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Practitioner Doctorate in Psychotherapeutic and Counselling Psychology (PsychD)

Research Dossier

A portfolio of research work, including a thematic analysis of how therapists use their embodied experiences in the therapeutic process.

By Joy Kokkalis ©

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Abstract:

This portfolio presents the research component of my work during my five-year training for the Practitioner Doctorate in Psychotherapeutic and Counselling Psychology at the University of Surrey. It comprises of a literature review and two qualitative research studies. My literature review explores the professional and ethical issues in the therapeutic relationship between clients who meet the DSM-5 diagnostic criteria for Borderline Personality Disorder (BPD) and trainee counselling psychologists. My first qualitative study then follows on from this review. This empirical research, is an Interpretative-Phenomenological Analysis (IPA) of trainee counselling psychologists’ lived experience of working therapeutically with clients who meet the DSM-5 criteria for BPD. Lastly, my final research project is a Thematic Analysis (T.A.) of how therapists use their own embodied experiences in the therapeutic process.
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Statement of Anonymity

To ensure the confidentiality and anonymity of all clients, supervisors and research participants, all potentially identifying information has either been omitted or replaced with pseudonyms throughout this portfolio.
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Introduction to the Research Dossier

My encounter with the research component of my training has been one of the most challenging and rewarding aspects of my experience. Intrinsic to the process of research, as I experienced it, is the capacity to ‘stay with’ and ‘make sense of chaos’ - whether that is in the form of qualitative research data, diverse and often contradictory theoretical perspectives, or existing empirical contributions to a particular topic. The urgency to ‘make sense of chaos’ propelled me to challenge my personal fears and inhibitions, and instead embrace my curiosity, critical and reflective thinking. This process ultimately allowed for a cross-fertilization between my research and therapeutic practice, and has been instrumental to my maturation as a ‘reflective-scientist-practitioner’. What follows is a brief overview of my research activity in the context of my PsychD training course.

My first engagement with the research component of my doctoral training, was through conducting my critical literature review. The aim of this review, was to identify and illuminate the professional and ethical issues in the therapeutic relationship between trainee counselling psychologists, and clients who meet the DSM-5 diagnostic criteria for BPD. The contribution of this review, lies on its critical and pluralistic take on the concept of ‘BPD’, as well as its nuanced and multifaceted consideration of the complex relational challenges that are encompassed in the therapeutic work with those clients. Overall, this topic is highly relevant to both supervisors/trainers as well as trainees, as the latter are increasingly likely to therapeutically encounter such clients through their various clinical placements.

The review concluded with the genesis of a research question, which materialized in my first empirical research piece. This research explored how trainees experience working with clients who meet the DSM-5 diagnostic criteria for BPD, through an Interpretative-Phenomenological investigation. Three clear superordinate themes emerged from my analysis: 1) the explosive and persecutory quality of embodied responses, 2) being ‘at the mercy of’ the client, and 3) hope and empowerment. This study contributed new knowledge in the field by: a) being the first investigation of its kind within the context of a rather
impoverished literature area and, b) drawing insights from experiential data directly from trainees’ voices. Overall, this work adds to a growing literature on relational and ‘reflexive’ ways of understanding and working with ‘BPD’, which is in alignment with the core philosophical and ethical values of Counselling Psychology (CoP).

I was struck by the findings of my IPA research study, and the visceral and forceful nature of trainees’ experiences of their therapeutic encounter with their ‘BPD’ clients. For me, these findings brought to the fore the therapist’s embodiment, and in particular, the therapist’s body as a potential source of hinderance to the psychotherapeutic process. This insight inspired me to focus on the theme of therapist embodiment more broadly, and moreover, make this the subject matter of my final-year research project. This shift of focus, necessitated my immersion with a completely new field of literature and evidence-base, which included philosophical readings on intersubjectivity, embodiment and empathy. Thus, my final-year research began with an open-ended question of wanting to explore how therapists use their own embodied experiences in the psychotherapeutic process, through a Thematic Analysis. My findings revealed the iterative, complex processes by which therapists ‘arrive at’, reflexively interrogate, and therapeutically incorporate, their embodied understandings. Altogether, I consider this research to be highly relevant to CoP, considering our field’s emphasis on the therapist’s ‘use of self’ in the therapeutic process.

What follows is a presentation of each of the three aforementioned research projects.
A critical literature review of the professional and ethical issues in the therapeutic relationship between trainee counselling psychologists and clients who meet the DSM-5 diagnostic criteria for Borderline Personality Disorder (BPD).

Abstract:

During their various training placements across clinical settings, trainee counselling psychologists are increasingly likely to therapeutically encounter clients who meet the DSM-5 diagnostic criteria for BPD. However, therapeutic work with those clients is known to pose relational challenges for the therapeutic practitioner; conversely, the ‘trainee context’ is characterised by its own unique set of idiosyncrasies. Therefore, it is timely and appropriate to consider professional and ethical issues pertaining to the therapeutic relationship between trainees and clients who meet the diagnostic criteria for BPD. I begin by exploring and critiquing the concept of ‘BPD’ from various ontological, epistemological and theoretical angles. I then discuss the two themes which emerged from my review of the literature on the therapeutic relationship with those clients, and argue why these are highly relevant to Counselling Psychology (CoP). Finally, I review the scarce existing literature on the topic of trainees and clients who meet the criteria for BPD, and conclude by suggesting a viable idea for future research.
BPD: a critical analysis of different perspectives and positioning of my own stance.

According to the DSM-5, “the essential feature of BPD is a pervasive pattern of instability of interpersonal relationships, self-image, affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts” (p. 663; APA, 2013). Females are more frequently diagnosed with BPD, by about 75%, while the median population prevalence of BPD is estimated to be between 1.6% to 5.9%. The DSM-5 diagnostic criteria for BPD include: frantic efforts to avoid real or imagined abandonment; a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation; identity disturbance; impulsivity; recurrent suicidal behaviour, gestures, or threats, or self-mutilating behaviour; affective instability; chronic feelings of emptiness; inappropriate, intense anger or difficulty controlling anger; transient, stress-related paranoid ideation or severe dissociative symptoms.

With regards to the aetiology of BPD, it is almost universally accepted that interlocking biological (i.e. ‘hyperbolic’ temperament), psychological and social factors influence the development of BPD (Belsky et al. 2012). Zanarini and Frankenburg (2007), cite 5 main environment factors thought to be of aetiological importance: (1) early separations and losses; (2) disturbed parental involvement; (3) experiences of verbal and emotional abuse; (4) experiences of physical and sexual abuse; and (5) experiences of physical and emotional neglect. Due to the existing empirical evidence indicating a high prevalence of childhood traumatic experiences, some researchers and theorists have proposed that that BPD might best be conceptualized as a chronic form of Post-Traumatic-Stress-Disorder (Herman et al., 1989).

Originally regarded as ‘untreatable’ and ‘treatment-resistant’ (Stone, 1993), this view has now been challenged by evidence indicating that even patients with severe BPD symptoms
can be successfully treated (Barnicot et al. 2012). Furthermore, symptom remissions are common and recurrences are relatively rare (Zanarini et al., 2003; Fonagy & Bateman, 2007). This shows that BPD may have a better prognosis than previously thought. The latter, Fonagy (2007) suggests, brings into question the conceptual framework which deems personality disorders as enduring structures upon which psychiatric syndromes are imposed. He suggests that what we term as BPD may be viewed as age-specific adaptations to biopsychosocial pressures, which are best treated by developmentally-specific interventions. Finally, a dimensional view of BPD difficulties is now being widely accepted. According to this, borderline phenomena can be viewed as existing on a spectrum or continuum (e.g. Meissner, 1988), a view which is consistent with clinical experience (Zanarini & Frankenburg, 2007).

From the point of view of CoP’s pluralism (Kasket, 2012; Orlans & VanScoyoc, 2009; Rizq, 2006), there is an underlying tension with regards to the notion of ‘BPD’, which needs to be defined and grappled with. This relates to the clash between competing philosophical positions: an essentialist/positivist viewpoint on the one hand, and social-constructionist and humanistic viewpoints on the other. Thus, prior to positioning my own work with respect to its stance on BPD, it is necessary to lay out the differences of the aforementioned viewpoints in terms of their understanding of BPD, based on their ontological and epistemological underpinnings.

To begin with, the notion of ‘disorder’ derives from a psychiatric vantage point, which in turn rests on the medical model (as exemplified by the DSM-5). The medical model seeks the origin of the patient’s distress and dysfunction in biological causes, and as such, firmly locates those within the individual (Joseph, 2017). Moreover, the person’s ‘psychopathology’ is viewed as an identifiable, externally verifiable phenomenon which is ‘treatable’ with specific pharmacological interventions (Larsson, Brooks & Lowenthal, 2012; Middleton, 2015). The presence or absence of this psychopathology is deemed by practitioners who are seen as holding expert knowledge (Aho, 2008). Overall, the medical
model rests on a view of Being as solipsistic and causally-determined by biology (i.e. objectivist ontology). Thus, the person (and their ‘psychopathology’) can be accurately known and treated from the standpoint of a neutral, detached observer (i.e. positivist epistemology) (Aho, 2008; Angen, 2000; King & Horrocks, 2010; Ponterotto, 2005).

In contrast to the above, a social-constructionist perspective would challenge the concept of disorder as a discrete entity encapsulated within the individual. This is because the internal/biological attribution of disorder overlooks the relational space between person and social environment. This vantage-point postulates BPD purely as a social construct. For instance, it has been suggested that the diagnosis of BPD may represent a disavowal or projection of society’s ‘shadow’ (Douglas, 2010). It has also been criticized as not being an objective scientific concept, but instead being based on social norms and moral judgements mainly passed on women (Coles, 2011). In line with this, others (Becker, 1997; Ussher, 1992) have put forth the idea of BPD as a label of social control aiming to individualise distress in order to protect the current societal status-quo, including those in power who commit abuse. A social-constructionist view of BPD, considers context as paramount, and thus pays attention to the social, economic, and political contexts to which BPD symptoms are a response to (Douglas, 2010). To challenge the ‘medicalising’ and ‘pathologizing’ view of a disease entity residing within the individual, social constructionists talk about ‘psycho-social difficulties’ and ‘distress’ (Afuape, 2011; Aho 2008), rather than BPD.

Narrative therapeutic approaches have been developed which are informed by social constructionism (Afuape, 2011; Davy, 2010). From this perspective, there is a concern about how the very act of diagnosis prevents the person from claiming a wider identity for themselves. They consider diagnosis to offer a stigmatising, oppressive, dominant, disabling, rigid and problem-saturated story which overlooks the relational space, and closes-down other narratives about the person’s life and experience (Afuape, 2011). Moreover, the notion of a ‘disordered personality’ is dually-contested: in addition to the ‘individualisation’ of distress which it implies, it also carries judgements about the ‘moral’
and ‘ethical’ status of one’s personality. As mentioned, a social-constructionist vantage-point contests any notions of BPD’s ‘objective’ status, and instead pays attention on how ‘BPD’ is constructed by language and culture, as well as the interests, values, and assumptions of the ‘enquirer’.

Similarly, from a humanistic perspective, as epitomised by the Client-centred model (Rogers, 1951), the notion of BPD would be rejected for two main reasons. Firstly, it implies an intrusion of ideas and categories deriving from an external frame of reference. This assumes an external expertise on the client’s needs, which undermines their autonomy, and ability to act as their own ‘best expert’ (Joseph, 2017; Orlans & VanScoyoc, 2009). Client-centred therapists strive to work from the subjective frame of reference of the client, and are especially keen in counteracting what they see as the limiting and restricting external ‘conditions of worth’ imposed on the individual from ‘the outside’. Associated with this, is the concern that with labels such as BPD, “each client is treated as representative of the category to which they are assigned by diagnosis” (p24; Joseph, 2017). Secondly, the medical model’s preoccupation with curing dysfunction and ‘fixing’ the malfunctioning symptoms of ‘BPD’, contradicts the humanistic values of an emphasis on promoting growth and development (Murphy, 2017).

From the above discussion, it can be discerned that the very concept of BPD represents a ‘thorny’ subject. As such, it involves a conundrum to navigate when attempting to conceptualise from a CoP perspective. This is even further complicated when taking into account the voluminous literature on the relational challenges that have been consistently reported in the therapeutic relationship with clients who meet the BPD diagnostic criteria, (which I will later explore). In terms of positioning my own angle in relation to BPD for the purposes of this review, I adopt a relational ontological view and a critical-realist epistemological stance (Willig, 2013). Such a premise acknowledges the ‘realness’ of the affective, relational, developmental, embodied experiences of people who meet the BPD criteria, as well as the ‘existence’ of particular features in the process in which their
dynamic internal and dynamic external worlds interact. This view is broadly compatible with certain psychological conceptualisations of BPD, such as attachment/mentalisation, object-relational, and affect (dys)regulation. Moreover, I understand this premise as sitting between the extremes of positivism and relativism. At the same time, critical-realism recognises that our attempts to understand the underlying structures and processes that generate the clinical phenomena we term BPD, can only ever reflect a partial reading which is mediated by contextual and interpretative processes. Nevertheless, in contrast to the extreme forms of relativism, this premise endeavours to maintain the distinction between the ‘objects of our enquiry’ and our ‘ways of attempting to describe them’. As Bhaskar (1986) noted, failure to distinguish between the two is ‘epistemic fallacy’.

With that in mind, before reviewing the professional and ethical issues in the therapeutic relationship with ‘BPD’ clients¹, I briefly explore key psychological conceptualisations of BPD which are compatible with my above position. This brief theoretical overview serves to contextualise my subsequent discussion, as theorists/practitioners often conceptualise some of their intense emotional reactions to these clients as ‘countertransferences’; furthermore, the latter cannot be grasped without due reference to the nature and manifestation of clients’ ‘transferences’.

Object-Relations Model/ Transference-Focused-Psychotherapy (TFP).

Kernberg’s (1975) object-relational model proposes that the main difficulty in BPD is that excessive underlying levels of early negative affect and aggression interfere with the developmental process of integrating persecutory and idealistic internal representations of self and others (Levy et al. 2006). This highlights the view of BPD as a ‘self-other representational disturbance’, characterized by sado-masochistic object relations and ego-states within a fractured representational world (Bender & Skodol, 2007; Blizard, 2001). Furthermore, to prevent the destruction of primitive idealistic internal images of the self and others by these aggressive impulses, the person relies on the use of primitive defences,

¹ From here onwards I refer to ‘BPD’ clients as opposed to ‘clients who meet the DSM diagnostic criteria for BPD’, for brevity’s sake.
such as splitting and projective identification (Kernberg, 1967). The use of such primitive defence mechanisms partly accounts for the challenging experiences and destructive interpersonal dynamics which are associated with BPD (Clarkin et al. 2007). TFP (Clarkin, Kernberg & Yeomans, 1999; Yeomans & Delaney, 2008) is based on this Object-Relational model, and focuses on facilitating the integration of the split mental images into a more coherent internal world. The latter is strived for through the use of counter-transference and transference interpretations of the affects, enactments, and themes that are played out in the “here-and-now” relationship with the therapist. The therapist’s ability to ‘contain’ these intense affective states is thought to facilitate the integration of internal representations for the client (Levy et al. 2006; Bion, 1962).

**Mentalisation model/ Mentalisation-Based-Treatment (MBT)**

This model conceptualizes BPD difficulties as ‘mentalization’ deficits (Fonagy 2000; Bateman & Fonagy, 2010) within the context of disorganised attachments (Holmes, 2003; Gunderson, 1984). Mentalising refers to the reflective capacity of thinking of one’s own and others’ mental states. It depends upon the availability of empathetic mirroring during development within the context of a secure attachment. This process allows the child to experience his/herself in the caregiver’s mind (Bateman & Fonagy, 2003). In cases of childhood maltreatment, the child ‘closes-down’ their mind to intersubjective interaction, in order to cope with the unbearable conception of an attachment figure who is experienced as harbouring malevolent intent toward the child (Fonagy, 1991). This defensive disavowal of the mental existence of the other, results in an impaired capacity for mentalizing, which is characterized by concrete thinking based on ‘psychic-equivalence mode’ (Fonagy & Bateman, 2007).

Proponents of this model call for certain modifications of the ‘insight-oriented’ psychoanalytic techniques due to what they understand as the patient’s weak sense of their own subjectivity. The latter, according to this model, renders those patients likely to experience the therapist’s interpretations as bewildering and alienating. Like TFP, MBT focuses on the “here-and-now” interactions between therapist and client; however, there
is a greater emphasis on a collaborative approach, in which therapist and patient both explore the latter’s subjective experience of self and other, through adopting a ‘mentalistic’ therapeutic stance of ‘not-knowing’.

**Affect-Dysregulation Model/ Dialectical-Behavioural-Therapy (DBT)**

Based on an ‘affective-dysregulation’ model, BPD patients have difficulties in regulating their emotions (Linehan, 1993). This is caused by an interaction of dispositional and environmental influences -i.e. an "invalidating environment". An invalidating environment affects the child’s developing sense of trust in his/her own experiencing, which in turn, leads to problems with behavioural and emotional regulation. In adult BPD patients, this manifests as a sense of helplessness, emotional instability and excessive need to rely on others for a definition of both internal and external reality. DBT is a highly structured treatment, which targets affective instability and impulsivity. It teaches patients behavioural skills-training of mindfulness, interpersonal effectiveness, distress tolerance and emotional regulation through the use of different treatment modalities (i.e. individual therapy, group-skills training, telephone-coaching). DBT aims at enhancing the client’s capabilities and motivation for skilful behaviour, and the application of these to the natural environment.

**Professional and ethical issues in the therapeutic relationship with ‘BPD’ clients.**

Having explored the various tensions that surround BPD’s ontological and epistemological status by the different philosophical positions, as well as meaningful psychological conceptualisations of its clinical presentation, I now turn into issues pertaining to the *therapeutic relationship* (T.R.) with ‘BPD’ clients. In particular, I aim to show how aspects of this T.R., render it as an area of unique significance and relevance to CoP, as a discipline
that has defined itself by virtue of its emphasis on a relational approach to practice and the therapist’s ‘use of self’ in the therapeutic process (Orlans & VanScoyoc, 2009).

My review of the literature on the professional and ethical issues in the therapeutic relationship with ‘BPD’ clients revealed two central themes. The first was about therapists’ challenging, emotional reactions to their patients. The second was about the influence of stigma, stereotypes and prejudice surrounding this diagnosis as a label. By focusing on practitioners’ situated emotional responses towards their ‘BPD’ clients and their experiences of their actual therapeutic relationships with them, it could be said that the first theme mostly highlights realist elements, such as relational experiences and intersubjective therapeutic processes. As such, it utilises the reflective elements of language, i.e. language as reflecting and describing experiences and processes. In contrast, the second theme focuses on how broader discourses around this diagnosis, shape attitudes and construct practitioners’ views, often before even a therapeutic contact/relationship has commenced. Thus, this theme highlights the constructive elements of language and supports a social constructionist view of BPD, outlined earlier. In what follows, I explore and critically review papers that support each of these two themes.

**Theme 1: the management of practitioners’ challenging emotional reactions.**

A number of qualitative studies explored whether therapists’ responses towards their patients differs as a function of the diagnostic criteria that they meet (Bourke and Grenyer, 2010; Brody and Farber, 1996; Liebman and Burnette, 2013; McIntyre and Schwartz, 1998). A consistent finding across all these studies was that ‘BPD’ clients evoked more negative and anxiety-laden responses by practitioners.

A prime example is the study by McIntyre and Schwartz (1998). The researchers sought to examine therapists’ differential ‘countertransference’ reactions towards clients who met
either the diagnostic criteria for Major Depression Disorder (MDD) or BPD, using a 2x2 ANOVA design. Practitioners’ personal perceptions and emotional reactions to these clients were assessed using the ‘Impact Message Inventory’ and the ‘Stress Appraisal Scale’. Findings indicated that ‘BPD’ clients evoked reactions such as competition, dominance, mistrust, hostility and detachment in therapists, whereas ‘MDD’ clients evoked submissiveness, succorance, agreeableness, nurturance and caring (p.928). Overall, the study revealed how professionals’ responses towards ‘BPD’ clients differed in quality and intensity. An important aspect was that the diagnostic label was not made known to participants (which was also the case with Brody and Farber’s (1996) study); instead, the study measured participants’ responses based on their viewings of “characteristically diagnostic interview sessions with either a client displaying MDD or BPD” (p.925). As I will show in theme 2, this is a crucial factor, as the awareness of a diagnostic label may exert an independent influence on reactions.

The study by Bourke and Grenyer (2010) employed a slightly different design but yielded similar results to that of McIntyre and Schwartz’s (1998). Again, it sought to examine therapists’ emotional and cognitive responses to BPD versus MDD patients. However, in an effort to address issues of poor ecological validity of previous empirical quantitative research, they used a ‘semi-structured interview procedure’ based on participants’ experiences with patients from their own caseload. Therapists’ narratives were elicited using the Relationship Anecdotes Paradigm interview method and then scored according to the core conflictual relationship theme Leipzig/Ulm method. The study’s findings indicated that the emotional valences of therapists’ responses were significantly more negative toward BPD patients and they perceived their therapeutic role with those patients in a less satisfactory light, despite their consistent intentions to be helpful to them.

Practitioners’ prolonged and unmanaged negative affectivity in response to their work with ‘BPD’ clients may be associated to occupational burnout. Moreover, there is research evidence by Perseius et al., (2007) tentatively indicating that particularly high levels of
occupational stress and burnout are experienced by therapists in treating ‘BPD’ clients who self-harm, with 32% of them scoring above the cut-off level for professional burnout at a 6-month assessment. However, this particular study’s aim was to track the trajectory of stress and burnout levels specifically in relation to therapists who start to use DBT (i.e. it employed a ‘within groups’ design). For that reason, it did not control for other variables, nor did it include a control group, thus limiting the scope of examining causal parameters regarding the experience of burnout in these practitioners. Nevertheless, there is empirical evidence linking burnout to therapists’ characterological defence styles (Carr and Egan, 2017; Egan et al., 2015), which will become relevant to the subsequent discussion.

Theoretical psychoanalytic literature delves deeper into the nature of therapists’ negative responses to ‘BPD’ patients, as well as how aspects of their own subjectivity are elicited and used in the therapeutic encounter (e.g. Adler, 1970; Carsky & Yeomans, 2012; Clarkin & Yeomans, 2013; Kernberg, 2003; Maltsberger & Buie, 1974; McHenry, 1994; Ruggiero, 2012; Volkan, 1993). As mentioned in my introduction, writers from the psychoanalytic school of thought understand and conceptualise their emotional responses to these clients through the prism of the ‘transferential-countertransferential’ therapeutic relationship (Clarkson, 2003). As a whole, the strength of this literature could be said to lie in its ecological validity and the fact that its theory derives directly from accumulated clinical experience. Arguably, the psychoanalytic ontological and epistemological conception of the subject-matter, differs to that of quantitative studies, which define and measure variables under controlled, experimental conditions. In what follows, I briefly explore and critically evaluate key insights from those psychoanalytic papers.

Maltsberger and Buie (1974) identify the various manifestations of ‘countertransferential hate’ which they see as heavily implicated in the treatment of those clients within formal psychiatric settings. They define the components of this countertransference hate as ‘malice’ and ‘aversion’ and point out the antitherapeutic, and potentially dangerous implications of enacting those. Furthermore, they directly link the presence of these
responses to what they refer to, as the client’s ‘transference onslaught’. This is defined as “client provocations” which are aimed at substantiating their hostile projections (p.626) - a form of disavowal of their own persecutory internal experiences by locating them externally into their therapist. This paper also designates the therapist’s narcissism as a ‘special target’ of the transference onslaught - a point which is also shared by Adler, (1970) and McHenry (1994). Moreover, Maltberger and Buie (1974) note that when the therapist’s conception of themselves as ‘all-loving’ is challenged by the client’s transference, this renders the therapist especially vulnerable to ‘countertransference rage and the defensive postures against it’ (p.628). The latter includes: repression of countertransference hate; countertransference hate turned against the self; reaction-formation (or, turning countertransference hatred into its opposite); projection of countertransference hatred; and lastly, distortion and denial of reality for validation of countertransference hatred. Adler also speaks of the introjection of ‘worthlessness’ in response to being repeatedly ‘devalued’ by the client. Finally, McHenry further expands this point by focusing on the emergence of the therapist’s ‘characterological issues’ in the therapeutic work with ‘BPD’ clients, and how these may lead to various therapeutic impasses, or even therapeutic failures.

Overall, I consider the above papers to provide insights which have powerful clinical utility for our work with ‘BPD’ clients. This is because they: a) alert us, as practitioners, to how our complicated and troublesome experiences as well as our defences against them, may render us prone to enactments, ethical violations and possibly burnout; b) they recognise inter-psychic meaning in those difficult experiences and interactions. The latter is especially important, as it ‘injects’ psychological thinking in situations which would otherwise risk collapsing into a state of affairs dominated by concretised thinking, where action (or inaction) takes precedence over the ability to reflect.

More recent psychoanalytic views (e.g. Carsky & Yeomans, 2012; Clarkin & Yeomans, 2013; Kernberg, 2003; Levy et al. 2006; Volkan, 1993) go a step further, by explicitly
arguing for the *therapeutic value* of practitioners’ negative countertransference. In particular, they emphasise how the ‘working-through’ of their difficult experiences, whilst concurrently ‘staying-with’ patients’ negative transferences, gradually provides practitioners access to the patient’s inner dynamics. In fact, therapeutic models of BPD, such as TFP (outlined in the introduction), are built around this very notion. For instance, they advocate that if the therapist can consistently ‘tolerate’ being the object of the client’s negative transference and furthermore, maintain the capacity to think and explore its meaning in collaboration with the client, then this can promote gradual awareness and integration of the client’s disparate and polarised ‘good’ and ‘bad’ object relationships. Case-study papers by Evans (2007) and Russell and Marsden (1998), have utilised this psychoanalytic framework for thinking about their own challenging experiences of therapeutic relationships with ‘BPD’ clients, as well as the troublesome ‘splits’ within teams that provide care to them -a clinical observation first made by Main (1957).

Lastly, recently there have been new additions to the literature coming from the qualitative research paradigm (Lowings et al., 2011; Millar et al., 2012; Rizq, 2012). This could be seen as addressing some of the methodological limitations of psychoanalytic papers (which arguably, tend to be too theory-led, and at times, obscure observation from inference), whilst at the same time, adhering to criteria of methodological rigour (Yardley, 2000). Among them, is the IPA study by Rizq (2012) on the phenomenological experiences of therapists when working with ‘BPD’ clients in the context of primary care. This study stands out as a methodologically and epistemologically coherent piece of work. In particular, it provides thick description of practitioners’ experiences through a systematic analysis and a process of ‘double-hermeneutics’ (Smith et al., 2009). Amongst the findings, ‘managing feelings of inadequacy’ was revealed as one of the three master-themes. In addition, certain vivid metaphors were captured from participants’ accounts of their experiences. This included the image of ‘walking on eggshells’ in the presence of those clients, as well as a quality of ‘vigilance’, which participants saw as characteristic of working with this client group. Finally, feelings of *intrusion and states of confusion* were also engendered within participants as a consequence of their therapeutic encounter.
Theme 2: the management of the stigmatising influences of BPD as a label

The papers that I will present under this section support the notion of the BPD label as associated with broader, stigmatising discourses which exert an independent effect on practitioners’ attitudes, emotional reactivity and therapeutic outcomes. For instance, Aviram et al.’s (2006) theoretical paper, puts forth the notion that stigmatisation associated with the BPD label, may have an independent contribution to negative therapeutic outcomes with ‘BDD’ clients. They emphasise how practitioners’ emotional withdrawal due to the stigma of BPD, may trigger the very core difficulties that ‘BPD’ clients struggle with, considering their extreme interpersonal sensitivity to rejection and abandonment. This may subsequently lead to patients’ negative reactions, such as self-harming and withdrawal from treatment altogether. Overall, the effects of BPD stigma results in what the authors refer to as a ‘self-fulfilling prophecy and a cycle of stigmatization’.

