A portfolio of academic, therapeutic practice and research work including a critical literature review on the impact of therapy upon clients’ attachment patterns

By

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Introduction to the Portfolio

This portfolio consists of three dossiers that cover the academic, therapeutic and research aspects of my doctoral training in counselling psychology at the University of Surrey. It aims to provide an overview of my journey towards becoming a counselling psychologist as this unfolded over the last two years of my studies. The first part of my training was completed at a different academic institution. Although the portfolio emphasises the last two years of my training, the reader will also be given some insight into my previous personal and professional experiences as these are part of my journey towards becoming a counselling psychologist.

Before introducing the dossiers, I am going to briefly reflect upon my personal experiences that contributed to my decision to pursue training in counselling psychology.

Background

From an early age I was interested in the human psyche, existence and being. This may come as no surprise when one considers my Greek cultural heritage. At school I was introduced to a plethora of ancient Greek writers and I found that Homer’s Odyssey and ancient Greek tragedies (i.e. Oedipus at Colonus) offered great opportunities for psychological exploration of both intrapersonal and interpersonal conflicts. This is how my interest in psychology began. My interest was then enhanced by studying Philosophy, Education and Psychology at the University of Athens. When I completed my bachelors, there were limited opportunities in Greece for postgraduate studies in psychology. To this end, I moved to the UK where I started an MSc in social psychology at the University of Surrey.

Although I enjoyed social psychology, my initial decision to study this subject was influenced by the fact that I was not eligible for the BPS Graduate Basis for Registration at the time because I held a combined degree from abroad. Thus I was not eligible to register for a psychology course leading to Chartered Status with the BPS
(i.e. counselling, educational, health, clinical). I considered that social psychology would be a stepping stone for me at the time. The MSc course offered me the opportunity to see how I would adjust to the UK and whether I could make a commitment to stay long enough in this country in order to study one of the branches leading to Chartered Status. I had enjoyed social psychology during my undergraduate studies, therefore I considered that an MSc in this field would help me to expand both my theoretical knowledge and research skills, and enable me to decide if ultimately I wanted to seek further training in psychology. I also hoped that it would increase my chances of being accepted to a PsychD course eventually. Moreover, as I was 24 years old at the time, I needed more life experience before I could make decisions that would probably influence the rest of my life, at least career wise.

One of the main experiences influencing my decision to study counselling psychology occurred when I was completing my MSc studies. My father was diagnosed with a heart condition and had a heart by-pass operation within a month of the diagnosis. I travelled to Greece to organise the operation as I am the eldest daughter of three. This was an extremely stressful moment in my life. During the operation there were complications and the whole family was breaking down in the waiting room. Fortunately, the operation was successful. Despite the fact that my father was operated in a private modern hospital, counselling was not offered to him prior to or post the operation. My father started smoking soon after the operation and continued to follow the same unhealthy lifestyle he had practised before he developed the heart condition. I inquired at the hospital whether they offered support groups or individual therapy for cardiac patients but the response was negative. It struck me that psychological factors were not taken into account whilst, in my opinion, these were of vital importance i.e. his addiction to smoking probably led to the operation at first place and such addiction was associated with other psychological difficulties. My father would probably submit himself to another operation without some kind of intervention. At the same time, the family had to tolerate shared feelings of anger and desperation in relation to his behaviour. Around that time, all the difficult feelings regarding my relationship with my father emerged. This is when I decided that I wanted
to explore my own internal pain and through this process ultimately help others. I also hoped that through becoming a counselling psychologist I would eventually be able to contribute to the development of counselling psychology in my country.

After I completed my MSc studies, I was employed as a researcher in a longitudinal project investigating young people’s transitions into adulthood. When analysing the research interviews, I became aware that some young people tried to treat the interview as a therapy session and reveal information that was extremely private to them. I was also noticing my own urges to psychologically analyse these peoples’ life-stories and try to understand how their experiences had influenced their way of being. Yet, at the same time, as the majority of the participants presented an array of interpersonal and intrapersonal difficulties, I felt powerless to help them as I was a researcher and not their therapist.

After a year of working in research, I applied for an introductory course in counselling psychology in order to further explore if counselling psychology was what I really wanted to pursue in the future. I greatly enjoyed practicing counselling skills during the introductory course and started to keep a journal in which I wrote any therapy related thoughts and feelings as well as self-reflections. I was fascinated by the theories introduced and the opportunities offered for both personal and professional development if one further engaged with counselling psychology. This experience confirmed to me that I wanted to study counselling psychology and prompted me to seek further training.

Finally, I would like to acknowledge that at a deeper probably unconscious level my choice was driven by a need to understand my own intrapersonal and interpersonal struggles and a strong desire to alleviate or reconcile some of my own internal pain. I believe that my earlier experiences of inconsistent and at times invalidating parenting, oscillating between extreme loving and punitive behaviours, meant that many of my psychological/emotional needs were not adequately met during my early development. My response to that environment was to develop defences/strategies that enabled my
survival during the early years of my life. The same defences/strategies had the potential to curse me (and they often did) over the years as at times they prevented me from being open to certain emotional experiences. Through the process of becoming a counselling psychologist, I got to understand my self in light of my previous experiences and as a result of this I have been facilitated to manage my internal pain. Moreover, through forming a reparative relationship (secure attachment) with my therapist I developed a template of a good enough relationship that has facilitated my extratherapeutic relationships and the relationship with my own self. Reworking and re-evaluation of my personal experiences have facilitated my therapeutic work greatly.

**Academic Dossier**

This dossier contains two essays that I wrote in relation to the psychodynamic and cognitive behavioural modules. The diversity of the topics discussed reflects the richness and diversity of epistemological stances employed by counselling psychologists.

