behind this might be the large similarities in the underlying principles of both the qualitative paradigm and clinical practice (Silverstain et al., 2006). However, has this paradigmatic shift taken place in our thinking? Has this paradigmatic shift infiltrated organisational and policy levels?

The findings of the present study underscore the significance of the therapist's personality and values, and the extent to which these are compatible with the therapist's perception of the CBT model and the organisation's values. Therefore, it is the therapist, not 'the therapy', which is the instrument of change (Butler & Strupp, 1986). Furthermore, other qualitative studies in the clients' experience of CBT have confirmed the importance of the therapist's flexibility. On the other hand, the time constraints within the organisation have been reported to undermine the clients' experience of CBT (Berg et al., 2008; Laberg et al., 2001).

However, to come back to the questions about the paradigmatic shift, the above issues do not seem to be reflected in the guidelines at organisational and policy levels. What one commonly finds in guidelines is recommendations for short-term CBT, based on randomised clinical trials and analyses of cost-effectiveness of different approaches. The actual experience of clients and of therapists, as portrayed by the present and other studies, is largely neglected. If CBT does not rely on techniques, but on the therapeutic relationship, and thus on the personality of the therapist and the client, what are the implications for the usefulness of guidelines just recommending CBT? It seems that quality of care can only be ensured through the provision of high quality therapy, rather than just by a certain type of therapy. Then qualitative criteria of what constitutes good and poor CBT need to be employed.

For the paradigmatic shift to take place at organisational and policy levels, one needs to first wonder about what types of knowledge are recognised as 'legitimate' evidence to influence practice (Corrie, 2003). Cushman and Gilford (2000) argue that evidence from qualitative studies has become marginalised, 'because of their allegedly inefficient complexity' (p.992). Lane and Corrie (2006b) propose a broadening of the definition of the scientist-practitioner model, so that a plurality of perspectives on methodologies and evidence is encouraged (Corrie & Callanan, 2001). Within that framework, therapy could be perceived as a hermeneutic activity (Cushman & Gilford, 2000), and evidence as the phenomenological understanding of the clients' stories (Corrie, 2003). Therefore, qualitative approaches could provide 'legitimate' evidence to inform clinical practice, service delivery, and development of guidelines.

The next question that arises concerns who must be involved for this paradigmatic shift to take place. The role of Counselling Psychology is central in this transition. The findings of the present study suggest that the therapeutic relationship surpasses the therapist-client interaction in the therapy room, and is affected by the organisation where it takes place. Consequently, Bilynsky and Vernaglia (1998) assert that it is now our ethical responsibility as therapists to advocate. In this advocacy role, the ethical principles of psychologists can be made known, and ethical dilemmas that arise from the dual allegiances to client and organisation resolved. Within this role, Counselling Psychologists can also inform stakeholders about the need for evidence from qualitative studies to inform the management of services and the development of guidelines. Therefore, the wider definition of the scientist-practitioner model that is proposed in the present study involves not only seeing ourselves as scientists and reflective practitioners, but also as advocates and reflective managers (Schon, 1983).

6 Implications for practice and training

Given the central role of reflexivity in Counselling Psychology, the findings of the present study shall be used as a starting point for reflection. The themes that emerged from the participants' accounts raise questions about how each one of us addresses such issues in clinical practice. It is important that from early on in training such questions and dilemmas are identified and reflected upon, rather than avoided. In line with the values of subjectivity in Counselling Psychology, the recommendations for practice are given in the form of questions. Each individual practitioner will find their own answers.

The following questions for reflection have emerged from the first master theme 'Intrapsychic processed towards integration' and its constituent themes:

- How do I integrate my personal and my professional self while with a client?
- Which aspects of my personal self do I want to be present while with a client? Are there any aspects of my personal self that I want to keep private?
- What are my strengths and limitations? Which parts of me do I find most difficult to accept?
- What is my relationship with Theory, as a body of knowledge?
- What is my relationship with the CBT model?
- How do I describe the type of CBT that I practise?
- Are the values of the CBT model compatible with my personality, personal values and epistemology?
- Do I integrate elements from other approaches when I practise CBT? How do I reach integration? How do I resolve any conflicts that emerge during the process of integration?
- What is the role of reflexivity in my practice?
- What types of activities promote my reflexivity?
- How do I respond to my client as I listen to their beliefs?

- How do I integrate all the information about my client into one meaningful picture?

The second master theme 'Interpersonal processes with client: perceiving and responding to client's reality' and its constituent themes have given rise to the following questions for reflection:

- How do I tailor the type of CBT that I offer to the individual client?
- How can I use the CBT principles and techniques to enhance the therapeutic relationship?
- What is the role of creativity in my practice of CBT?
- What values are particularly important to me? What values do I incorporate in my practice of CBT? How are these values expressed?
- How permeable is the boundary between myself and my client? How do I balance the distance between myself and the client? How does this affect the therapeutic relationship?
- In which situations do I find that the boundaries between myself and the client get blurred? In which situations do I choose to break the boundaries?
- What does failure in therapy mean to me? What type of feelings does it evoke in me? How do I respond to these feelings?
- What choices do I have that will move me and my client out of an impasse?
- What is the role of the therapeutic relationship in my practice of CBT?
- How can I help my client move towards a more positive direction by exploring the therapeutic relationship?
- How do I use my self in CBT?
- What type of messages do my client and I convey through our body language? How do I respond to my client's non-verbal communication?

Finally, the following questions to reflect upon are raised from the third master them 'Working within a setting' and its constituent themes.

- How does the context where I work affect the therapeutic relationship with my clients?
- How can I maintain a positive alliance both with my organisation and my clients?
- How does time affect me and my client in the therapeutic relationship?
- How does the context where I work affect the therapeutic approach that I choose? What is the impact on the therapeutic relationship?

Finally, it seems important to remember Cottone's (1988, as cited in Clarkson, 2003) words when reflecting upon such issues.

'We are born out of relationship, nurtured in relationship, and educated in relationship' (p.363)

Relationships are at the heart of our existence, and so therapy can only take place within and through a relationship.

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Appendices

Appendix 1

Interview Schedule

Semi-structured Interview Schedule

- Thank participant for coming and agreeing to participate.

- Initially talk to participant about their day, the weather, and generally help put participant at ease.

- Give Participant Information Sheet and Consent Form.

- Explain the way that the interview will be conducted (e.g 'I will now ask you to think about your clients, and ask you some questions about your relationship with them. There are no right or wrong answers, just talk as freely as you feel comfortable with, as I am mainly interested in your subjective experience. If at any time you would like to stop the interview, you can let me know.')

- Ask participant if they have any questions

- Ask participant to sign the Consent Form

- Ask participant to not mention the clients' name or any other identifying information and explain that if that happens, this part of the interview will be deleted and not transcribed.

- Ask participant if I can turn tape recorder on.

<u>General headings of questions that may be asked:</u>

1. Approach

How would you describe the approach you use with your clients?

Prompts: What does CBT mean to you?
How would you describe the role of CBT in your practice?
Do you incorporate elements from other approaches in your CBT framework? If so which ones?

2. General therapeutic relationship in CBT

In the way that <u>you</u> practice CBT, what is the role of the therapeutic relationship?

How would you describe in your words the most important elements of your relationship with your clients?

What type of feelings might you experience towards your clients while practising CBT?

3. Development of relationship over time

Do you think that your relationship with your clients changes over the course of therapy, in the way that you practice CBT? If so, in what way?

Prompts: How would you describe your relationship with your clients in the beginning of therapy? Middle? End?

4. Core conditions

How would you describe the role of empathy in your work with your clients? – How might you express it?

What does it mean for you to express your feelings to your clients?
What does it mean for you to share your thoughts with your clients?
Prompt: Can you give an example of how you may do that?

How would you describe your ability to accept your clients as they are?
What are your limitations on that?
Prompt: How might you deal with it? - example

5. Working alliance

How would you describe a good working alliance between you and your client in the way that you practise CBT?

Prompt: How do you decide on the goals you would work towards with your clients?
How do you decide on the specific tasks (e.g. homework) that you set in your work with your clients?

6. CBT and relationship in practice

How do you manage to maintain the therapeutic relationship with your clients in the way that you practise CBT?
Do you think that using CBT influences your relationship with your clients? If so, in what way?
How do you manage any problems that may arise in the therapeutic relationship?

7. Individual style and relationship

What is it about your style of practising CBT that you think helps you develop and maintain working relationships with your clients?

- Ask participant if they want to add anything
- Round up the interview and thank participant for their time and information
- Ask participant if I can turn tape recorder off

- Ask participant how they found the interview

- Ask participant if they have any questions about the interview or any issues that the interview might have raised for them.

- Give participant Available Support sheet

Appendix 2

Participant Information Sheet

Participant Information Sheet

The therapeutic relationship

You are being invited to take part in a research study. This leaflet explains why the research is being done and what it will involve, in order to help you decide whether or not you wish to take part. Please take time to read the following information carefully.

What is the purpose of the study?

The aim of this study is to examine how the therapeutic relationship develops in specific types of therapy. The purpose of the research is to gain a deeper understanding of the therapists' experience of their relationship with their clients and it is hoped that this understanding will contribute to further development of therapeutic practice. The research is organised by a doctorate student in Counselling Psychology who also offers therapy to clients. City University has approved the proposed research.

Why have I been chosen?

We are contacting psychologists registered with the British Psychological Society and who use Cognitive Behavioural techniques as part of their practice. We are asking 8-12 therapists in total.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form. You are still free to withdraw at any time and without giving a reason.

What will I have to do?

If you would like to participate, you will be asked to participate in an interview lasting approximately one hour which will be recorded on a tape recorder. It will be a semi-structured interview during which I will ask you a few open questions about your personal experience of the therapeutic relationship with your clients. I would like to assure you that I will not be making any judgements about you or the way you practise therapy; instead I see you as an expert in this area.

What are the possible disadvantages of taking part?

This project is not expected to involve any risks of harm any greater than those involved in daily life. In case you find some of the questions upsetting, you will be provided with a list of help lines that you can contact.

What are the possible benefits of taking part?

You may find the interview interesting and insightful; it might encourage you to think about the therapeutic relationship from a new perspective. We hope that the information we get will contribute to further development of therapeutic practice. If you would like to be sent a summary of the findings, please note that on the consent form.

Will my taking part in this study be kept confidential?
Yes. Your consent form will be stored securely in a locked location. Your name will not be attached to the tape recorded interviews or the transcripts. As soon as the interviews are transcribed, the tapes will be destroyed. At the end of the study, the transcripts will be kept so that they can be reanalysed in the future, but anything that could identify you (e.g. consent forms) will be destroyed according to the Data Protection Act 1998. Furthermore, any references to comments from interviews used in the final report will be quoted anonymously.

What will happen to the results of the research study?
The aim is that the results of this study are included as part of a thesis and published in a scientific journal. Your name or any other identifying information will not be mentioned in any of these documents. You can also be sent a summary of the findings if you wish so.

Who has reviewed the study?
This study was given a favourable ethical opinion for conduct by City University Research Ethics Committee.

Contact details for further information:
Chief investigator: If you have any questions before or during the research study, I will be more than happy to answer them
Mobile: 0789 178 6718
E-mail address: nina_levi@yahoo.com

City University Research Committee: If you have any concerns about the conduction of this research, please contact the supervisor of the study Professor Marina Gulina, School of Social Sciences, City University, Northampton Square, EC1V 0HB or on 020 7040 4583, who will pass your comments on to the City University Research Committee.

Thank you very much for taking the time to read this leaflet.

Appendix 3

Participant Consent Form

Therapist Consent Form

Title of project: ***The therapeutic relationship***

Name of researcher: **Nina Levi**

Please tick box

1. I confirm that I have read and understood the information sheet for the above study. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐

3. I understand that the interview will be recorded on a voice recorder and that I can request for the taping to cease at any time. ☐

4. I understand that my name will not be attached to the transcripts of the tape recorded interview. ☐

5. I agree to participate in the study. ☐

Name of participant	Date	Signature
Name of researcher	Date	Signature

Thank you very much for your participation.

Request for summary of the findings (optional)

Please tick box

I would like to receive a copy of a summary of the research findings ☐

at (*please circe*)
either my e-mail address:

_____

or my postal address:

_____

Appendix 4

Debriefing information

Available support

Thank you very much for participating in this study. Since you have been asked to think about the relationship with your clients, I understand that this may have given rise to some difficult thoughts and feelings. If this was upsetting for you, you may wish to contact one of the help lines listed below.

Organisation name	Services
Careline 020 8514 1177 (Mon-Fri: 10am-4pm 7pm-10pm) www.carelineuk.org	Crisis telephone counselling service for children, young people and adults on any issue, including relationship difficulties, depression, mental health, child abuse, bullying, rape and sexual assault, domestic violence, drug and alcohol problems, stress.
Samaritans 0845 790 9090 www.samaritans.org.uk Email at:**mailto:jo@samaritans.org**.	Provides 24 hour confidential and emotional support for anyone in crisis
Saneline 0845 767 8000 (Mon-Fri: 1pm-11pm) **www.sane.org.uk/**	Provides information on mental health. Also operates a helpline, providing emotional support and information to people experiencing mental illness, their family, carers and health professionals

Appendix 5

Authentication of transcripts

To Whom It May Concern

27th November 2008

I can confirm that I have listened to extracts from all the 8 recordings of the interviews for Nina Levi's thesis: Counselling psychologists' experience of the therapeutic relationship while practising Cognitive Behavioural Therapy. They all contained real interviews and match the transcripts that I have reviewed.