Similarly, Scanlon and Adlam (2013) focus on the assumptions of intent and deliberation which underpin the stigmatising views of BPD. Taking the notion of ‘deliberate self-harm’ as an example, they argue that the attribution of intentionality to the ‘BPD’ client’s acts of self-harm, is a form of structural violence deployed by society against the ‘excluded outsider’. This is because it negates the ‘figure’ of the act of self-harm, against the ‘ground’ of the cumulative traumatisation and adversity that the individual has experienced on a societal and familial level. Through this vantage point, the attribution of intentionality to such acts, represents a defensive disavowal on the part of a societal in-group of its own harmfulness in order to maintain its exclusive position, while the wider psycho-social and socio-economic and ‘social unconscious’ causes of this violence remain ‘silent’. Therefore, from this perspective, stigmatising notions of deliberation associated with BPD are not only harmful and self-fulfilling, but also, perhaps more insidiously, serve as a sort of ‘societal dustbin’.
Compelling empirical evidence which demonstrates the independent effect of the stigmatising label of BPD comes from a quantitative research study by Lewis and Appleby (1988). 173 UK psychiatrists registered with the Royal College of Psychiatrists took part in the study. Participants had a mean of 16.5 years of psychiatric experience. They were randomly allocated to one of the six brief case histories, which they were asked to read before completing and returning an accompanying questionnaire. The case history included a short case description in the form of a brief GP referral about a depressed patient with a prior diagnosis of PD. The vignette across all 6 conditions was largely the same, with the diagnosis manipulated as one of the controlled variables. The controlled conditions (in relation to diagnosis variable) included: 1) no previous diagnosis mentioned in vignette; 2) previous diagnosis given as depression; and 3) PD diagnosis was given, but participants were informed that researchers were interested in the labelling effects of certain psychiatric diagnoses and were asked not to let themselves be influenced by previous labels. The findings indicated that psychiatrists were less favourable toward a vignette with information that the patient had previously received a PD diagnosis compared to other scenarios in which the PD diagnosis was left out. In particular, patients were more likely to be described as ‘manipulative, difficult to manage, unlikely to arouse sympathy, annoying, and not deserving of NHS resources.’ Also, when a suicide attempt was mentioned in the PD vignette, that was considered by clinicians to be ‘attention-seeking’ rather than genuine. From their study’s results, the authors concluded that the presence of PD diagnosis leads clinicians to form pejorative, judgmental, and rejecting attitudes.

The recognition of stigma around BPD diagnosis prompted the publication of policy documents, such as ‘Personality Disorder: no longer a diagnosis of exclusion’ (NIMHE, 2003). This aimed to improve the evidence-base of effective treatment for those patients and also mitigate stigma. Nevertheless, despite such initiatives, when the Lewis and Appleby (1988) study was replicated by Chartonas et al. in 2017 using 76 trainee psychiatrists as participants, it yielded similar results. Moreover, participants held significantly more negative attitudes towards PD rather than depression. Overall, the implications of such findings perhaps call for rigorous professionals’ training in this area. The latter needs to entail an in-depth understanding of subjective and intersubjective
processes that are implicated the therapeutic relationships with those patients, acquaintance with the nature of emotional reactions that they may evoke, as well as ways of managing those in an effective and therapeutic manner (as per the psychological frameworks outlined earlier).

Relevance to CoP

I argue that the identified professional and ethical issues in the therapeutic relationship with ‘BPD’ clients, raises concerns which are of principal importance to CoP, on the basis of its philosophical and ethical premises. As a discipline, CoP is founded on the primacy of the therapeutic relationship (Strawbridge & Woolfe, 2003; 2010), and explicitly endorses the therapist’s use of self in the therapeutic process (Lewis, 2008; Orlans & VanScoyoc, 2009; Rizq, 2005). As such, the subjectivity of the therapist is viewed as an active ingredient and a vehicle to therapeutic change. This outlook aligns CoP with psychological models underpinned by a ‘two-person psychology’ paradigm (Aron, 1990; Stolorow, 1997). Furthermore, CoP is also mindful of the “significance of wider social, cultural, spiritual, political, and economic domains within which counselling psychology operates” (p.11; BPS, 2017), and takes a stand against issues of discrimination (p.16).

Overall, the aforementioned CoP features render the relational challenges which are associated with working therapeutically with ‘BPD’ clients (i.e. both in terms of practitioners’ emotional responses, as well as in terms of the diagnostic label’s stigmatising effects), of direct relevance to the field. As explicated earlier, due to the nature of these emotional responses (which encompass troublesome, conflictual experiences and defences), there is a constant risk of drifting into enactments or even an ‘antitherapeutic’ stance altogether, as well as developing burnout. Moreover, anti-therapeutic stances can be subsequently ‘rationalised’ by virtue of the stigma associated with the BPD label. Thus, cultivating a therapeutic stance characterised by reflective self-awareness is an ethical
imperative (Shillito-Clarke, 2003), and one which is further necessitated when working with this particular client group, in order to ensure that the person is treated in accordance to the humanistic and relational values which underpin CoP.

The trainee context

Having set the context of the professional and ethical issues in the therapeutic relationship with ‘BPD’ clients, as well as their relevance and significance from a CoP perspective, I now turn to trainee matters. During their various placements across clinical settings, trainees are increasingly likely to therapeutically encounter ‘BPD’ clients. Moreover, trainees may undertake placements in services which offer specialised psychological treatments to this client group, such as secondary or tertiary NHS services (Steffen, 2013). Alternatively, they may undertake placements in settings such as primary care, which are increasingly being presented with complexity and BPD symptomatology (Rizq, 2012). Consequently, it is timely and appropriate to consider matters pertaining to the therapeutic relationship between trainees and ‘BPD’ clients. Furthermore, it is plausible to expect that the aforementioned relational challenges that are entailed in the therapeutic work with ‘BPD’ clients, would be further ‘amplified’ in the case of trainees, due to the particularities of their context which shapes their subjectivity. Indeed, reviewed evidence in the following sections supports this notion. In what follows, I intend to offer a brief overview of the key features of this ‘trainee context’.

Literature mainly deriving from humanistic and psychodynamic perspectives, highlight trainees’ ‘unrealistic expectations’ which place them in a psychologically vulnerable place. This vulnerability includes, among other things, acute performance anxiety, porous emotional boundaries, and fragile sense of practitioner-self (Skovholt & Ronnestad, 2003). As Skovholt and Ronnestad aptly put it, it takes time for trainees’ ‘glamourized expectations’ to be replaced by ‘realistic’ ones.
Misch (2000), has also written about “the great expectations” of beginning psychodynamic psychotherapists, which include a potent mixture of unconscious fantasies. These include beliefs such as: 1) ‘I should completely see and understand everything, and do so immediately without having to struggle’; 2) ‘I should always say or do the right thing, which will produce a magic cure’; 3) ‘if my patient doesn’t get better quickly, I must not be doing a good job’; 4) ‘my patient’s failure to improve is a personal failure on my part’; 5) ‘neither I, not my patient should ever have ‘bad’ or ‘inappropriate’ feelings (e.g. anger, envy, sexual attraction) toward one another, and if one of us does have such feelings, it is an indication that therapy is going badly and that there must be something wrong with one or both of us’; and finally, 6) ‘everyone else, including not only my supervisors but also my peers, is doing this better than I am’.

Similarly, Szymanska (2002) explored the perfectionistic and unrealistic expectations of trainee counselling psychologists, which include views such as: ‘this course must teach me everything I need to know to be an effective practitioner; the trainers will have all the answers; by the end of the course I will understand myself’, etc. Moreover, Szymanska makes the point that such absolutist expectations often hinder trainee personal and professional development, as perfectionism can lead to anxiety and procrastination, both of which block progress.

As mentioned, these ‘perfectionist’ standards expose trainees to psychological vulnerability. This may also ‘spill-over’ to their personal life which is has already endured significant disruptions as a result of training (Jensen, 1995; Kumary & Baker, 2008; Truell, 2001). Most importantly, their idealistic expectations in combination with their emotional vulnerability may affect the manner in which trainees engage with the therapeutic process.

In his theoretical psychoanalytic paper, writing from his perspective as an experienced clinical supervisor, Davis (2002) noted how trainees tend to deflect or discourage a patient’s developing transference. In particular, he observed that trainees are tempted to use self-disclosure or nondisclosure in order to close-off, rather than ‘stay with’, the
patient’s intense transference feelings. This view aligns with trainees’ reports of their own experiences of countertransference, in which they convey their lack of confidence in managing their responses (Cartwright et al., 2014).

Lastly, there is also empirical evidence indicating a high degree of narcissistic injury among trainee counselling psychologists (Halewood & Tribe, 2003), as well as high prevalence of parentification (DiCaccavo, 2002). These very factors may propel trainees towards the CoP profession, but at the same time may hinder them in terms of how they make sense of their relational and professional self.

Overall, it is credible to expect that the above combined difficulties would undermine therapeutic progress with ‘BPD’ clients, considering the emphasis placed around the therapist’s ability to: a) work effectively within the transferential-countertransferential relationship; and b) withstand strong feelings in the room whilst concurrently maintaining the capacity to think about them. Arguably, these therapeutic capacities are key across all therapeutic modalities that have been specifically devised for ‘BPD’ presentations (such as TFP, MBT and DBT - which I reviewed earlier).

The therapeutic relationship between trainees and ‘BPD’ clients.

The perspectives and evidence outlined in the previous section served to contextualise aspects which shape trainee subjectivity. Moreover, they illuminate issues that direct us towards the realisation that trainees may constitute a distinct group of professionals, characterised by different concerns, difficulties, professional-developmental conflicts and challenges, etc. Altogether, these form part of their own ‘process of becoming’ as a person and as a professional. Due to the unique features that constitute their context, in conjunction
with what is already known about the *relational challenges* of working with ‘BPD’ clients, it seems important to look closely at the therapeutic relationship between ‘BPD’ clients and trainees *on its own merit*. This endeavour is further necessitated by the fact that the vast majority of the literature has understandably been written from the vantage point of experienced clinicians, and in contrast, the literature on trainees is extremely scarce. Thus, in what follows, I aim to review the existing literature on the topic.

The first piece of evidence that attests to the ‘uniqueness’ of the therapeutic relationship between trainees and ‘BPD’ clients, comes from quantitative studies, some of which I already reviewed under theme 1. Moreover, Brody and Farber (1996), Liebman and Burnette (2013), and McIntyre and Schwartz (1998), all sought to examine therapists’ differential counter-transferential reactions towards ‘BPD’ clients, across different levels (diagnosis, age, gender, years of experience as a therapist, etc.). A stable finding across all of the studies was that therapists’ emotional reactions toward their patients varied significantly as a function of years of professional experience, such that more clinical experience among clinicians was associated with more positive reactions to clients. On the basis of their findings, McIntyre and Schwartz concluded that: “further empirical studies are needed to specify countertransference phenomena among different clientele, to extend the depth of understanding related to reactions within and between therapists…” Indeed, this conclusion seems valid, considering the inherent limitations of the positivist, hypothetico-deductive epistemologies in informing us about the complexity, nuance and multidimensionality of the therapeutic relationship between trainees and ‘BPD’ clients.

Further evidence which alludes to the particularity of challenges inherent in the therapeutic relationship between ‘BPD’ clients and trainees, comes from supervisors’ perspectives. For instance, Fazio-Griffith and Curry’s (2009) qualitative study, sought to examine clinical *supervisors’ perceptions* of the supervision process with trainees who counsel clients with borderline personality characteristics. Participants perceived this therapeutic relationship as eliciting feelings of anxiety for the trainee which, in turn, exacerbate ‘power struggles’ and ‘parallel’ dynamics during the supervision process. Moreover, participants identified
distinct differences during the supervision process between trainees who counselled ‘BPD’ clients, and those whose clients did not exhibit these characteristics. This was apparent in subtheme D, which was about ‘acknowledging trainee frustration when the client exhibits BPD characteristics’, as well as subtheme E, which indicated ‘substantial growth and development opportunities for the trainee’. What is noteworthy here, is that the trainees’ experience of working with the ‘BPD’ client is portrayed by these supervisors as entailing a paradox; moreover, it is seen as loaded with exceptional difficulties, yet also encompassing opportunities for professional development. Arguably, a deeper understanding of the subjective and intersubjective processes in the therapeutic relationship between the ‘BPD’ client and the trainee is necessitated, in order to better understand the nature of anxieties elicited and the type of supervisory support that is required.

To some extent, theoretical psychoanalytic papers by Briggs (1979), Lynch (1987) and Spurling (2003), address this gap. Building on from the original paper by Maltsberger and Buie (which I explored under theme 1), Briggs makes the case that the main difficulty for the trainee lies in ‘acknowledging and managing his/her hostile countertransference’. Briggs draws attention to the mediating role of the ‘unconscious myths’ that the trainee brings to his/her training, i.e.: what Maltsberger and Buie succinctly summarised as the 3 narcissistic snares of: ‘heal all, know all, love all’. Briggs positions these unconscious myths as counterproductive and hindering to the trainees’ capacity to work effectively in the transference-countertransference relationship with the ‘BPD’ client. Moreover, he lists the various ways in which the trainee can get caught-up with enacting his/her defences against hostile countertransference.

Similarly, Lynch (1987) conceptualises the difficulties that trainees experience in their therapeutic relationships with ‘BPD’ clients, as ‘narcissistically-based crises” (p.103). He defines this as the trainee’s ‘over-identification’ with the patient’s ‘hateful transferences’, in terms of perceiving them as confirming his/her own worst fears about him/herself, as opposed to perceiving them for what they truly are, i.e. ‘transference distortions’ (p. 103). Lastly, Spurling (2003), concurs with this premise by suggesting that: “The projections
counsellors are bound to have most difficulty with are those which most threaten the sense of themselves as caring, effective, or potent therapists.” (p.37).

Arguably, what seems to be currently missing from the literature, are trainees’ own voices about their experiences of therapeutically working with ‘BPD’ clients. Moreover, no qualitative study exists up to now. Nevertheless, there is one published case study by Cambanis (2012). In her paper, Cambanis candidly details her own experience of working with a ‘BPD’ client as a trainee, after recognising the paucity of literature in the area. Interestingly, her account echoes meanings which map into a number of themes that I have been exploring in this review. Therefore, in what follows, I will attempt to bring these themes to life by discussing relevant extracts from her paper, through employing a ‘hermeneutics of suspicion’ framework (Ricouer, 1981; as cited in Davy, 2010). Through this framework I intend to open-up a plurality of interpretations with regards to how experience and meaning are constructed within the text.

One of the first aspects which stood out from Cambanis’s account was the complicated and troublesome process by which her client referral was handled. Moreover, it appeared as if this stirred-up considerable anxiety in her and fuelled associated fantasies about her client, before even any clinical contact had taken place. In particular, we see in the following segment how broader stigmatising discourses around the BPD diagnosis may have played out in unconscious interactions characterised by a projection of anxieties:

“Anxiety levels soared when my supervisor, after watching a DVD of the intake interview, said that she hoped for my sake that Candice had dependent personality disorder and not BPD [...] The derogatory comment [...] left me feeling extremely insecure regarding my ability to treat Candice” (p. 103).
The above conveys a foreboding sense regarding the ‘imagined/anticipated’ therapeutic relationship. In particular, Cambanis’s experience seems to be characterised by an anticipatory, amorphous fear which threatens her sense of professional competency. We also see how the stigma of BPD in interaction with projective processes, is setting-up a ‘self-fulfilling prophecy’.

The sense of un-containment in relation to Cambanis’s anxieties, is perhaps evident in her need to discover ‘magical’ or ‘omnipotent’ solutions that will help reduce her uncertainty:

“I attempted to manage this anxiety by turning to the DSM-IV-TR and to literature on BPD and dependent PD [...] My lack of experience in treating clients with BPD and the absence of guidance from my supervisor led to my use of DBT, as I felt somewhat comfortable with its clear therapeutic stages and interventions [...]” (p. 103)

Moreover, clinging on to manuals and structures may serve as a ‘coping strategy’ with the function of minimising uncertainty and the anxiety that goes along with it; yet, this comes with a heavy tax on the trainee’s relational capacity to ‘be with’ the client, in the ‘here-and-now’:

“My need for her to communicate in a particular way was linked to my need to control and structure the sessions and to “squeeze” her into a framework to help reduce my anxiety...” (p. 105).

To some extent, the above aligns with the psychoanalytic authors’ insights, regarding trainees’ defensive postures and manoeuvres against strong feelings in the room. Notions of ‘countertransferenceential hate’ also become apparent in the next segment:
“My countertransference reactions to Candice’s projections were often uncomfortable and sometimes intense [...] My reaction to this session was so intense that I cried after she left.”

Furthermore, Cambanis describes how thoughts and feelings she experienced in relation to the client overwhelmed her as they threatened her idealistic self-concept. Thus, a conflict emerges between idealistic expectations on the one hand, and felt experiences on the other:

“My aggressive thoughts caused much anxiety within me as I felt that a “real” psychologist would never experience such an empathic failure and that I would thus never be a successful psychologist.” (p.50).

Conclusion:

This literature review aimed to identify and illuminate the professional and ethical issues in the therapeutic relationship between trainee counselling psychologists and ‘BPD’ clients. Despite being largely overlooked as a research area, evidence suggests that trainees are increasingly likely to therapeutically encounter these clients through their clinical placement settings.

I began by exploring and critiquing the concept of ‘BPD’ from various ontological, epistemological and theoretical angles. After explicating my own position with regards to it, I proceeded to critically reviewing the literature on the professional and ethical issues in the therapeutic relationship with ‘BPD’ clients. My analysis of published papers in the area revealed two major themes. The first theme included the management of the therapist’s challenging, emotional responses to their client. The second theme included the management of the stigmatising influences of BPD as a diagnostic label. I provided support
for each of these themes by drawing from a range of evidence - including quantitative research, qualitative research, case-study research, and theoretical papers. On the basis of my review, I argued that the relational challenges that are intrinsic to the therapeutic relationship with these clients, represents an area of great significance and relevance to CoP, given CoP’s emphasis on a relational approach to practice and its underpinning humanistic values.

I then proceeded to arguing why the therapeutic relationship between trainee counselling psychologists and ‘BPD’ clients constitutes a distinct clinical and theoretical area, influenced by the particularity of the ‘trainee context’. My review on the scarce literature in the area enabled me to reach the following conclusions: 1) on the whole, by virtue of their lesser years of clinical experience in comparison to qualified therapists, trainees tend to have more negative or ‘amplified’ emotional reactions towards ‘BPD’ clients; 2) the supervisory needs of trainees who work with ‘BPD’ clients, are recognised as ‘complex’ and ‘unique’ due to the anxiety evoked in the trainee by the therapeutic process; 3) trainees’ ‘unconscious myths’ interfere with their capacity to emotionally tolerate, understand and effectively work with the dynamics of the transference-countertransference relationship with the ‘BPD’ client; and 4) presently, there is a paucity of papers written from the vantage point of trainees’ own voices, with the exception of 1 case study; moreover, there is no qualitative research in the area whatsoever. Given the above, my critical literature review provides solid justification and rationale for a phenomenological study on trainees’ experiences of working with clients who meet the BPD criteria. This research may provide the rich type of idiographic data which would be of relevance to trainees, those who supervise them, as well as training providers.
References:


British Psychological Society (2017). *Standards for the accreditation of Doctoral programmes in counselling psychology*


Qualitative Research Study 1: What is trainee counselling psychologists’ lived experience of working therapeutically with clients who meet the DSM-5 diagnostic criteria for BPD? - An Interpretative-Phenomenological Analysis (IPA).

Abstract:

This study aimed to explore how trainee counselling psychologists experience working with clients who meet the DSM-5 diagnostic criteria for BPD, through a hermeneutic-phenomenological investigation. The research question emerged following my critical review of the literature, which concluded that trainees may be left ‘exposed’ in their work with this client group, considering: a) the particular challenges introduced by the ‘trainee context’, and b) the relational difficulties intrinsic to the therapeutic work with this client group. Furthermore, the present IPA investigation will address a substantial gap in the literature, considering the paucity of papers in the area as well as the lack of a qualitative study in particular. In-depth, semi-structured interviews were conducted with seven trainee counselling psychologists, who had experience of working with at least one client meeting the BPD diagnostic criteria. The interviews were transcribed and analysed using IPA (Smith et al., 2009). Three clear superordinate themes emerged from my analysis: 1) the explosive and persecutory quality of embodied responses, 2) being ‘at the mercy of’ the client, and 3) hope and empowerment. These findings are discussed in terms of their contributions to the literature, as well as their implications for CoP training and practice.
Introduction

Two major findings emerged from my literature review (Kokkalis, 2014): firstly, relational difficulties are by far the most challenging aspect of working with ‘BPD’ clients; moreover, the literature is fraught with accounts of practitioners’ challenging emotional reactions and complex interpersonal dynamics. Secondly, there is a profound scarcity of studies exploring trainees’ experiences of working with ‘BPD’ clients, and no qualitative study exists up to now. Adopting a hermeneutic-phenomenological epistemological angle and a relational ontology, I critically examine the construct of ‘BPD’ and the relational challenges associated with working with this clinical presentation. Through critical discussion from a CoP perspective, I argue that investigating practitioners’ experiences in relation to their ‘BPD’ clients forms an epistemological and ethical ‘imperative’.

CoP trainees are increasingly likely to encounter and work with ‘BPD’ clients in the context of their therapeutic practice, e.g. through undertaking placements in clinical settings, which either offer specialised psychological services to this client group (Steffen, 2013), or are increasingly being presented with it (Rizq, 2012). A few studies have mentioned the possible benefits to being exposed to working with this client group early during one’s training. This includes the improvement of clinicians’ familiarity and comfort, thereby reducing prejudice and stigma and enhancing the quality of therapeutic engagement in the long-run (Liebman & Burnette, 2013; Millar et. al., 2012). It also includes the opportunities for growth and development that are afforded to the trainee through this experience (Fazio-Griffith & Curry, 2009). However, I argue that the complexities introduced by the ‘trainee context’ may further ‘amplify’ the relational difficulties intrinsic to working with ‘BPD’. Therefore, this necessitates a more in-depth understanding of the subjective and inter-subjective processes involved in the therapeutic encounter. In view of this need, the scarcity of literature on trainees’ experiences of working with ‘BPD’ -and the absence of a qualitative investigation in particular- is highly problematic. The present investigation will attempt to address the paucity of literature in this area, through a phenomenological exploration of trainees’ lived experiences of
working with ‘BPD’ clients. This knowledge may help CoP training courses and supervisors to better support their trainees. It may also help to ‘normalise’ emotional reactions and foster a reflective and ethical way of working with the relational challenges presented by this client group, in a way that is consistent with the CoP values.

‘BPD’ from a CoP perspective

There is an inevitable epistemological and ontological ‘tension’ which exists throughout this project, pertaining to the use of the term ‘BPD’ with its underlying medical model connotations, whilst arguing from a CoP perspective which promotes a subjective understanding of such difficulties from the vantage point of human distress (BPS, 2014). The challenge of being faced with this type of tension could be seen as reflective of CoP’s position in general. To deal with this predicament, CoP embraces a ‘pluralistic outlook’. This allows the discipline to hold and engage with the tension between contrasting perspectives and different forms of knowledge, whilst exploring their experiential possibilities (Kasket, 2012; Orlans & VanScoyoc, 2009; Rizq, 2006). Hence, CoP’s pluralistic outlook provides the platform for this project to critically explore the concept and engage with the phenomenon, without necessarily colluding with the medical model. This firstly requires an ‘unpacking’ of the term ‘BPD’ and the assumptions underpinning it, followed by an explication of this study’s position in relation to it.

The construct of ‘BPD’ derives from the medical model (as exemplified by the DSM-5), which assumes that ‘maladaptive’ patterns of affect and behaviour reside ‘within’ the individual, whose distress is attributed to biophysical aetiologies and fit into pre-existing diagnostic categories. The person’s ‘psychopathology’ is viewed as diagnosable and ‘treatable’ with specific pharmacological interventions (Larsson, Brooks & Lowenthal, 2012). These pre-established frameworks of understanding reality are deemed by practitioners, who are seen as holding ‘expert’ a-priori knowledge regarding their client’s experience (Aho, 2008). Therefore, the medical model’s underlying ontology rests on an interpretation of the self as an encapsulated, solipsistic entity, and causally-determined biological body (i.e. objectivist ontology) which can be accurately studied, objectively
known and treated from the standpoint of a neutral, detached observer (i.e. positivist epistemology) (Aho, 2008; Angen, 2000; King & Horrocks, 2010; Ponterotto, 2005).

The above view is contested from a hermeneutic-phenomenological vantage point which instead views ‘BPD’ as distress and difficulties in living, inherent to the human condition. Furthermore, the therapist/inquirer attempts to understand this distress from the point of view of the person’s own lived-experience and sense-making, which are examined in relation to the multiple layers of context to which the individual’s life is embedded in (Aho, 2008). In line with this Heideggerian view of the person as inextricably dynamic, fluid, contextually-embedded and relational in nature (Langdridge, 2007), the therapist/inquirer is no longer a neutral/detached/objective observer, but rather an agent who profoundly affects, and is affected by, the client’s subjectivity and the therapeutic process (Angen, 2000; Bohm, 1996; Ponterotto, 2005).

Thus, consistent with the hermeneutic-phenomenological stance which I adopt for the purposes of this enquiry, the concept of ‘borderline’ is conceptualised as a dynamic, complex, multi-layered phenomenon and construct. It is understood as referring to a particular cluster of meaningful, subjective, embodied, and affective experiences, whilst highlighting the interpretative, contextual, and relational processes that give rise to it. Therefore, despite my use of the term ‘BPD’, the hermeneutic-phenomenological angle which I adopt markedly differs from the medical-model’s view of ‘borderline’ as ‘disorder’.