In the first essay entitled ‘Making the most of erotic transference and countertransference feelings and reactions in psychodynamic psychotherapy’, I present psychodynamic ideas on erotic transference and countertransference and discuss how these relate to therapeutic practice. My decision to further explore this topic stemmed from having encountered erotic transference in my therapeutic work in previous years but having felt under-equipped to work effectively with it. The essay demonstrates that most therapists ‘shy away’ from erotic transference feelings often because they are offered limited opportunities to explore these feelings further during their training and/or in supervision. Through undertaking this essay, I aimed to develop some knowledge in this area so that I could work more effectively with erotic transference and countertransference feelings. I also hoped that such exploration would allow me to instigate conversations including erotic feelings in supervision if these appeared relevant to the therapeutic work. I believe that both these aims were fulfilled as during the last year of my training I worked with a client who had developed intense erotic transference towards me, and felt confident to
discuss this in supervision both at my placement and at the university. Moreover, my knowledge of the relevant theory facilitated my therapeutic work with this client greatly.

The second essay is titled ‘Is cognitive behavioural therapy an effective therapy for treating depression? A critical evaluation of the literature accounting for technical and common factors’. This essay aimed to critically evaluate a popular discourse suggesting that CBT is the most effective approach for treating depression. Whilst my review of the literature demonstrated that CBT was effective, other treatments were found equally effective (i.e. IPT). Moreover, most papers highlighted the importance of a good therapeutic relationship in order for CBT interventions to be effective. I found this to be a powerful argument towards demonstrating that Counselling Psychologists’ training with its emphasis on the therapeutic relationship enables them to provide CBT in a competent manner.

**Therapeutic Practice Dossier**
The therapeutic dossier relates to my clinical practice and provides information about the placements and the client populations I have worked with during my training at the University of Surrey. It also contains a ‘Final Clinical paper’ discussing my development as a relational counselling psychologist. This is titled: ‘On becoming a counselling psychologist: Setting out for the unknown but never alone’. In this paper, I demonstrate how my clinical work, engagement with theory, personal therapy and other life experiences have influenced my development as a counselling psychologist and how this has been reflected in my therapeutic practice.

**Research Dossier**
This dossier contains one qualitative research project and one critical literature review undertaken during the second and third years of my studies respectively. This choice was made in accordance with the course requirements outlined when I was accepted to enter Year 2 of the PsychD in Psychotherapeutic and Counselling Psychology at the University of Surrey.
The qualitative report is titled ‘How does individual therapy influence the heterosexual couple relationship? A grounded theory analysis of the accounts of partnered clients’. The choice of this topic was inspired by my personal experience of being in a committed and close relationship (marriage) whilst engaging in long-term weekly psychodynamic psychotherapy. By conducting this study, I aimed to further explore a popular discourse suggesting that therapy-related changes in the partners who are in therapy (client-partner) threaten their romantic relationships (deterioration hypothesis). The reader will come to see that the localised theory emerging from participants’ accounts presented a much more complex and elaborate picture than the one suggested by the deterioration hypothesis. This is the only piece of published work, to my knowledge, exploring client-partners’ accounts on this topic. Previous research focused solely on the accounts of the partner who did not receive therapy. I thoroughly enjoyed conducting and writing up this study. This was, in part, due to the fact that participants provided me with particularly reflective and insightful accounts; thus facilitating my engagement with the data. Perhaps this is another effect of therapy: it increases individuals’ reflective ability. This statement is based on comparing my experience of this study to my previous research experience of analysing interviews of participants who had not undergone therapy. Through conducting, reflecting upon and writing up this study, I have become more sensitive and attuned to the systemic effects of individual therapy.

In my third year, I conducted a literature review titled ‘Can therapy instigate change in clients’ attachment patterns? A critical literature review’. When I completed my psychodynamic year I felt that there was much more to be explored and studied in psychodynamic theory, especially with regards to its contemporary trends focusing on intersubjectivity, attachment and mentalisation. Therefore, I decided to ‘dig into’ this field further and investigate the function and possible effectiveness of psychodynamic therapy with regards to influencing clients’ attachment patterns. Through an extensive review of studies exploring adult attachment stability and change, the function of therapists as attachment figures, and changes in clients’ attachments in relation to therapy, this review demonstrated that therapy may shift clients’ attachment patterns from insecure to secure.
Having developed a preference for the psychodynamic approach during my second year placement, I was disappointed to realise that whilst conducting my third year placement at a specialist DBT (Dialectical Behaviour Therapy) service, I was often criticised when I provided psychodynamically informed formulations. Whilst my intention was to understand historically some of the clients' difficulties rather than use psychodynamically driven interventions, some DBT practitioners (thankfully my supervisor was not one of them) would argue that psychodynamic ideas were unsubstantiated. The question often posed was: what is the evidence? Despite being aware that psychodynamic therapy is not particularly popular within the NHS, I would often be left thinking that psychodynamic theory was actually attacked by some practitioners and this was not always to the benefit of the client. My reaction to these attacks was of a constructive nature: I decided to conduct a literature review that would highlight areas for evaluation of the effectiveness of psychodynamic psychotherapy, and generate ideas for future research. I believe that unlike psychotherapy training that focuses on practice, counselling psychologists' training and interest in conducting research may promote the evaluation and use of therapy models that have previously been under-researched because of political, financial and contextual issues.

Despite the fact that at first glance the aforementioned studies seem unrelated, they both explore how therapy can influence clients' interpersonal relationships. The qualitative study focused on the impact of therapy upon close romantic relationships, whilst the literature review explored studies suggesting that the therapeutic relationship, as an attachment relationship, may help clients shift from an insecure to a more secure attachment pattern. It was proposed that attachment shifts may be extended from the therapeutic relationship to extratherapeutic relationships. The choice of my research topics demonstrates that relationships are at the core of my research and personal interests. This interest reflects my personal yearning for meaningful and fulfilling relationships, as with time I have come to realise that my emotions (both pleasant and unpleasant) have mostly been elicited by and experienced within the context of relationships. This is another reason why I have been attracted to counselling psychology:
its emphasis on relationships as these are captured, reenacted and repaired within the context of the therapeutic relationship.

Conclusion
In conclusion, this portfolio is the culmination of a two year study of the PsychD in Psychotherapeutic and Counselling Psychology at the University of Surrey. I hope that in the years to come, through gaining further experience in academic work, therapeutic practice and research, I will be able to expand upon or maybe challenge some of the views I have presented in this portfolio.