Yours sincerely

M. Gulina

Professor Marina Gulina
Psychology Department
School of Social Sciences
City University
Northampton Square
London EC1V 0HB

Appendix 6

Extract from document with initial thoughts and reflections upon data

Collaborative relationship had many different meanings and aspects for her. It's initially about empowering the client by explaining the CBT, being very open about what therapy entails. It's about sharing expertise with them (like M. NHS interview), saying client is the expert of their own life, I'm the expert in CBT, lets put the two together (p.9, 13-14). It's very much about doing the behavioural exposure together with the client, which again has a lot of hidden, underlying messages: in a way it provides equality, since they both do the same thing, rather than therapist adopting the role of a 'supervisor' above the client, but also, it's about encouraging client to take the risk, and learn something new, in the same way that a good parent would do with a child ('childlike p.11, l.10), e.g. when teaching them how to swim for the first time. That would mean giving the child/client a good role model, and at the same time emotionally encourage, rather than forcing the child/client to do it, telling them to do it. Maybe it implies some sort of different involvement with the client, not just verbal, but more active involvement, actually doing things with them, getting themselves into the same position with them. Maybe refers to the experiential aspect of therapy, she is involved in it rather than observe the client. She also mentions about clients with needle phobia 'I ll stick it in my own finger' (p.11,l.6), is it again like modelling, showing a small child that there is nothing to be afraid of, or is it also about sharing the client's pain and suffering, getting so involved with the client that she puts herself in position of even causing a small 'harm' to herself for the benefit of the client.

Empathy: She also mentions this aspect of empathy, not getting too close, differentiating it from sympathy, and also making sure that there is some distance when client talks about painful issues. Is she afraid that something terrible will happen if she does not distance herself? Is the distance something helpful, to maintain professional identity, and be able to provide help, or is it a defence against the enormous pain, afraid she will be out of control if she allows herself to empathise. She says something like that, p.13,l.23 'I can distance myself without empathising, rather than just jump in there, and sort of sit there with floods of

tears with them.' But it might just be the not losing the 'as if' quality that Rogers talked about. Also another important aspect of empathy is that it comes effortlessly, it's something that comes naturally, without any effort or conscious awareness. This might be connected to reference by Gelso and Hayes (1998) found in article about Therapeutic relationship in CBT, where they suggest that 'applying techniques to the therapy relationship will appear ingenuine to clients'. Maybe it's important that something comes naturally, rather than applied as a technique. That might also be connected with the level of experience that Jo Wood had talked about in the Certificate (did we also do this in person-centred module in 1st year? I'm not sure). It said that in the beginning it's conscious incompetence, then conscious application of techniques, or sth like that, and in the end it is all not self-conscious, but naturally using techniques. Maybe that's important about empathy as well.

Empathy-sympathy: Almost all participants talked about that distinction and the need for some psychological distance to exist. She says that if you think that someone's story is so terrible, that 's sympathy not empathy, and it gets in the way of therapeutic work, so it becomes an obstacle rather than a facilitative condition. The way she describes it, it's as if empathy and sympathy are quite close, there is a fine line between them, so there is a danger to move from empathy to sympathy, it's as if there is some grey area between them. So sympathy would mean when therapist is over-involved with client, over-identifies with them, while losing the 'as if' quality? Or is it portrayed by her as just too much empathy? What she says a bit later, p.13 l. 22-25 supports that it's too much empathy, so when a client is in a really bad situation, maybe because she is aware of her own limitations and dangers she may encounter, she will use her 'coping mechanism' of distancing herself. We don't know how much she distances herself, but it's as if she is afraid that if she does not distance herself, she ll get just soooo over-involved with the client, that she will 'sit with floods of tears with them', as if the over-involvement will get out of control, she will lose

control. So she avoids over-involvement with client by creating some distance between them, by not empathising with them.

Appendix 7

Example of the list of themes with quotes for 1 interview

List of themes with quotes

Explaining CBT (socialising clients with CBT model, empowering clients)	we've got ten-fifteen sessions together, and lets spend maybe the first and second session explaining a little bit more, and learning a little bit more about the client rather than sort of going straight to doing a lot of the actual...hardcore techniques...for them to start, to feel a bit more comfortable and explain CBT more. I think explaining CBT, explaining how it works, really bringing them very much into the picture.	1:29 – 2:8 9:10-11
NHS vs private practice: time and quality of therapy	I think when I was in the NHS it was far more, you know, you only had this time with this client, so you lost a lot of that more of a therapeutic approach I think, I can do it more in private practice.	2:8-11
Taking time to explore clients' concerns about beginning therapy	here the client is very anxious, and they are sitting there saying, 'Oh I'm really anxious about being here'. You know that may be ok, fine, lets take a few minutes out to talk about what it is that is worrying you about being here	3:5-8
Using different models to think and to communicate with clients	Sometimes I might sort of take this analytical think about, you know, certainly if they start talking about bringing up their past in the session. But obviously in a CBT way, you, you use that very differently, like in core beliefs, you know where they come from, how they affect their life now, and, and sort of explain that, how their core beliefs have maybe made them feel how they feel now, they are generally their beliefs about themselves, not necessarily world views, and so, sort of just explain to them a little bit about, but I may be thinking, 'Oh, I see where this is coming from', but I wouldn't necessarily share that in an analytical way.	3:21-30
Difficulty to practise CBT while thinking in different models	I wouldn't analyse how they, what they are doing in the session, how they are being in the session, I don't go into that depth, because it's impossible to stay CBT focused if your mind is sort of somewhere	3:30-4:3
Reflecting about own process outside / after the session	I do make some notes about it myself, maybe after a session, possibly how I felt within the session, use some of that process for myself, in a personal way	4:3-6

	I could keep my own personal notes you know, about, um, if I found a session particularly difficult, or if I found myself feeling deskilled in some way, I might sort of question that, and why did I, why did I use this technique with this person, why am I not using that, am I worried about this, or you know, my own sort of reflections. I spend time thinking about it really	5:1-9
Exploring in advance potential problems in the therapeutic relationship	But if I can straight away have someone, you know, that's very worried or bullied at work and authority figures, and I'd be well, I might be appearing as a bit of an authority figure here, you know, sitting in a big chair, so, I sort of could say, so how does it feel being here now. Sit back sort of thing, does this feel a bit, if you feel that I'm asking you questions that you don't feel comfortable, this is very collaborative way of working. So I might be thinking, you know, I don't want to come here as the expert, so lets try to work with that before it becomes a problem	4:8-19
Being cautious about personal issues coming up	I'm aware of my own stuff might be coming up as well. Cause I've done that on the training and I'm aware that I might be sort of finding that something's quite difficult. You know, when there is question of suicide, when there is a question of self-harming, you know, I am aware that ooh, you know, I got to be a bit careful how I work with this person. So I'm aware of my own processes	4:21-27
Pressurised by time / setting	So I'm aware that this person is coming with six sessions being funded by an insurance company, their employer, etc. I then have this big pressure to actually get that done. So I can sometimes feel a bit, ooh, under pressure myself.	5:25-28
The perception of CBT by setting / referrer	Because the people who are referring, the insurance companies, the solicitors, etc, don't generally understand what happens in therapy. So they sort of think: well we ll send them off, we read about CBT, it's, you know, those people get it done in six sessions, which is fine, if they are coming about their driving problem, but suddenly when they sit in here, they come up, you know, they were abused when they were 6 years old!	5:28-6:6
Shock / taken aback	And suddenly you start thinking, oh you know, ooh, cant do anything with that.	6:6-7
Conflict between	But it is quite difficult when someone suddenly discloses something about themselves to say, to	6:10-20

setting/referrer's directions and client's needs	be aware that there is part of me as a therapist that is wanting to help them with that bit of information, but it's also they've got six sessions because they've got a driving phobia and you have to balance that. So I don't like that part of it, to be honest	
Following setting's directions on therapeutic goals	I'm very aware that I have to keep those sessions very structured, when they are being, you know, when this is what they have said to me from the insurance company, I know that those sessions have to be very structured, and therefore I cant always be as maybe um, um, open in the sessions as I would like to be, it's very CBT focused, it's very much working in a way that this is about, you know, this is about driving phobia, we are going to work on the driving phobia, only the driving phobia, which is, maybe my remit, but maybe some people sitting in their chair suddenly think: Ah! I'm in front of the therapist and I can tell them everything about my life that I have. And it's quite difficult to try and keep that, that balance.	6:30-7:11
CBT practised as opposed to typical / stereotype of CBT (therapeutic relationship, following agenda)	I think the understanding of people who have CBT is that it's such a structured approach, that the therapeutic relationship is there, but not as it would be in a person-centred or psychodynamic therapy, In CBT it's there, but it's not, you know, part of the work. But I always feel that why would somebody do some of the behavioural exposures if they didn't have a relationship with me? I think that's maybe when I'm talking about slightly gentle approach to CBT, in terms of that, it's, you know, not about this is what we are going to do in every single session, and this is how we are going to tackle it. It's very much like, this is where we are going with this session, but lets just see what happens, and if something else happens that's more important, then we ll look at that.	8:8-15 22:1-6
Collaboration through sharing expertise	their life obviously is very important, I know the CBT so lets put the two together. The work is 100% collaborative	9:13-15
Rationalising failure	And I had some clients who, who, obviously it doesn't work with, how the, you know, therapeutically we don't match, maybe, um, 5 or 6 in the last couple of years who have decided	10:7-16

	that they didn't want to come back for whatever reasons, that's fine. Some people might not like my approach, some people might not like me, some people may have a thing with people with my hair colour, I don't know, or I may be, you know, they are going through a bad divorce with somebody who I might remind them of, they will not want to come back into the sessions	
Collaboration through behavioural exposure together with client	Working in a collaborative way, saying to clients I wouldn't ask you to do anything, if I wouldn't expect myself to do it.	10:25-26
Acting as a parent for the client	people have um blood phobias or needle phobias, you know, I ll hold the needle, I ll stick it in my own finger, you know, and so, that they can that, it's modeling in a way, that they ll do this, lets do this together, you know, it's sort of childlike in a way, but, lets do this together, then what does that mean if I say we are going to do this together, it sort of gives them a different message, rather than I'm being made to do this, but she is not, why?	11: 4-13
Using non-conventional tools / creativity	Well I've worked with people who thought that they are going to have an anxiety attack, and crash the car. I would be the passenger. I said to a client the other day, she is doing really well with her driving, but she said it's really hard for me to think about having a passenger in the car. I said, well I ll be your passenger.	11:15-19
Being myself – integrated self	just being a human being. I'm not a therapist in here and somebody else outside. What they get here is me. I am me, and, um, when I work with people I'm still me	11:24 23:21-22 33:16-17
Principles about self-disclosure	I wouldn't tell them my, everything about me. If it's a story, it's a silly story that fits into the story, I don't see this as a problem. I don't disclose personal information about myself, I don't disclose my beliefs or thoughts or feelings, you know, all these sort of things, like 'Ah! My life is so terrible, this has happened to me!' I don't disclose that, but I will disclose a funny situation, like I tripped over the road and made, you know, a complete fool of myself once, and everyone just stood there and laughed, and, I ll disclose that	12:9-17

The boundary between self and client (empathy-sympathy)	if you cant use empathy and sitting there, oh God, that person's story is so terrible, so sad, that's what I mean sympathy, then you are not going to be able to work with that person, cause all of that stuff is going to get in the way. In a session, if someone is in a very bad situation, I can distance myself without empathising, rather than jump in there, and sort of sit there with floods of tears with them	13:10-15 13:22-24
Empathy facilitated through shared humanity	So, everybody knows what it's like to be sad, or unhappy, everybody, you know, nobody goes through life with everything 100 percent. I cant empathise with every single one of my clients, otherwise my life would be a disaster if I did that (laughs) but I certainly can empathise with what they re bringing	13:15-20
Empathy: natural use	but empathy is something I just use naturally now, I don't think about it really just naturally empathise with people	13:25-28
Using the here and now	I would say, when we spoke about that, I could see it made you unhappy, I could see the tears in your eyes. Can we talked about that again, what was it that made you so unhappy, I mean, when we were talking? What was it that made you cry when we talked just now? So, you can get that empathy in there... which is very much CBT, very much about what's happening in the room now, you know, what's going on through your mind	14:5-16
Acceptance of own limitations (UPR)	So I have been in situation, where, you know, I think, that this person, uh...(laughs), they are saying, 'Oh I'm so boring', and you are like, mmm, you are a bit (laughs) and sometimes those things go through your mind. So it's never, sort of, 100 percent unconditional. You might be a therapist but I'm still a human	15:1-8 15:30
Attributing failure/ problems in therapeutic relationship to clients' problems	I had maybe one or two people that were slightly BPD, but they generally do, either don't come to therapy or they ll come for one or two sessions, and then decide that you re not good enough, you are not the right person for them. And you know that's part of the problem Sometimes someone's a bit difficult, but I understand that's part of their problem, so I don't take that as being, you know, a personal thing,	16:10-14 16:22-24
Finding the balance	if someone says that they are worthless human	17:3-

between empathising and challenging	beings, that's quite difficult. And in CBT you need to challenge that, so you re looking at challenging the way someone's thinking, and staying with them in a congruent or empathic way. It's quite a balance sometimes...sometimes I find it quite difficult actually, with people with very, very strong beliefs, I try not to impose the, the, too much, you know, the quite structured CBT way of working	13
Exploring without challenging	other people say, it doesn't really matter whatever you say, I still don't feel any different, so you know that you need to work in a slightly more emotional way with these people, staying far more with the emotions and feelings, you know, how that affect their life, what are they feeling now, um, how it's for them, um how they can change that, that way, do they feel like that all the time, or is it always like that, is there any time they might feel differently,	17:18-29
Sharing own thoughts in tentative way	sometimes I ll say, you know, thoughts come to my mind: dara, dara, dara, or I ll say, I was just sitting here thinking, and tell me if I'm right and if I'm wrong, I might be completely going off on the wrong thought here, but I just wondering if, and sort of I ll say it in that way.	18:7-11
Supervision	if it was very strong [feeling], I would keep it personal or take it to supervision, I spoke to my supervisor, two supervisors, I spoke to them in depth about it, what do I do? What do I say? Do I say anything at all?	18:20-21 26:6-8
Need to express self	she was just the most incredible lady... And I actually shared with her I'm really humbled by you... I don't do it very often, whether it was right or not I don't know, but it was how I was feeling and I just wanted to share that with her.	19:5-21
Goal oriented CBT	it is goal oriented CBT	20:26
Acceptance of own limitations and confidence	I think now I've become far more, um, confident in myself, and I cant know everything, I don't know everything, I know a pin, the top of a pin, compared to what there is to know in therapy, and I'm well aware of that...generally I'm far more comfortable with myself in this work,	22:29-23:4
Attributing failure to reasons other than	If someone really doesn't like me, I cannot make them like me, so, if somebody really doesn't want to work with me, that's, that's fine, it's not	23:5-9