**Epistemological and ethical ‘imperative’ of investigating practitioners’ experiences**

The hermeneutic-phenomenological stance outlined above, has implications not only for our understanding of ‘BPD’, but also for the phenomenon of practitioners’ challenging emotional responses to their ‘BPD’ clients, which has been consistently noted in the literature. Some of these reactions include: panic, inadequacy, hate, anger, hopelessness, frustration. These have been repeatedly revealed by psychoanalytic case studies (Carsky
In light of the *intrinsic inter-subjectivity* of the therapeutic encounter, these emotional responses form part of the *therapist’s subjectivity*, which actively constructs the meaning, selection and interpretation of the engagement with client (Aron, 1990; Finlay 2003; Stolorow, 1997). Furthermore, *how* they are subjectively lived, made sense of, and ‘regulated’, is crucial to the outcome of the psychotherapeutic endeavour (Bordin, 1979; Luborksyy et al., 1986—both cited in McHenry, 1994; Rasmussen, 2005; Teicholz, 2014). From a hermeneutic-phenomenological vantage point, the practitioner’s emotional experience in relation to the client needs to be examined and critically interrogated, in order to reach deeper layers of understanding of the therapeutic process and the client’s subjective experience (Finlay, 2003; 2008; 2011). Thus, the exploration of the therapist’s emotional reactions forms an *epistemological imperative* and a process which also enables a transformation of practitioners’ intense and complex emotional responses from a potential ‘barrier’ into a therapeutic ‘opportunity’. This stance is central to the CoP ethos (BPS, 2014; Orlans & VanScoyoc, 2009; Strawbridge & Woolfe, 2003).

When intense emotions remain a barrier, practitioners may resort into a ‘defensive’ mode and emotionally retreat from their clients (Hinshelwood, 1999; Main, 1957; Vaillant, 1992). In turn, such distancing reactions can exacerbate ‘BPD’ clients’ relational difficulties, thereby establishing a ‘vicious cycle’ (Aviram et al., 2006). Under such relational pressures and highly affectively-charged states, clinicians may fall back on *stereotypes* that carry pejorative connotations (e.g.: “manipulative”, “attention-seeking”, etc.). When left unexamined, these can undermine the therapeutic relationship and provide the basis for stigmatization leading to negative therapeutic outcomes (Aviram et al., 2006; Liebman & Burnette, 2013). Indeed, this argument converges with quantitative research
evidence indicating high levels of occupational stress and burnout in practitioners working with ‘BPD’ clients (Arvay, 2001; Vredenburgh et al., 1999 -both cited in Everall & Paulson 2004; Perseius et al., 2007).

The above issues raise potential challenges to working ethically as they predispose the therapeutic dyad to enactments, and undermine the clinician’s phenomenological attitude of empathetic openness, curiosity, and wonder. This attitude allows us to investigate and understand the phenomenon of the client’s lived experience in a manner that respects his/her ‘Otherness’ (Levinas 1961; cited in Lowenthal & Snell). Furthermore, they increase the risk of the client being related to as an ‘it’ rather than ‘Thou’ (Buber, 1958; cited in Cooper, 2003) -i.e. an object entirely submissive to the inquirer’s pre-conceptions. Hence, from a CoP perspective, an in-depth understanding of the ‘how’ of our experience of being-with the client constitutes not only an epistemological, but also an ethical imperative which safeguards the client against possible ‘it-ification’ (Everall & Paulson, 2004; Finlay 2011, 2008; McHenry, 1994; Shillito-Clarke, 2003).

**Trainees and ‘BPD’**

I suggest that the need to investigate therapists’ experience in relation to their work with ‘BPD’ clients on epistemological and ethical grounds, is further necessitated by the complexities introduced by the ‘trainee context’. As mentioned earlier, this may further amplify those relational difficulties intrinsic to working with ‘BPD’ clients. Literature mainly deriving from humanistic and relational-psychodynamic orientations, highlights trainees’: ‘unrealistic expectations’ about themselves as a practitioner and the psychological vulnerability which this introduces (Misch, 2000; Szymanska, 2002; Skovholt & Rønnestad, 2003, 2001; Truell, 2001); high prevalence of ‘narcissistic injury’ (Halewood & Tribe, 2003); weak sense of ‘practitioner-self’ and emotional self-regulation skills (Williams et al. 1997; Skovholt & Rønnestad, 2003); distress arising from pressure of juggling diverse demands within the context of CoP training (Kasket, 2012; Moran, 2011; O’Brien, 1997; West, 2012), as well as personal life disruptions as a result of training (Jensen, 1995; Kumary & Baker, 2008; Truell, 2001).
As elaborated earlier, such aspects form part of the therapist’s subjectivity which is bound to affect the therapeutic process. Indeed, they may undermine trainees’ capacity to be open and fully present with a client, and affect the attitude in which impasses are experienced and dealt with during therapy (Davis, 2002; DeStefano, et al. 2007). Additionally, they weaken their capacity to tolerate paradox and embrace ambiguity, which are hallmark of effective therapeutic practice (Ronnestad & Skovholt, 2001). Altogether, I argue that the above premises support the notion that trainees may be left particularly ‘exposed’ to the relational challenges in their work with BPD clients. This is further supported by a qualitative study’s finding, which identified that supervisors who supervise trainees working with this client group experience that supervision with those trainees poses ‘unique challenges’ (Fazio-Griffith & Curry, 2009). For those reasons, I suggest that an in-depth investigation into trainees’ subjective experience of working with ‘BPD’ clients is warranted, in order to gain better understanding and clarity into the phenomenon.

Critical Review of studies in the area

Literature on trainees’ experiences of working with ‘BPD’ is extremely scarce and disparate and no qualitative study exists up to now. Furthermore, the vast majority of the literature is entirely based on, and written through, the vantage-point of qualified practitioners’ experiences. Below, I critically review the most key studies, before demonstrating how the current research project will contribute to the literature. Due to word-limit restrictions, I have limited my review to a few studies which I group under two strands: a) quantitative studies, b) theoretical papers with case vignettes written by supervisors/qualified practitioners.

Three studies (Brody & Farber, 1996; Liebman & Burnette, 2013; McIntyre & Schwartz, 1998) employed quantitative research methodology to examine if clinicians’ reactions to ‘BPD’ vary as a function of clinician- and client-level variables. A consistent finding across all three studies was that therapists’ emotional reactions toward their patients varied significantly as a function of professional experience, such that more clinical
experience among clinicians was associated with more positive reactions to clients. Whilst this finding provides evidence which further strengthens the rationale for the current research project, the studies’ actual data tell us very little about the subjective experience and sense-making of participants. This is due to the underlying epistemologies and ontologies (i.e. positivist, hypothetico-deductive), which overlook the dynamic and complex nature of the experience, hence leading to findings which seem somewhat unrelated to the immediate experience of clinical practice.

In contrast, the theoretical papers written by supervisors/qualified practitioners (Briggs, 1979; Lynch, 1987; Occhiogrosso & Auchincloss, 2012; Spurling, 2003), provide us with compelling insights which are potentially more directly, clinically-relevant for therapists. They offer psychodynamic conceptualisations of trainees’ predicaments in relation to their work with ‘BPD’ clients, proposing that the major difficulties they face, pertain to: a) the identification and management of their ‘negative countertransference’, b) their over-identification with clients’ ‘transferences’, and c) their ‘narcissistic’ needs interfering with the therapeutic work. However, from a hermeneutic-phenomenological angle, these papers present some methodological limitations; namely: their tendency of being too theory-led (i.e. excessive amount of theory superimposed on some fragment of data) which ‘overshadows’ the phenomenon of lived experience, obscures observation from inference, as well as the dialogical-dialectical process of meaning-making. Finally, there is also a lack of explicit consideration of the authors’ role in ‘co-constructing’ the insights presented.

**Purpose, Aims and Contribution**

The current study is a qualitative investigation which aims to deepen our understanding of the lived, subjective experience of trainees in relation to their work with clients who meet the ‘BPD’ diagnostic criteria. It will address the reviewed papers’ limitations, by providing rich phenomenological data which will illuminate the ‘how’ of the experience and meaning-making, and offer a nuanced exploration of the phenomenon through a dialogical-dialectical negotiation of meaning between researcher and participant. Methodological rigour will be strived for, through adhering to the criteria for ‘good qualitative research’
(Yardley, 2000). The type of data produced will be relevant to practitioners’ therapeutic work (Corrie, 2010), as well as resonate with the philosophy and values underpinning CoP identity (BPS, 2014). It is hoped that knowledge from this study will inform training delivery through offering insights which course providers and supervisors will be able to utilise in their endeavour to support trainees in their clinical work with this client group. Additionally, it is hoped that it will directly benefit to trainees, through opening-up a platform where their experiences and emotional responses can be thought about, ‘normalised’, and reflected-upon. Overall, this may foster a relational, reflexive, and non-pathologising way of managing the difficulties and challenges associated with working with this client group. Indeed, this relational attitude constitutes a core element of CoP philosophy, a learning outcome of its training, and a transferable skill (BPS, 2014).

Methodology

Method

The research question focuses on the sense-making and lived experiences of CoP trainees in relation to their clinical practice with ‘BPD’ clients, and in context of being in training. Thus, there are experiential, affective, constructivist, interpretative, relational and contextual components to the phenomenon under investigation. As such, it lends itself to be explored through a hermeneutic-phenomenological epistemological position, which highlights the descriptive-phenomenological, as well as the interpretative-contextual dimensions of the enquiry.

IPA was deemed the most appropriate methodology, given its exploratory focus on the HOW of lived experience and meaning-making, (Smith & Osborn, 2008). Like Descriptive Phenomenology (DP), IPA has roots in Husserlian phenomenology of bracketing and
focusing on a phenomenon as it appears to consciousness. Unlike DP, IPA is also informed by Heideggerian phenomenology and as such, acknowledges the centrality of contextual meaning-making in understanding and mediating experience (Langdridge, 2007). Furthermore, IPA’s hermeneutic component, allows me as a researcher to embrace the interpretative dimension of my enquiry, as I strive to unveil the multiple layers and hidden meanings of my participants’ lived experiences (Smith & Osborn, 2008). IPA’s emphasis on interpretative engagement with the data, marks the shift of focus away from the search for essences, which is the main concern in DP (Langdridge, 2007).

Alternative hermeneutic-phenomenological research methods were also considered. Those included Langdridge’s Critical Narrative Analysis (CNA) and Van Manen’s Hermeneutic Phenomenology (HP) (cited in Langdridge, 2007). CNA employs a particular type of hermeneutics with a heavy emphasis on ‘hermeneutics of suspicion’, and specifically drawing from critical social theory. This research method claims to “enable a perspectival shift in understanding of the lifeworld, through a critical interrogation of the social imaginary of narratives they inhabit and […] reproduce naturally in the stories they tell of their lives” (p. 136-7). Arguably however, circumscribing the nature of hermeneutics being employed (i.e. suspicious interpretations drawing solely from critical social theory), would somehow limit the scope of the present research enquiry, which instead seeks to make links with -and situate its findings in the context of- existing psychological literature. It is precisely this feature of IPA, i.e., its ability to facilitate engagement with mainstream psychological literature, which made it preferable over both CNA and HP. Moreover, as a research method, HP has been developed within fields of pedagogy and the humanities, as opposed to psychology. Lastly, the fact that IPA specifically invokes psychological concepts in its analysis as part of the interpretative process, made IPA more appealing over HP.

Methodologically, IPA is defined by its two complementary commitments: the phenomenological requirement to understand and ‘give voice’ to the experiential claims/concerns of participants, and the interpretative requirement to contextualize and ‘make sense’ of these claims/concerns from a psychological perspective (Larkin et al.,
2006). In turn, these commitments are founded on IPA’s theoretical underpinnings in phenomenology, hermeneutics, idiography, critical-realism, and symbolic interactionism (Smith et al., 2009; Willig, 2013). IPA is said to be phenomenological in its inclination, in that it is concerned with participants’ lived experiences. Yet, it also recognizes that the lifeworld of the individual is contextually-bound and already immersed in a linguistic, relational, social, cultural and physical world. Therefore, IPA is hermeneutic in its implementation because it recognizes that experience cannot be accessed directly, but only through a process of inter-subjective meaning-making (Eatough & Smith, 2008; Larkin & Thompson, 2012). According to hermeneutics, understanding takes place through reflexively engaging ‘meaning horizons’ between researcher and participant (Gadamer, 1975, cited in Davy, 2009; Larkin et al., 2006; McLeod, 2003), and the interplay between the ‘hermeneutics of empathy’ and the ‘hermeneutics of suspicion’ (Ricoeur, 1970, cited in Willig, 2013). In IPA, this co-creation of meaning is referred to as the ‘double-hermeneutic’ process of interpretation, according to which the researcher tries to make sense of the participant trying to make sense of his/her own experience (Smith et al., 2009).

Thus, knowledge produced via IPA are the co-constructed product of participants, researcher, and their relationship. Because of the interpretative influence of the researcher being an ‘inescapable’ aspect in the knowledge-production, considerable attention was placed on reflecting-upon my role as a researcher in producing these interpretations, as well as in setting-up measures to ensure their ‘quality and rigour’ (Larkin et al., 2006; Larkin & Thompson, 2012; Smith et al., 2009, Yardley, 2000).

Participants

In line with IPA’s commitment to the idiographic method which aims at depth and quality, this project opted for a ‘purposive and homogenous’ sample, using small numbers of participants, selected for their ability to illuminate the research question (Smith et al., 2009). Thus, a sample size of seven participants enabled: a) detailed illustration of subjective experience and rich interpretative accounts; b) focus on convergences and divergences across accounts; c) adherence to the ‘contextual requirements’ of the PsychD
course (i.e. word-limit restrictions). The inclusion criteria were a current status as ‘trainee counselling psychologist’, with current or past experience of providing therapy to at least one client who meets the DSM-5 diagnostic criteria for ‘BPD’. An additional requirement was for trainees to be under supervision for their clinical work. The final sample stood as an all-white Caucasian group which included two men and five women, with ages ranging from 26 to 61. Their length of training varied from 1-7 years, and two of the participants were in part-time mode. All were undertaking university-based CoP trainings, with the exception of one who was training through the BPS-independent route. The clinical contexts in which they worked included: IAPT, NHS secondary care/PD service, drug and alcohol service, and bereavement-counselling charity. The practiced modalities in those settings included: psychodynamic, CBT, person-centred, schema-therapy. Three of the participants worked with their clients within a short-term therapy duration, whilst four worked within a mid-to long-term duration (26 sessions to 2 years). Table 1 below, shows the demographics of the sample.

### TABLE 1 Participants’ demographics.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Name</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Jill</td>
<td>38</td>
</tr>
<tr>
<td>2</td>
<td>Lauren</td>
<td>61</td>
</tr>
<tr>
<td>3</td>
<td>Oliver</td>
<td>33</td>
</tr>
<tr>
<td>4</td>
<td>Leticia</td>
<td>26</td>
</tr>
<tr>
<td>5</td>
<td>Katherine</td>
<td>27</td>
</tr>
<tr>
<td>6</td>
<td>Paul</td>
<td>52</td>
</tr>
<tr>
<td>7</td>
<td>Natalie</td>
<td>29</td>
</tr>
</tbody>
</table>

*(All names have been changed to preserve confidentiality).*
Procedure

Recruitment

Participants were mainly recruited via training providers (e.g. university-based CoP trainings). Course leaders of CoP training programmes, were contacted via email and asked to forward my recruitment email (Appendix 2), inviting trainees who fulfil the recruitment criteria to take part in my study. This email outlined the study’s aims and included my details as a researcher. Attached with it were also the information sheet (Appendix 3), demographics’ questionnaire (Appendix 5), and consent form (Appendix 4). Additionally, my recruitment email was circulated within CoP online trainee forums, and promoted via ‘word-of-mouth’ and ‘snowballing’. Individuals who met the inclusion criteria and expressed interest in participation, were invited to contact me individually to further discuss this.

Briefing, consent, debriefing

Candidates who contacted me were given the opportunity to discuss and clarify any questions they had about the study. They were given time to think about their participation as well as the option to discuss it with a third party if needed (i.e. details of my supervisor were provided in the information sheet for that very purpose). Candidates were informed about measures taken to preserve their (as well as their clients’) confidentiality and anonymity. The voluntary nature of participation was reiterated, as well as participants’ right to withdraw from the study at any point and without prejudice/having to state a reason. Individuals who agreed to take part, signed the consent form and filled-in the demographics’ questionnaire. Time, date and location of the interview was negotiated on a mutual basis, taking into consideration factors such as availability of confidential and quiet space, as well as logistical restrictions. Eventually five of the participants were interviewed in their own home, and two via Skype. Interviews were audio-recorded and subsequently transcribed. Audio-recordings were securely stored on an encrypted USB.
Names and identifying features were removed during transcription. Transcripts were stored in a password-protected file. Upon completion of the interview, participants were offered the opportunity to have a debrief with me. I further elaborate on these aspects and their function under ‘ethics’ section (see further down) and ‘reflexivity’ (appendix 10).

**Data collection**

A semi-structured interview approach was used to collect detailed, reflective, first-person accounts from research participants about *how* they experience and make sense of their clinical practice with clients who meet the diagnostic criteria for ‘BPD’. The interviews aimed to explore and clarify the richness and complexity of participants’ emotional experiences and facilitate the emergence of rich idiographic data- consistent with IPA’s epistemology. Interview duration ranged between 40-90 minutes to ensure the necessary elaboration and depth during the interviewing process. Transcription was performed with meticulous accuracy and included indications of pauses, mis-hearings, apparent mistakes, and speech dynamics where these were notable.

An interview-schedule (Appendix 9) was designed to flexibly steer the interview by offering me ‘mental maps’ of the areas of lived experience I needed to explore with my participants. The flexible nature of the semi-structured interview allowed participants to have a strong say in where the interview went, and for ‘novel'/unanticipated areas to be revealed as a result of this dynamic-dialogical interaction (Eatough & Smith, 2008). In conducting the interviews, I embraced the *phenomenological attitude*, as put-forward by Finlay (2008; 2011). This enabled me to remain empathically open and sensitive to receiving my participant’s experience, through both, bracketing and using my own pre-understandings to interrogate evolving meanings of participants’ experiences. Supervision and audit, enabled me to reflect upon my interviewing stance and ensure that I adhere to the phenomenological attitude (see appendix 8).

The above attitude was strived for across all interviews - whether conducted via skype or face-to-face. Similarly, ethical considerations (see later section) - such as ensuring that the
location where the individual interviews took place, preserved the confidentiality and privacy of participants - were also present across all interviews. Nevertheless, it is of interest to briefly reflect upon the distinctive features of using Skype as a medium through which to conduct qualitative research interviews, as well as the strengths and weaknesses of this approach. As has been pointed out by Hanna (2012), Skype provides synchronous interaction between the researcher and their participant; moreover, to some extent this synchronicity preserves the visual and interpersonal aspects of the interaction, in contrast to telephone interviews. Additional benefits, include ease of access, elimination of travel costs and the participant option to remain in the comfort of one’s own environment, if so wished. Nevertheless, some disadvantages regarding the use of Skype in research have also been pointed out. These include technical interruptions (such as pauses, inaudible segments), inability to read full body language and nonverbal cues, as well as loss of intimacy compared to traditional in-person interviews (Seitz, 2016). With regards to interpersonal perception, the fact that the researcher and participant are not in each other’s physical presence, prevents from perceiving the presence of the other through the full range of the senses available. This was noted to a small degree in the present research (e.g. especially with regards to only having partial visual access to the participants’ bodies, and at times, missing direct eye contact due to the camera/screen positioning). Nevertheless, what was also noteworthy, was the fact that meaningfully-rich body gesture was powerfully present within one of the Skype interviews, which subsequently enriched data analysis.

Data Analysis:

Transcripts were analysed using IPA guidelines (Smith et al., 2009) as a basis. Analysis involved a close and detailed interpretative engagement with the data. This enabled me to explore and interpret manifest and latent themes, which captured the richness of participants’ experience, both within and across accounts (Eatough & Smith, 2008; Finlay, 2014a; 2014b; Larkin & Thompson, 2012; Willig, 2012; 2013). This was a cyclical process proceeding through several iterative and inductive stages, which I describe below.
Firstly, I began with a ‘first-order’, descriptive coding (Larkin et al., 2006): i.e. a line-by-line analysis of the experiential claims, concerns and understandings of each participant. This entailed a close reading and re-reading of individual transcripts along with listening to the voice-files, noting anything that appeared significant and of interest on the left side of my transcripts (i.e. descriptive, symbolic, conceptual, and linguistic/discursive aspects). This initial stage involved a process of empathic ‘immersion’ in the situations described and ‘dwelling’ in each moment of the experience, allowing new understandings to emerge and deeper meanings to come to the fore (Finlay, 2014a, 2014b).

Secondly, I proceeded to identifying ‘emergent’ themes which captured the essential quality of what was found in the text. This allowed for a higher-level of abstraction, occasionally invoking more psychological terminology as well as imagery and metaphor, yet always ensuring that this is grounded to the core experiential material. This stage involved a more interrogative, questioning dimension in analysis and a ‘dialogue’ between the ‘phenomenological coding’, myself, and psychological knowledge, about what it might mean for participants to have expressed these concerns in this particular context/situation (Larkin et al., 2006). Supervision and audit at this point enabled me to check the ‘rigour’ of my interpretations, in terms of adherence to the two complementary commitments of IPA (i.e. ‘giving voice and making sense’) (see appendix 6).

Thirdly, I chronologically listed all my ‘emergent’ themes for each participant’s transcript. I then looked for links/connections between them and identified possible thematic clusters. This allowed me to generate a hierarchical list of themes for each transcript which most strongly captured the respondent’s concerns.

Fourthly, I proceeded to looking for connections/links between themes across transcripts, and identifying concepts and labels which capture the essence, quality and function of these clusters. This process generated a number of ‘subordinate’ and ‘superordinate’ themes which represented the patterns of meaning in my data-set, accommodating for convergence and divergence within it (Smith et al., 2009). This phase involved considerable iterative movement. Themes were constantly checked and cross-linked with participants’ accounts,
to ensure that each theme was represented within the data (Larkin & Thompson, 2012). During this stage, I found it helpful to critically interrogate the data by: a) holding in mind *existential givens* (i.e. being and becoming; embodiment and identity; belonging and needs), b) bringing-in *reflexivity*, (e.g. by drawing-upon and comparing my own experience with that of participants) (Finlay, 2014a). Supervision and audit at this point enabled me to ensure that themes were ‘phenomenologically-grounded’ and captured the quality and essence of what was ‘found’ in the accounts.

Finally, I constructed a table of super-ordinate and sub-ordinate themes, giving sample illustrative references within the transcripts for each theme. This was then used as my basis for developing a narrative of my cross-case analysis, illustrating each super-ordinate and sub-ordinate theme with transcript excerpts. This approach aimed to elucidate the *interplay* between my interpretative activity and the participant’s account of the experience in their own words (Finlay, 2014a).

The data analysis steps described above are further illustrated in my *audit trail* (Appendix 7).

**Ethical considerations:**

This study received ethical approval from the faculty of Health and Medical Sciences (FHMS) ethics committee (Appendix 1) and adhered to ethical practice, in accordance with BPS codes of ethics (BPS, 2009; 2010). However, ethical issues were conceptualised as ‘fields of uncertainty’, requiring *on-going reflexive thought* regarding dilemmas, conflicts and ambivalences that were introduced throughout the research process (Brinkmann & Kvale, 2008; Thomson & Chambers 2011). Holding in mind the three principles set-forth to govern human research, i.e. *Beneficence, Respect for subjects,* and *Justice* (Sieber, 2009), I identified five key areas of negotiating ethical dilemmas; these are:

- Maintaining Confidentiality of participants and their clients.
- Facilitating Voluntary, Informed, and Processual consent.
- Managing potential risks and maximizing benefits to participation.
• Recruiting and conducting research within peer relationships.
• Analysing ethically.

Finally, given the close link between *quality issues* and *ethical concerns* in qualitative research (Flick, 2007), some of the issues discussed in Appendix 11 (quality assessment), will be relevant here. In what follows, I unpack the above identified ethical areas.

**Confidentiality of participant and their clients**

Safeguarding the confidentiality of participants as well as the clients they talk about, was a significant area of ethical concern considering the risks to both parties if their anonymity was to be inadvertently breached. Some of these risks include: jeopardy of their therapeutic relationship, distress, and negative consequences for participant’s position. Therefore, taking measures to *ensure confidentiality* and *privacy* of participants and their clients remained a top priority. Some of the measures taken include:

• minimal inclusion of client clinical material in the study (and only when serving research purposes- e.g., contextualising participants’ emotional experiences).
• avoiding the use of lengthy excerpts and minimising the use of specific personal demographic details.
• disguising the identity of participants through: use of pseudonyms, adhering to safe data ‘handling’, ensuring that the location where the individual interviews took place preserved the confidentiality and privacy of participants.
• finally, dealing with confidentiality issues as an on-going process (e.g. engaging with a participant’s request for certain information not to be included in the final study through a respectful and collaborative stance).

**Facilitating Voluntary Informed, and Processual consent**

Voluntary informed consent was obtained from all seven participants. Facilitating participants in making a fully-cognizant decision to participate in the study was of the
utmost importance, and a way towards adhering to the principle of *respecting autonomy* (Thomson & Chambers, 2011; Sieber, 2009; Steffen, 2016). Obtaining voluntary informed consent was achieved by: providing sufficient time for considering participation; reiterating the voluntary nature of it; emphasizing withdrawal right; giving sufficient information regarding the purpose and procedure of the investigation; clarifying potential advantages and disadvantages to participating; and specifying measures taken to preserve confidentiality and anonymity. In addition, consent was also engaged with as an on-going process, through enabling a relationship in which participants felt safe to ask questions (e.g. clarifying how their data might appear in the final form of the study, etc.). This process aimed at empowering participants, and reinforcing the view that they are free to reconsider their participation and reaffirm their wish to continue at any point.

**Managing potential risks and maximizing benefits to participation:**

The experiential nature of the interviews as well as participants’ engagement with sensitive topics which could potentially invoke distress, meant that precautions needed to be taken to ensure that any potential harm was outweighed by potential benefits. Consequently, using my interpersonal skills towards the creation of a ‘facilitative environment’ was paramount. This entailed the effective negotiation of the two areas which I described above, as well as my *attunement* to the *emotional experience* of my participants (e.g. through empathetic-reflection, checking-in, and ‘staying with’ emotionally-charged subjects).

The use of debriefing at the end of the interview was a particularly powerful tool towards maximizing the *benefits of participation*. It offered the opportunity for participants to consolidate, integrate and process their experience of the interview, thereby engaging in *reflection-on-action* (Schön, 1983). All participants stated that they identified positive aspects to their participation, in terms of gaining better clarity about past events, recalling nuanced details of inter-subjective processes with their clients, having their voice heard, reflecting upon their professional and personal development. In addition, debriefing enabled me as a researcher to ‘ground’ my participants back, and ensure they were not left in an emotionally vulnerable place following their interview.
Recruiting and conducting research within peer relationships:

Recruiting and collecting data within peer and collegial relationships involving pre-existing and/or ongoing contact between myself and three of my participants, was an area introducing specific ethical dilemmas. Those revolved around: relational aspects, consent & power issues, managing assumptions and confidentiality. Specifically, of the three participants, one was a former course-mate of mine, and two were undertaking their placement in the same organisational setting as me. In the case of the pre-existing relationship, I found that the rapport, familiarity and respect between us facilitated a rich, in-depth exploration and dialogue, which in turn, resulted in the deepening of our mutual respect and appreciation. However, this ‘advantage’ needed to be monitored against the potential for blurred boundaries, given the multiple roles involved. Furthermore, a major consideration in recruiting among peers was the issue of coercion (i.e., peers feeling ‘obliged’ to consent to participation, due to pre-existing relationship). Therefore, I took measures to mitigate against this risk and ensure the fair and equitable treatment of all participants. Some of these measures included: forwarding my recruitment email to candidates collectively rather than individually; reiterating the voluntary nature of participation; and maintaining professionalism throughout. An area for consideration in conducting interviews within peer relations was the management of pre-existing knowledge about the person, in a way that is consistent with the phenomenological attitude. This required ‘more’ reflexivity on my part, in terms of monitoring how my prior knowledge about the individual could affect the collection and interpretation of data. Also, the issue of confidentiality became more pertinent in the case of interviewing those individuals, due to increased chances of their identities being identified within those systems. Therefore, in addition to placing strict confidentiality measures as outlined earlier, I took extra care to ensure that I did not inadvertently reveal to mutual peers the identities of those individuals involved in my research.