NB. The names of the clients and research participants, the people they refer to, location names and other identifying details have been omitted or changed in order to preserve their confidentiality and anonymity.
Introduction to Academic Dossier

This dossier contains two essays. The first essay discusses psychodynamic ideas on erotic transference and countertransference and how these can be used to inform practice. The second essay, through reviewing relevant literature, evaluates the effectiveness of CBT in treating depression, taking into consideration both technical and common factors.
Title: Making the most of erotic transference and countertransference feelings and reactions in psychodynamic psychotherapy.

Introduction
Erotic transference was first introduced as a theoretical concept by Freud in 1915 in his paper 'Observations on transference love'. Ever since and especially during the last two decades, some analysts¹ have revisited Freud's paper either in order to elaborate and build upon his thoughts or in order to criticise, challenge and offer alternative recommendations with regards to working within erotic transference and countertransference. In this essay, I will start by reviewing the relevant literature placing emphasis on the possible meanings of erotic transference, as they have been proposed by various analysts. Then, I will focus on the impact of erotic transference on therapists' countertransference, as this may have a major impact upon the therapeutic work. In the final part of the essay, I will discuss how the relevant literature has informed my own thinking with regards to using erotic transference and countertransference feelings and reactions in therapy. In the end, it will be argued that therapists' attunement to the erotic in the analytic/therapeutic situation enables the access of and working through clients' early development material. Moreover, it alleviates clients' and therapists' anxieties related to manifestations of erotic feelings within the therapeutic dyad; thus improving the therapeutic relationship and work.

Meanings of the erotic transference
When reviewing the literature on erotic transference and countertransference one surprisingly realises that despite psychoanalysis having been born out Freud's observation that incestuous erotic desires can find expression within the analytic setting, most therapists seem to fear any expression of eroticism within the analytic dyad. The first reported incident of erotic transference was developed in 1882 in one of Dr Josef Breuer's patients, a hysteric woman called Anna O. Despite the fact that her analysis appeared to be successful, near the completion of her therapy Anna O started hallucinating and

¹ The terms analyst and therapist as well as analysis and psychotherapy are used invariably as most papers within the psychodynamic tradition have been written by psychoanalysts.
accused Breuer of having impregnated her. Breuer’s response was to run away and go on a second honeymoon with his wife in order to save his marriage (Mann, 1997).

The case of Anna O has been proven of seminal importance to the development of psychoanalysis, providing Freud with emerging insights into transference and countertransference that were further examined and consolidated in the course of his career (Blum, 1994). Freud (1915) in ‘Observations on transference love’ suggested that love in real life resembles love in the analytic setting, however it also entails a major difference: love expressed in analysis can be used as a defence against remembering painful experiences. Apart from being a form of resistance, Freud also viewed the potential of love to function as a facilitating medium that enables the expression of unconscious desires and conflicts. However, those clients who physically wanted to actualize their erotic transference were regarded as being untreatable. Freud adamantly stressed that under no circumstances was the doctor (therapist) to succumb to the sexual and erotic longings of his clients. For Freud, erotic transference was a manifestation of the repetition compulsion of the oedipal transference and was typically restricted to the male analyst-female client dyad.

The concept of erotic transference remained unaltered until 1973, when Blum suggested a new form of transference that he called erotised: “The erotized transference is a particular species of erotic transference, an extreme sector of a spectrum. It is an intense, vivid, irrational, erotic preoccupation with the analyst characterized by overt, seemingly ego-syntonic demands for love and sexual fulfillment from the analyst” (p. 63). Blum, unlike Freud, proposed that even clients who express an extreme erotised transference might be analysable if they are able to test reality. For Blum erotised transference has four functions: it may serve as a drive for gratification of oedipal strivings, repetition of trauma (parental seduction in which adults denied their complicity) aiming at mastery, ego adaptation and defence, and finally it can be employed for the regulation of self-feeling.
Whilst Freud and Blum have related erotic transference to the oedipal strivings and ego functioning dimensions, most recent views have focused on its defensive, relational or narcissistic functions (Flax, 2000). Wrye and Wells (1989) introduced the concept of the maternal erotic transference that is anchored in the mother-child preoedipal period. Drawing upon infant research on preoedipal development, they challenged Freudian thinking that erotic transference was typically developed between female clients and male therapists. Within the erotic, they included all the preoedipal tender and sensual wishes as well as the sadistic and masochistic wishes that arise in the transference. It was suggested that maternal erotic transference is transformational and creative although it may be “defended against as humiliating and frustrating” (Wrye, 1993, p. 241). Mann (1997) has also stressed the importance of erotic transference for clients’ growth seeing it as the most powerful and positive quality in the therapeutic process. He has suggested that the relationship between mothers and babies is extremely erotic but extremely de-eroticised in psychoanalytic thinking due to a reluctance to see the erotic dimension of maternity.

Whereas the classical psychoanalytic and object-relation schools have attempted to conceptualise erotic transference in relation to oedipal and preoedipal strivings, an alternative theorisation of erotic transference has been offered by self-psychology. For Trop (1988), erotic transference may help the client to complete a curtailed developmental need. Trop like Blum (1973) made a distinction between erotic and erotised transference. Although, he suggested that “intensified and manifest sexuality in the transference is often an eroticisation of self-object needs for mirroring” (p. 282); thus he associated erotised transference with a defensively structured self-esteem based on sexuality. Unlike erotised transference, Trop (1988) saw erotic transference as a healthy developmental trend and a belated effort to manage failures associated with lack of mirroring of the sexual self during the oedipal developmental stage. Buirski and Monroe (2000), also drew upon ideas of self-psychology, stressing the intersubjective element of the psychoanalytic experience and locating clients’ falling in love in the present. According to them, erotic transference is developed as a result of therapists’ responding
to their clients' needs for being cared for and provided with significant functions for the self.

Extrapolating from the above, it could be postulated that erotic transference has been conceptualised differently by different schools of thought. Flax’s (2000) review of the literature on erotic transference concluded that erotic transference has multiple meanings and analysts should not confine themselves only to those ones supported within their own theoretical tradition. For example, in various papers erotic transference has been seen as a) defence, b) expression of oedipal drives, c) repetition of trauma, d) reflection of an internal object relation, e) expression of hostility, f) used in the service of narcissistic needs, g) a mode of expressing and maintaining connection, h) and finally as expression of preoedipal themes. Flax (2000) suggested that through understanding the multiple meanings and connections of erotic transference, therapists can better identify with the roles projected onto them. Such an understanding enables them to analyse and make sense of their own countertransference; thus preventing them from shying and running away from an experience that can contribute immensely to the their clients’ therapy.