clinical practice	generally about me, or them, or anything, it's just something that doesn't click between us. I don't know about the people who don't like me, because if they don't like me, they wont come back, or maybe cant afford to see me, or maybe I charge too much, or you know	32:7-10
Acceptance of who I am	I cant deal with being somebody I'm not. And I know that, I'm not the best academic, I'm not the best therapist, I'm not anything, I am just me, and I ll do the best job I can in here. And if someone doesn't like me, I cant be somebody else, just for the client, it doesn't work. cause it's not, I'm not working normally and naturally there I wouldn't want to change me	24:28-25:4 32:1
Evaluating the impact of potential self-disclosure	I had [serious illness]. And if you say that to a client, they'll suddenly think, 'Oh my God,' you know, 'she's human, and she's not...and she's fallible she's going to die in one week', I was worried that that's what they might think it would really interfere with our work	25:28-26:4 27:4
Promoting equality with client	if they cancel within 24 hours I ask to charge, but if I cancel with less than 24 hours, I don't charge them for the next session, which I think it's very therapeutic way of looking at it	26:13-16
Not knowing what to do – dilemma regarding self-disclosure	while working, and that was, that is something, do you bring it into the sessions? Do you not? It's not a normal situation so it was a quite difficult one to handle So, you know, what do you do? Maybe, you know, do you tell them, don't you tell them?	27:19-23 28:3-4
Avoiding clients' sympathy	I don't want them to feel sorry for me	29:8
Self-disclosure as breaking boundaries	it's, you know, crossing that line between this is client-therapist relationship, not client, this isn't a friend...I cannot tell them, and 'I'm this, I got this', I cant do that ...it's not therapeutic, it's not ethical, and, so it's quite a difficult one to handle	29:25-31
The importance of the therapeutic relationship in behavioural exposure	fear of lifts, which is a great one, you go in the lift with the client, you know, and then you come out and then you say, 'right, now it's your turn' and if, if, they don't have that relationship, if they don't believe in that, in what they're able to do, if you haven't worked on that enough in the session, you're not going to get them to do this work outside of there,	32:20-25

Addressing openly problems in therapy	in the session you can say, 'you know this is a problem, we have a problem, because I'm not sure whether you, you like working like this, or, you know, it seems that, when we set up homework, you are really, really keen, and then you go away and never do anything, so we have a problem here'. So, you can actually be quite open with them in that way.	33:30-34:4
The influence of colleagues on current practice of CBT	I just notice how other people work, you know, in a very normal, natural way, you know OTs, um, social workers...I just need to be myself with clients.	34:4-10
Prompting client to take responsibility	I ll say, 'it's not about what I think you ought to do, this isn't about me in here at all, this is about, you know, what do you think you ought to do? What do you think would be a better way of going on here? So I ll give that back to them,	35:21-24

Appendix 8

Example of Summary table for 1 interview

Summary table for 1 interview

Cluster 1: Difficulties, dilemmas, failure and ways of dealing with them		
Being cautious about personal issues coming up	I'm aware of my own stuff might be coming up as well. Cause I've done that on the training and I'm aware that I might be sort of finding that something's quite difficult. You know, when there is question of suicide, when there is a question of self-harming, you know, I am aware that ooh, you know, I got to be a bit careful how I work with this person. So I'm aware of my own processes	4:21-27
Exploring in advance potential problems in the therapeutic relationship	But if I can straight away have someone, you know, that's very worried or bullied at work and authority figures, and I'd be well, I might be appearing as a bit of an authority figure here, you know, sitting in a big chair, so, I sort of could say, so how does it feel being here now. Sit back sort of thing, does this feel a bit, if you feel that I'm asking you questions that you don't feel comfortable, this is very collaborative way of working. So I might be thinking, you know, I don't want to come here as the expert, so lets try to work with that before it becomes a problem	4:8-19
Addressing openly problems in therapy	in the session you can say, 'you know this is a problem, we have a problem, because I'm not sure whether you, you like working like this, or, you know, it seems that, when we set up homework, you are really, really keen, and then you go away and never do anything, so we have a problem here'. So, you can actually be quite open with them in that way.	33:30-34:4
Principles about self-disclosure	I wouldn't tell them my, everything about me. If it's a story, it's a silly story that fits into the story, I don't see this as a problem. I don't disclose personal information about myself, I don't disclose my beliefs or thoughts or feelings, you know, all these sort of things, like 'Ah! My life is so terrible, this has happened to me!' I don't disclose that, but I will disclose a funny situation, like I tripped over the road and made, you know, a complete fool of myself once, and everyone just stood there and laughed, and, I ll disclose that	12:9-17
Evaluating the impact of potential	I had [serious illness]. And if you say that to a client, they'll suddenly think, 'Oh my God,' you know, 'she's human, and she's not...and she's fallible she's going to die in one week', I was	25:28-26:4

self-disclosure	worried that that's what they might think it would really interfere with our work	27:4
Self-disclosure as breaking boundaries	it's, you know, crossing that line between this is client-therapist relationship, not client, this isn't a friend…I cannot tell them, and 'I'm this, I got this', I cant do that …it's not therapeutic, it's not ethical, and, so it's quite a difficult one to handle	29:25-31
Shock / taken aback	And suddenly you start thinking, oh you know, ooh, cant do anything with that.	6:6-7
Not knowing what to do – dilemma regarding self-disclosure	while working, and that was, that is something, do you bring it into the sessions? Do you not? It's not a normal situation so it was a quite difficult one to handle So, you know, what do you do? Maybe, you know, do you tell them, don't you tell them?	27:19-23 28:3-4
Avoiding clients' sympathy	I don't want them to feel sorry for me	29:8
Attributing failure/ problems in therapeutic relationship to clients' problems	I had maybe one or two people that were slightly BPD, but they generally do, either don't come to therapy or they ll come for one or two sessions, and then decide that you re not good enough, you are not the right person for them. And you know that's part of the problem Sometimes someone's a bit difficult, but I understand that's part of their problem, so I don't take that as being, you know, a personal thing,	16:10-14 16:22-24
Attributing failure to reasons other than clinical practice	If someone really doesn't like me, I cannot make them like me, so, if somebody really doesn't want to work with me, that's, that's fine, it's not generally about me, or them, or anything, it's just something that doesn't click between us. I don't know about the people who don't like me, because if they don't like me, they wont come back, or maybe cant afford to see me, or maybe I charge too much, or you know	23:5-9 32:7-10
Rationalising failure	And I had some clients who, who, obviously it doesn't work with, how the, you know, therapeutically we don't match, maybe, um, 5 or 6 in the last couple of years who have decided that they didn't want to come back for whatever reasons, that's fine. Some people might not like my approach, some people might not like me, some people may have a thing with people with my hair colour, I don't know, or I may be, you know, they are going through a bad divorce with somebody who I might remind them of, they will	10:7-16

	not want to come back into the sessions	
The boundary between self and client (empathy-sympathy)	if you cant use empathy and sitting there, oh God, that person's story is so terrible, so sad, that's what I mean sympathy, then you are not going to be able to work with that person, cause all of that stuff is going to get in the way. In a session, if someone is in a very bad situation, I can distance myself without empathising, rather than jump in there, and sort of sit there with floods of tears with them	13:10-15 13:22-24
Reflecting about own process outside / after the session	I do make some notes about it myself, maybe after a session, possibly how I felt within the session, use some of that process for myself, in a personal way I could keep my own personal notes you know, about, um, if I found a session particularly difficult, or if I found myself feeling deskilled in some way, I might sort of question that, and why did I, why did I use this technique with this person, why am I not using that, am I worried about this, or you know, my own sort of reflections. I spend time thinking about it really	4:3-6 5:1-9
Supervision	if it was very strong [feeling], I would keep it personal or take it to supervision, I spoke to my supervisor, two supervisors, I spoke to them in depth about it, what do I do? What do I say? Do I say anything at all?	18:20-21 26:6-8

Cluster 2: Practising CBT within a setting		
NHS vs private practice: time and quality of therapy	I think when I was in the NHS it was far more, you know, you only had this time with this client, so you lost a lot of that more of a therapeutic approach I think, I can do it more in private practice.	2:8-11
The perception of CBT by setting / referrer	Because the people who are referring, the insurance companies, the solicitors, etc, don't generally understand what happens in therapy. So they sort of think: well we ll send them off, we read about CBT, it's, you know, those people get it done in six sessions, which is fine, if they are coming about their driving problem, but suddenly when they sit in here, they come up, you know, they were abused when they were 6 years old!	5:28-6:6
Conflict between setting/referrer's directions and client's needs	But it is quite difficult when someone suddenly discloses something about themselves to say, to be aware that there is part of me as a therapist that is wanting to help them with that bit of information, but it's also they've got six sessions because they've got a driving phobia and you have to balance that. So I don't like that part of it, to be honest	6:10-20
Following setting's directions on therapeutic goals	I'm very aware that I have to keep those sessions very structured, when they are being, you know, when this is what they have said to me from the insurance company, I know that those sessions have to be very structured, and therefore I cant always be as maybe um, um, open in the sessions as I would like to be, it's very CBT focused, it's very much working in a way that this is about, you know, this is about driving phobia, we are going to work on the driving phobia, only the driving phobia, which is, maybe my remit, but maybe some people sitting in their chair suddenly think: Ah! I'm in front of the therapist and I can tell them everything about my life that I have. And it's quite difficult to try and keep that, that balance.	6:30-7:11
Pressurised by time / setting	So I'm aware that this person is coming with six sessions being funded by an insurance company, their employer, etc. I then have this big pressure to actually get that done. So I can sometimes feel a bit, ooh, under pressure myself.	5:25-28
The influence of	I just notice how other people work, you know, in	34:4-

colleagues on current practice of CBT	a very normal, natural way, you know OTs, um, social workers…I just need to be myself with clients.	10

Cluster 3: Finding the balance between empathising and challenging in CBT		
Finding the balance between empathising and challenging	if someone says that they are worthless human beings, that's quite difficult. And in CBT you need to challenge that, so you re looking at challenging the way someone's thinking, and staying with them in a congruent or empathic way. It's quite a balance sometimes…sometimes I find it quite difficult actually, with people with very, very strong beliefs, I try not to impose the, the, too much, you know, the quite structured CBT way of working	17:3-13
Exploring without challenging	other people say, it doesn't really matter whatever you say, I still don't feel any different, so you know that you need to work in a slightly more emotional way with these people, staying far more with the emotions and feelings, you know, how that affect their life, what are they feeling now, um, how it's for them, um how they can change that, that way, do they feel like that all the time, or is it always like that, is there any time they might feel differently,	17:18-29
Sharing own thoughts in tentative way	sometimes I ll say, you know, thoughts come to my mind: dara, dara, dara, or I ll say, I was just sitting here thinking, and tell me if I'm right and if I'm wrong, I might be completely going off on the wrong thought here, but I just wondering if, and sort of I ll say it in that way.	18:7-11
Using the here and now	I would say, when we spoke about that, I could see it made you unhappy, I could see the tears in your eyes. Can we talked about that again, what was it that made you so unhappy, I mean, when we were talking? What was it that made you cry when we talked just now? So, you can get that empathy in there… which is very much CBT, very much about what's happening in the room now, you know, what's going on through your mind	14:5-16
Empathy facilitated through shared humanity	So, everybody knows what it's like to be sad, or unhappy, everybody, you know, nobody goes through life with everything 100 percent. I cant empathise with every single one of my clients, otherwise my life would be a disaster if I did that	13:15-20

	(laughs) but I certainly can empathise with what they re bringing	
Empathy: natural use	but empathy is something I just use naturally now, I don't think about it really just naturally empathise with people	13:25-28
Taking time to explore clients' concerns about beginning therapy	here the client is very anxious, and they are sitting there saying, 'Oh I'm really anxious about being here'. You know that may be ok, fine, lets take a few minutes out to talk about what it is that is worrying you about being here	3:5-8

Cluster 4: Internal processes: the relationship with self and CBT model		
Acceptance of own limitations (UPR)	So I have been in situation, where, you know, I think, that this person, uh...(laughs), they are saying, 'Oh I'm so boring', and you are like, mmm, you are a bit (laughs) and sometimes those things go through your mind. So it's never, sort of, 100 percent unconditional. You might be a therapist but I'm still a human	15:1-8 15:30
Acceptance of own limitations and confidence	I think now I've become far more, um, confident in myself, and I cant know everything, I don't know everything, I know a pin, the top of a pin, compared to what there is to know in therapy, and I'm well aware of that...generally I'm far more comfortable with myself in this work,	22:29-23:4
Acceptance of who I am	I cant deal with being somebody I'm not. And I know that, I'm not the best academic, I'm not the best therapist, I'm not anything, I am just me, and I ll do the best job I can in here. And if someone doesn't like me, I cant be somebody else, just for the client, it doesn't work. cause it's not, I'm not working normally and naturally there I wouldn't want to change me	24:28-25:4 32:1
Need to express self	she was just the most incredible lady... And I actually shared with her I'm really humbled by you... I don't do it very often, whether it was right or not I don't know, but it was how I was feeling and I just wanted to share that with her.	19:5-21
Being myself – integrated self	just being a human being. I'm not a therapist in here and somebody else outside. What they get here is me. I am me, and, um, when I work with people I'm still me	11:24 23:21-22 33:16-17
Using different	Sometimes I might sort of take this analytical	3:21-

models to think and to communicate with clients	think about, you know, certainly if they start talking about bringing up their past in the session. But obviously in a CBT way, you, you use that very differently, like in core beliefs, you know where they come from, how they affect their life now, and, and sort of explain that, how their core beliefs have maybe made them feel how they feel now, they are generally their beliefs about themselves, not necessarily world views, and so, sort of just explain to them a little bit about, but I may be thinking, 'Oh, I see where this is coming from', but I wouldn't necessarily share that in an analytical way.	30
Difficulty to practise CBT while thinking in different models	I wouldn't analyse how they, what they are doing in the session, how they are being in the session, I don't go into that depth, because it's impossible to stay CBT focused if your mind is sort of somewhere	3:30-4:3
Goal oriented CBT	it is goal oriented CBT	20:26