Analysing ethically
Lastly, the issue of ‘analysing ethically’ was an important area of reflexive-ethical thinking, considering the researcher’s power in shaping what comes to be known about someone’s experience (Willig, 2012). The risk against the potential interpretative ‘abuse’ of my power, was to some extent mitigated through the ‘minutiae-monitoring’ of the function of my interpretations, as well as the nature of my interpretations (i.e. whether they are constructed in a responsible, tentative, dialogical and empowering way). Finally, the use of language regarding the clients in relation to whom the participants explored their experiences, was also handled in an ethically and epistemologically consistent manner. Moreover, congruent with the hermeneutic-phenomenological understanding of ‘BPD’ which I put forth in the introduction, I took care in promoting a use of language which preserved the ‘otherness of the Other’ and avoided ‘it-ifying’ or concretising clients’ subjectivity. This manifested in instances of tentative and thoughtful use of language -both during the interviews and in my writing. For example, during the interviews I referred to clients as ‘having difficulties which meet the DSM’s criteria for BPD’, as opposed to ‘clients having BPD’. Also, throughout my writing I placed the word ‘BPD’ in inverted commas, which signify this underlying vantage-point.

Findings

Three clear super-ordinate themes emerged from my analysis: 1) the explosive and persecutory quality of embodied responses; 2) being ‘at the mercy of’ the client; and 3) hope and empowerment. Table 2 below represents these super-ordinate themes with their related sub-themes.
Super-ordinate Theme 1: explosive and persecutory quality of embodied responses.

The phenomenological concern for the ‘whatness’ of the encounter with ‘BPD’ clients, was vividly described by participants in embodied and visceral ways. Indeed, in one interview I noted how the participant slapped her face to demonstrate the intense element of shock, unpredictability and ambush in her experience of being with the client. This use of the physical to describe and make sense of participants’ experiences of their interaction with ‘BPD’ clients was registered in a variety of ways.

Subtheme 1: the experience of being under attack.

A particularly poignant theme permeating most participants’ accounts related to their potent, embodied reactions to their clients. Lauren below describes her extreme physical response:
sensations in response to this client group, with reference to religious torment. Furthermore, she describes her lived experience as ‘visiting hell’ when she entered a BPD unit:

L: ...“you walked inside and the temperature changes....
J: In what way did it change?
L: It got very cold, and yet it was very intensely hot....And that’s the only way I can describe it. It sort of reminds me of some descriptions I’ve read of hell... where you’re roasting in hell...but it’s cold and barren and bleak...”

This sense of punishment or torment is described by Lauren as “exhausting”, particularly because the feared attacks are understood in physical terms: “[if] somebody’s going to attack me physically, I’m not in shape to defend myself”. Katherine on the other hand, described her feelings of attack in more ambiguous terms. She oscillated between a visceral worry for an inevitable impeding attack, and a capacity for sense-making that modified this original sense:

“I don’t think she would’ve physically attacked me. So, when I look back at it, I just wonder what it was I was afraid of...because I don’t think I was afraid of a physical attack, but...[I] just didn’t want to displease her...yeah... Didn’t want her to shout at me, but, why, I’m wondering, you know, why”.

Thus, it appears as if Katherine is retrospectively struggling to make sense of, and ‘logically’ account for, the intensity, concreteness and ‘viscerality’ of her anxiety of being-with her client.

Subtheme2: like walking in a minefield
The embodied and persecutory quality of being with ‘BPD’ clients was also described by one trainee in stark militaristic terms. Battles were waged and weapons were discharged: Oliver described the HOW of his experience of being with a client as akin to:

“stepping on landmines or something...you didn’t quite know where they were, so you’d tiptoe around, hoping that you don’t hit one”.

Moreover, for Oliver the ‘landmine’ was considered to be the threat of suicide made by the client in response to him as her therapist: “I was terrified that, if I said the wrong thing, she’d go and kill herself”. Overall, trainees’ descriptions of their experiences as ‘explosive’ and ‘attacking’ alludes to a state of persecutory anxiety which arguably leaves little space for reflective thought.

Super-ordinate Theme 2: being ‘at the mercy of’ the client.

The visceral sense of attacks described in super-ordinate theme 1, as a clear description of ‘whatness’ when confronted with the emotional reality of work with ‘BPD’ clients, is also elaborated upon by thinking and feeling states that seem to leave trainees preoccupied about their own vulnerability in relation to the client, as though they are totally exposed, or ‘at the mercy’ of the client.

Subtheme 1: sense of self being over-taken and ‘colonized’ by client

Trainees’ accounts highlighted how ‘BPD’ clients would invade and encroach upon their own sense of self. The excerpt below from Leticia illustrates the way in which there was a dissolution of her own sense of self:

“I guess I feel, kind of, submerged into it, like, I know what she’s doing, but I find it hard to resist...”
Indeed, this submersion is experienced as so complete that Leticia remarks: “It felt like I... was HER...!” Leticia goes on to qualify this exclamation by explaining the quality of feeling submerged:

“I really felt like I was her in that moment... it was really strange. I’ve never quite felt that level...of connection...before, without a, kind of, awareness”.

What is striking here is how Leticia both recognises a connection, the forceful submersion, whilst also outlining the limits of her sense-making on this occasion, as it occurs without awareness. This was also conveyed to me as the researcher during the interview. Moreover, I was aware that despite various prompts to enquire about the trainee’s own experience of being with the client, I found myself in elaborate descriptions of the client, without due reference to her own self. It was as though Leticia’s own self and sense-making functions were absent from the encounter.

If Leticia’s sense of colonisation by the client was to lose herself in the encounter, Paul’s was noticeable by the violent, and indeed, nauseating intrusion of the client into all areas of his life. This occurred in relation to being perceived by the client as an abuser. He evocatively described the experience as: “Fucking horrible, absolutely made me sick to my stomach”. Paul goes on to suggest that this sickness permeated everything: “I was so sensitive to it, and [it] started to infect everything”. In hindsight, Paul attempts to make sense of how the client’s perception of him, directly threatened his own self-construct:

“I think, as people, we protect ourselves from those feelings...They’re immoral...and it’s really hard to be with somebody who constantly sees you in that light...It’s a very difficult thing to tolerate as a person, to be seen in that light...”
Thus, in both Leticia and Paul’s accounts one gets a powerful sense of intrusion with the transgression of boundaries between self and other. To work with ‘BPD’ clients, according to the participants’ accounts, is to experience something that leaves one feeling as though one is ‘at the mercy of’ the client.

Subtheme2: self-doubt and loss of confidence

In line with the loss of boundaries between self and other, there is also the entry of prominent self-doubt that is engendered in working with ‘BPD’ clients for trainees. It might be suggested that the sense-making from the encounter, leads to trainees being unable to find a stable professional self to rely on. Jill explained that:

“It does knock your confidence. I remember feeling quite upset, and thinking, ‘Wow, you know, I’ve put so much effort into this client as she’s turning around and acting like […] Well, hey, you’re not good enough anymore, you’re only a trainee, you’re not qualified. And it’s almost like it takes away all the training that you’ve done”

What is striking is the description of the client’s sweeping and annihilating effect on the trainee’s nascent professional self. However, it is not merely an attack on her nascent professional identity that is experienced by Jill, but also more personal feelings of intense ‘worthlessness,’ leading to a sense of withdrawal from the therapeutic encounter: “I probably checked-out as well”.

Likewise, in the following excerpt Lauren illustrates her worrisome and self-doubting thought-processes in her encounter with her client, which lead her to question her very sense of self and reality:

“I used to feel terrible: ‘Oh, I’m a lousy therapist…Maybe I did [say it]…did I?’ second-guessing yourself, ‘Did I say it in a dictatorial [way],
what exactly did I say’ ‘[…], ‘Oh God, you know, what did I actually say? I’m sure I said that, but did I….? Maybe I’m in the twilight zone, which is very, very disconcerting […] ‘Oh God, what did I actually say [worriedly]? Did I actually say it that way that she’s saying?’

Subtheme3: client as a judge.

The client was experienced by some trainees as an all-powerful presence. In Katherine’s case, this was described in terms of an ever-present surveillance that was installed between them which, at times, led to severe doubt in the clinical work. Katherine conveyed her sense that ‘BPD’ clients can somehow recognise her fear of inadequacy:

“They can sense that, they can see that, and I’m afraid of giving the wrong responses or interpreting them in the wrong way”.

For Leticia, the surveillance by the ‘BPD’ client is experienced as a watchfulness for error and quick judgemental retaliation:

“I feel like she’s waiting for me to slip up, maybe...as a trainee”.

Thus, the lived experience and sense-making from trainees was not merely of disturbing affect or troublesome emotions, but also wariness in the face of the perceived authority of the ‘BPD’ client as a powerful noticing and judging presence.

Super-ordinate Theme3: hope and empowerment

Super-ordinate themes 1 and 2 described experiences which were marked with visceral and often troublesome emotions, as well as ‘hindering’ states. However, super-ordinate theme 3 details some of the more creative uses of these difficult experiences, in ways that led
towards professional development, transformation and growth, along CoP values. Concomitant with this professional development was an increasing hopefulness and empowerment amongst trainees. The empowerment described was not one of instrumental action - what might be ‘done to’ an individual with a DSM-5 diagnosis, but how work that is both meaningful and relational might occur. The subordinate themes support the increasing movement towards professional growth by highlighting some of the useful conditions that helped trainees to find reflective spaces to think and grow. Greater reflection was noted by trainees’ ability to consider their own contributions to the therapeutic process.

Subtheme1: freeing-up thinking

Trainees described the importance of utilising facilitative contexts which help process some of their troublesome experiences and promote understanding of the subjective and inter-subjective processes implicated in their therapeutic work. A key context that allowed for this to occur was the containing qualities of supervision.

Oliver’s experience of clinical supervision was that it enabled him to think more freely about the relational aspects of his therapeutic work, by distributing concerns about clinical risk:

“…he [supervisor] was able to reassure me that the risk may not be quite as high as I feared it to be, and, [that] this is not uncommon with clients with personality disorders, to...self-harm and threaten suicide...so, in a sense, he held that aspect of it for me, so I could do the work”

Similarly, Paul credits his supervisor for encouraging him to “stay-with” the overwhelming feelings that were evoked for him in the therapeutic encounter, and consider them as valuable pieces of clinical information:
“just stay with it...That gives you some insight into how difficult it must be for your client...that’s what they feel they’re receiving from people all of the time.”

Moreover, this framework enabled Paul to transform his initial anxieties into curiosities:

“My [initial] response to it was, ‘I must be the worst therapist in the world [...]’ and, then, when you get a framework for it, you think, ‘There are so many ways this person is communicating with me’”

Conversely, Paul also identifies ‘anti-facilitative’ features from his supervisory experience within a different service context from the one described above. Furthermore, he situates ‘uncontainment’ as a troubling ethos within that service as a whole:

“I’m in a placement now that says: ‘You have no place for feelings in the room.’”

Paul described his experience of supervision in that context as a place where his feelings about clinical work were considered ‘irrelevant’ and thus remained ‘unhoused’. However, reflecting upon both of his supervisory experiences in hindsight, he is able to recognise that the transference-countertransference dynamic, which emerged and featured so profoundly in his work with his ‘BPD’ clients, are ‘always at work’ in the therapeutic situation:

“I will always understand that there’s a transference at work. I mightn’t feel it, I mightn’t be listening to it, I mightn’t understand it, I might dismiss it, but I will always understand that there is a transference at work.”

Overall, the containing functions of supervision facilitate thinking and linking, which is particularly vital for the trainees, considering their states of visceral fusion and anxiety described in earlier themes.
Subtheme 2: learning and growth

Transformative insights with regards to trainees’ ‘self-in-relation’ was evident in the transcripts. During these ‘lightbulb’ moments of clarity, connections and links were established which brought together self- and client-understanding.

For instance, Jill recognises how the intense difficulties she experienced within the therapeutic relationship, were the product of a co-creation: “the feelings that it brought-up for me around not feeling good enough...”, in combination with clients’ relational difficulties, which propel them to: “reject you [as their therapist.] before you reject them”.

Similarly, Lauren spoke very candidly about how the client’s intimidating and erratic behaviours tapped into traumatic elements of her own history of relating to her mother:

“My mother behaved in very similar ways...and...so, instantly there’s countertransference [...] I know it comes from that, and I know that’s why it bothers me so much and makes me so tired...”

In Lauren’s case, she connects the emergence and quality of her experience with the client to her pain of not being able to ‘heal’ her own mother: “I really couldn’t help mum...and maybe I would’ve liked to.”

Also, under this theme we begin to encounter a shift from earlier self-doubt and loss of confidence to a more grounded, nuanced and balanced type of sense-making regarding one’s capacity to function therapeutically. Oliver identified the need for the learning to be based in a sense of what was possible within specific therapeutic relationships, arguably, drawing the parameters of what might be hoped for. This sense was noted when he discussed clinical outcomes for his clients:
“You have to be realistic about...what you can achieve within therapy with them, and also although there may not, necessarily be completely overt, positive outcomes, actually, sometimes the relationship that they develop with you, and how they experience that can be quite profound for a lot of these people. So, you know, again, making me look at the outcome of therapy in a different way for these clients, which was really nice”

Overall, for both Oliver and Paul, the learning that took place from working with ‘BPD’ clients under the facilitative contextual parameters outlined in the earlier subtheme, was cited amongst some of the most empowering work that they achieved as trainees. Indeed, Oliver expressed that learning to recognise the relational aspect of the work (including his difficult feelings around it), was “very formative”, and “directed the rest of my professional work”. Paul experienced his learning as “terrifying...reaching into the real guts of being human”; and at the same time, “it was the most powerful piece of learning I think I’ve done in the time on my course”.

Lastly, Natalie described feelings of hope and empowerment within her recognition of her own and her client’s shared humanity. Moreover, she considers the latter to have enabled her to relate to her client ‘beyond their diagnosis’ and at the same time, free herself from anxiety coloured by prejudices and stereotypes around the diagnosis. She states:

“...working in a person-centred approach, you’re there as a fellow human and providing the conditions of worth, you can really take that to anybody, and you don’t necessarily need to have specialist knowledge of different diagnoses...”

In all of the above accounts, there is evidence of reflexivity and an advancement towards CoP values. Also, it appears that hopefulness abounds when there is the possibility to think and work meaningfully and purposively with clients. This is both empowering and on a professional level, transformative.
Discussion:

This research employed IPA methodology to systematically explore trainee counselling psychologists’ lived experiences of working with clients who meet the BPD diagnostic criteria. The findings included three superordinate themes. Those described the explosive and persecutory quality of trainees’ embodied responses, their sense of ‘being at the mercy of’ their client, as well as glimpses of hope and empowerment by the opportunities for growth and transformation that were afforded through their experiences. In what follows, I critically evaluate the empirical contribution of my findings in light of relevant literature. Following this critical evaluation, I draw upon theory to conceptualise and contextualise my findings. I will then conclude by discussing the implications of my research for CoP training and supervision.

Critical evaluation of findings

In order to ponder the contribution of my research findings with respect to the ‘particularity’ of the trainee experience of working with ‘BPD’ clients, I will explore some of the most relevant literature and then critically compare findings and insights. The research study by Rizq (2012), also employed IPA in order to examine the experience of seasoned therapists when working with borderline clients in the context of primary care. In her findings, a quality of ‘vigilance’ emerged, which participants saw as characteristic of working with this client group. Furthermore, they used vivid metaphors such as “walking on eggshells”, to convey their caution in relation to the extreme fragility of their clients. Participants in my study spoke in highly volatile and indeed militaristic terms (e.g. “walking in minefields”). Explosions were one step away in a ‘landmine’ of affect and risk. This difference may indicate how for trainees there seems to be a felt experience of working with ‘BPD’ clients, which is characterised by more affective extremity and danger.
Another finding in Rizq’s study, were the feelings of intrusion and states of confusion which were engendered within participants as a consequence of their encounter with their clients. Moreover, participants portrayed their experience of clients as ‘getting under their skin’ and conveyed their struggle to disentangle ‘which feelings belonged to whom’. This quality constituted a source of anxiety which was often carried over outside work hours. Broadly-speaking, this finding is not dissimilar to that of my study’s. Furthermore, trainees in my research conveyed their intense confusion as their sense of self was experienced as ‘over-taken’ and ‘colonised’ by their client. Thus, transient felt states of ‘self-other’ boundary disintegration and their concomitant anxiety, seem to be a common feature within practitioners’ phenomenological experiences of working with this client group, regardless of whether they are qualified therapists or trainees.

In contrast, perhaps more apparent differences in the quality of experience between trainees and seasoned therapists, are observed when to comes to ‘managing feelings of inadequacy’. Indeed, this constituted a super-ordinate theme in Rizq’s study. In particular, participants felt that “whatever they provided, [and] however ‘good’ they were as therapists, this was unlikely to be enough” (p.39). This sense of inadequacy was linked to what was perceived as the client’s emotional “neediness, which is bottomless” (p.40). In my study, ‘self-doubt and loss of confidence’ was prevalent in trainees’ experience in relation to their clients. However, this doubt appeared to have a more ‘all-encompassing’ and dramatic effect to trainees’ professional self, which readily tapped into their personal feelings of worthlessness too. The latter was alluded within statements such as: “it takes away all the training that you’ve done”, “I’m a lousy therapist”, “infecting everything”, “it knocks your confidence”. Furthermore, this sense of personal annihilation and failure appeared to be linked with persecutory anxiety in relation to their encounter with their clients. This was communicated through notions of the ‘client as a judge’ and as an all-powerful presence, who can somehow ‘sense’ and ‘see-through’ their inadequacies.

So far, the critical discussion of my research findings points towards the trainee’s vulnerability to the ‘BPD’ client’s impact, as well as the experienced threat, invasiveness, and (con)fusion. Some of these features can also be observed in the published case study
of Cambanis (2012). Cambanis detailed her own experience of working with a ‘BPD’ client as a trainee, after recognising the paucity of literature in the area. She candidly offered a personal account of her troublesome and challenging experiences in relation to her client, and the anxiety these stirred-up for her. She writes: “My countertransference reactions to Candice’s projections were often uncomfortable and sometimes intense [...] My reaction to this session was so intense that I cried after she left.” Furthermore, Cambanis describes how thoughts and feelings she experienced in relation to the client terrified her as they violated her idealistic expectations of herself: “My aggressive thoughts caused much anxiety within me as I felt that a “real” psychologist would never experience such an empathic failure and that I would thus never be a successful psychologist.” (p.50). To some extent, this was also observed in my study, through Lauren’s and Paul’s distressing responses to their clients’ perceptions of them as ‘dictatorial’ and ‘abusive’, respectively. Paul characteristically stated that: “as people, we protect ourselves from those feelings...They’re immoral...”. Moreover, this ‘protection’ from thoughts and feelings deemed to be ‘immoral’ is what makes it: “...a very difficult thing to tolerate as a person, to be seen in that light...”

**Theoretical Analysis**

At this point, the critical discussion lends itself towards delving deeper into relevant theory, in order to conceptualise this quality of ‘explosive-vulnerability’ which powerfully emerges within trainees’ phenomenological experiences of working with those clients. Moreover, trainees’ *permeability* to their clients’ impact, and the *extremity* of their embodied-affective responses in the therapeutic encounter, could be understood as instances where their reflective capacities become curtailed and there is a corresponding difficulty in regulating their affect. In particular, the ‘as if’ quality seems to be compromised within their reflective functioning, when their clients’ perceptions of them are taken as somehow *isomorphic* to their very identity as people. Overall, it is noteworthy that these aspects mirror the longstanding psychological difficulties that ‘BPD’ clients themselves are known to struggle with (Fonagy et al., 2002; Fonagy & Target; 1996; 2000; Linehan, 1993).
As argued in my introduction, from a ‘two-person psychology’ paradigm, the subjectivity of the therapist actively constructs the meaning, selection and interpretation of the engagement with the client. For that reason, it is imperative that the trainees’ experiences (as described so far), are understood with reference to what is known from published literature regarding the ‘trainee subjectivity’. In turn, this understanding might help shed light into the specific intersubjective processes underpinning trainees’ relational experiences with those clients. To that end, I identify certain features of the ‘trainee context’, which I deem as most pertinent to this discussion. These are: trainees’ idealistic expectations and the high prevalence of their narcissistic injuries. Thus, in what follows, I unpack each of these components before considering their potential role in the intersubjective process between trainees’ and ‘BPD’ clients.

Psychoanalytic literature has identified ‘unconscious myths’ that trainees often bring with them upon embarking their trainings. The myths revolve around preconceived notions of what it means to be a ‘good therapist’ (Briggs, 1979, p.136). Briefly, these myths/preconceptions, are: that therapists love their clients, that they are endowed with magical powers of understanding, that clients are invariably appreciative and that therapists are eternally forgiving. Similarly, Maltsberger and Buie (1974), describe the 3 narcissistic snares as: ‘heal all, know all, love all’. In both conceptions, these ‘myths’ are considered counter-productive to therapeutic work by inhibiting exploratory engagement. For Briggs, mobilisation of these myths within the trainee, are components of how unthought-of transference might bind and disable the therapeutic capacity of the work. Additionally, trainees’ idealistic expectations have been associated with psychological vulnerability, such as feelings of inadequacy, self-blame, guilt, etc. (Skovholt & Ronnestad, 2003; Ronnestad & Skovholt, 2001).

I argue that these myths/idealistic expectations powerfully feature within trainees’ own internal worlds, as shaped by their development. This hypothesis is supported by the ‘wounded-healer’ literature, as well as a quantitative study by Halewood and Tribe (2003). The latter indicated a high degree of narcissistic injury among trainee counselling
psychologists (as compared to matched, non-psychologist controls), and its relationship to the quality of the perceived parent–child relationship.

In their paper, Halewood and Tribe (2003) begin by reviewing and synthesizing literature on narcissism and narcissistic injury, loosely defining the former as a loss of a sense of self, and the latter as damage to the individuals’ experience of their ‘real self’, resulting from environmental impingement (from a Winnicottean perspective). When impingement becomes systematic in children’s early developmental history, they lose touch with an authentic sense of themselves (including their needs, feelings, etc.). At the same time, they develop an acute sensitivity to the narcissistic needs of their caregivers and others, and tend to be compulsively accommodating to those. Their anxiety not to anger, upset, or distress others, subsequently defines their mode-of-relating. Altogether, these relational patterns may attract these individuals to the therapeutic professions. Perhaps more worryingly, their professional role might provide a means for them to project their own disavowed needs into others, as opposed to dealing with them directly (Menninger, 1957; Glickauf-Hughes & Mehlman, 1995; both cited in Halewood & Tribe, 2003). Based on their study’s findings, Halewood and Tribe (2003) tentatively suggest that the presence of narcissistic injury among trainees, supports the notion that those with a high degree of narcissistic injury are attracted to the therapeutic field. This is also in alignment with other ‘wounded-healer’ literature (e.g. Barnett, 2007; Huynh & Rhodes, 2011; Truell, 2001), as well as another quantitative study by DiCaccavo (2002), indicating high levels of ‘parentification’ in therapists’ past.

Thus, from a psychodynamic perspective, it is plausible to hypothesize that the trainee’s negative internal object relationships (e.g. ‘needy’ self in relation to an inattentive, misattuned or dysregulating caregiver) and their associated affect (e.g. anger or terror), remain largely split-off or denied aspects of the self. Furthermore, the therapeutic relationship itself, may initially serve as an opportunity to further deny the awareness of those aspects within the self, through striving to enact an endowed, idealised object relationship, shaped by the trainees’ ‘unconscious myths’ about their role as ‘helper’. Interestingly, this premise accords with a couple of psychodynamic clinical observation
papers written by experienced practitioners/supervisors, regarding the defensive manoeuvres which trainees appear to employ in session (Briggs, 1979; Davis, 2002). According to the two authors, such defensive manoeuvres aim to prevent one from ‘staying with’ intense and powerful feelings in the room, associated with the transferential - countertransferential therapeutic relationship.

With the above in mind, during the therapeutic encounter with the ‘BPD’ client, trainees are confronted with a particular type of transference manifestation, which has been the focus of extensive psychoanalytic theorising (e.g. Carsky & Yeomans, 2012; Clarkin & Yeomans, 2013; Kernberg, 2003; Levy et al. 2006; Volkan, 1993). Briefly, this transference has been characterised as ‘flooded’ by the client’s projections of his/her constantly-shifting, disparate and polarised ‘good’ and ‘bad’ object relationships, infused with intense affect. Within those transferred relational configurations, the therapist will often find him/herself in assigned roles of abuser/sadist, victim, or resuer. In order to promote awareness, understanding and integration of those configurations within the client’s sense of self, the therapist must tolerate being the object of the client’s negative transferences, and furthermore be able to think and explore their meaning in collaboration with the client. However, as Spurling (p.37; 2003) aptly puts it, “The projections counsellors are bound to have most difficulty with are those which most threaten the sense of themselves as caring, effective, or potent therapists.” Furthermore, considering my argued notions about the trainee’s defensive investment in this ‘idealised helper’ role, the encounter with the ‘BPD’ client’s transference, would emotionally confront the neophyte therapist with precisely those aspects of the self which are felt as most unbearable and thus have been dissociated from awareness. In this way, the ‘BPD’ clients’ intense transferences powerfully resonate within trainees. Moreover, this idea may partly account for the quality of ‘explosive-vulnerability’ in trainees’ felt experiences within this study, which transiently undermines their capacity for reflective thinking and affect regulation.

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2 In turn, these relational constellations have been shaped by the developmental histories of these clients, which includes a high prevalence of trauma, attachment difficulties, and adversity (Balbernie, 2001; Perry et al., 1995; Schore, 2001a; Herman et al., 1989).
Implications for training and supervision

The discussion so far, provides a platform from which to consider the implications of these emerging understandings for CoP training and supervision. With that in mind, it is important to revisit my 3rd theme and its emphasis on ‘hope and empowerment’. That theme outlines trainees’ growth and development in areas such as: self-awareness, self-reflexivity, and deeper understanding of the inter-psychic processes in the therapeutic relationship. Overall, in this theme we encounter a noticeable difference in trainees’ depictions of their experiences. The earlier ‘fight-or-flight’ states begin to give way to more grounded, balanced and realistic appraisals of their self-in-relation. This movement can be conceptualised as a milestone in the trainee’s development towards acquiring a more mature professional identity. Indeed, many of these trainees deemed their supervised work with those clients as the most formative aspects of their CoP training. This view of the work as ‘uniquely challenging’ yet also potentially ‘growth-promoting’, accords with supervisors’ views (Fazio-Griffith & Curry, 2009).