Finally, it is important to mention ideas regarding the analytic dyad that does not experience any erotic feelings during therapy. Elise (2002) suggested that therapists should be alerted to the absence of erotic transference as this could give them some indication about their clients’ issues. For example, Kernberg (2000) argued that the absence of erotic desire in clients (not confining it to the analytic situation) may reflect either a primary deadening of the erotic or a profound repression of infant sexuality. According to Kernberg, such clients are likely to either defend against the emergence of erotic transference or suppress any erotic feelings that emerge during their analysis. Similarly, Person (1985) has argued that in cross-sex analytic dyads, men resist developing an erotic transference to their female analysts, unconsciously avoiding the anxieties related to postoedipal development during which the boy must renounce his tie with his mother. According to Elise (2002), analysts’ curiosity and exploration of the
absence of the erotic may lead to exploring areas they would not have been able to access otherwise.

The impact of clients’ erotic transference on therapists’ countertransference
Therapists ‘running away’ from or deflecting when issues of erotic transference arise is a common theme in the relevant literature as well as in therapists’ supervision and informal conversations. Let us take for example Breuer’s countertransferential reaction to Anna’s erotic transference that was reported above. Reflecting upon this incident Davies (1998) has been wondering “whether Breuer ran from Anna or from himself, from her sexual feelings or his own, and whether we have all, as a profession, been running from these feelings ever since” (p. 747). It seems that what Breuer experienced was a countertransference feeling of horror (in the literature most authors seem to agree that Breuer was terrified of reciprocating any loving or sexual feelings towards Anna O) that for some people creates a flight response similar to his. Actually, it was Kumin (1985) who suggested that most therapists’ experiences of erotic countertransference can be better described as ‘erotic horror’. Therapists’ erotic horror though, restricts the elucidation of their clients’ erotic transference. His view was that “the correct interpretation, whether spoken or silently understood, mitigates the frustrated desire and resistance of both client and analyst” (Kumin, 1985 p. 3).

Kumin’s (1985) views are in accordance with the literature suggesting that erotic transference is a defence employed by the client. However, Kumin also adds the notion of analysts also defending against their own erotic countertransference. As early as 1959, Searles pointed out that analysts’ resistance to deal with and understand their own countertransference, was often related to their training; expecting analysts to hold rather than suspect any strong feelings they develop in relation to their clients. Until today, despite the fact that new views regarding erotic transference and countertransference have been developed, the topic is still infrequently addressed within training (Elise, 2002). Kumin (1985) argued that in cases of erotic transference and countertransference, analysts’ reluctance to acknowledge their part of reciprocal feelings leads to a
reenactment of the Oedipal parent-child situation during which parents deny their own seductive role. This can be very confusing for the client especially if we consider Davies’s (2001) argument suggesting that psychoanalysis “is both a deeply penetrating and implicitly seductive process... as we wend our ways into the deepest recesses of people's most intimate and private experiences... we clearly work from a position of influence well within the patient's most private interior spaces” (p. 759).

In this sense, as Wrye (1993) has argued, the biggest problem for analysts is not in resisting their feelings but allowing themselves to participate in the erotic transference-countertransference situation. By participation, he does not imply acting out but recognising and analysing the therapist’s erotic countere transference feelings. According to Wrye (1993), such an analysis can be very helpful towards understanding the client’s personality organisation and bridging the schizoid distancing within the analytic dyad. Coen (1992 cited in Gabbard 1994, p. 400) has also argued for analysts to allow themselves to fully develop an erotic countertransference as a response to their clients’ erotic transference in order to better understand and eventually help their clients grow. He suggested: “Whatever is difficult for the analyst to bear in himself, he will, of course, have trouble bearing in his patient. The analyst thus must maintain both an interpersonal and an intrapsychic focus for himself and especially for his analysand. It is not an either or choice; both are necessary” (p. 11). In line with Coen’s suggestion I would like to go back to Breuer’s example and suggest that Anna O’ s analysis could have possibly moved onto a different level if Breuer continued the analysis with her and made use of his erotic countere transference in order to explore the oedipal, preoedipal or any other strivings she might experienced.

Mann (1994) has warned on the dangers entailed for those therapists who avoid using their erotic countertransference thoughts and feelings in order to inform their therapeutic work. He stresses that “the twin dangers are on one hand to repress, deny, split off feelings, this leading to displacement or projection onto the client, or on the other hand, to be overwhelmed by feelings, thereby leading to acting out with the client” (p. 350). In a
similar way Davies (1998), who links the fear of acting out to Breuer’s analysis of Anna O, concludes that erotic countertransference makes most therapists want to act; thus distracting them from what they are actually expected to do which is to understand the intrapsychic, interpersonal and developmental significance of erotic countertransference. It seems that their fear of acting out turns into an obsessive thought that they would actually enact their loving and sexual feelings. According to Blum (1994), such an enactment could be possible in cases of erotised countertransference that is demonstrated by therapists falling in love with their patients, initiating seductive overtures to them and requesting reciprocal love from the patient. Enactment of erotised countertransference is likely to stem from analysts’ own unresolved oedipal or preoedipal issues that need to be attended to. As Gabbard (1994) highlights, analysts should not assume that all the loving feelings they develop in relation to a patient stem from their patient’s internal world.

Another danger related to therapists’ erotic countertransference is the implications for the client when any erotic feelings are communicated to them. Whilst most analysts have argued against any self-disclosure with regards to such feelings (Gabbard, 1994; Mann, 1994) there are few who believe, especially those following the constructivist tradition, that the analyst’s tactful and judicious disclosure could be beneficial for the analysis (Davies, 1998, 2001, Rabin 2003). Gorkin’s (1987 cited in Rabin 2003, p. 682) personal experiences with clients led him to stress the detrimental effects that self-disclosure of loving/sexual feelings had for some of his clients. For this reason, he stressed that the revelation of such material could be as overwhelming for the client as when an analyst discloses a wish to strike or harm their clients.