Cluster 5: The importance and the underlying messages about the therapeutic relationship in CBT		
The importance of the therapeutic relationship in behavioural exposure	fear of lifts, which is a great one, you go in the lift with the client, you know, and then you come out and then you say, 'right, now it's your turn' and if, if, they don't have that relationship, if they don't believe in that, in what they're able to do, if you haven't worked on that enough in the session, you're not going to get them to do this work outside of there,	32:20-25
Acting as a parent for the client	people have um blood phobias or needle phobias, you know, I ll hold the needle, I ll stick it in my own finger, you know, and so, that they can that, it's modeling in a way, that they ll do this, lets do this together, you know, it's sort of childlike in a way, but, lets do this together, then what does that mean if I say we are going to do this together, it sort of gives them a different message, rather than I'm being made to do this, but she is not, why?	11: 4-13
Collaboration through sharing expertise	their life obviously is very important, I know the CBT so lets put the two together. The work is 100% collaborative	9:13-15
Collaboration	Working in a collaborative way, saying to clients I	10:25-

through behavioural exposure together with client	wouldn't ask you to do anything, if I wouldn't expect myself to do it.	26
Using non-conventional tools / creativity	Well I've worked with people who thought that they are going to have an anxiety attack, and crash the car. I would be the passenger. I said to a client the other day, she is doing really well with her driving, but she said it's really hard for me to think about having a passenger in the car. I said, well I ll be your passenger.	11:15-19
Promoting equality with client	if they cancel within 24 hours I ask to charge, but if I cancel with less than 24 hours, I don't charge them for the next session, which I think it's very therapeutic way of looking at it	26:13-16
Prompting client to take responsibility	I ll say, 'it's not about what I think you ought to do, this isn't about me in here at all, this is about, you know, what do you think you ought to do? What do you think would be a better way of going on here? So I ll give that back to them,	35:21-24
Explaining CBT (socialising clients with CBT model,	we've got ten-fifteen sessions together, and lets spend maybe the first and second session explaining a little bit more, and learning a little bit more about the client rather than sort of going straight to doing a lot of the actual...hardcore techniques...for them to start, to feel a bit more comfortable and explain CBT more.	1:29 – 2:8
empowering clients)	I think explaining CBT, explaining how it works, really bringing them very much into the picture.	9:10-11
CBT practised as opposed to typical / stereotype of CBT (therapeutic relationship, following agenda)	I think the understanding of people who have CBT is that it's such a structured approach, that the therapeutic relationship is there, but not as it would be in a person-centred or psychodynamic therapy, In CBT it's there, but it's not, you know, part of the work. But I always feel that why would somebody do some of the behavioural exposures if they didn't have a relationship with me?	8:8-15
	I think that's maybe when I'm talking about slightly gentle approach to CBT, in terms of that, it's, you know, not about this is what we are going to do in every single session, and this is how we are going to tackle it. It's very much like, this is where we are going with this session, but lets just see what happens, and if something else happens that's more important, then we ll look at that.	22:1-6

Appendix 9

Final Summary table of master themes and constituent themes

Final Summary Table

	Sandra	Annette	Lea	Carla	Barbara	Joy	Rachel	Mary
1 Intrapsychic processes towards integration								
1.1 Relationship with inner self: self acceptance and integration	14:1-3 15:27-16:2	17:30-31	12:24-31 15:1-8 24:28-25:4	20:15-23	28:9-14 5:13-14	3:20-29		25:24-31 28:30-29:5
1.2 Relationship with CBT model: integration or conflict?	1:6-9 1:25-27	4: 14- 19 11:4-6 9: 8-10 2: 30- 3:6	3:21-30 3:30-4:3	2: 9-21	25:19-21 1:21-27 25:27-29	2:1-4, 8-14 27:7-9, 18-19	2:20-22 2:22-24 5:16-24	11:10-19 2:21-3:3 7:7-11
1.3 Reflexivity		15:24	18:20-21	13:5-11 22:21-23:8	11:13-16	4:1-6	10:19-24 13:2-6	12:2-11
2 Interpersonal processes with client: perceiving and responding to client's reality								
2.1 Promoting human values of honesty, equality and respect through the practice of CBT	18:15-22 11:22-23 8:29-9:13	17:9-11	17:3-13 26:13-16 9:13-15	2:29-3: 8 16-24	4:21-31 5:16-17	5:27-6:8	14:11-15	13:17-24 28:27-29
2.2 Personalising and tailoring CBT to clients	13:16-24 12:30-13:12	17:31-18:4	11:15-19 8:8-15		9:2-25 1: 9-16 24:29-25:8	5:5-7 4:18-24	7:3-11 15:11-15	1:21-27 21:22-22:2
2.3 The permeable boundary between self and client	16:4-8	10: 6 - 31	29:25-31 13:10-15	9:17-22 11:28-12:19	7:14-20 13:29-31 17:3-6	11:3-15 3:12-20	8:6-13	8:15-19 24:19-4
2.4 Therapeutic impasses and failure	11:4-6	21:10-18 21:17-21 12: 29-13:1	33:30-34:4 23:5-9 10:7-16	4:24-5:1 13:22-14:5	13:10-11 12:11-15 8:17-20	26:23-26 17:30-31	12:27-13:2 3:13-23	29:8-22
2.5 Using the therapeutic relationship as a tool	6:7-11	9: 10-14 20:17-22	14:5-16	,9:11-14	3:4-10		9:17-22 11:13-	

			11: 4-13	7:25-29			21	
2.6 Non-verbal communication in the therapeutic relationship	14:9-20	9:14-27			6:3-15	2:24-3:4 19:7-10	14:5-11 21:6-7	
3 Working within a setting								
3.1 Time pressure and the therapeutic relationship		10: 9-11 13:1- 7	5:28-6:6 6:10-20 5:25-28	18:30 -19:3	20:1-3 19:21-28 21:3-11	9:7-13 9:9-12 12:12 -24		30:3-5 30:5-10 30:21 -25
3.2 The decision to use CBT: free choice versus mandatory	1:6-9 1:25-27	5: 20-23			25:19-21	1: 5-7		1:30-2:2 2:11-14

Appendix 10

Summary of reflections on the initial research design and the decision to move away from it

Summary of reflections on the initial research design and the decision to move away from it

Looking back on my initial research design, I see a very well planned study. However, it seems to me that it is not much different from the previous studies that have been conducted in the area. The novelty aspect of it lies mainly the attempt to incorporate qualitative data in the research. Nevertheless, my intention was to quantify the clients' responses. Even though I was critiquing the emphasis on the quantitative methods, without realising it, I was still adhering to it. In reality, I didn't truly believe that I could find a pattern of how the therapeutic relationship develops in CBT, simply because I did not believe that such a pattern exists. However, I was quite seduced by the idea that such a pattern could be identified, and disregarded my experience of the therapeutic relationship with my clients, which indicated that the development of each relationship is unique. When thinking about which would be the most appropriate method to study the therapeutic relationship, a part of me knew that interviews would reveal the complexity of the concept and would add something new in what we already know. At the same time, another part of me felt very insecure about the prospect of conducting interviews. On the contrary, I felt very confident with statistics and SPSS, mainly because of my positive previous experience with it in other research studies. When recently I read Lorion's (1990, as cited in Willig, 2001) metaphor about someone 'looking for his missing keys under the street lamp because the light is better there' (p 20), I identified with it. I realise that I had been seduced by the convenience of statistics for me and the clear cut answers that I was hoping to get, that I did not want to look further away.

I moved away from the original research design for various reasons: my growing understanding that quantitative methods would not provide any new insights in the topic I was interested in, as well as a lot of practical problems and difficulties in recruiting participants that I had not foreseen. Had these difficulties not existed, I am not sure whether I would have proceeded with the initial research design or not. I amended and modified my research design a number of times,

until I decided to use qualitative methodology. I did not take that decision overnight; rather it involved a lot of steps, consultation with my research supervisor and others, difficult dilemmas and reflection upon them. I found this experience particularly stressful, as I felt insecure, as if I did not know what I was doing and where I was standing. It was also very painful for me to come to terms with the fact that my original research design needed to be modified to such an extent, that it was no longer applicable. Indeed, I was in a crisis for a long time during this process. My decision to use qualitative methodology in some ways made me feel insecure about my ability to conduct research of high quality, but at the same time it was a relief to know that my research was in accordance with my values about therapy. I decided to include this whole process in the write-up of the study, as I consider it an integral part of the research. It has been a learning process which reflects the development of the study through many struggles and dilemmas.

SECTION C: CASE STUDY

The importance of feelings: A cognitive behavioural study of a client with anger problems

1. PART A – Introduction and the start of therapy

1.1 Introduction / implicit rationale for the choice of the case

I chose to write about this client, because my work with him highlights the importance of feelings and the therapeutic relationship in cognitive behavioural therapy. It sheds some light on the complexities of the therapeutic alliance, and the effective and ineffective ways of resolving the ruptures that may emerge. As at the heart of every type of therapy lies the working alliance, the discussion of this theme is relevant to all Counselling Psychologists and therapists in general. Furthermore, this case study illustrates the powerful role of the therapeutic relationship in CBT; in my work with this client, the therapeutic relationship was the vehicle through which unhelpful behavioural patterns were broken, and long-held core beliefs were identified and disconfirmed. The therapy with this client also shows that the integration of empathy is fundamental in CBT. Finally, working with this client had a particularly significant impact on me: it increased my self-awareness and made me realise that the identification of core beliefs is often associated with intense affect. In this way, it helped me develop my own style of practising Cognitive Behavioural Therapy in an empathic and genuine way.

1.2 Summary of the theoretical orientation

Cognitive Behavioural Therapy (CBT) is a directive, time-limited, structured approach developed by Beck and his colleagues (1979). It is based on the idea that the way in which a person interprets events influences greatly how he/she feels and behaves. People's early experiences in life lead them to form core beliefs about themselves, the world and others (Beck, 1995). These core beliefs

are cognitive structures which help people categorise and evaluate their experiences. Problems occur when the above beliefs are rigid and overinclusive, and therefore consistently lead people to evaluate information in a negatively biased way. Anger in particular is often aroused when a person thinks that important rules or expectations have been violated (Greenberger & Padesky, 1995). The therapist's aim is to identify the dysfunctional components of the pre-anger state and challenge them, so that in the future the client can incorporate this aspect of therapy and challenge his/her own thoughts. In addition, problem-solving can help the client use angry feelings in a constructive, task-focused manner (Deffenbacher, 1999). The establishment of a strong working alliance is considered fundamental in the cognitive behavioural approach, because it facilitates the therapist and client's common effort in achieving the goals of therapy.

1.3 The referral, context for the work and the presenting problem

In the interest of confidentiality, the client's name and all identifying information have been changed. Mat was referred for therapy by his GP, because of his anger management problems. The NHS Secondary Care Service offers medium-term Cognitive Behavioural Therapy and is based in a hospital. Mat was assessed by a psychiatrist and presented with difficulty dealing with his anger towards his partner and children only. The problems began thirteen years ago, when he first made a relationship with his current partner. Mat's anger outbursts had various triggers and happened 2-4 times in a week. During them Mat would verbally abuse his partner, shout excessively at his children, and be physically violent with objects (e.g. kick the door, break the light switch). However, he would never be physically violent with people nor did he pose a risk to his children. Mat was motivated to change his behaviour, as he was worried about the effect it might have on his relationship with his partner and on the personality of his children.

1.4 Summary of biographical details of client

Mat is a 34-year old white English man who is currently living with his partner and their two sons, aged 4 and 2, and a newborn daughter. Mat and his partner have been together for thirteen years. Mat used to be a successful consultant, but quit his job after the birth of his eldest son who was suffering from diabetes. Since then, he takes care of the children and the house, while his wife, who works in the public sector, is the breadwinner.

Mat has two older brothers that have had convictions for violent behaviour, and one older sister. Mat's father had been diagnosed with multiple sclerosis (MS), and had been on a wheelchair for most of his life. Mat had a particularly close relationship with his father and acted as his carer together with his mother. When Mat was a child, his mother worked fulltime as a nurse. Mat explained that she had increased pressure to take care of her disabled husband and the four children, as well as be the breadwinner. As a result of this high pressure, Mat's mother frequently had anger outbursts, which she expressed by being verbally abusive towards all the members of the family.

Mat's father died 5 years ago, and Mat's mother was subsequently diagnosed with MS. Mat's mother is still alive and they have a relatively good relationship.

1.5 Initial impression

Mat appeared as a tough man, who at the same time was sensitive and reflective. I found it difficult to imagine him having anger outbursts. His insightfulness in combination with his motivation to change made me like him instantly and feel optimistic about his progress in therapy.