In light of my earlier discussion, growth and development would be expected in those areas which contributed to trainees’ felt experience of ‘explosive vulnerability’ in the first place. Moreover, I propose that this work provides opportunities for the trainee to gain a more complex and nuanced appreciation on the nature of (their own and their client’s) subjectivity. The latter encompasses an encounter with the more uncongenial aspects of the self, and the chance to recognise and ‘own’ denied/split-off aspects of their experience. Rizq (p.462; 2005), has written eloquently about the: “necessity to think about, acknowledge and tolerate the most painful, unbearable aspects of ourselves, and our human tendency to disown and reject these by locating them in others.” Moreover, she positions this as a hallmark of CoP’s relational approach to practice. With this nuanced view of subjectivity, also comes trainees’ fuller appreciation of the intricacies of the therapeutic relationship. The latter becomes increasingly less dominated by their assumptions, emotional investments and ‘idealistic expectations’ about their role as a professional. For example, this is evident in Paul’s transformation of acute anxiety and black-and-white
thinking, to a more curious stance: “My [initial] response to it was, ‘I must be the worst therapist in the world [...]’ and, then, when you get a framework for it, you think, ‘There are so many ways this person is communicating with me’”

Before closing this discussion, it would be useful to briefly explore the facilitative conditions under which the aforementioned growth and development seems to occur, and the implications of this understanding for CoP training and supervision. On that note, the containing aspects of supervision emerged as by far, the most powerful and facilitative context for trainees in this study. Moreover, they noted how supervision as a space for containing their anxieties, allowed for the development of curiosity within their therapeutic work which ‘freed-up’ their thinking. Consequently, the absence of this space was registered with a degree of distress and despondency.

Interestingly, this sense was echoed in Rizq’s (2012) study too, where participants expressed feeling unsupported by the type of supervision which was heavily geared towards “providing expert advice and technical information, rather than examining complex unconscious process issues” (p.42). In Fazio-Griffith and Curry’s (2009) study on ‘clinical supervisors' perceptions of the supervision process with trainees who counsel clients with BPD characteristics’, one of the subthemes indicated the importance of ‘acknowledging and validating trainee frustration’. However, participants also expressed the need for specialised training for supervisors in this particular area. In that regard, I suggest that the potential relevance of Bion’s (1959, 1962a, 1962b) theories on ‘linking’ and the ‘container-contained’ relationship, merits examination in relation to the supervisory needs for trainees who provide therapy to ‘BPD’ clients. Overall, there is also a need for supervisors (and trainees) who work in certain service contexts whose ethos and models of practice may not necessarily be compatible with the level of emotional participation that is demanded by therapeutic work with ‘BPD’ clients, to reflect upon issues and dilemmas arising from this conflict. This is an area which CoP is highly adept to grapple with, due to its pluralistic and relational outlook, and ability to hold rather than resolve tensions (Orlans & VanScoyoc, 2009).
Apart from the containing aspects of supervision, other considerations pertain to personal and professional development components within training; specifically, questions around the extent to which personal therapy and structures incorporated within CoP training programmes themselves (such as PPD groups and experiential workshops), facilitate trainees’ self-awareness. Rizq (2003; 2005; 2010a; 2010b) has written extensively about the need for personal therapy to provide trainees with a relational context in which the intricacies of their own subjectivity can be thoroughly explored. Likewise, from a more purely psychoanalytic perspective, Spurling (p.38-39; 2003) writes about the importance of “an acquaintance with […] the more psychotic parts of one’s personality. If these more primitive aspects of one’s make-up can be known about and accepted, they are less likely to be experienced as overwhelmingly frightening or alien when they start to resonate with the mad parts of the borderline client”

In conclusion, I wish to emphasise that the experiences and developmental conflicts described here are continually revisited and ‘reworked’ by practitioners throughout their careers (as reflected by the voluminous literature on therapists’ struggle to manage their ‘difficult countertransferences’ with those clients). Yet, the findings of this study indicate how trainees’ initial exposure to ‘explosive-vulnerability’, along with the ‘working-through’ (Brenman-Pick, 1985) of their experience, may well represent a ‘baptism of fire’ as a relational-psychotherapeutic practitioner. Finally, considering the presence and potency of embodied responses in this study, future research may benefit from a closer examination of how therapists’ embodied experiences manifest and come to be utilised therapeutically.
References:


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List of Appendices:

1. Ethical Clearance
2. Recruitment Email
3. Participant Information Sheet
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5. Demographic Questionnaire
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Appendix 1: Ethical Clearance

Fast Track research ethics Checklist Form and Summary Ref: FT-PSY-208-15 - Confirmation to proceed

Earl JE Mrs (FHMS Faculty Admin)

02/12/2015
Dear Joy

Thank you for submitting your ethics study Checklist form and Summary to the Faculty of Health and Medical Sciences Ethics Committee via the Fast Track procedure. I am pleased to confirm that your project, as stated in your application, does not raise any issues that would necessitate a full review and you are therefore able to proceed with your research.

Please keep your original checklist form and summary with the reference given above together with a copy of this email, as no copies are kept by the ethics committee.

If there are any significant changes to your project which require further scrutiny, please contact the Ethics Committee before proceeding with your Project.

Many thanks and good luck with your research

With best wishes

Julie

Julie Earl
Administrator Faculty of Health and Medical Sciences Ethics Committee
Summary of the project

Objective: The aim of this research is to investigate how trainee counselling psychologists experience and make sense of their clinical practice with clients who meet the diagnostic criteria for ‘borderline personality disorder’ (BPD), using Interpretative Phenomenological Analysis (IPA). It is hoped that this research will inform course providers and supervisors in relation to training and also provide other trainees a better understanding of the lived experience of working with this client group.

Participants & Procedure: A semi-structured interview approach will be used and interviews will last approximately 60-90 minutes. An interview-schedule will be used as a general guide, with questions designed to tap into participants’ experience and meaning-making in relation to the phenomenon. Interviews will be audio-recorded stored on an encrypted USB and subsequently transcribed using IPA guidelines (Smith et al., 2009). Analysis will involve a close and detailed interpretative engagement with the data which will enable the researcher to critically explore and interpret manifest and latent themes that capture the richness and breadth of participants’ ‘lived reality’ in relation to the phenomenon, within and across accounts. A sample size of around 6-8 participants is deemed appropriate for the current study. Two inclusion criteria are proposed: 1) current
trainee counselling psychologist, 2nd) with current or past experience of providing therapy to a client(s) who meet the ‘BPD’ diagnostic criteria.

Participants will be recruited through two main avenues: training providers (e.g. university-based CoP trainings), and relevant clinical settings (e.g. BPD specialist units/services/psychotherapy departments). Course leaders of CoP training programmes and service directors will be contacted via email and asked to forward an electronic leaflet/email, prepared by the researcher, calling for participants to take part in the study. This leaflet will be outlining the study’s aims and include the researcher’s details. Individuals who meet the inclusion criteria and willing to discuss participation will be asked to contact the researcher. Potential participants will be given an information sheet, a consent form to sign, as well as a brief demographics questionnaire. Upon completion of the interview, participants will be offered the opportunity to discuss any questions they might have regarding the interview process, as well as offered a debriefing sheet.

Ethical considerations: Whilst no specific risks have been identified for participating in this study, the nature of this enquiry involves participants’ engagement with sensitive topics that may uncover distressing/sensitive material. The following steps will be taken to ensure adherence to ethical practice in accordance with the BPS codes of ethics (BPS, 2009 & 2010). These include – but are not limited to – obtaining ethical approval from Surrey University prior to commencing research; gaining participants’ voluntary informed consent; safeguarding confidentiality/anonymity of participants as well as their clients in accordance with the Data Protection Act (1998); briefing and debriefing; clarifying withdrawal right; providing opportunities for clarifications; informing about potentially invoking upsetting material; and taking measures to eliminate risk/distress.

Researcher: Joy Kokkalis,
Faculty of Health and Medical Sciences Ethics Committee (School of Psychology)

Project Title: How do trainee counselling psychologists make sense of their clinical practice with clients who meet the diagnostic criteria for 'BPD'? - An Interpretative Phenomenological Analysis.

Name of student: Joy Kokkalis       Course: PsychD in Psychotherapeutic and Counselling Psychology

Supervisor: Dr. Elena Manafi

The following applies to ALL undergraduate and postgraduate (Masters) level research.

Some types of research need ethical approval. The following checklist is designed to allow you and your supervisor to establish very quickly whether your study will need ethical approval. It will also allow you to discuss alternative approaches that do not require ethical approval with your supervisor.

You should, in discussion with your Supervisor, complete the attached form, and sign where indicated. Your Supervisor must countersign the form. Please provide a summary of the project, (approximately 500 words), including its principal aims and objectives with this form. This should provide a clear description of who is doing what, to whom, to how many, how long, where, when and why – in non-technical, lay terms.

- If your research requires review by NHS Research Ethics Committee an application for ethical review to the School of Psychology Ethics Committee is NOT necessary.
- If you answer 'NO' to all questions, the form together with the attached summary should then be taken to Julie Earl (16DR03), where staff will record that your form has been completed. The form will be stamped and returned to you. Then your research is considered to be ethically acceptable according to the 'Ethical Guidelines for Teaching and Research' and you may proceed without further notice.
- If you answer 'YES' to any of the questions (but question 1) but think that this is covered by a favourable ethical opinion from another Ethics Committee (or other credible ethical review body), please attach confirmation of this ethical opinion (that is, a letter from the Chair of that Committee or review body). The form should then be submitted to the School of Psychology Ethics Committee (fhmsethics@surrey.ac.uk). You will receive a decision on your application within one week.
- In any other cases you should seek full formal ethical review from the relevant Ethics Committee.

YOU MAY NOT COLLECT DATA BEFORE IT HAS BEEN CONFIRMED THAT ETHICAL APPROVAL IS NOT REQUIRED, OR UNTIL A FAVOURABLE ETHICAL OPINION IS OBTAINED. ALL STUDENTS MUST INCLUDE THE COMPLETED FORM IN THEIR DISSERTATION/REPORT AS AN APPENDIX.

Declarations:

I the undersigned confirm that I have read the 'Ethical Guidelines for Teaching and Research at the University of Surrey' and I am aware of the 'Code on Good Research Practice'. I understand that the project is monitored and audited by the Faculty Ethics Committee to ensure that it is carried out in accordance with good practice, legal and ethical requirements and any other guidelines.

I am also aware that any knowingly wrong answer to any of the questions below and any research misconduct reported to the Faculty Ethics Committee may lead to disciplinary measures after investigation. In case of dissertation projects, the provision of knowingly incorrect information or proven research misconduct will lead to failure to complete the dissertation project.
Investigator: Joy Kokkalis, 28/11/2015,

Project Title: How do trainee counselling psychologists make sense of their clinical practice with clients who meet the diagnostic criteria for ‘BPD’? - An Interpretative Phenomenological Analysis.

1. NHS Review
   a. Does the study require review by an NHS Research Ethics Committee? Yes ☐ No x

2. Research Participants
   a. Is the research proposal to be carried out by persons unconnected with the University, but wishing to use staff and/or students as participants? Yes ☐ No x
   b. Does the study involve prisoners or young offenders? Yes ☐ No x
   c. Does the study involve children under 16 years or other vulnerable groups such as those 16 and over who may feel under pressure to take part due to their connection with the researcher? Yes ☐ No x
   d. Do you plan to provide financial payments or payments in kind to participants above reimbursement for out of pocket expenses, provision of refreshments or entry into a low-value prize draw, or could the compensation amount to an hourly rate more than the minimum wage or more than £100 in total, or do you otherwise plan to offer incentives which may unduly influence participants’ decision to participate? Yes ☐ No x
   e. Are you investigating existing working or professional practices among participants, identifiable to yourself as the researcher at the University of Surrey? Yes ☐ No x

3. Research Protocol
   a. Does the study involve any risk to a participant’s health or well-being (for example intrusive physiological or psychological procedures)? Yes ☐ No x
   b. Could questioning – in questionnaire or in interview – or other methods used, cause offence, be distressing or be deeply personal for the target group? Yes ☐ No x
   c. Does the research involve the new collection or donation of human tissue from a living person or the recently deceased according to the Human Tissue Authority? Yes ☐ No x
   d. Does the research require participants to take part in the study without their knowledge and/or consent at the time (e.g. covert observations, emergency research)? Yes ☐ No x
   e. Does the research involve deception other than withholding information about the aims of the research until the debriefing? Yes ☐ No x
   f. Does the research involve activities where the safety/wellbeing of the researcher may be in question? Yes ☐ No x
   g. Could the behavioural/physiological intervention possibly lead to discovery of ill health or concerns about wellbeing in a participant incidentally even if the intervention in itself causes no more than minimal stress is to the research participant? Yes ☐ No x
4. Data Protection
   a. Does the study involve access of records of personal or sensitive confidential information? Yes □ No x
   b. Are you linking or sharing personal data or confidential information beyond the initial consent given (including linked data gathered outside of the UK)? Yes □ No x
   c. Will you collect or access audio/video recordings, photographs or quotations within which participants may be identifiable and with the intention to disseminate those beyond the research team? Yes □ No x

Investigator: Joy Kokkalis, 28/11/2015,

Supervisor’s approval of the above assessment:

Yes □ No □ Date: 30th November 2015
Appendix 2: Recruitment Email

Are you a trainee counselling psychologist?
Do you have experience of clinical practice with at least one client who meets the DSM diagnostic criteria for ‘Borderline Personality Disorder’?
Are you under supervision for your clinical work?

If the above 3 criteria apply to you, then please read the following as it may be of interest to you...

My name is Joy Kokkalis and I am in my second year of training for my PsychD in Psychotherapeutic and Counselling Psychology at the University of Surrey. I am currently looking to recruit participants for my qualitative research project exploring trainee counselling psychologists’ experiences of working with clients who meet the diagnostic criteria for ‘Borderline Personality Disorder’ (BPD).

To enquire potential interest, I am contacting trainee counselling psychologists through BPS-accredited training institutions as well as specialist psychotherapy units. I am interested in interviewing trainees who are currently working, or have worked, with clients who meet the DSM diagnostic criteria for ‘BPD’.

On this basis I would like to invite you to read attached Information Sheet detailing the proposed research and your potential role if you are interested in participating. Please read this carefully. You should only participate if you want to; choosing not to take part will not disadvantage you in any way.

Please feel free to contact me if there is anything that is not clear or if you would like more information. If you are interested in participating in this project it would be great to hear from you to talk about the next step.

Thank you for taking the time to read this e-mail.

Best wishes,
Joy Kokkalis.
Appendix 3: Participant Information Sheet

Participant Information Sheet

Practitioner Doctorate in Psychotherapeutic and Counselling Psychology

RESEARCH STUDY:

Exploring trainee counselling psychologists’ experiences of working with clients who meet the diagnostic criteria for ‘Borderline Personality Disorder’ (‘BPD’) - An Interpretative Phenomenological Analysis.

I am a trainee counselling psychologist at the University of Surrey conducting a research study which focuses on an interpretative phenomenological investigation of trainee counselling psychologists’ experiences of working therapeutically with clients who meet the diagnostic criteria for borderline personality disorder (‘BPD’). During the first year of my training I conducted a literature review which focused on the relational processes that are involved in working therapeutically with clients who meet the diagnostic criteria for ‘BPD’. It emerged that: a) relational challenges - such as practitioners’ challenging emotional reactions and complex interpersonal dynamics- are a key feature of the work, and b) the majority of literature that has been carried out is from the vantage point of qualified practitioners whereas the perspectives of trainees seem to be largely absent. Up to date, there is no published research on trainee experiences in relation to working with this particular group and it is important to explore this novel area considering the fact that trainees are likely to be working with these clients from the early stages of their training. It is hoped that knowledge from this research will provide us with valuable insights on trainees’ experiences in relation to their work and shed light which will help to enhance the care of these clients as well as offer training institutions and supervisors a better understanding of how to support trainees who work with clients who meet the diagnostic criteria for borderline personality disorder (‘BPD’).
You are being invited to take part in this study but before you decide whether you wish to participate, it is important that you understand what it will involve. Please take the time to read the following information, think about it and decide whether you would like to take part. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. If you have any questions or anything is unclear, please do not hesitate to ask me.

**Participation**

If you agree to take part in my research, I will invite you to participate in an interview with me in which I will ask you some questions about your experience of this topic. The interview will take place within a quiet and confidential space, at a mutually agreeable time, date and location. No preparation is required for any part of your participation and I will meet with you just once for about an hour and a half. Prior to our interview I will ask you to sign a consent form and fill-in a very brief participant demographics questionnaire, which has been included in this email. Following the interview, we will have time for debriefing and discussing your experience of the interview and any concerns that you might have relating to the interview process. Please note you that you may withdraw from the study at any time without providing any reason.

**Confidentiality:**

Your interview will be audio-recorded, securely stored on an encrypted USB (to which only I will have access to) and subsequently transcribed for analysis. At all times your identity will be protected and any information that might identify you or your clients will be concealed to safeguard confidentiality and anonymity (Data Protection Act, 1998). Following analysis, the results will be presented in my thesis. Any quotations used in the write-up of the research report will be anonymised so that you and your clients cannot be identified from what you have shared with me. Transcripts of the recordings may be made available in a totally anonymous form to my supervisor for research purposes only. This means that, with your permission, my supervisor will have access to the answers you provided, although they will have no means of identifying you. My research study may later be published in a journal (all participants’ names and any identifying information will be withheld).

**Are There Any Risks Involved in Participating?**
No known risks have been identified for participating in this study. However, given the experiential nature of the enquiry, engagement with the questions may potentially touch off sensitive areas that could trigger discomfort or distress for you. If you have any concerns during any stage of your participation, I will endeavor to discuss them with you and consider the various options for resolving your concerns. If there are questions that you find distressing or intrusive you are free not to answer or withdraw from participating. As mentioned earlier, there will be allocated time at the end of the interview for debriefing and checking-in with your experience of being interviewed. If you subsequently feel that you could use some support to discuss anything which may have arisen for you during the interview, I can provide you with a list of suggested supports that you can make use of if you wish. These suggested supports will include people such as your supervisor, your personal therapist, your course leader, your GP and helpline numbers.

**Are There Any Benefits to Participating?**
The interview can be used as an opportunity for engaging in reflection-on-practice which is an essential ingredient of your training.

**Ethical Clearance:**
This study has received ethical approval from the University of Surrey, Faculty of Health & Medical Sciences Ethics Committee.

If you have any questions about this study or are interested in taking part, please contact me on: j.kokkalis@surrey.ac.uk. Or alternatively you could contact my research supervisor, Dr. Elena Manafi, on: e.manafi@surrey.ac.uk.

Thank you for taking the time to read this information sheet.

Yours Sincerely,

Joy Kokkalis

Counselling Psychologist in Training.
Appendix 4: Consent Form

Participant Consent Form

I, the undersigned, voluntarily agree to take part in the interpretative phenomenological investigation of trainee counselling psychologists’ experiences of working therapeutically with clients who meet the DSM diagnostic criteria for ‘borderline personality disorder’ (‘BPD’). I have read and understood the Information Sheet provided and been given a full explanation by the conductor of the nature, purpose, location, and likely duration of the research interview, and of what I will be expected to do. I have been given the opportunity to ask questions on all its aspects and have understood the advice and information given as a result. I give permission for my interview with Joy Kokkalais to be audio-recorded and transcribed and I understand that interview recordings and subsequent transcripts will be treated in the strictest of confidence, in accordance with the Data Protection Act (1998). I understand that any information that might identify me or my clients will be concealed to safeguard confidentiality and anonymity, and disguised and anonymised extracts from what I say may be quoted in the thesis and subsequent publications. I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice. Finally, I confirm that I am under supervision for my clinical work.

I confirm that I have read and understood the above and freely consent to participate in this research. I have been given adequate time to consider my participation and agree to comply with its instructions and restrictions.
Appendix 5: Demographic Questionnaire

Demographics questionnaire.

The following information will help to further contextualise your interview. All information will be treated confidentially, in accordance with the Data Protection Act (1998). Nevertheless, if you don’t want to answer some of these questions, please feel free not to.

1. What is your gender? ________________________________

2. How old are you? ________________________________

3. What is your ethnic background? ________________________________

4. In which institution are you currently undertaking your Counselling Psychology training?

________________________________________________________________________

5. What is the length of your training and how many years have you completed so far?
6. How would you describe the theoretical orientation of your training?

____________________________________________________________________

7. What theoretical paradigms have you been taught so far in your training?

____________________________________________________________________

8. In which clinical context have you been working with this client group?

____________________________________________________________________

Thank you very much for taking the time to answer this questionnaire.
Appendix 6: Excerpt from the Analysis of a Transcript

( Due to confidentiality reasons, only a brief segment is presented.)
I felt like I was her mother. So, at times, she felt like when we were working together, she was trying to please me and she was trying to, like, 'Look at this, and I've been doing this homework,' and she'd be bringing stuff in, which I hadn't asked her to do, but she was, she was, like, doing loads on the outside as well. And then, at other times, you know, she'd be like, 'Oh, this is going really well, this is helpful, enthusiastically,' and then she'd come back the next week and be like, 'Oh, but I've just had, like, erm... a work evaluation, you know, er, a review at work, and, erm... I, with, say, like, coach or something, and who's told me I've got XXX wrong with me, or this is what I need to do in my behaviours,' and it would almost like, I felt rejected, then, when she would come in and she would be like, 'Oh, well, this person... and it almost felt like that person knew better,' disappointedly.

Shift from being a very good, helpful therapist to being a crap one.

It was a difficult feeling in relation to client, feeling rejected by client, not good enough.

He feels shut out by client being difficult.

So, we had... I felt we'd got quite close through the therapy... and, then, near the end, it was like there was a switch in the person, in her personality, and she came in and she was very much like, 'Oh, I'm... I don't...'... [thinking] yeah, what was it? I'm trying to remember now. She, I think she was like, 'Oh, I need to be fixed now, I need to be fixed, this, I'm not sure this is working for me,' or something... And, then, erm... and we work, we talked through it... because she had, or, got it in her head then she needed DBT instead, instead of this. And... she'd also talked about a diagnosis, like feeling like... [thinking]... that was it...
Appendix 7: Audit trail of Analysis

(Omitted due to confidentiality reasons).
Appendix 8: One Complete Transcript with feedback from supervisor on interviewing stance

(Omitted due to confidentiality reasons).
Appendix 9: Interview Schedule

INTERVIEW SCHEDULE:
- (start: what attracted you to take part in this research project?)
  1) What is your own understanding of ‘BPD’? (Exploring participant’s sense-making processes).
     Prompts:
     • What informs this understanding?
     • Different areas of training (e.g., theory, supervision, clinical practice, diagnostic criteria, etc.)

(Transition from exploring participant’s understanding of ‘BPD’ to exploring experience of working with BPD):
Now that we talked about your understanding of BPD, I would like us to turn to discussing your own experience of working with clients with BPD. Prompts: A) do you frequently work with clients who have been diagnosed with BPD? B) In what context are you working with them? C) Can you recall a client with whom you worked whose presentation met the BPD diagnostic criteria?

  2) What has been your experience of working with this group of clients? (Exploring participant’s lived, subjective, contextual experience).
     Prompts:
     • Could you tell me more about the experiential element of your work (i.e., your feelings towards the client, any changes of how you experienced the client during therapeutic work, any defining/pivotal moments in your therapeutic work that stood out, etc).
     • What about being a trainee?

  3) What informed your practice when working with these clients and how did it do so? (Exploring experiences of support in relation to trainees’ work with these clients).
Prompts:

- Prompts: supervision, personal therapy, theory, other?

4) Overall, what have you learned from your experience of working with these clients, as a trainee? *(exploring impact of experience on trainees’ developing professional identity)*
   - How has it influenced your professional & personal development?

5) *(Concluding remarks)*: Is there anything else you that would like to add?
Appendix 10: Reflexivity

(Omitted due to confidentiality reasons).
Appendix 11: Quality Assessment

Yardley's (2000) Evaluative Criteria: Sensitivity to context; Commitment and rigour; Transparency and coherence; Impact and importance.

Ways in which the above criteria are satisfied in the current research:

✓ Thorough contextualization of the research question within theoretical literature (see Introduction and Discussion)
✓ Use of supervision and audit, to help test and develop the coherence and plausibility of my interpretations (outlined in data analysis steps and relevant appendices)
✓ Consideration of reflexivity and, in particular, personal and theoretical influences in my interpretative frameworks and how those shaped the ‘findings’ throughout each stage of the process (see ethics and reflexivity sections)
✓ Data collection in accordance with the epistemological position of the methodology (description of my stance and provision of a full transcript)
✓ Detailed, painstaking engagement with the analysis of the data and transparent provision of the data analysis steps involved (see data analysis steps, relevant appendices)
✓ Nuanced consideration of relational ethics.
✓ Elaboration on theoretical and practical implications of the research’s findings (see discussion)
✓ Choice of method and rationale for its adoption, (argument about fit between research question and methodology)
✓ Sensitivity and respect to participants’ experiences (demonstrated through interviewing stance and relational ethics)
✓ Attention to detail in analysing data
✓ Prolonged engagement with the topic and immersion in the data through meticulous analysis.
Qualitative research study 2: How do therapists use their embodied experiences in the therapeutic process? – A thematic analysis.

Abstract:

The therapist’s embodied presence in the therapeutic encounter has been an area of increasing theoretical and clinical interest. This mirrors the gradual shift from a so-called ‘one-person’ to a ‘two-person psychology’ paradigm (Aron, 1990). Yet, despite the acknowledged significance and ‘inevitability’ of the phenomenon, at present there is a paucity of empirical research. The current qualitative investigation sought to explore how therapists utilise their embodied experiences in the psychotherapeutic process. In particular, it aimed to offer an in-depth understanding of the subjective and intersubjective processes underpinning this endeavour. This topic is of vital relevance to Counselling Psychology (CoP), as it is consistent with the relational values underpinning its philosophy; specifically, its emphasis on the therapeutic relationship and the therapist’s ‘use of self’ in the therapeutic process (BPS, 2017). In-depth, semi-structured interviews were conducted with 6 qualified and experienced therapeutic practitioners (counselling psychologists and psychotherapists). The interviews were transcribed and analysed using Thematic Analysis (Braun & Clark, 2013). The following iterative themes emerged from my analysis: (1) Using somatic experiences as ‘raw data’ from which to make sense of the client and the therapeutic process; (2) Using embodied understandings to grapple with ethical and reflexivity issues in the therapeutic relationship; (3) Different ways of incorporating embodied experiences into a therapeutic intervention. The contribution of these findings is discussed with reference to the existing empirical and theoretical literature. Finally, their implications in terms of CoP theory and practice are elaborated.
Introduction:

Contextualising the phenomenon under investigation.