For Elise (2002), analysts’ decision to self-disclose is primarily based on analysts’ anxieties related to the incest taboo. The taboo against expressing erotic desire within the family is transferred in the analytic dyad that in most cases feels familial. As a result, clients are not encouraged to voice the loving emotions they repressed as infants. In a similar way, Davies (1998) argues that the analyst, like the oedipal father, could feel uncomfortable due to developing countertransference reactions of romantic fantasy and
sexual arousal. According to Davies, when analysts do not address issues of erotic transference and countertransference in certain cases of disavowed sexuality, they contribute to an incestuous reenactment by holding onto the role of the ‘adored other’. In a sense, it appears that what is feared the most is reenacted in the analytic relationship, with the analyst being the silent parent who allows past oedipal conflicts to remain unconscious, feared and perpetuated in the present.

Using erotic transference and countertransference feelings in therapy
In this essay, I tried to offer a brief overview of the literature on erotic transference and countertransference, focusing on the possible meaning of the erotic for the client and its impact on the analyst, as both these aspects can inform the analytic work. It was demonstrated that therapists’ willingness to explore clients’ erotic transference enables them to access their clients’ early development material. This can be of tremendous value for the clients, as it allows them to relive and ultimately make sense of unconscious fantasy. According to Schafer (1977), a manifestation of erotic transference involves both the repetition of infantile object relations and an attempt to understand and then change unconscious beliefs related to unsatisfactory conditions of loving. For Schafer, the shift from understanding unconscious fantasy to creating new meaningful experiences is dependent upon successful transference interpretations. As well as contributing to the understanding of unconscious fantasies, transference interpretations may also alleviate clients’ anxieties related to their feelings of erotic transference. Such feelings may be unmanageably intense, impeding and/or sometimes leading to an early end of their treatment (Person, 1985).

Therapists experience intense and uncomfortable feeling too, with the main feeling being that of ‘erotic horror’ (Kumin, 1985). As a result of ‘erotic horror’ some therapists may ‘run away’ or choose to ignore any erotic manifestations related to the analysis; thus adding to their clients’ anxieties by not enabling them to verbalise and understand where their erotic transference stems from and what it means to them. In my clinical work, I have encountered one instance during which an overt manifestation of my client’s loving
feelings towards me was made. I failed to work efficiently with it, as I was not familiar with the multiple meanings of erotic transference at the time (at the time I had little knowledge of psychodynamic theory). This client (Mr P) was a 48-year-old man who was referred for anxiety but was interested in working with his relationship difficulties and sexual dysfunction. When Mr P expressed his loving feelings for me, I regarded his expression of love to be a defence against working on past and present painful experiences; thus I made an interpretation along those lines. It now seems, though, that such an interpretation was defensively employed by me in order to alleviate my embarrassment and my fear of being perceived as a sexual object. Upon reflection, I believe that my client’s erotic transference was triggered by his need for mirroring of the sexual self (see Trop, 1988) as such need was not probably fulfilled by his mother during his oedipal development (this assumption is based on his accounts of his childhood experiences). I now wonder to what extent he would have benefited from our therapy, had I explored the meaning of his infatuation for me, instead of me interpreting it as a defence that needed to be removed. Moreover, I ask myself whether a more attuned transference interpretation would have helped him to shift his focus from trying to be my object of desire to actually understanding and working on his relational and sexual difficulties.

With regards to self-disclosure, I did not experience any sexual or erotic feelings for Mr P. Having read the literature on analysts’ self-disclosure of erotic countertransference feelings, I believe that if I had such feelings, I would have probably tried to process and understand them in order to inform my interpretations, but I would have not openly discussed them with Mr P. As demonstrated in this paper though, erotic transference can take various forms and some analysts have argued that under certain circumstances, some clients may benefit from therapists’ self-disclosure. To this end, I understand that there might be some cases where purposeful self-disclosure (previously discussed in supervision) can prove effective.
Conclusion

In conclusion, it seems that therapists' attunement to erotic transference and countertransference feelings and reactions has many advantages. First, it informs therapists' formulations by enabling them to access early development material (oedipal and preoedipal). Second, it informs their interpretations; thus allowing clients to make connections between their early object-relations and the present analytic situation. Finally, by understanding the meaning of erotic transference and countertransference, both clients and therapists become less anxious of possibly acting out their loving and sexual feelings; thus they can be more open to the psychotherapeutic experience and less fearful of the therapeutic relationship.
References


Title: Is cognitive behavioural therapy an effective therapy for treating depression? A critical evaluation of the literature accounting for technical and common factors.

Introduction
Depression is the most common mental disorder affecting between 8 and 18% of the general population at least once in the course of their lifetime (Beach & Jones, 2002). Epidemiological research has suggested that given depression's incidence and prevalence it constitutes a major social problem with social, familial and economic implications. In an attempt to overcome such implications, researchers from the fields of psychiatry, psychology and pharmacology have placed a special interest in finding effective ways for treating depression. Psychological research has mainly focused on investigating the efficacy of Cognitive Behavioural Therapy (CBT) as a treatment for depression. To this end, Randomised Control Trial (RCT) studies have compared CBT to non-treatment or other treatments for depression. Based on evidence stemming from such research, this essay will evaluate the effectiveness of CBT towards treating non-bipolar, non-psychotic depression (or else Major Depressive Disorder/MDD). The critical evaluation of the literature will focus on both common and technical factors contributing to the treatment of depression. Despite focusing only on research on CBT and MDD, it will be briefly demonstrated how these studies contributed to the evolution of CBT. Finally, there will be a reference on what such evolution means to Counselling Psychology.

Firstly, a definition of MDD will be presented as this is the type of psychological disturbance for which CBT was originally designed and tested. MDD is characterised by one or more depressive episodes and the absence of manic episodes (Roth & Fonagy, 2005). The most useful diagnostic criteria of MDD come from the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (DSM-IV; American Psychiatric Association, 1994) that specifies that at least five out of nine specific depressive symptoms must be present nearly everyday for two weeks in order for a person to be diagnosed with MDD. Such symptoms are related to depressive mood, loss of interest, disturbances in appetite, weight and sleep, psychomotor agitation or retardation, fatigue,
feelings of guilt and worthlessness, difficulty concentrating, suicidal attempts and recurrent thoughts of death.