1.6 Initial hypothesis / formulation of the problem

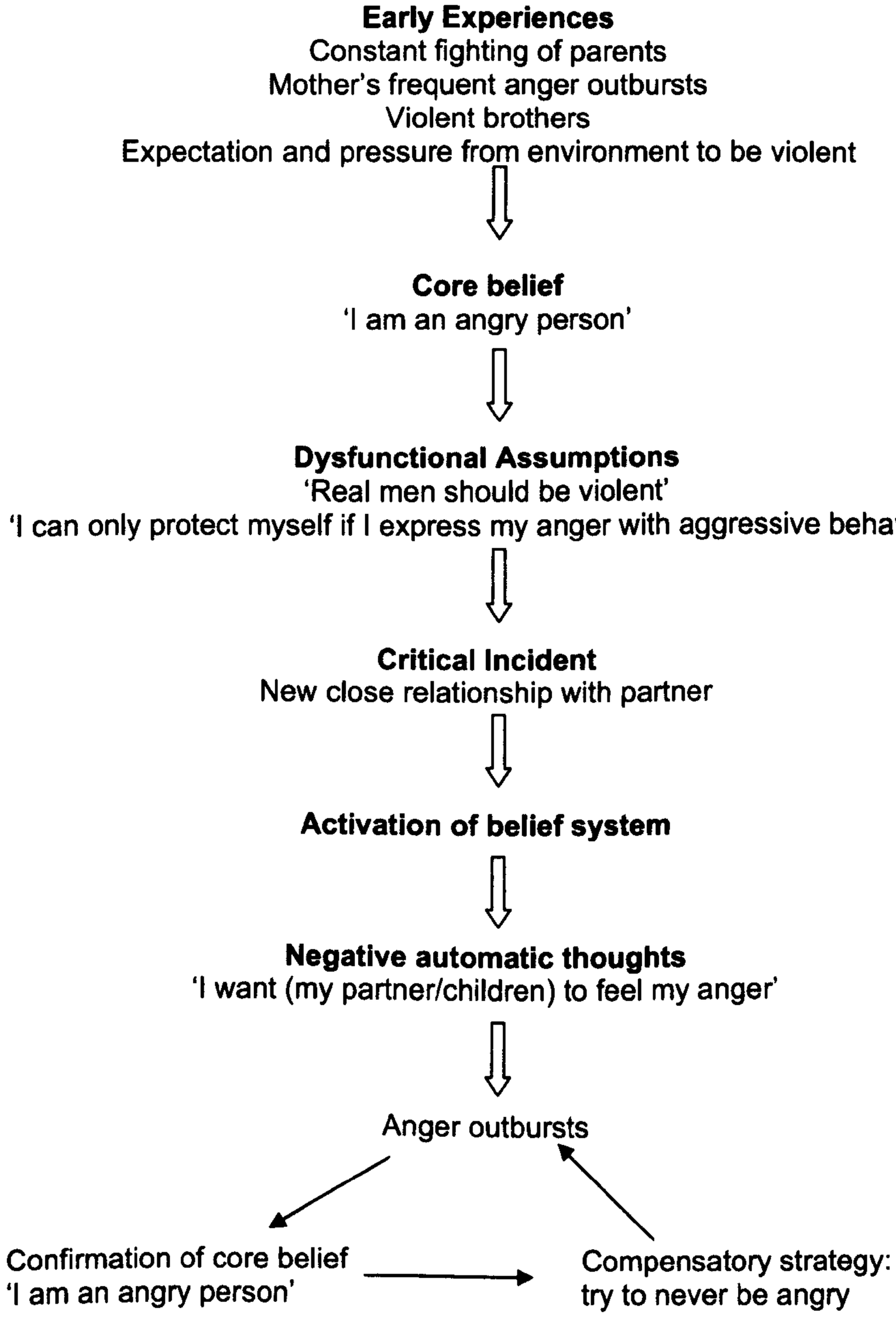
As the formulation of the client's problems plays such an important role in guiding the treatment (Persons, 1989), Mat and I spent the first two sessions assessing his difficulties and formulating. Mat explained that there was a strong link

between his behaviour and his mother's frequent anger outbursts on the rest of the family. He added that his parents were constantly fighting, and that his brothers were violent both at home and at school. For this reason, people expected from him that he should also be violent. In accordance with Miedzian's (1992) view of rearing boys, Mat had been brought up in an environment where masculinity and violence were strongly connected. As core beliefs are seen to develop from childhood (Beck et al., 1979), I hypothesised that Mat's early experiences led him to form the belief 'I am an angry person' and the dysfunctional assumptions that 'Real men should be violent' and 'I can only protect myself if I express my anger with aggressive behaviour'. When he formed a new close relationship with his partner, the above dysfunctional beliefs were activated. Whenever Mat fought with his partner or children, he had negative automatic thoughts such as 'I want you to feel my anger', which in turn led to aggressive behaviour. This seemed to confirm his core belief 'I am an angry person'. Mat's compensatory strategy of trying to never be angry probably maintained the vicious cycle and led to further angry outbursts.

Nevertheless, a number of protective factors made me feel optimistic about Mat's treatment. His aggression was 'ego dystonic', at variance with his values, and Mat was the one who decided to begin therapy. Furthermore, Mat seemed to have some skills of controlling his anger, since he had never been physically violent to a person.

A diagram of the formulation Mat's difficulties can be found in figure 1.

Figure 1: Diagram of the initial formulation of Mat's difficulties



Protective factors: Ego dystonic aggression
Own decision to have therapy
Some skills of controlling anger

1.7 Negotiating a contract and the decision to use the cognitive behavioural approach

I initially thought that the psychodynamic approach would be suitable, because Mat's difficulties stemmed from his childhood and he appeared to be very insightful. However, the final decision to use Cognitive Behavioural Therapy (CBT) took account of both research findings and Mat's goals from therapy. In reviewing the literature, it appeared that several meta-analyses suggest that CBT is very effective, and therefore the treatment of choice, for people with anger problems (Vecchio & O' Leary, 2004; Beck & Fernandez, 1998; Edmondson & Conger, 1996). Furthermore, Mat explained that he came for therapy in order to gain the skills required to manage and express his anger more appropriately. Therefore, we agreed that CBT would help Mat restructure the beliefs that he formed as a child, as well as provide him with new tools of controlling his anger and interpreting and reacting to situations in a different way. Mat appeared suitable for this type of treatment, as he already disapproved of the short-term and long-term effects of his aggressive behaviour (Howells, 1998).

Mat came up with the following specific behavioural goals he would like to achieve:

- Express anger to the people that have given rise to it
- Express anger verbally, without raising the voice too much or being physical with objects
- Ensure that most of the times the children are not present when arguing with partner
- Express anger proportionately to the event that has given rise to it

Mat and I agreed to meet for 10 weekly sessions.

2. PART B – The development of the therapy

2.1 The therapeutic plan

The formulation of Mat's problems indicated that it would be helpful to first work on the maintaining factors, which was his strategy of trying to never be angry. Therefore, the first treatment goal was to help Mat accept his angry feelings, which was in accordance with Jongsma and Peterson's (1999) treatment plan for anger management. Since Mat's early experiences contributed significantly to his current behaviour, I also aimed to explore the origins of his aggressive anger and help him develop alternative beliefs and behaviours, as suggested by Jongsma and Peterson (1999). In this way I thought that Mat would then be able to achieve his behavioural goals about handling angry feelings in constructive ways. Furthermore, my supervisor made me aware of the reactive theories of violence that suggest that men may be aggressive when their means for successful achievement are blocked (Hearn, 1998). We hypothesised that Mat's anger may have been exacerbated since he quit his job and lost his sense of achieving a goal, and therefore planned to explore other ways through which he could restore that.

2.2 Content and process issues in therapy before the summer break

During our initial sessions, we spent a lot of time formulating, as I hoped this would promote Mat's awareness about the links between past and present, as well as the relationship among different problems (Persons, 1989). Since exploring how influential people in the past have modelled anger expressions is a vital component of therapy (Jongsma & Peterson, 1999), Mat and I discussed how angry feelings were expressed in the family where he grew up. Mat's mother and brothers had a low threshold for frustration, and expressed their anger actively with physical aggression towards people and objects, and by using abusive language. On the contrary, Mat's father would suppress his anger and try to avoid conflict. We realised that Mat was trapped between conflicting role models, which is common with individuals with anger problems (Deffenbacher,

1999). Mat subsequently understood that both under-controlling and over-controlling one's anger may lead to aggressive behaviour in the long term (Blacukburn, 1971 as cited in Howells, 1998), and that his desire to never be angry actually maintained his problems. Psychoeducation helped Mat accept anger as a normal feeling and set realistic goals about how to express it. Through psychoeducation, we also addressed the relationship among different stressors and anger towards his family members. Within this context, I encouraged Mat to actualise his plans about setting up his own business, which would in turn foster his sense of self-efficacy and achievement. Finally, I asked Mat to keep a diary of his anger outbursts and the negative automatic thoughts and feelings evoked; in this way, I aimed to access his rules and schemas and help him challenge any biases in his appraisal processes (Greenberger & Padesky, 1995).

Mat attended six out of the ten originally planned sessions; he engaged well in therapy and appeared highly motivated and insightful. However, he never completed the thought diary at home, because he was too busy or tired. During every session I would emphasize the importance of this tool for CBT and encourage him to do it the following week. Only after Mat started cancelling his sessions did I realise that this had led to an alliance rupture. Even though we both agreed on the goals of therapy, we disagreed on the means through which to achieve them, which is one of the three necessary conditions for a positive therapeutic alliance in general (Bordin, 1976), and with clients with anger problems in particular (Deffenbacher, 1999).

After Mat cancelled our planned 9th session, I telephoned him in order to explore the issues behind his cancellations, and encourage him to attend our final session. Mat explained that his anger problems persisted, and that he was worried about the forthcoming ending of therapy. I validated Mat's feelings, while at the same time pointed out that it was difficult to progress in therapy if he did

not attend the sessions. Mat and I agreed to discuss all these issues in the following session.

Mat attended our last planned session, and we began by discussing the alliance rupture which had occurred. Influenced by the alliance rupture model developed by Safran and colleagues (2001), I conceptualised Mat's cancellations as withdrawal behaviour. In this model it is recommended that, in order to resolve withdrawal ruptures, the therapist needs to encourage the client to communicate their discontent and self-assertion. In this process, it is crucial that the therapist recognises and validates the client's experience. During our discussion, Mat explained that he had not understood the rationale behind keeping the thought diary, but at the same time took responsibility for missing many sessions. I accepted my contribution to the problems in our relationship, as suggested by Safran and Segal (1990), since I had not explained clearly the therapeutic rationale, and had not addressed earlier these problems. I realised that by persisting with the same homework task, I had failed to prioritise Mat's subjectivity above the recommendation for specific techniques in the CBT model. Nevertheless, I felt that during that session both Mat and I handled our angry feelings in a constructive way. This experience may have been very significant for Mat, as the maladaptive behavioural pattern of suppressing anger and then exploding had been broken within the therapeutic relationship.

After exploring and resolving the alliance rupture, Mat requested if he could have a few more sessions with the condition that he would attend them and engage in therapy. When faced with this dilemma, I initially thought that it was not normal practice in our Service to extend therapy for clients who had missed a number of sessions. However, the formulation of Mat's problems helped me realise that non-attendance may have served as a compensatory strategy of trying to suppress or not express directly his anger towards me. Since we had managed to break that pattern in our last session, it made sense to extend therapy in order

to complete the therapeutic work. Therefore, Mat and I agreed to meet for another six sessions, after a four-week summer break.

2.3 Content and process issues in the first session after the summer break

In the beginning of the first session after the summer break, Mat said that his new-born daughter might be suffering from a terminal illness. The agenda for the session that I had had in mind was to explore his anger during the previous weeks. However, I felt that it would be completely inappropriate to bring this up, since the health of Mat's daughter was a matter of urgency. Furthermore, I recognised that if Mat's daughter was indeed suffering from a terminal illness, this would have an even more powerful impact on Mat, given that both of his parents suffered from MS, and his eldest son from diabetes. Therefore, I put my agenda aside.

As Mat was talking about his daughter, I felt deeply empathic, as if this was happening to me – I was shivering, felt desperate, and angry with God and the world for this unfairness. At the same time, I wasn't losing the 'as if' quality of this experience (Rogers, 1957), and noticed that Mat's voice was calm and he appeared emotionally flat. I shared my observation with Mat: there was a mismatch between the content of his experience and his emotional state. I also disclosed how I was feeling listening to his story. Mat immediately became tearful. He explained that since he was a child, his father always told him that he should never be sad. His father adhered to this rule and, despite his disability and constant fights with his wife, he never expressed any feelings of sadness or discontent. Mat had internalised this rule and never allowed himself to experience any negative emotions. Mat concluded 'I am not an angry person, I am just sad'. It seems that as Mat was re-experiencing the pain evoked in his childhood, he was able to access cognitions that he was previously unaware of (Greenberg & Safran, 1986 as cited in Josefowitz & Myran, 2005). Equipped with his new awareness, Mat was then able to disconfirm his core belief 'I am an angry person'.

During that session, Mat had said that he would find out whether his daughter was suffering indeed from an illness within that week. While we were discussing, he received a text on his mobile phone, which we both disregarded at the time. After the end of the session, and as I was walking Mat through the corridor of the hospital towards the exit, he read the text and said, 'She is OK, my partner just got the results of the medical exams!'. Mat immediately started sobbing. Even though these were very good news, they were also very powerful news, and I thought that Mat might need to debrief all this experience. Therefore, I asked Mat whether he would like to come back in the therapy room for a little while. Mat nodded yes, and for the next ten minutes Mat cried and talked about the impact of this experience on him.

2.4 Changes in the formulation and the therapeutic plan

In the first session after the summer break more elements were added to the initial formulation. The early experience of being in a family where painful feelings, such as sadness, depression, or despair, were never expressed seemed to have led Mat to develop the dysfunctional assumptions that 'I can protect myself from painful feelings by ignoring them' and 'I should never be sad'. It seems likely that every time he experienced a negative emotion, he had a negative automatic thought 'I feel bad, therefore I must be angry'. This probably led to aggressive behaviour and further confirmation of this core belief 'I am an angry person'.

The revised formulation indicated that the focus of our work should not be angry feelings; so, we broadened our perspective to all types of negative or painful emotions. We aimed to explore the early roots of the rules associated with these emotions, as well as their effect on Mat's current life. I hoped that Mat would begin to accept his 'vulnerable side', and gradually start showing it to the people close to him, as he had done in therapy.