In my previous research study, I explored CoP trainees’ experience of working with clients with a diagnosis of borderline personality disorder (‘BPD’) and noticed their forceful visceral responses (Kokkalis, 2016). In particular, trainees’ encounter with ‘BPD’ clients, was vividly described in visceral ways and their experience was characterised by ‘fight-flight-freeze’ states, immobilisation, restriction of thought and incongruence in the therapeutic process. This striking finding led me to consider the role of the therapist’s body in the therapeutic encounter more generally, and in particular, ways in which it may come to be utilised therapeutically. Indeed, as I will later discuss, the role of therapist’s embodied presence in the therapeutic encounter is an area of increasing theoretical and clinical interest.

The phenomenon may take various forms and has been documented to range from subtle (e.g. alterations to voice, adjusting posture, etc.), to more powerful visceral responses (e.g. muscle tension, nausea, pains and aches, headaches, feelings of suffocation, sleepiness, hunger, numbness, sexual arousal) (Booth et al., 2010; Egan & Carr, 2008; Shaw, 2003; 2004). Coming from a Jungian perspective, Stone (2006) suggested that the phenomenon tends to be more ‘amplified’, in situations where a number of conditions come together, i.e.: 1) working with client presentations involving trauma, borderline, and narcissistic traits; 2) when there is fear of expressing strong emotions directly; 3) when the “typology” of the analyst is characterized as being that of an “introverted intuition” (p.118). Similarly, in his small-scale research study based on 30 psychotherapists, Samuels (1985) noted that patients with what he refers to as ‘instinctual problems’ (i.e. difficulties centred around sex, aggression or eating), were more likely to evoke a physical response in the therapist. With regards to the frequency of therapist responses, Samuels estimated that 46% of reported ‘countertransference’ responses, fell into the ‘embodied’ category, namely “a physical, actual, material, sensual expression in the analyst of something in the patient's
inner world” (p.52). In contrast, writing from a phenomenological ‘lived-body’ perspective, Shaw (2003; 2004) positioned the phenomenon as a ‘ubiquitous’ feature of the therapeutic endeavor and part of ‘day-to-day practice’, as opposed to a ‘special’, ‘one-off’ type of experience. This has been further corroborated by a quantitative study by Booth, Trimble and Egan, (2010).

Several authors have noted that despite the ubiquity of the phenomenon, it has historically been overlooked as an area of theoretical interest (Athanasiadou & Halewood, 2011; Orbach, 2004; Rumble, 2010; Shaw, 2004, 2003; Soth, 2006). Some attribute this ‘oversight’ to Cartesian dichotomies permeating our field, whilst others emphasize the role of therapists’ own ‘defenses’ against bodily insights which can confront them with their own vulnerabilities (Miller, 2000; Ross, 2000; Gubb, 2014). This is not surprising considering that earlier psychoanalytic orthodoxies were characterized by a preoccupation with the ‘hysteric’ patient’s body and its contortions as a site of study, whilst leaving the therapist’s body unexamined (Freud & Breuer, 1896; McDougall, 1986; 1989). Furthermore, according to psychoanalytic formulations of psycho-somatic ‘illnesses’, the existence of visceral/embodied responses in the therapist would be deemed as evidence of ‘neurotic conflicts’ needing to be addressed in personal analysis (Field, 1989). As Ross (2000) aptly puts it: “my experiences with these and other clients forced me to consider my own somatizing […] Part of the difficulty was the way somatizing has been traditionally described as ‘primitive’ and ‘borderline’. Neither of these two words cries out to be claimed” (p.455). Overall, regardless of the underlying reasons, the ‘oversight’ of the phenomenon raises some ethical dilemmas. Furthermore, writing from a clinical perspective, Forester (2007) pointed out how ‘ignoring, minimizing or devaluing’ therapist somatic phenomena increases the clinician’s vulnerability to them over time, as well as the likelihood of vicarious traumatization.

Adopting a critical-realist epistemological angle and a relational ontology, I critically examine how recent theoretical developments have placed the embodied aspect of the therapeutic relationship- including the therapist’s embodied presence in the room- at the epicentre. Furthermore, this is reflected in the proliferation of concepts such as: ‘somatic-countertransference’ (Field, 1989; Samuels, 1985; Stone, 2006), ‘bodily -reverie’ (Pinkas,
Therapist’s body: From ‘obstacle’ to ‘therapeutic tool’.

There is a pool of published theoretical papers and clinical case studies written from a more contemporary psychoanalytic orientation, which are primarily concerned with demonstrating the clinical usefulness of the therapist’s somatic experiential phenomena in the therapeutic encounter (Field, 1989; Forrester, 2007; Gubb, 2014; Lemma, 2014; Orbach, 2004; Pinkas, 2016; Ross, 2000; Samuels, 1985; Stone, 2006). Furthermore, authors invoke the construct of ‘somatic-countertransference’ to make sense of their somatic experiences in the therapeutic encounter. This is defined as physical manifestations in the therapist’s body experienced in relation to the client, as opposed to the more ‘frequently experienced’ fantasies, thoughts, and mental imagery. In their personal accounts, ‘somatic-countertransferences’ are portrayed as valuable tools in understanding unconscious communications occurring in the session. For instance, Lemma (2014, 2015) proposes that “projective processes” which “bypass verbal articulation and are deposited in the body” are implicated in ‘somatic-countertransferential reactions’ (p.226). In her thoughtful and insightful clinical paper, Lemma (2014) discusses how her therapeutic work was informed by somatic-countertransference and how she used her embodied reactions to
the patient (such as a keen sense of her own shallow breathing, or the restriction of her waistband). Furthermore, she elaborated her thesis on how her embodied interaction with her patient enabled her to gradually uncover the patient’s ‘symbiotic transference’ and unconscious wish for an ‘undifferentiated fusion with the object’. Likewise, Field (1989) illuminated therapist embodied phenomena as ‘means of access to primitive levels of communication’ and thus, ‘a vital part of the therapeutic process’ (p.513).

Coming from an attachment theory perspective, Orbach’s (2004) paper agrees in part with Lemma’s position and acknowledges that awareness of a body countertransference can enrich an analysis. However, a crucial difference lies in Orbach’s insistence that not all of her embodied reactions should be siphoned to the realm of mental activity and ultimately find usefulness to the therapist and patient in interpretative, verbal activities. Orbach colourfully writes that this is a position borne out of “our non-reflected-upon habit of endowing superiority of the mind” and making all imagined therapeutic work a “hyper-mentalist” endeavour (p.142). Rather, Orbach contends that the body also discloses and speaks its own distress. It is not merely a receptacle of unwanted or poorly elaborated contents of the mind. The “wildcat feelings” (p.145) therapists experience in their embodied responses to patients thus find a therapeutic use by alerting the therapist to a body that is disorganised and insecure. Rather than dismiss this disorganised body, an invitation is made to ponder the multiple defences deployed by the patient to steer this rudderless, distressed body. This is achieved by the therapist allowing their own body to be available to the patient, “to be scrutinised or used” (p.149).

The recognition of embodied primordial intersubjectivity.

Alongside this scepticism regarding psychoanalysis’ ‘hyper-mentalist’ outlook, some psychoanalytic authors have recognised that objectivist assumptions, such as that of an ‘insulated inner world’ (Thompson, 2001; Varela, 1994) underpinning major theoretical constructs, fail to account for the more ‘inter-corporeal’ facets of the therapeutic relationship.
For instance, Field (1989) notes how: “in spite of the hypothesis of projective-identification, we really cannot explain how the unconscious of one mind can directly affect that of another…there exists at present no reliable means of identifying what belongs to whom” (p.521). Through this critical questioning, Field places the occurrence of transference-(somatic)countertransference phenomena within the context of a shared space, which is part of a “larger mystery” (p.512). Furthermore, he describes this as a “subtle place where subjective and objective, self and other…all meet” (p.521). Similarly, Samuels (1985) describes this space as the ‘mundus-imaginalis’: the intermediate space between analyst and patient, which sheds light to the nature of embodied countertransference. Samuels asserts that: “on one countertransference level the therapist’s body does not belong to him at all but to a virtual midpoint between him and his patient” (p.210).

Overall, the above descriptions allude to an ontology which approaches the Merleau-Pontian vision of ‘inter-corporeality’ and ‘embodied-intersubjectivity’, and rejects Cartesian dualisms. In this ontology, Being is not solipsistic. Rather, subjects meet and encounter one another with a pre-reflective awareness of the lived body, lived space and intercorporeality, which leads to an interpenetrating ‘openness’ between self and Other (Merleau-Ponty, 1968; cited in: Crossley, 1996; Finlay, 2005, 2006; Fuchs, 2012). Writers whose theories, practice and research adhere to this ontology include, among others, practitioners from the intersubjective psychoanalytic school of thought (Diamond 1996; 2013; 2018; Stolorow, 1997; 2013; Preston, 2008; Teicholz, 2014), as well as developmental researchers (Beebe & Lachmann, 1988, 1994; Lyons-Ruth, et al., 1998; Stern et al., 1998; Stern 2004). Diamond (1996), boldly criticizes theoretical use of language and clinical practices which are predicated on the notion of a divide between ‘inner and external reality’, and instead argues that the intersubjective field is primary. She furthermore links embodied experience to the subject’s relational experience of being with others, as opposed to factors ‘residing within’ the individual. As such, she places embodied transference-countertransference communication firmly within the context of intersubjective and intercorporeal relating.
Empirical research studies on therapist embodiment.

So far, I have mainly reviewed clinical case studies and theoretical perspectives. Although insightful and compelling, there are nevertheless methodological limitations to these. Namely, they are densely theoretical and at times only loosely based on clinical data. Also, observation and inference elide in ways that obscure the author’s positioning to data and the conclusions that are drawn. In what follows, I critically review empirical studies, which address some of the aforementioned methodological limitations. Furthermore, I attempt to arrange the literature in ways that illuminate how openings and gaps helped to clarify my own research question.

A couple of quantitative studies have sought to systematically identify the occurrences and manifestations of body counter-transferences experienced by clinical psychologists (Booth et al., 2010; Egan & Carr, 2008). In both papers there is an implicit attempt to normalise these various body-centered counter-transferences. Despite the ‘normalising’ function of these findings however, the methodology employed is underpinned by a positivist, hypothetico-deductive epistemology, which precludes a more nuanced and detailed engagement which recognizes the dynamic and complex nature of the phenomenon. For instance, the phenomenology of the therapist’s embodiment as well as the underlying processes implicated in the phenomenon are not addressed; arguably such questions lend themselves to be explored through qualitative research methods.

The qualitative investigation by Athanasiadou and Halewood (2011), goes some way into addressing the above questions. Using a grounded theory with a constructivist epistemology, they inductively arrive at the factors that constitute therapists’ processing of their somatic-countertransference. In their findings, they outline six developmental processes which constitute how therapists increasingly relate to the body in the countertransference. The developmental movement is described as a shift from ‘defending against the experience’ towards ‘working with somatic-countertransference.’ The authors claim they do not set-out to provide a “grand theory” for somatic-countertransference, but instead limit its operating definition in their study, to “the therapist’s responses” (p.252). However, despite this statement, using theoretical constructs in a qualitative investigation
which sets-out to arrive to findings inductively is somewhat questionable epistemologically. In that respect, I share Totton’s (2015) view that approaching embodiment in psychotherapy must be reconceived from the ‘ground-up’ (rather than the ‘top-down’). Furthermore, theoretical constructs of transference and countertransference tend to imply a certain ‘linearity’ which is too ‘orderly’, and which does not give credence to the ‘messiness’ of the embodied interaction (Gaitanidis, 2018).

Finally, the qualitative studies by Shaw (2003; 2004) and Rumble (2009), are more epistemologically and methodologically coherent in that regard. They helpfully elucidate the phenomenological resonances of therapist’s embodied responses in the therapeutic setting. In keeping with this phenomenological stance, they do not directly attend to more theoretical or speculative conceptualizations of the phenomenon. Shaw was the first researcher to systematically enquire about therapist’s embodiment, and Rumble (2009) sought to extend Shaw’s work. By using IPA, Rumble was able to focus on idiographic analysis, which draws out thick description to add further texture and nuance to an understanding of therapist embodiment within the therapeutic setting. The themes revealed were: ‘a sense of connection with body,’ ‘a body experienced in relation to the client’ and ‘a reciprocal impact of therapist and client’s body’ (p.118). Together, Shaw and Rumble’s work generates new knowledge in the field by illuminating the significance and extent of therapist’s bodily experiences and awareness in the therapeutic setting. Overall, in all the qualitative studies reviewed so far, the question of therapeutic utilisation remains relatively aside. It is this absence in the existing literature, how and when therapists might use their embodied experiences in their work, that the current research project hopes to answer.

Aims, relevance, and contribution.

Having established the importance and ‘inevitability’ of therapist embodiment, the current study seeks to make an original contribution by questioning more specifically how therapists’ embodied experience informs their therapeutic practice. Therefore, it endeavours to offer an in-depth understanding and systematic exploration of how therapists
use their embodied experiences in the context of the psychotherapeutic process. This encompasses an aspiration to elucidate the subjective and intersubjective processes underpinning ‘praxis’. In turn, such processes are understood to tap into implicit, tacit, pre-reflective, embodied understandings and procedural knowledge.

The endeavour to illuminate the specific contours of how therapists make use of their own embodied experiences therapeutically is of vital relevance to CoP, as it attends to two of its central philosophical tenets. Namely, the primacy of the therapeutic relationship and the therapist’s ‘use of self’ in the therapeutic process (BPS, 2014; 2015; Orlans & VanScoyoc, 2009; Strawbridge & Woolfe, 2003). It is hoped that knowledge produced through this study will contribute towards promoting an embodied, relational, holistic and phenomenological way of working with somatic experiences in the therapeutic encounter.

Overall, the reviewed literature points to a need for embracing a more dynamic vantage point for understanding somatic experiences in the therapeutic relationship, along with an inductive, ‘bottom-up’ approach to knowledge generation. Thus, it seems fitting that the current research ontologically orients itself within Merleau-Ponty’s philosophical perspectives (as elaborated earlier).

Methodology

Choice of Method: Thematic Analysis (TA).

The RQ seeks to explore and elucidate specific subjective and inter-subjective processes which underpin therapists’ use of their embodied experiences in the therapeutic process. In turn, these processes are understood to tap into pre-reflective understandings, embodied cognition, and procedural knowledge. Qualitative research approaches are concerned with the quality and texture of experience and are suitable for investigating dynamic phenomena which are not defined by preconceived, researcher-defined, cause-and-effect variables (Willig, 2013). Specifically, TA method was deemed as highly adept for the purposes of
this enquiry, considering its a-theoretical, flexible, and adaptive nature (Braun & Clarke, 2006; Braun et al., 2014). Furthermore, TA is appropriate for exploring why and how people think, feel, or do particular things (Braun & Clarke, 2006; Clarke & Braun, 2016). This made it an ideal option for exploring patterns of the phenomenon under investigation within therapists’ accounts of their own therapeutic practices.

Other suitable methods for investigating the topic, could have arguably included Interpretative Phenomenological Analysis (IPA). This is especially due to recent refinements in its method of data collection and analysis, which emphasise the centrality of the embodied relationship between researcher-researched. In particular, scholars such as Finlay (2005; 2006a; 2006b; 2014), challenged IPA’s tendency to overemphasise language as the sole medium through which to gather data, arguing instead for the active incorporation of embodiment into IPA research. Finlay introduces this ‘bodily-informed’ process of sense-making, via terms such as ‘reflexive embodied empathy’ (Finlay, 2005; 2014). The latter, refers to a special type of attunement to the ‘more than verbal’ aspects of interpersonal communication. Whilst these methodological developments are compatible with the ontological and epistemological premises of the present investigation, the phenomenon of interest in the present enquiry is concerned with accounts of practices and/or exploration of processes, as opposed to exploration of lived experience (which IPA has been specifically designed for). Furthermore, not only is TA ideal for exploring the processes and patterns which are the subject-matter of the current research, but also, the flexible and adaptive nature of the method, render it able to accommodate the philosophical underpinnings of my RQ and incorporate the embodied relationship between researcher-researched as a source of rich, meaningful data (see following sections: “TA: Approach to Analysis”, and “Data Analysis”).

**TA: Approach to analysis.**
As a method, TA is designed to recognise and organise patterns of meaning in qualitative data. Unlike IPA, TA is not affiliated to a particular theoretical and epistemological framework. Due to TA being an adaptable and flexible method, it is paramount that the researcher defines their own approach to TA (Braun & Clarke, 2006; Clarke & Braun, 2016). This entails positioning of the RQ in terms of its ontological and epistemological assumptions; defining the type of knowledge produced through the enquiry; and explicating the role of the researcher in the research process (Willig, 2013).

The present RQ invokes a realist ontology inasmuch as it assumes the existence and operation of processes which occur independently of what may come to be known, or understood about them by the researcher. It furthermore encompasses the realist aspiration to ‘uncover’, identify and convey these processes (Willig, 2016). At the same time, it acknowledges that these are neither materialist/objectivist in nature, nor residing within the ‘internal world’ of the participants. Rather, they are predicated on a relational conceptualisation of experience, in accordance with the Merleau-Pontian intersubjective ontology. Furthermore, it is assumed that knowledge produced through this enquiry is bound to be mediated by contextual factors that are implicated in the meaning-making process- most notably, the embodied intersubjective encounter between researcher and participant. The incorporation of this ‘bodily-informed sense-making’ is consistent with the ontological and epistemological positioning of my topic, and also addresses Cartesian tendencies which paradoxically characterise much of qualitative research (Ellingson, 2017; Finlay, 2005; 2006; 2011; 2014; Finlay & Evans, 2009; Sharma et al., 2009; Todres, 2007). Thus, the findings produced from this enquiry can only ever be partial, provisional and representing a specific reading, as opposed to a true, undistorted reflection of ‘reality’.

The inclusion of a reflexivity statement (Appendix 6), reflects the inevitable influence of my own subjectivity as a researcher in the meaning-making process. Finally, methodological rigour is strived for through adhering to Yardley’s (2000) criteria for ‘good qualitative research’. These include: sensitivity to context; commitment and rigour; transparency and coherence; impact and importance (see further details on how these are met in Appendix 10).
To sum-up, my approach to knowledge generation is critical-realist in orientation. Meaning derives through my interpretation of the data, which includes attention to the embodied intersubjective aspects of the research process. My role as a researcher is mostly characterised by a ‘discovery’ orientation, utilising the reflective/expressive elements of language. My generated interpretations represent ‘open, explorative, possibilities’ rather than ‘closed, prescriptive, certainties’ (p.147; Willig, 2012). Finally, my approach to data analysis is inductive, seeking both semantic as well as latent meanings within the data in order to capture depth and nuance.

Participants

Sample size and inclusion criteria:

A sample of 6 participants was purposively sought. This number was deemed appropriate, given the various parameters that needed to be weighed-in; in particular, the requirement for depth of analysis and challenge of ‘languaging’ therapists’ embodied practices, in conjunction with word limitations and time-constraints. The decision-making process is consistent with Braun and Clarke’s (2013) guidelines, which urge researchers to have enough data to tell a ‘rich story’, but not too much that it precludes a deep, complex engagement with the data in the time available. The participant inclusion criteria included: 1) a qualification as a psychologist and/or psychotherapist with one or more of the major accrediting bodies (i.e. BPS, UKCP, BACP); and 2) self-identification as practicing from an inter-subjective, relational, embodied perspective.

Sample’s demographics:

The final sample stood as an all-white Caucasian group, comprised of 4 males and 2 females, ranging from 35 to 61 years of age. Psychotherapeutic modalities trained in and currently practicing included: Existential-Phenomenological, Gestalt, Systemic,
Psychodynamic, CBT, Solution-Focused, Transcendental, Developmental-Somatic-Psychotherapy, Person-Centred, Dance-Movement-Psychotherapy, and Integrative. All participants currently work in private practice. Participants have prior therapeutic practice experience within the NHS as well as the charity sector. Years practicing as a psychologist/psychotherapist ranged from 6 to 25. Table 1 below shows the demographics of the sample.

Table 1: Participants’ demographics.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Name*</th>
<th>Gender</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Stefan</td>
<td>male</td>
<td>41</td>
</tr>
<tr>
<td>2</td>
<td>Jack</td>
<td>male</td>
<td>49</td>
</tr>
<tr>
<td>3</td>
<td>Athena</td>
<td>female</td>
<td>61</td>
</tr>
<tr>
<td>4</td>
<td>Emily</td>
<td>female</td>
<td>35</td>
</tr>
<tr>
<td>5</td>
<td>George</td>
<td>male</td>
<td>35</td>
</tr>
<tr>
<td>5</td>
<td>Daniel</td>
<td>male</td>
<td>38</td>
</tr>
</tbody>
</table>

* (All names have been changed to preserve confidentiality).

Procedure

Recruitment

Participants were mainly recruited via ‘word of mouth’ and the ‘snowballing’ method. This begun by inviting permanent staff members of the Surrey CoP programme to recommend any of their colleagues who: 1) met the study’s inclusion criteria, and 2) might potentially be interested in participating. Selected visiting lecturers of the course were invited to participate on the same bases. All identified candidates -whether recommended by others,
or approached directly by myself- were contacted via email. The email contained the Participant Information sheet (Appendix 2) and Consent Form (Appendix 3). Individuals who met the inclusion criteria and expressed interest in participation were invited to contact me individually to further discuss their participation. Prior to their interview, participants were invited to fill-in a brief Demographics Questionnaire (Appendix 4).

**Briefing, consent, debriefing**

All candidates were given the chance to discuss with me any questions regarding participation. They were informed about measures taken to preserve their, as well as their clients’, confidentiality and anonymity. The voluntary nature of participation was reiterated, as well as their right to withdraw their participation and/or data from the study at any point and without having to state a reason, provided that this occurred within a two-week period following their interview. Individuals who agreed to take part, signed the consent form and filled-in the demographics’ questionnaire. Time, date and location of the interview was negotiated on a mutual basis, taking into consideration factors such as availability of a confidential and quiet space as well as logistical restrictions. All interviews were audio-recorded. Audio recordings were securely transferred on an encrypted USB device. Names and identifying features were removed during transcription. Audios and transcripts were stored in a password-protected file. Upon completion of the interview, participants were offered a debrief with the aim of ‘checking-in’ with them their experience of being interviewed.

**Data collection**

Semi-structured interviewing was chosen as a method of data collection. Interviews ranged between 50’ to 90’, using an interview-schedule (Appendix 5) to flexibly steer the interview. Interviews were audio-recorded and subsequently transcribed with meticulous
accuracy for TA analysis. Supervision enabled me reflect upon my interviewing stance and ensure that it remains congruent with the aims of my RQ.

In conducting the interviews, I endeavoured to foster a facilitative, collaborative environment, in which the ‘HOW’ of participants’ embodied therapeutic practices could be explored and clarified in detail. In addition, I embraced a research stance informed by Finlay’s (2005; 2014) ideas regarding ‘reflexive embodied empathy’, and Todres’s (2007) ‘responsive order’. This stance is consistent with the enquiry’s approach to knowledge-generation, which pays attention to the researcher’s reflexive engagement with the embodied intersubjective encounter. ‘Reflexive embodied empathy’ involves the researcher attending and interrogating their body’s response to, and relationship with, the body of the research participant. ‘Responsive order’ refers to a type of ‘body-based hermeneutics’, in which qualitative meanings are pursued by an iterative “movement between words and their felt complexity in the lived body” (p.180).

Employing the above stance in the interviewing process enabled me to attune to the embodied relationship with my participant, monitor the ‘responsiveness’ of our language use, attend to meaningfully significant moments in our dialogue, and open-up to the ‘more-than-verbal’ modes of communication (See Appendix 6/ Reflexivity). My observations regarding the ‘embodied interview process’ were noted down (Appendix 9), and subsequently informed my data analysis.

All research interviews were conducted within private, confidential rooms - either in participants’ own consultation spaces, or in booked rooms within university libraries. Additionally, considering the nature of the topic under investigation, as well as the epistemological positioning of the present enquiry (i.e. emphasis on the embodied medium of interpersonal communication as ‘data’), all interviews were conducted face-to-face as opposed to via Skype or telephone. This was important, given that some of the limitations that have been noted regarding the use of Skype in qualitative research (e.g. Seitz, 2016), would have direct relevance to the scope of this enquiry. In particular, those limitations stem from the fact that, in the case of video-based software applications such as Skype, the researcher and participant are not in each other’s physical presence. Moreover, this aspect may prevent from experiencing the presence of the other through the full range of the
senses available, resulting in somewhat compromised holistic, relational-embodied perception.

Data Analysis

Transcripts were analysed using T.A. guidelines (Braun & Clarke, 2006; 2013; Clark & Braun 2016; Terry, 2016). 1) **Familiarisation** included ‘immersing’ myself in the data by transcribing, careful listening, reading and re-reading, whilst noting down initial observations (including ones regarding the ‘embodied interview process’). 2) **Coding** was thorough, inclusive and comprehensive, and generated relevant labels which captured both semantic and latent aspects of the data. Use of supervision ensured that my coding was aligned with my RQ aims. 3) **Searching for (preliminary) themes** comprised of clustering codes together, by searching for repeated concepts, ideas, and meanings. 4) **Reviewing of themes** included checking how they fit in relation to the data-set and coded extracts, as well as how they relate to each other. This involved making appropriate adjustments to reflect these inter-relationships. 5) **Defining and naming themes** required identification of the “essence” of each theme, determining its importance in relation to the RQ, as well as selecting suitable supporting extracts/illustrations from the data-set. 6) The **write-up** included a combination of the illustrative and the analytical style. The aforementioned steps are illustrated in detail under the Audit Trail (Appendix 8). The latter is informed by Braun & Clarke’s (2006), ‘15-Point Checklist of Criteria for Good Thematic Analysis’, and satisfies the requirement for methodological rigour and transparency (Yardley, 2000). In keeping to the inductive approach, theoretical concepts were kept in abeyance during the process of Analysis and write-up of Findings, but were appropriately introduced in the Discussion.

Ethics
This research received ethical approval from the faculty of Health and Medical Sciences (FHMS) ethics committee (Appendix1), and adhered to the BPS codes of ethics (BPS, 2009, 2010). The entire research endeavour was approached reflexively and with an ethical mindset (Steffen, 2016; Thompson & Chambers 2011). This entailed holding in mind the three human research principles, i.e. Beneficence, Respect for subjects, and Justice (Sieber, 2009), as well as negotiating ethical dilemmas as ‘fields of uncertainty’ (Brinkmann & Kvale, 2008). In what follows, I demonstrate how ethical thinking informed my stance towards the dilemmas I encountered. Due to word-limit constraints, I have thus chosen to concentrate on two key areas; i.e.: 1) maintaining confidentiality of my participants and their clients; 2) analysing ethically.

The first concern, pertains to my foremost responsibility of safeguarding the anonymity of participants as well as the clients they talk about. This is important, considering that participants are entrusting me with material, which if inadvertently breached, would potentially render them personally and professionally vulnerable. I therefore approached this aspect with care and consideration, making sure that I disguise all personal-identifying information and include minimal client material in the study and only when serving research purposes. In addition, I avoided the use of lengthy, detailed, and identifiable clinical vignettes.