In 1979 Beck and his colleagues introduced CBT as an innovative psychological model for treating depression. CBT consists of a complex interweaving of both cognitive and behavioural techniques targeting clients' cognitive and behavioural aspects respectively. Beck’s model (1967, 1976) suggests that, through experience, people form cognitive schemas (about themselves and the world) according to which they interpret their experiences and govern their behaviour. Whilst the above can be characterised as adaptive schemas, difficult experiences may lead to the formation of maladaptive schemas which, according to Beck, are responsible for depression. The latter activate negative automatic thoughts reflecting themes of loss and generating negative views regarding the self, the world and the future (negative cognitive triad). In addition to negative cognitive schemas, depressed patients seem to be susceptible to such information processing distortions as arbitrary inference and selective abstraction, and as a result of this they find it hard to use positive experiences in order to correct dysfunctional schemas (Hollon et al., 2002).

According to Beck et al. (1979, p. 3) cognitive therapy is “an active, directive, time limited structured approach....based on an underlying theoretical rational that an individual’s affect and behaviour are largely determined by the way in which he structures the world”. Based on the aforementioned assumption Beck et al. (1979) suggested a model that aimed at modifying patients’ maladaptive beliefs. It was proposed that cognitive changes would produce mood and behavioural changes. Their innovative model generated various criticisms. For example, CBT was criticised for not paying any attention to environmental factors, for overestimating the processing errors, for claiming an unidirectional effect of cognition on mood and for overemphasising conscious thoughts at the expense of unconscious processing (Blackburn & Moorhead, 2001). However, as it will be demonstrated below, CBT has evolved over the last 35 years by
using the above criticism in a constructive way. Thus, today CBT is recommended as the preferred psychological treatment of depression by the NHS NICE guidelines (2007, p. 11).

**Is CBT an effective therapy for treating depression?**

Since CBT was first introduced, numerous studies have investigated its efficacy as a treatment of depression. The first systematic pieces of research were RCT studies comparing CBT to medication. Whilst some meta-analyses suggested that CBT was equal to or superior to pharmacotherapy (Dobson, 1989; Gaffan et al., 1995) other research indicated the opposite (TDCRP, Elkin, 1994). De Rubeis and Crits-Cristoph’s (1998) review of studies comparing CBT to pharmacotherapy suggested that only 26% of patients treated with CBT, either alone or with medication, relapsed in the first year follow-up as opposed to 64% of patients treated with antidepressants only. In addition, follow-up data from the NIMH Treatment of Depression Collaborative Research Program (TDCRP, Elkin, 1994) indicated that CBT appeared to be slightly more effective than pharmacotherapy (24% and 16% respectively). However, it was not clear whether this represented a preventative effect of CBT over pharmacotherapy. Findings from the same programme suggested that pharmacotherapy might be superior to CBT in the treatment of severely depressed patients. On the other hand, other research has shown that the treatment type was unrelated to clinical course among severely depressed patients (Schulberg et al., 1998). In addition, a small scale research paper suggested that very depressed patients who did not respond to medication showed a greater response to CBT than continued medication (Moore & Blackburn, 1997).

Apart from pharmacotherapy, CBT was compared to other psychotherapeutic modalities. The TDCR Programme (Elkin, 1994) was a very thorough and well-designed study that aimed to examine the efficacy of CBT and interpersonal psychotherapy (IPT) by comparing them to a well established medicine (imipramine) with clinical management and a placebo condition with clinical management. Analysis of the data showed that few substantial differences were found amongst the four conditions with IPT and imipramine.
appearing to be slightly more effective with severely depressed patients. However, in the 18-month follow-up IPT and CBT had similar recovery rates (23% and 24% respectively). Similarly, the 2nd Sheffield Psychotherapy Project (Shapiro et al., 1994) showed that both IPT and CBT were equally effective suggesting that there was scant evidence of more rapid change in CBT. As opposed to TDCRP, there was no support of differential response to CBT or IPT with regards to initial depression severity.

Shapiro et al. (1994) suggested that some of the advantages of CBT over IPT claimed in earlier literature reviews might have been due to researchers’ predominant allegiance to CBT. Similarly, Robinson et al. (1990) proposed that differences shown by previous research were due to researchers’ allegiance to their preferred approach. This view was also supported by Gaffan et al.‘s (1995) metanalysis demonstrating that the superiority of CBT (over pharmacotherapy and other psychotherapies) in Dobson’s (1989) metanalysis was predictable from researchers’ allegiance. However, they suggested that researchers’ allegiance mainly existed in earlier studies because only studies that showed strong effects of CBT over other treatments were accepted for publication in the past. When accounting for researchers’ allegiance, Gaffan et al. (1995) suggested that CBT was still more effective than other treatments. However, they obtained smaller effect sizes than Dobson et al. (1989) and only the differences in the waiting list and attention control groups were significant. In conclusion, when accounting for research biases most major studies have suggested that CBT is an effective but not exclusive method for treating depression.

Apart from comparing CBT to other modalities, some studies attempted to identify which component of CBT, behavioural or cognitive, is more conducive to therapeutic change. Jacobson et al. (1996) attempted to provide an answer by allocating 150 depressive patients to three different conditions. The first group received only behavioural activation (BA), the second group received behavioural therapy with some work on automatic thoughts (AT) and the third group received the full CBT focusing on modifying core depressogenic schemas. A component analysis of data, collected after 20 sessions of
therapy and at a six months follow-up, suggested that there was no evidence that CBT was more effective than the other two treatment conditions (BA and AT). These findings were not consistent with Beck et al.'s (1979) hypothesis suggesting that changes in negative schemas maximise treatment outcome and prevent relapse. Additional 12, 18 and 24 months follow-ups of the same study showed that CBT was no more effective than its components (Gortner et al., 1998). However, another study conducted by Beever et al. (2003) suggested that the bigger the changes in both the content and the form of dysfunctional thinking, the longer the time to recurrence of depression.