2.5 Content and process issues in subsequent sessions

In the following sessions, we explored further the relationship between anger and sadness in general, as well as in the family in which he grew up. Mat realised that anger had been masking all the negative emotions he had been avoiding. He experimented on expressing painful feelings to his partner, and felt relieved when he managed to do so. Even though Mat's angry outbursts decreased, we continued processing them and seeking for alternative behaviours (Jongsma & Peterson, 1999). As imagery has been proven as a useful anger management strategy (Greenberger & Padesky, 1995), I asked Mat to imagine ideally how he would like to deal with the problematic situations. Mat found this technique particularly useful, as it allowed him to channel his angry feelings towards constructive solutions of everyday problems.

At the same time, Mat started pursuing his dream of setting up his own business with the help of a friend. As a result, he spent less time at home and shared the household tasks and childcare with his partner. This had an important impact on his identity, since he could now view himself not just as a partner and a father, but as a successful businessman, as well.

2.6 Difficulties in the work and making use of supervision

The most important contribution of my supervisor in my work with Mat was to help me develop a flexible therapeutic approach that is tailored to the client's complex needs. My supervisor encouraged me to focus on the presenting problem, while constantly assessing the influence of contextual factors. Therefore, supporting Mat actualise his plans for his business was incorporated in the therapeutic plan, as this would promote his sense of achievement. Furthermore, this approach enabled me to put my agenda aside and explore the potential illness of Mat's daughter when I felt that this had a huge impact on his mood, and consequently his anger, as well.

The other significant contribution of supervision was to provide me with a safe space to reflect on the therapeutic process and evaluate the effectiveness of my interventions. Since I had a strong therapeutic alliance with my supervisor, I felt comfortable discussing the painful feelings of disappointment and incompetence that I was experiencing, while Mat was failing to complete his homework, and later to attend our sessions. The fact that my supervisor was accepting my feelings and at the same time challenging some of my interventions (such as insisting on the same homework task for weeks), helped me realise my contribution to the alliance rupture with Mat. Since I had processed those feelings in supervision, I was then able to be open and not defensive in the actual session with Mat, and thus re-establish our alliance (Safran et al., 2001).

3. PART C – The conclusion and evaluation of the therapy

3.1 The therapeutic ending

Even though Mat showed very big improvement over time, he had difficulty recognising his success. I hypothesised that thinking errors, such as paying selective attention only to the times when he did not manage to control his anger, while ignoring all the situations in which he handled his angry feelings in a constructive way (Curwen, et al., 2000), were obstructing him from evaluating his progress objectively. After discussing this with my supervisor, we concluded that Mat needed to rate himself weekly on the behavioural goals he had set in the beginning of therapy. These objective criteria helped Mat realise that he was meeting each of his targets from 80 to 90 percent of the time. Since Mat's rules had become less rigid, he was content without achieving his goals 100 percent of the time. We agreed that as part of the relapse-prevention plan, Mat needed to continue rating himself on the same criteria routinely, in order to maintain his sense of achievement and his motivation levels high.

Another part of the relapse prevention plan, was the arrangement for couple therapy for Mat and his partner, as it has been found effective in anger management (Beck, 1999; Greenberger & Padesky, 1995). Furthermore, couple therapy linked in well with Mat's new strategy of expressing his negative feelings to his close people. I hoped that strengthening the couple's communication skills and increasing their positive interactions, would help Mat maintain and even increase his therapeutic gains.

3.2 What I learnt about psychotherapeutic practice and theory

My work with Mat has highlighted the importance of tailoring the means used in therapy according to the client's needs and environment. In the same way that the goals of therapy are directed mainly by the client, the cognitive behavioural interventions should also be the product of discussion and collaboration between client and therapist (Deffenbacher, 1999). This increases motivation and

empowers the client. I also realised that even though CBT is considered a structured and symptom-focused type of therapy, it is vital to constantly assess the influence of contextual factors on the presenting problem, and if appropriate focus on them for a while. It was this movement away from the emphasis on anger to the potential illness of Mat's daughter, that enriched the formulation and deepened our understanding of his problems.

Furthermore, my work with Mat underscored the significance of integrating empathy as part of cognitive behavioural therapy (Josefowitz & Myran, 2005). Empathy is not merely a warm attitude towards the client, but a powerful emotional experience for the therapist. It guides the therapist regarding what to focus on, when, and how. It was my empathic understanding of Mat's experiences which allowed me to feel his despair, and notice the mismatch with the emotions that Mat was expressing. In turn, this observation led Mat to connect with the feelings he had been trying to avoid, and identify the related core belief.

Finally, I realised the importance of feelings in CBT. I now understand that the identification of beliefs that stem from childhood can be an emotionally intense experience (Josefowitz & Myran, 2005). If CBT is applied in an intellectualised manner, the client may never become aware of those beliefs. Therefore, it is my task as a therapist to try to be emotionally connected to the client, and communicate any meanings which he/she may be scarcely aware of (Rogers, 1957).

3.3 Learning from the case about myself as a Counselling Psychologist

Through my work with Mat I realised that although I discuss openly any problems occurring in most of my relationships, I tend to avoid raising such issues in close relationships, one of which is the therapeutic relationship. In Mat's case I initially tried to resolve the alliance rupture, by emphasising the utility of the thought diary; this technique of trying to resolve problems in the relationship by adhering

more to the CBT model has been found inefficient (Goldfried et al, 1996 as cited in Castonguay et al, 2004). I was probably avoiding confrontation, in a similar way that Mat was suppressing his angry feelings. When I took the risk and expressed genuinely how I felt I had contributed to the alliance rupture, Mat was also able to do the same. Had I initiated this discussion earlier, Mat would probably not have cancelled so many sessions. Therefore, I now understand that the earlier the problems in the therapeutic relationship are addressed the better. At the same time, I realise that the strong alliance with my supervisor is a great aid in this process. Finally, my work with Mat increased my confidence in my ability to resolve such issues in an open and genuine way. Given that at the heart of Counselling Psychology lies the therapeutic relationship, I feel that my work with Mat has increased my self-awareness, and therefore helped me develop more as a Counselling Psychologist.

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SECTION D: CRITICAL LITERATURE REVIEW

The Role of Empathy in the Cognitive Behavioural Treatment of Depression

1 Introduction

According to the National Enhanced Service (NES, 2003), depression is one of the top three leading causes of disability. Prevalence of depression in the U.K. ranges from 0.98% (National Institute for Clinical Excellence, 2004) to 5% (NES, 2003). Since depression affects millions of people nowadays, numerous studies have been conducted in order to determine the types of therapy that are most effective, as well as the mechanisms through which a reduction of depressive symptomatology is achieved.

Cognitive Behavioural Therapy (CBT) is one of the most widely used types of therapy in the treatment of depression nowadays, since it has been proven to be at least as powerful as other types of therapy and pharmacotherapy (Dobson, 1989). It was developed by Beck and his colleagues (Beck et al,, 1979) specifically for the treatment of depression, and emphasises the important role that negative cognition plays in affective mood. At the moment, cognitive behavioural therapy is recommended as the treatment of choice for depression by the National Institute for Clinical Excellence (2004).

Even though CBT has consistently demonstrated a positive impact on clients suffering from depression (Hollon, et al., 1991), there is also ample evidence to suggest that its efficacy is not universal (Parker et al., 2003). For example, two studies (Elkin et al., 1989; Hollon et al., 1992) indicated that only 64-68% of clients who began treatment, completed it, and only 50% of the completers actually recovered. If then only one third of clients receiving CBT for depression significantly improve, it is imperative that counselling psychologists improve their practice, so that more people can benefit.

Since empathy has been associated with a positive outcome in general, (Orlinsky et al., 1994), as well as in cognitive behavioural therapy in particular (Bohart, et al., 2002), it seems worth exploring the effects it has on clients receiving CBT for depression. Therefore, this review aims to examine the role of empathy in the cognitive behavioural treatment of depression and its potential contribution to clients' improvement. If it was found that empathy leads to a positive outcome in CBT for depression, that would have significant implications for professionals in the field. Empathy could then provide the means of engaging, and helping improve, more clients suffering from depression. Given the high prevalence of depression, and the wide use of CBT for its treatment, it seems crucial to strive for the constant development of this type of therapy. Empathy can fulfil a variety of functions within CBT (Thwaites & Bennett-Levy, 2007), and this could be applicable to the treatment of depression in particular.

2 Outline

Initially, the description of the method of the review will be presented. This will be followed by the diagnostic criteria for depression, the cognitive behavioural treatment of depression and the role of empathy within it. After the definition of empathy is provided, the identified articles on the topic will be presented and critically evaluated, with an emphasis on highlighting any methodological limitations and gaps in the literature. In the end conclusions will be drawn about the role of empathy in cognitive behavioural treatment of depression, and suggestions will be made for future research.

3 Method of review of sources

Reports were collected of empirical studies examining the role of empathy in the cognitive behavioural treatment of depression. It was decided to concentrate on sources that were likely to contain material of clinical relevance, which included computerised online bibliographic searches using PsychINFO, Ovid Online, and PsychARTICLES. The terms used in the searches were: empathy and cognitive behavioural therapy, core conditions or facilitative conditions or Rogers'

conditions and cognitive behavioural therapy, therapeutic relationship and cognitive behavioural therapy and depression. Once the main instruments to examine empathy were identified, additional searches were conducted using the following terms: Psychotherapy Process Q-Set or PQS and cognitive behavioural therapy, Collaborative Study Psychotherapy Rating Scale or CSPRS and cognitive behavioural therapy, empathy scale and cognitive behavioural therapy, Barrett-Lennard Relationship Inventory or B-L RI and cognitive behavioural therapy. The articles identified in the previous two searches were subsequently reviewed to examine whether they fulfilled the criteria of examining the role of empathy or aspects of it, and having participants suffering from depression. References in the relevant publications were also cross-referenced. In addition, the research literature was checked through for additional references, including journal articles and books. However, it should be noted that the literature review presented in this paper is not a systematic review.

4 Diagnostic criteria for depression

Diagnostic criteria for depression are provided both in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (APA, 1994) and in the International Classification of Diseases (ICD-10) (WHO, 1992). There is a big overlap in the diagnostic criteria outlined by both the American Psychiatric Association (APA) and by the World Health Organisation (WHO). The main difference between the two is that, according to ICD-10 a differentiation is made between mild, moderate, and severe depressive episodes depending upon the number, type, and severity of symptoms present. The main symptoms of depression outlined in DSM-IV and ICD-10 are depressed mood, loss of interest and pleasure in nearly all activities, and loss of energy for a minimum duration of two weeks. Additional symptoms include changes in appetite or weight, sleep, psychomotor activity, and concentration. Depressed individuals commonly also experience feelings of worthlessness or guilt, and have recurrent thoughts of death and suicidal ideation. The full DSM-IV (APA, 1994) and ICD-10 criteria (WHO, 1992) are provided in Appendices 1 and 2 respectively.

5 The cognitive behavioural model of depression and the role of empathy within it

Beck's model of depression (Beck et al., 1979) is the most commonly used model in CBT. It suggests that people who become depressed possess maladaptive schemas, which were developed due to negative experiences in childhood. These schemas are structures through which the person categorises and evaluates their experiences. Even though schemas are sometimes latent, a stressful experience can activate them and influence the way people think. As a result, people distort their experiences and make systematic cognitive errors, such as absolutistic thinking and magnifying the negative aspects of an event. These biases are also reflected in what Beck called 'the cognitive triad', which consists of the negative view of oneself, one's experiences, and the future. The cognitive behavioural treatment of depression involves identifying and challenging the client's negative thoughts, as a means of modifying the depressive affect. In addition, clients are instructed to complete homework assignments, in order to examine and disconfirm their negative beliefs and change their unhelpful behavioural patterns.

The significance of empathy in cognitive behavioural therapy has been underscored by leading theorists, such as Thwaites and Bennett-Levy (2007), and Burns and Auerbach (1996). Furthermore, Josefowitz and Myran (2005) argue for a movement towards person-centred CBT. In the cognitive behavioural treatment of depression in particular, Beck and colleagues (1979) were the first to highlight its potential therapeutic role. Influenced by Rogers' conceptualisation (1957), Beck considered empathy as a necessary condition for successful therapy. Even though he maintained that the facilitative conditions, and therefore empathy, were not sufficient to lead to therapeutic change, Beck described several therapeutic functions that empathy could fulfil as part of the cognitive behavioural treatment of depression (Beck et al., 1979). He asserted that empathy could facilitate collaboration between therapist and client, which is a

vital component of CBT for depression. Furthermore, empathy was portrayed as helpful to the therapist, since an empathic understanding of the client's experiences would safeguard the therapist from any judgemental and antitherapeutic reactions. Beck also maintained that the therapist's empathy could enhance their understanding of the client's difficulties. This could happen since an empathic attitude would encourage the client to disclose more of his thoughts and feelings. Even more, empathy allows the therapist to understand the cognitive basis of the client's feelings. Beck also highlighted the central role of empathy when treating depressed clients with suicidal ideation, as it allows the adaptation of strategies to the specific needs of the individual client, and provides the groundwork for challenging the suicidal thoughts.

Similarly, Overholser and Silverman (1998) consider empathy as an important aspect of using the therapeutic relationship for the cognitive behavioural treatment of depression. They emphasise that empathy helps the therapist understand the client's perspective and their thoughts and feelings. The communication of empathy also has an impact on the client's mood, since it reduces their emotional distress. Moreover, empathy facilitates the client's expression of difficult thoughts and feelings, which in turn leads to changes in the client's cognitions and interpersonal relationships.