Approaching the second concern necessitated an awareness of my interpretative power as a researcher, along with the inherent risk of that power being abused (Willig, 2012). For that reason, I strived to monitor the function and type of interpretations that I produced. In particular, I endeavoured to convey them in a flexible, tentative manner, in accordance with my epistemological stance, but also the humanistic, ethical and reflexive values of CoP (BPS, 2017). The latter encompasses meaning-making which preserves the ‘otherness of the Other’ (Levinas, 1961; cited in Lowenthal & Snell, 2003). A useful compass for me was to continually check-in with myself regarding the extent to which: a) my interpretations are capturing a ‘selected fact’ or an ‘overvalued idea’ (Britton & Steiner, 1994); b) I remain truly open to being informed by the phenomenon of interest.
Findings:

The following iterative themes emerged from my analysis: (1) Using somatic experiences as ‘raw data’ from which to make sense of the client and the therapeutic process; (2) Using embodied understandings to grapple with ethical and reflexivity issues in the therapeutic relationship; (3) Different ways of incorporating embodied experiences into a therapeutic intervention. Table 2 below, shows these themes along with their related sub-themes.

<table>
<thead>
<tr>
<th>1.0 Using somatic experiences as ‘raw data’ from which to make sense of the client and the therapeutic process.</th>
<th>2.0 Using embodied understandings to grapple with ethical and reflexivity issues in the therapeutic relationship.</th>
<th>3.0 Different ways of incorporating embodied experiences into a therapeutic intervention.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 ‘Volitional’ and ‘non-volitional’ ways of interacting with the therapeutic process on a somatic level.</td>
<td>2.1 Critically interrogating the role of one’s own embodied subjectivity in the therapeutic process.</td>
<td>3.1 Using the bodily-derived insight/understanding as the basis for therapeutic intervention.</td>
</tr>
<tr>
<td>1.2 ‘Staying with’ the somatic response and allowing oneself to become curious about it.</td>
<td>2.2 Careful consideration of client’s process prior to therapeutic intervention.</td>
<td>3.2 Using the body itself, as the basis for therapeutic intervention.</td>
</tr>
<tr>
<td>1.3 Using embodied response (and the associations to it) to build hypotheses about the therapeutic process and client’s formulation.</td>
<td>2.3 Identifying and navigating contexts which mediate the use of therapist’s embodied self.</td>
<td>3.3 Tracing client’s response to the intervention.</td>
</tr>
</tbody>
</table>

Table 2: Themes and subthemes derived from my analysis. The arrows between themes indicate the pattern of succession between them. Altogether, the themes reflect a series of processes by which therapists ‘arrive at’, reflexively interrogate, and therapeutically incorporate, their embodied understandings.
1.0 Using somatic experiences as ‘raw data’ from which to make sense of the client and the therapeutic process.

Embodied experiences within the therapeutic setting can range from the tacit, more quiet awareness, to more forceful experiences that are hard to ignore. Irrespective of the quality of experiences, and the extent to which their meaning is derived in-action versus on-action, the data point towards a unifying tendency for the therapists to use the embodied experiences within a session to help make sense of the clinical encounter. Thus, embodied responses do not remain solely in the therapist’s body, but rather, lead towards an epistemophilic process, whereby experiences are transformed into therapeutic curiosity, which in turn, forms the basis for therapeutic understanding and formulation-building.

1.1 ‘Volitional’ and ‘non-volitional’ ways of interacting with the therapeutic process on a somatic level.

Embodied experiences may naturally unfold within the context of the therapeutic process in a manner that allows the therapist to fluidly monitor and elaborate upon the experience in-action. There is a capacity for the therapist to choose when and how they make sense of the clinical experience. By contrast, on occasion, therapists might encounter sudden non-sequiturs in the work, embodied sensations that often seem like intrusions without historical precedence. In this scenario, the capacity for immediate understanding is diminished, and sense-making requires engagement with later processes which may allow for meaning to emerge and transformations to occur.

In the case of the ‘volitional’ way of engaging with the therapeutic process, the therapist’s somatic experience and its relational understanding appear to exist in a state of fluid interaction, which suggest a rhythmical, intersubjective process, akin to a dance. In the following segment, Stefan describes how in a confusing encounter with a verbose client, he was able to transfer his awareness to a different sense-making capacity, via his body.
As he puts it, through the body a “resonance” was found (which was subsequently used for tapping into the more implicit, ‘unspoken’ aspects of the client’s experiencing):

“...a patient comes in and they’re talking: ‘Ta-ta-ta-ta [speedily],’ and I feel utterly confused, I actually say to myself, stop thinking or listening to the words for a moment and try to actually feel. And I’m conceiving of my body, as a body of resonance.”

It seems as though Stefan’s muddled and perplexed response to the client’s ‘bombardment-like’ quality of speech, signalled the need for him to tune-in to the sensory/visceral frequency of their interaction, whilst concurrently ‘toning-down’ his focus on the verbal/cognitive aspects of their exchange. Furthermore, this volitional ‘switch’ into a bodily ‘resonance’ is presented as a ‘portal’ into gaging the client’s affective states:

“...are they heavy, are they anxious, are they in melancholy?...Most distressed patients, I can actually track by what it does to my body...in terms of doing this [mimicking physical alertness response], or to my body actually being irritated and disinterested [mimicking aversion/withdrawal], because, if you open yourself up, you actually pick-up the patient immediately[...] If you’re connected to your body, it becomes a very visceral experience...”

Athena places further emphasis on the necessity to actively occupy an observing stance of curiosity in relation to her own “bodied process”, as it unfolds in interaction with the client’s. She demonstrates how engaging with this ‘internal dialoguing’ process may look like ‘in-action’:

“OK, [I think to myself] that’s really useful information...I walked into the room, I met you at the door, I was interested. Something has happened...something is happening in the contact here that I’m having that kind of...embodied visceral feeling[...] I’m so bored, I feel shut down. I feel disinterested, a bit low [Puffs] Where’s my energy gone? I feel myself slumping. [...] it’s like, OK, come right back to me. What is happening? What’s going on here?...What’s mine?...And what’s yours?...What’s going
The signal for this curiosity is the visceral ‘pull’ from the body which prompts a search for sense-making. This rhythm, or continuum of interaction, between visceral experience and relational understanding, is what characterizes this ‘volitional’ way of engaging with one’s bodily responses in the therapeutic encounter.

In contrast, certain somatic experiences, often more troublesome in nature, disrupt this rhythmical process by introducing a sense of intense alienation and disturbance in the therapist. As a result, the relational fluidity, mutuality and connectivity between therapist-client gets compromised. Participants offered examples, such as enduring coughing fits, nausea, bodily tension, nightmares and responses of disgust. The common feature of the non-volitional responses is that in being aversive, they cannot be easily and immediately incorporated into therapeutic relational understanding. Rather, the intensity and ‘acceptability’ or otherwise, of the experience must first be processed by the therapist.

Jack endures a sharp somatic experience of disgust, at the point of the client’s disclosure of paedophilic impulses:

“I had a, a sense that he was going to say-, and then he shared it with me[…] it’s that moment of a disgust, a moment of…deep sort of like…you know…yeah, a disgust…”

The somatic disgust is sharply aversive, and leads to a distancing from the client and their material, rather than a potential for further therapeutic contact:

“…when he told me [clicks fingers], it was almost like, [zooming noise], a sense of pulling away from him…”

In the above example, the somatic response seems to be directly linked to the specificity and particularity of the client’s disclosure. However, sudden somatic experiences might also occur without an identifiable ‘trigger’. Emily feels very aware of her recurrent perturbing and uncomfortable somatic state in a session; however, its incitement cannot be tracked at that point:
“A client kept saying, ‘I’m not sure about therapy, and I’m not sure about being here, and I’m not sure what I’m bringing,’ [...] and I kept being nauseous, and then my stomach was cramped...doing some circular movements, and I wasn’t quite sure what was going on...”

Similarly, Stefan spoke about enduring sudden, overwhelming “waves of strong coughing sensation”, which actually forced him to interrupt the session. The disturbing nature of the experience appeared to be tinted by Stefan’s negative self-attributions:

“it caused me quite a bit of distress when it first happened, because I don’t like leaving the session; it’s like I’m abandoning the patient, [...] and it felt like failure...”.

The therapist’s vulnerability to self-criticism represents an additional challenge involved in the management of such somatic states.

Because of the sudden disruption to the rhythmical intersubjective process brought about by these intense and/or alienating somatic experiences, the therapist deliberately and systematically endeavours to engage with later processes, often over repeated instances, before the somatic experiences are processed and integrated. Some of these processes include the cultivation of a reflective, ‘observer’ stance.

1.2 ‘Staying with’ the somatic response and allowing oneself to become curious about it.

After experiencing, and indeed enduring, the destabilizing and disrupting somatic experiences, therapists later struggle to hold onto these responses. The capacity to ‘stay with’ the response, gradually allows space for curiosity to develop. Curiosity then helps to shed light to more hidden, nuanced facets of the therapeutic encounter.

The quality of ‘staying with’ seems to be partially defined by the therapist’s capacity to contain their impulses to ‘flee’ from and/or ‘get rid’ of their disturbing somatic experience. Some of these, manifest as a desire to (re)act unreflectively, or intellectualise. For instance, George described that after suffering troubling somatic experiences in-session, and later
nightmares (which he understood as engendered from these experiences), he battled with a:

“strong urge to share my nightmares with John, because I felt that these were strongly related to my work with him.”

However, in hindsight, George acknowledged that:

“I was glad I didn’t share my nightmares, because I felt that me sharing my nightmares with him would have been [an attempt to] processing my own anxiety.”

Thus, for George, resorting to disclosure at that point in time, would have been an action partially motivated by his need to ‘diffuse’, or make more ‘palatable’, his own disturbing somatic state. Furthermore, George credited his supervision with enabling him to work through this struggle and strengthening him to ‘stay with’ his experience, as opposed to (re)acting prematurely.

Similarly, Jack highlighted how ‘theorising’ our somatic response could also represent a covert attempt to renounce bodily experience through rationalisations. He attributed that to an underlying:

“fear: the sense of, ‘I can control and rationalise this and have theories, structures and a formulation’. If we allow the embodied, -whoa-, it could completely disorientate that formulation and we could be somewhere else […] but, of course, that rocks us as therapists. […] I think that’s why a lot of people don’t allow the embodied, because they think it will ruin the therapy.”

Thus, being guided by an underlying fear of chaos and the clinging to safety and control, undermines our endeavour to ‘stay with’ our bodily experience. Instead what promotes it, is a quality of opening-up to the experience in its totality and dwelling in its inherent chaos.

The above paves the way for an enlivened inquisitiveness, which includes making observations about the therapeutic encounter and discovering new facets of it.
Athena demonstrates how her position of curiosity and imagination allows her to work differently in the room, drawing awareness to the client’s own body and self-esteem. The process begins by Athena noticing how nauseatingly disgusted she feels in response to her client plucking and throwing hair onto the consultation room floor. Holding on to her visceral disgust, then sensitizes her to noticing the client’s facial expressions, and begins a process of curiosity about what these might denote:

“[Interestingly], she has a lot of movements in her mouth that really express a lot of disgust at herself.”

Athena continues by noticing further details in relation to her client’s disgust-inducing action:

She’s completely unaware that she’s doing this [...] She has no awareness of the other at all- me...”

Returning to the earlier clinical vignette about aversive bodily reactions following his client’s disclosure of pedophilic impulses, Jack retrospectively appreciated that:

“holding onto it [my embodied response], helped me to see that client in a much fuller way; to move beyond the disgust[...] and to be open to this person who was deeply struggling.”

Thus, holding on to his initial “objectifying” reaction, gradually enabled Jack to discover more facets of his experience of the client, including perhaps discovering some sympathy for his struggle.

1.3 Using embodied response (and the associations to it) to build hypotheses about the therapeutic process and the client’s formulation.

Curiosity and imagination about the context of the somatic response invigorate the therapist’s potential to build hypotheses that feature in formulation and enrich the therapeutic process. These might arrive as sudden moments of connectivity, insight and meaning.
George discovers meaning in the ‘loud’ experience of his body in relation to his client:

“my body is shouting…it’s shouting, and it’s trying to tell me something, which I feel cannot be verbalised. But the body puts words into it.”

Furthermore, George gains insight on how his client’s:

“immobilisation, his paralysis, was speaking to a personal paralysis...”

Thus, the disorderly body that ‘shouts’ now becomes the body that starts to know, using somatic experience to inform his formulations. George goes on to further elaborate about how the inchoate, dissociated experience of his client was mirrored in his own bodily experiences:

“It brought a split, and that split was related to John’s experience of...the splits between his mind and body. So, he was trying to understand his body as a body which he doesn’t own. And that was similar to my experiences...[it] was a parallel experience[...] all these were embodied in my own experience. So, I was becoming a huge mirror for what was John was going through.”

The above hypothesis, is the result of a creative transformation of initially aversive experiences into ones that eventually hold important potential clinical application for future therapeutic work. Furthermore, it is based on knowledge in which the self- and other-understanding are intimately intertwined.

2.0 Using embodied understandings to grapple with ethical and reflexivity issues in the therapeutic relationship.

Having experienced and ‘stayed with’ their embodied responses in the therapeutic encounter, therapists then interrogate these to inform praxis. This is a dynamic cyclical process, one that helps the therapist calibrate the awareness of their own embodied subjectivity as an interpretative position, thereby opening-up therapeutic practice towards
a more ethically-considered stance. This reflexive self-awareness is predicated on the notion of the therapist-client couple as composed of two separate embodied subjectivities who interact and mutually influence each other, and at the same time, embedded in a wider social context.

2.1 Critically interrogating role of therapist’s embodied subjectivity in the therapeutic process:

Participants demonstrated a thorough, systematic and creative approach in how they described and reflected upon the role of their own embodied subjectivity in the therapeutic process. Occupying this ‘meta-position’, they emphasised the importance of utilising their own embodied subjectivity in a way which strikes a balance between an embodied ‘immersion’ with the client’s process, and a more critical view of the therapeutic situation. Jack usefully invokes the ‘Dionysian-Apollonian interplay’ as a metaphor to denote this balance:

“the Dionysian, it can feel a bit disorientating and intoxicating and Apollo….my understanding of those two Gods is one is the God of drink and excess…and the other one is the God of structure and straight lines…I think therapists feel more secure in the Apollonian…but it’s an interplay.”

Thus, this ‘Dionysian-Apollonian dialectic’ consists of the therapist’s readiness to open-up and ‘welcome’ the chaos and ‘intoxication’ of inter-corporeal effect, whilst at the same time being ‘anchored’ in the order and structure of a more distanced, critically-observing position. Jack goes on to elaborate on the idea of this creative balance between spontaneity and reflection:

“It’s about reflective intuition. It’s not just spontaneity all the time; it’s about a spontaneity that’s thought-about…because, of course, the repercussions could be that the therapy is derailed…”

The idea of a ‘thought-through’ spontaneity acts as a kind of therapeutic compass for the therapist, whilst also safeguarding against unethical practice. These ideas find a similar
expression in Athena’s account. For Athena, the embodied response, measured in the body as “excitement”, is held and worked-through as a process of “calibration”. This is ultimately to align the excitement into an intervention that is in the service of enhancing the client’s agency and self-awareness:

“I’ll get that kind of excitement and interest in my body […] what I’ve learnt is that I then have to calibrate that, because I can get very excited about something, and […] I have to calibrate it so it’s their interest and their curiosity… and their excitement; that they might get in touch with…”

Thus, this bodily excitement could act as a compass, helpfully directing therapeutic attention, yet also requiring some form of ‘calibration’ due to its potential for ‘hijacking’ the therapeutic process.

Emily speaks eloquently about the importance of critically interrogating one’s embodied responses by thinking in detail about the interaction between the horizontal (intersubjective/interpersonal) and vertical (intrapsychic/intrapersonal) axes:

“I think that’s a very difficult barrier in working with embodied responses, because sometimes one might not be absolutely sure whether that’s personal or whether that’s part of the therapeutic relationship. [pause] I always cringe a little bit when I hear case studies where the therapist immediately acts upon the embodiment…[...] where is the responsibility we take of reflecting, actually, what goes on, on the vertical line of ourselves, and why is it always on the horizontal between us and the client? Have you given enough time to yourself to really reflect what goes on or whether the idealisation of embodiment leads us to another kind of authority: ‘I know I react like this because it’s the material from the client’…How sure are you?’”

Therefore, Emily suggests a thoughtful caution against the eagerness to locate all embodied responses to the horizontal axes and subsequently basing therapeutic interventions on that premise. Furthermore, she views the overshadowing of the vertical axis as an ethically risky venture, as we:
“avoid the responsibility of our own embodied history, and this might be interfering in our work with clients.”

It follows that a more thoughtful, nuanced process involves ‘filtering’ and ascertaining which aspects, and ‘how much’, of the embodied response belongs to the therapist, client, and their therapeutic relationship, respectively. To that end, a thorough exploration of the bodily dimension of therapists’ subjectivity is necessary. This may involve awareness of how one experiences the therapeutic relationship ‘from both sides’, his/her: “own moving repertoire, responses, body needs, […] distances, ways of being” (Emily). Additionally, it may involve awareness of one’s: “stuck-ness and blocks” (Athena). Finally, it may involve: “welcoming the whole spectrum of embodied experience”, without self-judgement or attachment (Jack).

2.2 Careful consideration of client’s process prior to therapeutic intervention.

Embodied understandings do not emerge in a vacuum and similarly, are not ‘offered’ to the client in a vacuum. This subtheme captures how therapists match their embodied understandings with those of the distinct character and quality of each particular therapeutic encounter with a client as a unique individual.

Jack carefully attends to the client’s idiosyncratic process, upon which he grounds his decisions regarding how to therapeutically intervene:

“The ‘how’ depends on whether that person is going to find it therapeutic, and you can only decide that…by knowing that person[...]; unless I meet you where you are, it doesn’t matter about embodied responses, cerebral responses, it doesn’t matter about…any responses[...], I’ve got to be in tune...with you.”

Furthermore, Jack highlights the futility of intervening using embodied understandings without weighing-in ‘specificity’ factors, such as the client’s mode of relating, his/her
readiness to receive and make sense of them, timing issues, and therapeutic relationship. He proceeds to offer an example about:

“a client for whom the idea of talking about...a felt sense [...] she would be so freaked out, because she doesn’t consider this as a relationship [...] there’s something in the intersubjective that is too challenging for her. So, for me to come forward in that space on a bodily level would freak her out”.

Similarly, Athena talked about her fine-tuned therapeutic work with a young male client who had experienced significant early deprivation and trauma. She talked about the importance of ‘relinquishing’ any ambitions of working with ‘bold’ or ‘deep’ interventions on her part, and instead, adapting her approach to the client’s ‘fragile’ process:

“he had no embodied sense at all...Working with someone who has so little sense of embodied self, emotional vocabulary zero, and had such powerful, creative adjustments to not feeling[...] you can’t just rip the thing open, you know? What, what good would that do? It wouldn’t do any good because he wouldn’t feel it...So tiny bit, by tiny bit.”

In contrast, Stefan considered that his work with a client who was particularly invested in a ‘victim’ narrative, required a ‘bolder’ intervention. Furthermore, he recognises the challenge that is associated with confronting his client with what he understands as her dissociated rage (which he claims to have felt on a visceral level in their prior interaction):

“in some ways, it calls on me to, on the surface, be disloyal to the story, by saying, ‘Actually, I think you’re more angry than helpless,’ to the person who’s saying... that they’re helpless, when actually they may be invested in being a victim of the world and say, ‘Everyone else is aggressive, but me, I’m innocent,’...”

Overall, the analysis of the above excerpts demonstrates the dialectical/dialogical process engaged with by therapists in finding a congruence between their embodied understandings, and the client’s processes and subjective frame of reference.
2.3 Identifying and navigating within contexts which mediate the use of therapist’s embodied self.

The use of one’s embodiment in the therapeutic process requires a reflexive awareness of how one’s embodied subjectivity is influenced by broader contexts of meaning to which the therapist-client couple is embedded in.

Stefan cites working in an NHS setting characterised by bureaucracy, outcome-measures and over-regulation as a restrictive factor in his freedom to relate to his client on an embodied level:

“Being able to truly focus on the relationship with the client, that is the only relationship I want to be thinking about; [and] when I do that, embodiment and resonance is pivotal…But if I work on behalf of an organisation, I am already in a primary relationship that I have to pay my dues to. I’m actually only partially available for the patient.”

Furthermore, Stefan described this inhibitory effect to also be present in the context of training:

“when we train, we are involved in a process of trying to get it right, which is a lot to do with our own fears, a lot to do with our past, and so on. So, actually, we are less engaged with our patients and more […] psychically preoccupied with our own fears […] And that, for me, makes the difference.”

Thus, this inward, fear-based preoccupation characterising own’s relationship with an organisation, is positioned as a hinderance to effectively working with embodiment in the therapeutic relationship. Jack’s account identifies how the worry about ‘getting it right’ ‘squashes’ the subtlety that is involved in attuning and utilising one’s embodied responses:
“When I was a trainee therapist or earlier I felt that I needed to do it right and I needed to do it like this. It’s like-, it squeezed it, it strangled it...The embodied responses get strangled because they’re the chaotic ones.”

Taking an even broader, social-constructionist perspective, Daniel considers how embodied relating in the therapeutic setting is defined by cultural and gender prescriptions:

“I’m also looking at this as part of the culture; so how much this is a representation of gender, how much this is a representation of culture. I see embodiment not only to be related to our emotions and family dynamics, but also to the permissions and prohibitions that are cultural.”

Furthermore, Daniel offered examples such as the regulation of speech, tone of voice and how therapist and client physically ‘take space’ in the therapy room, as shaped by these wider social and cultural norms.

3.0 Different ways of incorporating embodied experiences into a therapeutic intervention:

After reflecting upon their embodied experiences, therapists draw from two main categories of intervention in order to effect therapeutic change, i.e.: 1) making hermeneutic use of their embodied experience by incorporating its meaning into an interpretation, reflection or therapeutic stance; and 2) using the medium of embodied relating to directly effect change. The extent to which the intervention produced an experiential shift is subsequently monitored in order to evaluate its therapeutic ‘potency’.

3.1 Using the bodily-derived insight/understanding as the basis for intervention
Jack’s interventions centred around an immediate, congruent reflection of his embodied awareness to the client, in the hope that this can facilitate a joint authentic exploration of the embodied ‘in-between’:

“I’d sometimes use the embodied felt sense as almost like a question to the clients saying, ‘I’m feeling something about what you’ve just said, and I wonder whether it’s worth us…talking about [it]’…I would offer it as a possibility.”

Furthermore, Jack emphasises the tentative and curious manner in which he offers such reflections as possibilities, as opposed to ‘fait accomplis’:

“I think it’s about selecting the time and offering it as a possibility… ‘I’m feeling so touched by that,’ or, ‘I’m feeling such a pressure on my chest when you say that. I wonder if there’s anything in that, which we could explore’”

Likewise, after constructing his formulation about the client’s ‘dissociated anger’ based on his own embodied experience and understanding of it, Stefan orients his verbal interventions in a way which is aligned with an attitude of curiosity and acceptance of these dissociated states:

“I suppose if we’re going into embodiment, it’s about encouraging them to be truly attuned with what they are feeling…and, for a moment, bracketing what that means or whether it is allowed to be said, because these are all already relational phenomena. If someone is angry, then, as a clinician, as a phenomenologist, I’m interested in that.”

3.2 Using the body itself as the basis for intervention
Features of embodied relating can be selectively deployed by the therapist to directly effect a shift in the client’s experience. These may involve synchronisation, mirroring, kinaesthetic moving, and embodied responsivity to the ongoing processes of the client.

Stefan describes how he adapts his tone and pitch so as to regulate the client’s levels of emotional arousal. Furthermore, he simulated the use and effect of this process in the here-and-now of the research interview in order to convey its ‘more-than-verbal’ meaning:

“So, I can talk to you like this right now, and you will probably think, ‘Oh, alright.’ If I keep talking like this [stressfully/faced-paced], you would at some point feel stressed because I’m involving stress just through the way I’m using my voice. And you can be really slow and try to [slowly], OK? So, what I’m trying to say here is, in terms of therapy going forward, we need to integrate thinking and all the sensory processing as a treatment method.”

Similarly, Athena described an encounter where she responded to her client’s severe state of internal deprivation through adopting a receptive posture, much like that of a mother towards her infant:

“I had very strong embodied feeling of wanting, to- I’ll show you [demonstrating physically]. So, I’m sitting in my armchair normally as you would, sitting-up with my hands just kind of loose on my thighs, and I suddenly had a very powerful feeling of wanting to slide down in my chair so that I was-, and stretch my legs out and cross them over, and just gently cross my arms kind of holding, like you would cradle a baby, OK? And my head is like upright and centred, but I felt that...I let myself do it. I just let myself just ease into this position, and my head just, ever so slightly, dropped a little bit to the left...And I just talked with him from this position.”

Athena’s account powerfully demonstrates how embodied relating can function as a therapeutic intervention on a ‘minutiae’ level, with the therapist actively using her body to regulate client’s affective state and responding on a sensory, intuitive, non-verbal way.
Finally, Emily uses gesture and movement as a way of vivifying the communication of her evoked imagery and embodied sense to the client:

“It was a combination of the movement that I gave to the client […] and there was a lot of animation going on, and me giving the movement as well as the imagery, and my understanding of something going on between us…”

3.3 Tracing client’s response to the intervention.

Therapists actively trace the impact of their therapeutic interventions. Indeed, the intervention and the monitoring of therapeutic effect are ongoing, insoluble processes.

After Athena adjusted her body posture to one of maternal receptivity, she noticed small but important shifts in her client’s capacity to relate to his own difficult emotions and indeed to the therapeutic relationship:

“It was minute; it wasn’t revolution, but it was the most tiny, quiet revolution ever…his voice just dropped a little bit and his sentences became a little bit more fluid, because he was very staccato and tense and so held in everything that he was saying.”

Athena noticed that the shift in her client’s body was also accompanied by a shift in what he felt able to express about himself and the clinical encounter:

“He would make a tiny shift, even if it was to say something like: ‘…I don’t like that box of things!’…it was a shift in his contact with me…and a shift in how he was…in contact with himself.”

Perhaps more evocatively, after using gesture and movement that helped to represent her client’s affective state, Emily noticed a much less subtle shift in the clinical material. Indeed, Emily noticed that it led towards the client’s disclosure of some painful, unprocessed life experiences:
“the client was very shocked and tearful, and went on to describe very painful experience of abortion [...] which was completely unprocessed and had stayed in her for many years.”

Thus, Emily’s intervention proved a ‘catalyst for change’ in aiding the client to get in touch with previously disavowed, unsymbolised experiences. However, the tracing of client’s responses to interventions can also be fraught with worry. Indeed, George reported a challenging interaction with a male client during his neophyte years as a therapist, which featured:

“A silence full of torture[...] I felt his anxiety and his anger to my bone...”

In the end, despite George’s fearfulness, he determines to intervene through disclosure, by stating that he would like to run away from the room. Post-disclosure, George was left feeling unsettled and disturbed:

“I left that room [...] and I started shaking[...]”