So far it has been demonstrated that most major outcome studies indicated only modest differences in therapeutic outcome across various treatments for depression and that both the behavioural and cognitive components of CBT are conducive to treating depression. However, Barber and Muenz (1996) have argued that 'although two treatments may look equivalent, they may be differentially effective for different kinds of people' (p. 957). For example, their thorough analysis of TDRCP suggested that IPT was more effective with depressed patients who demonstrated higher levels of obsessiveness whilst CBT was more effective with avoidant patients. In addition, they found that married patients did improve after CBT whilst single and cohabitating clients benefited more from IPT. In an empirical review of three influential studies, Blatt et al. (2001) found that patients' personality characteristics influence the therapeutic outcome and process. For example, the analysis suggested that highly perfectionist individuals did not benefit from brief therapy for depression (i.e. CBT) whilst moderate perfectionists did, if they felt early in therapy that their therapist was empathic and available. These findings contradict earlier evidence suggesting that psychotherapy may produce similar benefits not only across different types of therapy but also across different types of patients (i.e. Robinson, 1990).
**Common factors and the therapeutic relationship**

Even if careful reanalysis of well-conducted research suggests that some patients respond better to specific treatments there is significant evidence suggesting that therapeutic process and outcome are closely related to common factors across treatments. For example, Robinson et al. (1990) concluded that as only few differences in the efficacy of different psychotherapies for treating depression were found, common factors and especially the quality of the therapeutic relationship may be core mechanisms for therapeutic change. To this end, Blatt et al. (1996) and Imber et al. (1990) used TDCRP data in order to assess the effect of the therapeutic relationship upon treatment outcome. Blatt et al. (1996) found that the quality of the therapeutic relationship reported at early stages in treatment contributed significantly to the prediction of the therapeutic outcome. Therefore, they concluded that extensive efforts to compare different psychotherapy approaches should also take into account interpersonal dimensions of the therapeutic process. Similarly, Imber et al. (1990) proposed that mode-specificity could not be claimed due to the fact that core processes operating across treatments appear to override differences among techniques. For example, research has demonstrated that therapist's empathy has a moderate-to-large causal effect on recovery from depression in patients treated with CBT (Burns & Nolen-Hoeksema, 1992).

Similarly, Castonguay et al.'s (1996) study of unique and common factors of depression showed that patients' improvement was predicted by the therapeutic alliance\(^1\) and the patients' emotional involvement rather than treatment modality. This finding was also supported by Stiles et al.'s (1998) analysis of alliance levels of participants in the 2\(^{nd}\) Sheffield Psychotherapy Project. According to Raue et al.'s analysis (1997) of the 2\(^{nd}\) Sheffield psychotherapy project, higher scores of therapeutic alliance were achieved in the CBT rather than the IPT modality. However, since comparative outcome research demonstrated no difference between the two modalities, the researchers concluded that CBT is just different but not better than IPT. The reader should note though, that Raue et

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\(^1\) For the purposes of this essay, the terms therapeutic relationship and therapeutic/working alliance are used invariably as different studies have used either term without a common consensus on an operational definition. This in itself may be regarded as a methodological flaw.
al.’s (1997) research was based on observers’ rates and that all observers were doctoral-level students whose training emphasised CBT. Therefore, observers’ allegiance to CBT may have biased their ratings. In general, though, high impact sessions were associated with high scores in therapeutic alliance independent of modality employed (Raue et al., 1997).

More supportive evidence towards the therapeutic relationship were provided by Rector et al.’s (1999) study investigating the role of technical and non-technical factors in cognitive therapy. Their findings suggested that a positive therapist-client bond could enhance the therapeutic effect of successful cognitive restructuring. They hypothesised that such effect could be achieved in two ways: a) through correcting cognitive distortions about relationships; and b) through helping the client to deactivate maladaptive beliefs and form alternative helpful beliefs.

**Evolution of CBT**

Considering the evidence suggesting the importance of non-technical factors, CBT has evolved by increasingly paying emphasis upon such common factors as the core conditions suggested by Rogers (1957, 1957). The core conditions facilitate a greater working alliance and a positive therapeutic relationship. As Goldfried (2003) has noted “the central theme that has characterised behaviour therapy and cognitive-behaviour therapy over the years is that of change” (p. 67). Since first developed by Beck et al. (1979) CBT has not remained a closed system, but has developed as an open and flexible model that has incorporated concepts and techniques from other approaches in order to meet the demands of clinical work (Robins & Hayes, 1993). In this sense, CBT has developed into an integrative approach that places greater emphasis on cognitive interventions but also accounts for such interpersonal factors as the therapeutic relationship and alliance.

For example, in light of research evidence highlighting the importance of common factors and the overestimation of the role cognitive processes play in precipitating and
maintaining depression, Safran (1990a, 1990b) suggested that the patient-therapist relationship is explored within cognitive therapies. This was regarded adherent to CBT approach due to the fact that organised cognitions in the form of schemas are based on previous self-other interactions and also shape any subsequent dyadic interactions. Safran’s contribution had a major impact in the evolution of CBT as the therapeutic relationship progressively started to be regarded as important as technical factors by many CBT therapists and is now often used as a vehicle for in vivo work aiming at modifying patients’ maladaptive schemas (Sanders and Wills, 1999). In an attempt to differentiate his proposed version of refined CBT from psychodynamic approaches, Safran (1990b) explained that the emphasis on the relationship is phenomenological rather than interpretative with the role of the therapist being: a) to help the client find active ways to test any dysfunctional expectations with regards to the therapeutic relationship, b) to encourage the patient to actively seek ways of using the therapeutic relationship in order to confirm or disconfirm previous hypotheses.