6 The definition of empathy and its implications for research

Empathy is a concept that has been defined and redefined numerous times in the counselling and psychotherapy literature. Rogers (1959) was the pioneer in the study of empathy and considered it as one of the necessary and sufficient conditions for therapeutic change. He defined it as the therapist's ability to 'perceive the internal frame of reference of another with accuracy...as if one were the other person, but without ever losing the 'as if' condition' (p.210); the client's frame of reference included both his/her thoughts and feelings. Rogers emphasized firstly the therapist's experience of the client, and secondly the communication of this experience to the client. With regards to research, Rogers

(1957) considered that mainly ratings from the therapist and independent observers would suggest the presence of empathy. On the contrary, Barrett-Lennard (1962) postulated that the most reliable evidence of the client's experience of empathy is his/her own report, since it is his/her experience that affects him/her directly. Recently, he argued that empathy should be viewed as a process comprising three phases: empathic resonation, expressed empathy, and received empathy (Barrett-Lennard, 1993). Within the past few years, different researchers have described and operationally defined empathy in various ways; however, the presentation of all of them is beyond the scope of this review.

Within the cognitive behavioural framework, there is also a lack of consensus on the definition of empathy. One would expect then that, since empathy is described as a Rogerian condition, its definition would be similar to Rogers' (1957) one. Beck (Beck et al., 1979) indeed cites Rogers, when he defines it as the ability of the therapist to 'step into the patient's world and see and experience life the way the patient does' (p.47). However, other leading researchers in the field (Burns, & Auerbach, 1996) use the terms empathy and therapeutic relationship interchangeably. In the same text, they also define two types of empathy. Thought empathy is defined as repeating the patient's words, while feeling empathy refers to an acknowledgement of what the patient may be feeling. Therefore, it seems that in the cognitive behavioural approach, empathy is studied at times as part of a cluster of the Rogerian therapist variables, at times as an equivalent to the therapeutic relationship, and at times as a therapeutic intervention.

The lack of a clear definition of empathy has also left the question of observational perspective unanswered. In a metaanalysis, Orlinsky and his colleagues (1994) reported that empathy was correlated to outcome in many more studies when it was assessed by clients, rather than when assessed by therapists or independent raters. Burns and Auerbach (1996) use this as an argument for studying only clients' perception of empathy. However, other

researchers (e.g. Coombs et al., 2002; DeRubeis & Feeley, 1990) use ratings by clinical judges.

It could be concluded that the concept of empathy as studied nowadays within the cognitive behavioural framework, has moved away from Rogers' (1957) original definition and refers to several other concepts, as well. In the present paper, the definition of empathy is derived from Barrett-Lennard's (1993) conceptualisation of empathy as a multiphased experiential process. Empathy is defined in the present paper as the therapeutic process which involves the therapist's experience of understanding and feeling the client's emotional state, the therapist's communication of this understanding to the client, and the client's experience of their therapist as understanding and feeling their emotional state. The literature review which follows presents papers that examine any of the above phases / aspects of empathy in the cognitive behavioural treatment of depression.

7 Research findings on the role of empathy in the cognitive behavioural treatment of depression.

The lack of consensus on the definition of empathy within the cognitive behavioural approach has also resulted in a lack of agreement among researchers on the methodology in general, and the measures of empathy in particular, which they use. Therefore, the studies reviewed will be presented according to the observational perspective they adopt (therapist, independent observers, or clients), and the instruments they use. It should be noted that no qualitative studies exploring the role of empathy were identified. Therefore, the review will focus on quantitative studies only.

7.1.1 Research findings on therapist-perceived empathy

As stated before, most researchers in the area do not consider data from the therapist's perspective as reliable (e.g. Burns, & Auerbach, 1996). Therefore, it is not surprising that no research that examines directly the relationship between

therapist-perceived empathy and outcome was identified. However, some interesting conclusions can be drawn from a study on therapists' intentions in sessions of cognitive behavioural therapy of depressed patients (Stiles et al., 1996). From the 19 items of the Therapist Session Intentions form, two of them seem to represent some aspects of empathy. The intention called 'support' refers to the aim of providing a warm, supportive, and empathic environment, in which the client feels accepted and understood; the intention called 'feelings-awareness' is described as the therapist's goal 'to identify, intensify, and/or enable acceptance of feelings, to encourage or provoke the client to become aware of or deepen underlying or hidden feelings' (p. 404). Therapists rated the extent to which they were working towards those goals generally in the session, immediately after the end of it. 'Support' was found to be the second most frequently stated intention, while 'feelings-awareness' the least frequently used. One possible explanation of this seemingly controversial finding is that 'support' refers to a much broader group of interventions in comparison to 'feelings-awareness'. CBT therapists seem to value the therapeutic relationship and may perceive themselves providing a warm and empathic environment by a number of different techniques. On the other hand, they seem to consider the aim of helping clients experience feelings more intensely, as less important or as not adhering to the cognitive behavioural approach.

7.1.2 Conclusions about research on therapist-perceived empathy

Even though the therapist's experience of empathy during CBT for depression is necessary for the client to receive it, there is a paucity of empirical research on this topic. A possible explanation for this is the fact that the therapist's ratings of empathy do not consistently correlate with outcome (Orlinsky et al., 1994). This finding may have discouraged researchers from investigating this area further particularly for CBT for depression. The one relevant study identified suggests that CBT therapists prioritise empathy in their practice. However, they may express it in a number of different ways, and not through an explicit focus on intensifying the client's emotions.

7.2 Research findings on observer-rated empathy

Some researchers believe that one accurate way of measuring empathy is by using ratings from independent judges who listen to audiotapes or watch videotapes of therapy sessions (Bohart, & Greenberg, 1997). Two measures were found to be used in the studies of empathy in cognitive behavioural treatment of depression: the Psychotherapy Process Q-Set (Jones, 2000), and the Collaborative Study Psychotherapy Rating Scale (Hollon et al., 1988, as cited in DeRubeis, & Feeley, 1990). The brief description of each instrument will be followed by the relevant research findings.

7.2.1 Research using the Psychotherapy Process Q-Set (PQS)

The PQS (Jones, 2000) is an instrument designed to provide reliable descriptions of the therapist-patient interaction. It is pantheoretical in its approach, and provides data suitable for quantitative analysis. Clinical judges review a videotape, an audiotape, or a verbatim transcript of an entire therapy hour. Then they sort the 100 items in the Q-set on a continuum of 9 categories from the least characteristic to the most characteristic, according to their frequency and intensity during the session. The possibility of halo effects and response sets is minimised, since the raters are required to sort a specific number of cards under each category, thus following a normal distribution. Some items of the scale seem to relate to different aspects of empathy (eg. PQS No6: therapist is sensitive to patient's feelings, attuned to patient, empathic, PQS No28: therapist accurately perceives the therapeutic process, PQS No14: patient does not feel understood by therapist). The PQS has demonstrated adequate reliability and validity (Jones, & Pulos, 1993; Jones et al., 1991).

Two of the questions that could be addressed using the PQS are the following ones: is empathy considered as an intervention characteristic of the cognitive behavioural treatment of depression by the therapists of this approach? And do CBT therapists actually use it with depressed clients? In a study aiming to

develop a prototype of the ideal cognitive behavioural therapy (Albon, & Jones, 2002), none of the Q-items that may represent aspects of empathy, were ranked by experts in the field within the 15 most characteristics items. In the same study, it was found that therapists did adhere to the protocol, thus implying that empathy was not an intervention frequently seen in actual CBT sessions. This is consistent with previous findings (Albon, & Jones, 1999). Furthermore, in the latter study, the therapist's focus on patients' feelings, (PQS No81: therapist emphasizes patient's feelings to help him experience them more deeply), was one of the least characteristic items during CBT sessions of depressed clients. These findings may imply that neither in theory nor in practice is empathy a primary focus in the cognitive behavioural treatment of depression. Another explanation for the findings though is related to the methodological limitations of using ratings from observers. The observers may have focused on the therapists' overt behaviours, and may have overlooked any covert processes through which empathy was expressed, and any instances of empathy being embedded in other therapeutic techniques.

The contribution of observer-rated empathy to a positive outcome in the CBT of depression seems to be an area in which it is difficult to draw conclusions. Albon and Jones (1999) did not report any relationship between the therapist's empathic attitude and the levels of depression experienced by the clients. However, a negative correlation ($p<0.01$) was found between the PQS No14 (patient does not feel understood by therapist) and the two outcome measures. This implies that patients who feel understood by their therapist are less likely to feel depressed at the end of their treatment.

In a more recent study (Coombs et al., 2002), a factor labelled Collaborative Emotional Exploration accounted for 18% of the reported outcome. This factor included statements that indicated the therapist's empathic resonance or communication, as well as items which suggested that the clients felt understood, and explored their inner thoughts and feelings. Therefore, it could be said that

this factor was related to empathy as a multidimensional construct. However, the same factor also included items that did not seem to be directly related to empathy, such as the patient's expectations from therapy, and his/her feelings towards the therapist. Consequently, it is not clear to which extent the reduction of depressed symptomatology was related to empathy.

In conclusion, research using the PQS suggests that empathy is not characteristic of the patient-therapist interaction in CBT of depression. Findings provide some support for the relationship between therapist's empathic interventions and positive outcome. However, the data is not sufficient to indicate a clear strong relationship. One possible explanation of that is the fact that CBT-therapists do not frequently use empathy; no correlation can then be found, since the range of empathy as a variable is very restricted. However, another possible explanation is related to the methodology used. In all three studies reviewed, judges read transcripts of the sessions. Therefore, they may have missed aspects of the emotional tone of the session, including empathic communication that was expressed nonverbally.

7.2.2 Research using the Collaborative Study Psychotherapy Rating Scale (CSPRS)

The CSPRS (Hollon et al, 1998, as cited in DeRubeis, & Feeley, 1990) is a 96-item scale that can be used to assess the extent or amount of specific therapist behaviours. Independent judges rate each item on a seven-point Likert scale, after reviewing the audiotape or videotape of a session. The CSPRS has an 8-item Facilitative Conditions subscale (CSPRS-FC), which reflects the Rogerian therapist variables of empathy, congruence, and unconditional positive regard. The CSPRS has demonstrated adequate interrater reliability and internal consistency (Hill, et al., 1992).

Three studies that explored the relationship between the facilitative conditions and outcome, using the CSPRS, were identified. All three of them (Markowitz et

al., 2000; DeRubeis, & Feeley, 1990; Feeley, et al., 1999) found that the facilitative conditions did not predict change in depressive symptomatology. However, serious limitations in these studies question the generalisability of their results. In all these studies, the samples were too small (14 - 25 patients) to reveal a relationship of a medium, or even of a large size (Howell, 2002). Moreover, the raters were undergraduate students or psychology graduates with no clinical experience. The low interrater reliability reported in the third study (coefficient was .57) further supports the fact that empathy is hard to be identified by individuals that are not therapists themselves.

Another study (Shaw et al., 1999) examined whether therapist competence was related to reduction of depressive symptomatology. The facilitative conditions did not predict the clients' levels of depression after treatment. However, only when their effect was controlled, was therapist competence found to correlate significantly to outcome. This implies that maybe there was a relationship between the facilitative conditions and outcome, but in this study it was not large enough to reach significance.

7.2.3 Conclusions about research on observer-rated empathy

It seems premature to draw definite conclusions about the relationship between observer-rated empathy and outcome. Studies of CBT treatment of depression used instruments that did not measure empathy separately from other related therapist interventions or attitudes. Therefore, even in the two studies that provided some support for a significant relationship, it is not clear to which extent empathy contributed to the positive outcome. Furthermore, the methodological limitation of using raters without any clinical experience may be a possible explanation for the lack of evidence for the association between observer-rated empathy and outcome. Taking into consideration the methodological problems involved in the relevant literature, the relationship between therapist empathy judged by independent raters, and levels of depression awaits further research.

7.3 Research findings on client-perceived empathy

Cognitive behavioural therapists have traditionally used clients' ratings in order to study the effect of empathy, because they postulate that it is what the client experiences that affects him/her directly (Barrett-Lennard, 1962). This is consistent with the research finings which suggests that it is mainly client-perceived empathy that is related to outcome (Bohart, et al., 2002; Orlinsky, et al.,1994). The vast majority of studies used the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1962), while only one study used the Empathy Scale (Persons, & Burns, 1985).

7.3.1 Research using the Empathy Scale (ES)

The Empathy Scale (Persons, & Burns, 1985) is a 10-item questionnaire that asks clients to rate on a 4-point Likert scale how they perceived their therapist during their most recent session. It contains questions that reflect aspects of empathy (eg.1. My therapist understood what I said today), as well as other qualities of the therapist or the therapeutic relationship (e.g. 6. Sometimes my therapist did not seem to be completely genuine, 1. I felt that I could trust my therapist). The Empathy Scale has shown to have a moderate degree of reliability and internal consistency (Burns, & Nolen-Hoeksema, 1992).

Burns and Nolen-Hoeksema (1992) used the Empathy Scale in order to investigate the effect of empathy on recovery form depression in cognitive behavioural therapy. Structural equation modelling allowed them to remove the causal effect of depression severity on clients' ratings of empathy. They found that empathy was associated with a positive outcome ($p<.01$), while controlling for homework compliance. They concluded that therapeutic empathy has a direct causal effect on recovery from depression. However, the authors acknowledge that their results should be treated with caution for various reasons. The causal nature of the relationship can be called into doubt, since the researchers did not perform an experiment, but only controlled the independent variable statistically. Furthermore, the drop-out rate of the subjects (21.6%) seems high enough to

threaten the internal validity of this study; the results may have been significantly different, had the ratings of clients that dropped out prematurely been included. In addition, empathy was measured only after the 12th session. Even though the effect of depression severity was removed, client's ratings of empathy may have been influenced by other factors, such as feelings of trust that had developed during their course of therapy. Finally, even though the measure the researchers used is called 'Empathy scale', it clearly includes ratings on qualities other than empathy, such as congruence. It could then be concluded that, even though a positive relationship between empathy and outcome was found, methodological problems undermine both the internal and external validity of this study.