In the rationalisation of his disclosure, there is an elision/bluring/confluence/fusion of subjectivities:

“I felt that all his frustration, all his energy, found home in me[...] my intervention, was an expression of my difficulty...hence that running away.”

It is no longer clear ‘who is doing what to whom’. Perhaps this account helps to illustrate the importance of delivering a timely intervention, when the therapist has sufficiently ‘worked through’ their responses, rather than disclosing/revealing them in their ‘raw’ form, which risks further intensifying the sense of un-containment.

Therapists’ own somatic responses following their interventions constitute ‘raw data’ which are utilised for further sense-making (Theme 1).
Discussion:

This research employed an inductive, thematic analysis approach to systematically investigate how therapists use their own embodied experiences. Three major iterative themes emerged. These reflect how therapists ‘arrive at’, reflexively interrogate, and therapeutically incorporate, their embodied understandings. Combined, these reflect a series of cyclical movements and dialogical processes by which therapists ‘transform’ their somatic experiences into meaningful, embodied understandings which guide their therapeutic practice. In what follows, I critically evaluate the contribution of my findings with reference to the existing empirical and theoretical literature. I also address their implications in terms of CoP theory and practice.

The first theme which emerged from my analysis was how somatic experiences are used by therapists as ‘raw data’ from which make sense of the client and the therapeutic process. As a whole, this theme aligns with the two shared findings by previous qualitative studies (Rumble, 2009; Shaw, 2004), regarding the therapist’s body functioning as a ‘receiver/resonance tool’, and an ‘empathetic resource’. It also encapsulates Merleau-Ponty’s (p.186; 1962) famous pronouncement that: ‘It is through my body that I understand other people’ (cited in Shaw, 2004).

However, a closer look at the current inquiry’s data identified their tendency to coalesce around two distinct ‘pathways’ through which this somatic sense-making process occurs. I termed these ‘volitional’ and ‘non-volitional’, as they reflect different modes of sensing, understanding and interacting.

I consider the ‘volitional’ process and its fluid, almost reflex-like arc, as illustrating what Gendlin (1969,1992) described as ‘felt sense’. Gendlin talks about the body as being capable of sensing ‘the whole situation’ and making novel elaborations that ‘implicitly shape our next action’ (p.345; Gendlin, 1992). Thus, the body, resonating with the environment, knows its next step. Stefan’s quotes under subtheme 1.1, encapsulates this state-of-being. Furthermore, he describes his body directly resonating with his clients’ bodily-affective states, and demonstrates his capacity to adjust his ‘resonance’ and respond
flexibly to the unfolding of those situations. Overall, the therapist’s body in this mode constitutes an ‘intentional body’, which understands the therapeutic encounter through intuitive ‘gut-feelings’. Interestingly, besides being utilised as a ‘sense-making’ tool, this mode also forms the basis for some therapeutic interventions (subtheme 3.2). For instance, affect-regulating the client through embodied relating was powerfully evident in Athena’s account of adjusting her posture to that of maternal receptivity. The latter appeared to have an immediate effect of grounding and containment for her client. This finding gives credence to perspectives advocating that change occurs at a procedural level; for instance, within ‘moments of meeting’ in the therapeutic encounter, which rearrange ‘implicit relational knowing’ (Stern et al., 1998; Lyons-Ruth, 1998).

In contrast, in the ‘non-volitional’ mode, this fluid and rhythmical way of interacting is suspended. The process is characterised by alienation, inward preoccupation and the sudden intrusion of the ‘materiality’ of the therapist’s body which emerges as an obstacle to connecting. In attempting to conceptualise this incapacity, Leder’s (1990) distinction between Lieb (lived body), and Korper (physical body), is helpful. Leder writes that in a range of routine daily tasks, the ever-present body is nevertheless absent from awareness. This ‘clearance’ of the body is necessary in order for the world to become open and manifest. It is a state of health where the Lieb blends effortlessly with its environment. Korper stands in contradistinction to this harmony. In states of dysfunction the potential immanence between the body and its environment is halted. The rupture of disease makes one aware of Korper without the expansiveness of Lieb. Emily’s quotes under subtheme 1.1, illustrate these ideas. Furthermore, her perturbing, nauseating state hinders any possibility of operating from a ‘felt sense’.

As immediacy and holistic understanding are frozen, ‘Korper-like’ states require the ‘working through’ of experiences before therapeutic use of any sort can be claimed (subthemes 1.2 & 1.3). Indeed, participants conveyed their struggle to ‘stay-with’ these troublesome responses and contain their impulses to ‘flee’ from them through ‘rushing into action’ -including premature meaning-making. This trajectory aligns with Athanasiadou and Halewood’s (2011) findings. Furthermore, their developmental model on how therapists relate to their somatic-countertransference, commences from ‘defending against
the somatic experience through resistance and disconnection’, which subsequently develops into ‘awareness’, ‘ownership’, and ‘reflection’. The conceptualization of this movement in terms of *therapist defenses* also draws attention to the therapist’s *own* ‘vertical axis’ of relating (i.e. individual’s mind-body relationship), in addition to the ‘horizontal’ -or intersubjective- axis of relating (Lombardi, 2016; Rumble, 2010).

The concept of the two axes is elaborated in the second theme, which captures how therapists use their embodied understandings to grapple with ethical and reflexivity issues in the therapeutic relationship. In subtheme 2.1, participants talked about their notions of: the ‘Dionysian-Apolonian dialectic’, ‘calibrating excitement’, ‘reflective intuition,’ and ‘thinking along vertical and horizontal axes’. Altogether, I consider these to imply that an embodied-immersion with the client’s experience needs to be supplemented and curbed by a more ‘removed’, critically observing stance -one which recognizes the separateness and intrinsic ‘*Other-ness*’ of the two subjectivities.

This awareness of the need to contemplate separateness (i.e. individuals’ idiosyncratic mind-body relationship and the multiple factors which constitute it), alongside embodied-immersion, is especially important, as discussions about the body and embodied therapeutic practices often draw upon *intersubjectivity theory*. Furthermore, certain strands of intersubjectivity may have ‘a vexing tendency to exaggerate the shared world and disparage the individual’ (p.58; Madison, 2008). However, when connection is over-emphasised, it is at the cost of ‘negating individual experience’ (p.65; Madison, 2008). Analogous observations are made within the field of relational psychoanalysis, with some writers expressing their skepticism of the postmodern, relativist influences which emphasize the *dissolution of the subject* and concurrently exalt the *intersubjective system* as a distinct *entity* of its own (Mills, 2017; Shill, 2008). For instance, Ringstrom (p.205; 2010) claimed that: “when the mind of the analyst is denuded of inner versus outer, one-versus two-person experiencing, reality versus fantasy, along with the dialectical relationship between them, it becomes far more difficult to discern what is impacting what and who is impacting whom and what is the nature of conflicts arising both within and between the participants.” Evidence of this state of (con)fusion was present in George’s clinical vignette, from his earlier years as a neophyte therapist. During the session, which
featured a “silence full of torture”, George conceptualised his state of extreme somatic unease as representing an immediate, direct reflection of the client’s experience of visceral terror and rage. Moreover, it appears as if George’s rationalization was predicated on a type of ‘knowing’ based on ‘volitional processes’ and ‘Lieb’.

I suggest that the 2 trajectories of embodied meaning-making (volitional and non-volitional), are differentially featured in each of the 2 axes of relating (body-world and body-mind), which in turn, tap into different facets of intersubjectivity. These encompass what Coelho and Figueiredo (2003), refer to as ‘trans-subjective’-intersubjectivity (based on the philosophies of Heidegger and Merleau-Ponty) and ‘intrapsychic’-intersubjectivity (based on Freud and British Object-Relations theorists). The former is characterised by a state of ‘quasi-undifferentiation’, and a ‘radical intercorporeal relationship’, where ‘subject-object dichotomies’ fade-away (p.201). It has also been described as: “a metaphysics of positivity, forward-directedness and most of all intentionality…where whatever going on, there is nothing ‘lurking behind’” (p.787; Forrester, 2006). In contrast, ‘intrapsychic’ intersubjectivity is based on the “intertwining of internal worlds of two partners”. It is predicated on the assumption of ‘inner’ objects interacting with the ‘outer’ world. This provides the “foundation for an understanding of the great splittings (such as those between body and mind, reason and passion, will and impulse)” (p.204), and the ever-present anxiety these introduce. This conceptualization has implications for our choice of frameworks to guide our embodied practice. Furthermore, this needs to congruently reflect the nature of subjective and intersubjective processes that are implicated at any given moment.

Finally, in terms of implications for reflective practice, I suggest that attention needs to be directed on how conceptualizations (and interventions) are selectively deployed, in light of the defensive processes that are implicated in therapists’ struggle to ‘stay-with’ some of their troublesome somatic responses. A related idea was put forward by Long (2015) in her theoretical paper on ‘the use of the concept of projective-identification’. Furthermore, Long claimed that the concept can sometimes be used defensively by therapists, in an attempt to rationalize and locate their own disturbing experience to the patient. She writes: “In the move toward intersubjectivity, there is a risk that what properly belongs to the therapist is
too easily, or too fully, shifted onto the patient…the concept can be used projectively…” (p.483).

**Contributions and Implications:**

In terms of empirical/theoretical contributions, the findings of the current enquiry could be seen as extending those of previous research (e.g. Rumble, 2009; Shaw, 2004), by adding further texture and nuance into the notion that the therapist’s body acts as a ‘barometer’ of the therapeutic situation. In particular, it fleshed out the intricacies of *how* the therapist’s embodied experiences aid the process of relational understanding and formulation-building. Additionally, it identified how the same embodied experiences subsequently constitute ‘benchmarks’ for therapist reflexive engagement. Finally, it clarified the different ways in which therapist embodied experiences eventually inform therapeutic interventions.

In terms of implications for practice, the findings of this research could be seen as giving credence to the embodied dimension of the therapist’s ‘use of self’ within the therapeutic encounter. The fact that psychotherapy is revealed as an *intrinsically embodied process*, has direct significance for CoP training, supervision and therapeutic practice. This is more so, considering the current political and socio-economic climate of our profession which increasingly tends to favour outcome-measurable, evidence-based practices and routinized processes (Strawbridge & Woolfe, 2003). Arguably, the disembodied tendencies that characterise these endeavours are in conflict with the relational, holistic and embodied ways of practicing, which were explored here. Moreover, the latter brings to the fore the ‘tacit’ and ‘uncertain’ dimension of therapeutic-relating, and altogether epitomize the ‘reflective-practitioner model’ (Schon, 1983). With this in mind, CoP training and supervision could actively work to *reclaim* the role of the body within the therapeutic encounter. As Shaw (p. 271; 2004) aptly puts it, “…as a profession we need to take our bodily reactions much more seriously than we have so far…” In this sense, I concur with both Shaw and Athanasiadou & Halewood (2011), that one of the ways in which this could
be promoted, is by considering therapist embodiment as a “common factor” element, present in all forms of psychotherapy. As such, given CoP’s integrative and pluralistic ethos, therapist embodiment ought to be examined and explored as an overarching dimension across all contexts of therapeutic practice and supervision, regardless of the theoretical model used. To that end, I would argue that the insights derived through this qualitative investigation could enrich the process and content of supervision, by informing fruitful areas for exploration. In particular, the findings could act as a helpful supervisory framework in facilitating trainee contact with, and understanding of, embodied experiences, as well as in considering therapeutic interventions which are directly informed by these experiences and understandings. Additionally, following on from my earlier discussion, effort should be allocated into drawing from theoretical frameworks which are corresponding to the specific nature of processes that are implicated in an embodied experience. Finally, CoP training providers could introduce more experiential workshops and modules that further facilitate and actively promote this embodied grounding, such as mindfulness practices.

Conclusion:

The critical discussion of my research findings argued how the two identified trajectories or modes of embodied meaning-making, i.e. volitional and non-volitional, map into Gendlin’s notion of ‘felt sense’ and Leder’s distinction between ‘Korper’ and ‘Lieb’, respectively. In addition, my critical discussion revealed the relevance of the framework of the ‘two axes of relating’ in promoting a deeper understanding of our embodied therapeutic practice. In particular, I suggested that the volitional and non-volitional modes/trajectories of embodied meaning-making, are differentially featured in each of these axes, which in turn, tap into different facets of intersubjectivity (i.e. ‘trans-subjective’ intersubjectivity and ‘intrapsychic’ intersubjectivity). These ideas have implications for our choice of frameworks, which we should endeavour to align with the nature of subjective and intersubjective processes that are implicated at any given moment. CoP’s epistemological
and theoretical pluralism renders it uniquely situated to grapple with these concerns. I also suggested that the role of therapist defenses against their own somatic experiences, merits further investigation; specifically, in regards to the role of such defenses in how therapists construct and shape their embodied therapeutic encounters. Future research may benefit from adopting a psycho-discursive approach to systematically explore this. Finally, empirical contributions and implications for practice were considered. Those included how CoP training, supervision, and practice, could actively work to ‘reclaim’ the embodied dimension within the therapeutic encounter, and how the findings of the present research could contribute to that end.
References:


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Appendix 1: Ethical Clearance

Fast track ethics application, Checklist and Summary Ref: FT-PSY-391-17 - Confirmation to proceed

From: Earl JE Mrs (FHMS Faculty Admin)
Thu 02/03/2017, 11:06
Kokkalis J Ms (PG/R - Psychology);
Manafi E Dr (Psychology)

Dear Joy

Thank you for submitting your ethics study application form, checklist and summary to the Faculty of Health and Medical Sciences Ethics Committee via the Fast Track procedure. I am pleased to confirm that your project, as stated in your application, does not raise any issues that would necessitate a full ethical review and you are therefore able to proceed with your research.

Please keep your original application, checklist form and summary with the reference given above together with a copy of this email, as no copies are kept by the ethics committee.

If there are any significant changes to your project which require further scrutiny, please contact the Ethics Committee before proceeding with your Project.

Many thanks and good luck with the study

With kind regards
Julie

Julie Earl
Administrator Faculty of Health and Medical Sciences Ethics Committee
Duke of Kent Building (16DK03) (Tuesdays, Wednesdays & Thursdays, 9-5.15)
Tel: +44 (0) 1483 689175
Email: j.earl@surrey.ac.uk
Web: surrey.ac.uk
Senate House, University of Surrey, Guildford, Surrey, GU2 7XH, UK
Appendix 2: Participant Information Sheet.

Participant Information Sheet

RESEARCH STUDY: How do therapists use their embodied experiences in the psychotherapeutic process? - A thematic analysis.

I am a trainee counselling psychologist in my final year of training at the University of Surrey, conducting a qualitative research study on how therapists use their embodied experiences in the psychotherapeutic process.

My previous research on counseling psychology trainees’ experience of working with clients who meet the diagnostic criteria of ‘borderline personality disorder’, revealed participants’ extreme embodied, affective, visceral responses which undermined their constructive and therapeutic use (Kokkalis, 2016). This finding led me to consider the role of the therapist’s embodiment in therapeutic practice, and the possible ways that it may come to be utilized therapeutically. The proposed qualitative study seeks to produce knowledge which will contribute towards promoting an embodied, relational, holistic and phenomenological way of working with somatic experiences in the therapeutic encounter, in accordance with the Counselling Psychology values (BPS, 2015).

You are being invited to take part in this study but before you decide whether you wish to participate, it is important that you understand what it will involve. Please take the time to read the following information, think about it and decide whether you would like to take part. You should only participate if you want to; choosing not to take part will not
disadvantage you in any way. If you have any questions or anything is unclear, please do not hesitate to ask me.

**Participation**

If you agree to take part in my research, I will invite you to participate in an interview with me in which I will ask you some questions about your experience of this topic. The interview will take place within a quiet and confidential space, at a mutually agreeable time, date and location. No preparation is required for any part of your participation and I will meet with you just once for about an hour and a half. Prior to our interview I will ask you to sign a consent form (which has been included in this email). Following the interview we will have time for debriefing and discussing your experience of the interview and any concerns that you might have relating to the interview process. Please note you that you may withdraw from the study at any time without providing any reason, within a two-week period after the interview. If you withdraw, your interview will be permanently deleted. However, it would not be possible to withdraw after the two-week period, as it would be difficult to separate the responses of individual participants from the overall analysis.

**Confidentiality:**

Your interview will be audio-recorded, securely stored on encrypted storage (to which only I will have access to), and subsequently transcribed for analysis. At all times your identity will be protected and any information that might identify you or your clients will be concealed to safeguard confidentiality and anonymity (Data Protection Act, 1998). Following analysis, the results will be presented in my thesis. Any quotations used in the write-up of the research report will be anonymized so that you and your clients cannot be identified from what you have shared with me. Transcripts of the recordings may be made available in a totally anonymous form to my supervisor for research purposes only. This means that, with your permission, my supervisor will have access to the answers you provided, although they will have no means of identifying you. My research study may later be published in a journal (all participants’ names and any identifying information will be withheld).
Are There Any Risks Involved in Participating?
No known risks have been identified for participating in this study. However, given the experiential nature of the enquiry, engagement with the questions may potentially touch off sensitive areas that could evoke discomfort or distress for you. If you have any concerns during any stage of your participation, I will endeavor to discuss them with you and consider the various options for resolving your concerns. If there are questions that you find distressing or intrusive you are free not to answer, or withdraw from participating. As mentioned earlier, there will be allocated time at the end of the interview for debriefing and checking-in with your experience of being interviewed. If you subsequently feel that you could use some support to discuss anything which may have arisen for you during the interview, I can provide you with a list of suggested supports that you can make use of if you wish.

Are There Any Benefits to Participating?
The interview can be used as an opportunity for engaging in reflection-on-practice.

Ethical Clearance:
This study has received ethical approval from the University of Surrey, Faculty of Health &Medical Sciences Ethics Committee. If you have any questions about this study, or are interested in taking part, please contact me on: j.kokkalis@surrey.ac.uk. Or alternatively if you would like to discuss it with a 3rd party, you could contact my research supervisor, Dr. Elena Manafi, on: e.manafi@surrey.ac.uk.

Thank you for taking the time to read this information sheet.

Yours Sincerely,

Joy Kokkalis
Counselling Psychologist in Training.
Appendix 3: Consent Form.

Participant Consent Form

I, the undersigned, voluntarily agree to take part in the qualitative investigation of therapists’ use of their embodied experiences in the psychotherapeutic process. I have read and understood the Information Sheet provided and been given a full explanation by the conductor of the nature, purpose, location, and likely duration of the research interview, and of what I will be expected to do. I have been given the opportunity to ask questions on all its aspects and have understood the advice and information given as a result. I give permission for my interview with Joy Kokkalis to be audio-recorded and transcribed and I understand that interview recordings and subsequent transcripts will be treated in the strictest of confidence, in accordance with the Data Protection Act (1998). I understand that any information that might identify me or my clients will be concealed to safeguard confidentiality and anonymity, and disguised and anonymized extracts from what I say, may be quoted in the thesis and subsequent publications. I understand that I am free to withdraw from the study at any time within the two-week period after the interview, without needing to justify my decision and without prejudice.

I confirm that I have read and understood the above and freely consent to participate in this research. I have been given adequate time to consider my participation and agree to comply with its instructions and restrictions.

Name of participant (in BLOCK CAPITALS):

Signed:
Date:

Name of researcher (in BLOCK CAPITALS):  Joy Kokkalis

Signed:
Date:
Appendix 4: Brief Demographics Questionnaire.

Demographics questionnaire.

The following information will help to further contextualise your interview. All information will be treated confidentially, in accordance with the Data Protection Act (1998). Nevertheless, if you don’t want to answer some of these questions, please feel free not to.

1. what is your gender?

2. How old are you?

3. What is your ethnic background?

4. How many years have you been practising as a psychologist/psychotherapist?

5. Which psychotherapeutic modalities have you been trained in?

6. How would you describe your theoretical/psychotherapeutic approach?

7. In what setting(s) do you currently practice? (e.g. NHS, private, etc.)

8. Which professional organisation(s) are you registered with? (e.g. BPS, UKCP, BACP, BPC, etc)

Thank you very much for taking the time to answer this questionnaire.

Sincerely Yours,

Joy Kokkalis.
Appendix 5: Interview Schedule

“How do therapists use their embodied experiences in the psychotherapeutic process? -A thematic analysis”.

1) (Start/warm-up):
   - I would like to start by asking you what motivated you to take part in this research?
   - Overall, how do you understand the notion of embodiment?
   - how would you sum-up the role that embodiment plays in your own therapeutic practice?

2) Could you describe to me a specific example from your therapeutic practice, during which you experienced some form of embodied phenomenon?
   Prompts:
   - Could you briefly describe the therapeutic situation: What was happening? Who was the client, and how were they presenting? What was their impact on you?
   - Could you describe to me in some detail your own somatic experience during that encounter: Where did you notice it? What did it feel like? Where did you feel it? Was it a subtle or a strong sensation?

3) How did you understand your somatic experience at the time?
   Prompts:
   - How did you respond to it?
   - How, if at all, did you use this understanding to inform your therapeutic practice?
   - What effect did that have in your therapeutic work with this particular client?

4) Looking back now, do you understand that somatic experience differently from before, and if so, in what way(s)?
   Prompts:
   - Based on your current understanding of that phenomenon, are there any different possible ways that you might have considered to respond?
   - How do you think this response would have impacted your therapeutic work with this client?
5) What do you think enabled you in ‘using’ your somatic/embodied experience, in the way that you described?

6) Overall, has your own sense of embodiment & how you make use of it therapeutically changed over time, and if so, in what ways?

7) (End):
   - Is there anything else you that would like to add before we end? - How has this experience (i.e. of the interview) been like for you?
Appendix 6: Reflexivity Statement.

(Omitted due to confidentiality reasons).
Appendix 7: Coded Transcript

(Due to confidentiality reasons, only a brief segment is presented).

Erm, and it’s at those… I think that’s where the subtlety lies, that’s where, when I talk about the idea of choosing or not to choose, to, to share with it. So I would sometimes, erm, I’d sometimes use the embodied felt sense as, as almost like a question to the clients saying, I wonder, I’m feeling something about what you’ve just said, and I wonder whether it’s worth us… talking about what I-, I would offer it as a, as a possibility, erm, rather than most of the time I, I wouldn’t… just for the sake of it. I, I don’t think that’s good therapy, a sense of… you know what, it’s, it’s my problem with, erm, Rogerian is, my problem with person-centred therapy, as sense of congruence, I-, I-, the idea of, if, you know, Carl Rogers talks about, you know, being congruent, so saying what I’m feeling all the time. I’m not sure about that. I’m not sure why, why that would be therapeutic, for me to just tell the client what I’m feeling all the time. I think it’s about selecting the time and offering it as a possibility. I’m feeling so touched by that, or, I’m, I’m feeling such a sort of, erm… erm, a pressure on my chest when you say that. I wonder if there’s anything in that that we could explore. You know, I’d offer it as a, as a, as a possibility.

So, overall, it’s much more nuanced to make the call about whether to share… Absolutely. Two… it’s almost two levels. It’s, the first level is, ‘Shall I share it at all?’ and the second level is, ‘How am I going to share it?’ Am I going to say, ‘I’m feeling this,’ or am I going to say, tentatively, ‘Listen, Client, I’m, I’m feeling something, I wonder whether it might be worth us doing that,’ because I want to give the client the choice. I know that some of my clients… would find that a bit freaky, for me to say, ‘I’m… feel,’ because of the type of person they are, because of the relationship. I know other clients would, would en-, would want that. So I think, again, it’s about the person you’re working with. The how depends on whether that person is going to find it therapeutic, and, and you can only decide that… by knowing that person. There’s no rule… This is why it’s so difficult, it’s, it’s because it’s about, it’s about, erm…. it’s about intuition, but it’s also about reflective intuition. It’s about… not just spontaneity all the time, it’s about a spontaneity that’s almost sort of thought about,… because, of course, the repercussions can be… I mean, you know, can be dangerous, but, more importantly, the repercussions, more often, could be that the therapy is sort of, erm, derailed; it’s almost like the client thinks, ‘Why are we going down,’ you know, ‘So what… if you’re feeling that [uninterested].’ And, and they’ve got a point. So what if I’m feeling that;
Appendix 8: Audit Trail of Analysis

*(Partially omitted due to confidentiality reasons).*

The first step following my coding, was to collate and list all codes across my 6 transcripts (Sub-Appendix A). Then, I began the process of identifying common patterns among the codes, which I indicated by the use of different colours (Sub-Appendix B). This was then followed by an iterative movement between:

- checking for internal coherence, consistency, and distinctiveness within the grouped patterns themselves,
- checking for the inter-relationships between these grouped patterns, as well as the coded data they are attempting to capture.

This iterative movement produced 4 subsequent versions of such grouped patterns, clusters, or ‘emerging themes’ (see Sub-Appendices C, D, & E). Following the reviewing of themes, I identified and ‘settled with’ the themes and subthemes of Sub-Appendix F, upon which I subsequently based my write-up of the Findings section. Appendix G shows those themes and subthemes, along with all their relevant codes.
Appendix 9: Interview Process Observations

(Omitted due to confidentiality reasons).
Yardley's (2000) Evaluative Criteria: Sensitivity to context; Commitment and rigour; Transparency and coherence; Impact and importance.

Some of the ways in which the above criteria are satisfied in this research are evidenced in the following:

- Thorough contextualization of the research question within appropriate literature (evidenced in the Introduction and Discussion sections). This contextualisation encompasses diverse literature drawn from a wide variety of epistemologies. Examples include theoretical literature and case studies on ‘somatic countertransference’, philosophical views on ‘embodied-intersubjectivity’, as well as critique of pertinent quantitative and qualitative studies.
- Approach to data collection and data analysis which is epistemologically congruent, coherent and plausible. The latter is evidenced in the description of the data analysis steps (under methodology), as well as the audit trail (appendix 8) which provides detailed and transparent evidence of my data analysis. In addition, congruence, coherence and plausibility of my data collection and analysis were facilitated and promoted through the use of supervision at regular intervals.
- Consideration of reflexivity (see appendix 6), outlining how my own (embodied) subjectivity as a person and as a researcher informed my interpretative frameworks and ‘co-created’ my research findings.
- Detailed, painstaking engagement and immersion with the analysis of data and transparent provision of the steps involved (see appendix 8/audit trail, and steps outlined under methodology).
- Nuanced consideration of relational ethics, conceived of as ‘ethics-in-action’. The latter encompasses dilemmas, such as: 1) interpreting ethically, 2) maintaining
confidentiality, and 3) being mindful of issues of power within research interviewing relationships.

✓ elaboration on theoretical and practical implications of the research’s findings (see discussion). This entailed an assessment of the contribution of my findings in light of existing empirical and theoretical literature on the topic of ‘therapist embodiment’, as well as a consideration of their implications for CoP theory and practice.

✓ choice of method and rationale for its adoption. This included building a solid argument regarding the fit between my RQ and the methodology employed, based on ontological and epistemological grounds.

✓ sensitivity and respect to participants’ experiences, demonstrated through my interviewing stance as well as ‘ethical-mindset’. Furthermore, my interviewing stance was underpinned by CoP’s relational and humanistic principles, advocating respect for the Other’s subjective experience and the enquirer’s task in co-creating meaning through empathic engagement.