7.3.2 Research using the Barrett-Lennard Relationship Inventory (B-L RI)

The B-L RI (Barrett-Lennard, 1962) is based on Rogers'(1957) view of the necessary and sufficient conditions for therapeutic change, and assesses the patient's perception of the therapeutic relationship. It requires the clients to rate their therapist on the following four subscales: Empathic Understanding, Level of Regard, Unconditionality of Regard, and Congruence. All subscales, as well as the total score, have shown to have high levels of internal consistency and retest reliability (Gurman, 1977). The B-L RI has also demonstrated high levels of validity (Barrett-Lennard, 1986; Gurman, 1977).

Beckham (1989) used the B-L RI (Barrett-Lennard, 1962) in order to determine whether the clients' perception of their therapist as empathic, warm, and congruent predicted their rapid response to cognitive behavioural therapy of depression. The research design involved the clients completing the scale prior to the second session. According to their level of depression after the sixth session, the patients were divided into rapid responders and non-rapid responders. No difference was found between the two groups in terms of their B-L RI scores. The author did not provide any explanation for not finding a relationship between clients' perception of their therapist and rapid response to treatment. Various methodological problems suggest that this study lacks

external validity. The sample was small (N=32), and the therapists were not experienced (they were psychiatric residents, psychology interns and social workers with some training in CBT). Therefore, it is not clear whether those results can be generalised to other clients receiving CBT for depression by skilful therapists. Furthermore, the clients' perception of their therapists may have been different, if the ratings were made earlier in therapy.

Barrett-Lennard (1962), when designing the B-L RI scale, recognised that the clients' perceptions result from the interaction of their own personality characteristics and their actual experience of their therapist. Therefore, some recent studies in the field take into consideration pre-treatment patient characteristics when investigating the effect of empathy on outcome.

For example, Blatt and colleagues (1996) studied the effect of the therapeutic relationship on depression for clients with different levels of perfectionism and need for approval. Factor analysis on the B-L RI scores indicated that the Empathy scale loaded at the highest level (0.93); this suggests that the findings concerning the experienced therapeutic relationship reflect to a large extent client-perceived empathy, as well. Results showed that the client's perception of their therapist did not significantly correlate either with their levels of depression after treatment or with their pre-treatment levels of perfectionism. Nevertheless, clients that dropped out of treatment before completing 12 sessions had significantly lower scores on B-L RI than completers ($p<.05$). Further analyses of the data revealed a complex interaction between perfectionism and the therapeutic relationship. The levels of experienced relationship were strongly related ($p<.001$) to outcome for people with moderate levels of perfectionism; on the contrary, the quality of the therapeutic relationship was not predictive of therapeutic gain at low levels of perfectionism, where outcome was generally good, or at high levels of perfectionism, where outcome was generally poor. Therefore, the authors concluded that all clients who perceived their therapist as being empathic, as well as acceptant and congruent, were more likely to

complete treatment; furthermore, patients with moderate levels of pre-treatment perfectionism that viewed the therapeutic relationship in a positive way, were more likely to have greater improvement. This study seems to be sound methodologically. However, it is not clear whether the reported clinical improvement refers to reduction in depressive symptomatology or to general functioning and social adjustment. Moreover, the effects of therapeutic empathy during the course of treatment were not examined. Nevertheless, this study indicates that empathy may have different types of effect on depressed clients with different personality traits.

Apart from pre-treatment characteristics, several researchers have also been interested in the relationship between the therapist's attitude of empathy, congruence, and unconditional positive regard on one hand, and the therapeutic alliance on the other. The following studies have used the B-L RI as well as a measure of the therapeutic alliance in order to investigate this area. However, in those studies as well, empathy is not examined separately from the other two Rogerian therapist variables. The implications of this will be discussed later on.

One study that investigated the relationship between the therapeutic relationship and the working alliance is that conducted by Zuroff and his colleagues (Zuroff et al., 2000). They asked clients to complete the B-L RI after the second and the last session of CBT for depression. Clinical observers completed the Vanderbilt Therapeutic Alliance Scale (VTAS; Hartley & Strupp, 1983), after reviewing videotapes of the 3rd, 9th, and 15th session. Both scales were found to predict outcome (p<.05 and p<.01 respectively), without being significantly correlated with each other. This may mean that empathy, as well as acceptance and congruence, are distinguishable constructs from the therapeutic alliance. However, another possible explanation for that may be the different observational perspective of the two instruments; several researchers (Bohart et. al, 2002; Marziali, 1984; Kurz, & Grummon, 1972) have shown that measures of empathy which are based on the perspective of the patient and observers are modestly or

not correlated at all. The main reason that could limit the generalizability of the results of this carefully designed study is the substantial drop-out rate of subjects (32%). It seems likely that the clients that withdrew from treatment perceived their therapist as less empathic than the completers, as other researchers have found (e.g. Blatt, et al.,1996). Nevertheless, this study provides data to support the view of empathy as contributing to the therapeutic outcome in cognitive behavioural treatment of depression. This finding has important implications for the attitude of counselling psychologists when they provide therapy to depressed clients.

A different view of the relationship among empathy, working alliance, and outcome in CBT of depression is presented by Watson and Geller (2005). Their research design involved clients completing the B-L RI after the 9th and 12th session, and the Working Alliance Inventory (WAI; Horvath, & Greenberg, 1989) after each session. They found that the client's perception of their therapist as being empathic, genuine, and acceptant was significantly correlated with reduction in depressive symptomatology (p<.05), as well as with the WAI scores (p<.01); moreover, the inclusion of the WAI scores in the regression equation rendered the correlation between the Rogerian conditions and outcome insignificant. The authors consequently claimed that the impact of empathy on outcome is mediated by the therapeutic alliance. However, this position needs to be re-examined by a study with a different research design, in which empathy will be measured earlier in treatment. Even though the relationship between empathy and working alliance needs further research, the positive effect of client-perceived empathy on outcome was demonstrated in this study.

The two previous studies attempted to identify the relationship among empathy, working alliance and outcome. The relation between alliance and empathy seems to be more complicated than a mediating one. In both studies, the two constructs were not strongly correlated. However, it is hard to determine whether and to which extent they overlap, since in the study by Zuroff and his colleagues

(2000) they were assessed by different people (patients versus clinical judges), and in the study by Watson and Geller (2005) at different periods of the treatment. Nevertheless, even if the exact nature of the relation is not clear yet, empathy and working alliance are related to some extent, and they are both associated with a reduction in depressive symptomatology.

All the studies reviewed so far, measured empathy at one or two points during treatment, and assessed the outcome only at the end of therapy. This left unanswered questions about the development of empathy throughout the course of therapy, as well as its long-term effects in the treatment of depression. Moreover, almost all the above studies did not take into consideration the patient's personality characteristics that may have influenced their view of their therapists; only two studies (Blatt et al, 1996; Zuroff et al, 2000) researched the interaction of perfectionism and need for approval, and the therapeutic relationship within the context of CBT for depression.

One study that addressed all the above issues is that conducted by Zuroff and Blatt (2006). Clients suffering from depression assessed their therapist's qualities using the B-L RI at intake, 4 weeks, 8 weeks, 12 weeks, and 16 weeks of their treatment, and completed outcome measures at the same intervals, as well as at 6, 12, and 18 months after the end of their therapy. Furthermore, several patients' pre-treatment personality and demographic characteristics were recorded. The results indicated a negative correlation between the B-L RI and symptoms of depression; this means that patients that perceived their therapist as empathic, genuine and acceptant, were less likely to feel depressed by the end of their treatment. The researchers also found an interaction between the B-L RI and time ($p<.001$); it is therefore suggested that patients with high scores on the B-L RI improved more rapidly than those with low scores. The effects of the therapeutic relationship on outcome during CBT seemed independent of all the clients' pre-treatment characteristics tested; consequently, the data support that the positive outcome reported at the end of treatment is due to some extent to

the patient's experience of being understood, rather than to their personality. However, the client's personality seems to play a role in the maintenance of the therapeutic gains after treatment. The analysis of the follow-up period showed that the B-L RI scores were associated with broad measures of life adjustment (p<.05), but not with measures that assess severity of depression. Since perfectionism was significantly correlated to the B-L RI scores, it seems possible that it accounted for the weaker effect that empathy had on outcome in the long term; that means that perfectionism may lead to both impaired therapeutic relationships, as indicated by Blatt and his colleagues (1996), and higher levels of depression in the long term. It could be concluded that this study provided strong evidence for the role of client-perceived empathy for both a positive and rapid outcome in the CBT for depression. Furthermore, it drew on the patients' characteristic of perfectionism, in order to present an explanation for the limited long-term effects of empathy.

7.3.3 Conclusions about client-perceived empathy

All studies identified, with the exception of one, investigated the role of empathy in the CBT of depression using the B-L RI (Barrett-Lennard, 1962). Only one researcher (Beckham, 1989) did not report a positive relationship between empathy and outcome; as discussed before, this could be attributed to the various methodological problems of that study, as well as to the fact that outcome was measured very early in treatment. The rest of the studies demonstrated a small to moderate relation between the B-L RI / ES scores and outcome. However, there is a serious limitation in interpreting those results as indicating a positive effect of empathy on the reduction of depressive symptomatology: both measures assessed other qualities of the therapist or the therapeutic relationship, as well as empathy. The fact that perceived empathy, congruence, and unconditional positive regard were examined as one factor in all the above studies, poses a question about the extent to which empathy contributed to the positive results. Furthermore, it is not clear whether empathy was indeed one of the variables investigated. It seems possible that both

measures assessed the clients' general perception of their therapists and/or their relationship with them.

8 Conclusions and directions for future research

Within the cognitive behavioural framework, empathy is viewed on one hand as a therapeutic intervention, and on the other hand as part of or synonym to the therapeutic relationship. At the same time, empathy refers to the process occurring between two people, and therefore consists of the phases of empathic resonance, expressed empathy, and received empathy (Barrett-Lennard, 1993). It could be argued that different studies focus on different aspects of empathy. Research on therapist-perceived empathy refers to empathic resonance, research on observer-rated empathy mainly measures expressed empathy, while research on client-perceived empathy assesses received empathy. Since all the instruments require overall ratings after the review of a session, therapists, observers, and clients may have at times considered empathy as a specific process or experience during therapy, and at times based their ratings on the general atmosphere that the session conveyed. Therefore, the low correlations between the different measures of empathy are not surprising.

Taking into consideration the complexity of the construct of empathy, it would seem premature to draw definite conclusions about its role in the cognitive behavioural treatment of depression. The existing literature indicates that therapists, when offering CBT to depressed clients, do not frequently use empathy as an intervention. Consequently, if a positive relationship between empathy as a therapeutic intervention, and outcome exists, it seems very hard to demonstrate in studies. However, data provide strong evidence that clients do feel understood by their therapists; and this feeling has been consistently related to a reduction of depressive symptomatology. This suggests that cognitive behavioural therapists may explicitly use empathy as a therapeutic intervention, but rather convey it through their nonverbal behaviour and/or by embedding it in other techniques which are more characteristic of CBT. For example, helping a

client identify his/her automatic thoughts or core beliefs may have various positive results; one of them may be that the client feels that their therapist understands their inner thoughts and feelings. Another possible explanation of why clients feel understood, is that the collaborative relationship established in CBT, may result in a positive view of therapy itself; this positive view of the therapeutic relationship may in turn motivate clients to provide high ratings of all aspects of therapy, including empathy. Regardless of which of the two above explanations is more plausible, studies have consistently shown that depressed clients who feel understood by their therapist, are more likely to improve by the end of their treatment. Therefore, counselling psychologists using CBT for depression need to monitor closely the therapeutic relationship, and ensure that their clients feel understood. Obtaining client feedback on their experience of empathy may prove helpful in that direction.

Even though a global relationship between therapist empathy and client outcome has been found in studies of CBT for depression, the nature and functioning of empathy still merits further research. Researchers need to take into account the fact that empathy is a multidimensional phenomenon; therefore, they are required to provide clear operational definitions, specify the exact aspects of empathy that they are measuring, and combine data from more than one observational perspective. Most importantly, it is necessary to study empathy separately from other related constructs, in order to determine the extent to which it contributes to the reduction of depressive symptomatology. Given the ethical and practical issues involved in experimentally manipulating therapist empathy, studying the moment-by-moment effects of empathy on the way depressed clients think and feel, seems crucial. Moreover, the development of empathy during the course of cognitive behavioural therapy, as well as its long-term effects, needs to be examined more carefully. Finally, the lack of qualitative studies in the area is striking. It will be useful if future studies explore the clients' and therapists' experience of empathy during the cognitive behavioural treatment of depression. Qualitative data can provide insights in the nuances of the process

of empathy that may not be captured at the moment with the use of standardised questionnaire measures.

Bohart and his colleagues' (2002) finding that empathy is more important to outcome in cognitive behavioural therapy than in other types of therapy shows an important direction to counselling psychologists: focusing on empathy is essential when using a therapy based on specific interventions about cognitions in order to treat an affective disorder. Further research which will provide stronger evidence on this is needed, so that more cognitive behavioural therapists integrate empathy as part of their practice while treating clients suffering from depression.

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Appendix 1: DSM-IV criteria for Major Depressive Episode

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g. feeling sad or empty) or observation made by others (e.g. appears tearful). Note: In children and adolescents, can be irritable mood.
(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
(3) significant weight loss when not dieting or weight gain (e.g. a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
(4) insomnia or hypersomnia nearly every day
(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
(6) fatigue or loss of energy nearly every day
(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms do not meet criteria for a Mixed Episode.

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g. a drug of abuse, a medication) or a general medical condition (e.g. hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

Appendix 2: ICD-10 criteria for Depressive Episode

In typical depressive episodes of all three varieties described below (mild, moderate, and sever), the individual usually suffers from depressed mood, loss of interest and enjoyment, and reduced energy leading to increased fatiguability and diminished activity. Marked tiredness after only slight effort is common. Other common symptoms are:

(a) reduced concentration and attention

(b) reduced self-esteem and self-confidence

(c) ideas of guilt and unworthiness (even in a mild type of episode)

(d) bleak and pessimistic views of the future

(e) ideas or acts of self-harm or suicide

(f) disturbed sleep

(g) diminished appetite