Active use of the therapeutic relationship contributes to emotional activation that according to research can be a mediator of change. Specifically, neuroscience research has revealed that there is an ‘emotional brain’ which allows events to be registered at emotional as well as thinking levels (Le Doux 1996 cited in Goldfried, 2003, p. 66). Taking into account such evidence, it appears that psychotherapy is more effective when it targets both thoughts and emotions. To this effect, there is a growing trend in CBT towards activating both cognitive and emotional levels. Emotional activation can be achieved through exploring and understanding the therapeutic relationship. This is reflected in Safran’s proposed model (1990a, 1990b) as well as in Schema therapy (Young, 1999) in which, amongst other ways, schemas are activated in session and are examined through the lens of the therapeutic relationship. As Bannan and Malone (2002) suggest ‘‘the therapeutic relationship can offer the patient a form of re-parenting, where their schemata can be directly challenged in the relationship with the therapist’’ (p. 95).
The use of the therapeutic relationship in my clinical work

When applying the CBT approach in my clinical work, I can strongly identify the usefulness of using the therapeutic relationship in the service of the client. This appears to be especially important when working with clients whose difficulties are of interpersonal nature. In specific, the relationship appears to be the ground base for applying the technical interventions and for understanding the clients’ beliefs and schemas about relationships. It also allows the therapist to anticipate, work through or possibly prevent any therapy ruptures.

To use a brief clinical example, having assessed Miss S (a victim of rape who presented with symptoms of PTSD and depression) and formulated her difficulties, I hypothesised that some of her core beliefs associated with the schemas of defectiveness/shame, cognitive avoidance and mistrust might influence the process of therapy in the following ways:

- Trying to please the therapist out of fear of criticism.
- Her shame and guilt might make it difficult for her to disclose her traumatic experiences.
- Dropping out of therapy as a result of shame and mistrust.

These potential problems were explored in session and allowed us to work effectively, making the best use of our time-limited therapy. Such discussion strengthened the therapeutic relationship as it explicitly demonstrated my empathic attunement towards Miss S. A strong therapeutic relationship facilitated attendance and the application of technical interventions. Finally, a positive therapeutic outcome showed Miss S that she was not as ‘defective’ as she thought and that she could achieve her goals if she was not avoidant. Moreover, through her trusting relationship with me she started to believe that she could increasingly trust others and expect that some people could help her and not abuse her.
CBT and Counselling Psychology

The refinement of CBT accounting for common factors and the therapeutic relationship is consistent with Counselling Psychologists' values according to which the therapeutic relationship is a fundamental component of the therapeutic endeavour (Strawbridge & Woolfe, 2003). In its original form, according to which CBT was based on the medical model with the therapist adopting the expert's role responding to client's pathology through technical interventions, CBT was not compatible with counselling psychology's humanistic value base according to which therapists adopt a facilitative rather than directive approach towards their clients (Strawbridge and Woolfe, 2003). In its refined form, though, CBT is welcome by most counselling psychologists who in turn, due to their integrative training, can contribute to further refinement of the approach via further research and integrative practice. For example, as demonstrated above, data stemming from the same research programme (2nd Sheffield Psychotherapy Project) produced conflicting findings due to researchers' allegiance to their therapeutic tradition. Counselling psychologists' typical training in several modalities may allow a less biased analysis and interpretation of similar data.

Conclusion

In conclusion, CBT has been documented to be an effective model for treating depression. In general, research has suggested that CBT is as effective as pharmacotherapy, IPT and behavioural therapy, with CBT having a prophylactic and enduring effect against depression. In an attempt to demonstrate mode specificity, some studies have shown that specific patient types respond better to CBT for depression than other treatments. The majority of research though, has indicated that common factors as the therapeutic relationship appear to be significant mediators of change. Based on such evidence, there is a growing trend in CBT towards placing equal importance on common factors as well as the cognitive and behavioural interventions. As most influential studies were conducted over 10 years ago, when CBT was mainly aimed at cognitive modification through technical interventions, it could be of major scientific interest to
obtain some new data stemming from well designed contemporary studies, comparing the effectiveness of a more integrative CBT (aiming at both emotional and thinking levels) to other treatment modalities. Such studies could possibly address new theoretical and empirical challenges.
References


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Introduction to Therapeutic Practice Dossier

This dossier relates to clinical practice and includes an overview of the two placements I undertook during the last two years of my training, which is when I transferred to the PsychD in Psychotherapeutic and Counselling Psychology at the University of Surrey (Year 2 and 3). This dossier also contains my 'Final Clinical Paper' which discusses how my clinical work, engagement with theory, personal therapy and other life experiences have influenced my development as a counselling psychologist and how this is reflected in my therapeutic practice.

As stated in the introduction to the portfolio, the names of the clients, the people they refer to, location names and other identifying details have been omitted or changed in order to preserve their confidentiality and anonymity.
I conducted my second year placement in a secondary care Adult Psychotherapy Department located in an inner city area. This clinic offered long term (one year minimum) psychodynamic individual, group and couple psychotherapy to clients suffering from moderate to severe psychological difficulties. Clients’ presenting problems varied from anxiety and depression to personality disorders and severe mental health illness. Moreover, individual and couple therapy were offered for psychosexual difficulties. Clients were referred to the service by their General Practitioners, Community Mental Health Teams, psychiatrists and other mental health practitioners. The clinic’s permanent staff consisted of consultant psychiatrists specialising in psychotherapy, psychodynamic psychotherapists, psychoanalysts and group therapists. In addition to the permanent staff, a large number of honorary therapists adhering to various psychodynamic traditions worked in the clinic.

My responsibilities included providing individual therapy and couple therapy. My individual work was supervised by two consultant psychiatrists specialising in psychotherapy. I was offered both individual and group supervision during which I presented and discussed verbatim transcripts of each session. The emphasis was on remaining adherent to the psychodynamic model and on developing a capacity to recognise and interpret unconscious communication as this unfolded in the transference. My couple work was behavioural therapy for psychosexual difficulties. The opportunity to work in this area arose through volunteering to see a couple together with a psychodynamic therapist who was also trained in the Masters and Johnson’s approach.
Additional responsibilities included attending:

1. Couple therapy workshops: I was able to participate in couple therapy workshops that took place once every three weeks and lasted for one hour. During these workshops therapist who worked with couples discussed the progress as well as any problems arising in their work.

2. Assessment workshops: I also participated in assessment workshops that lasted for one hour and were conducted once every three weeks. In these workshops, senior staff would discuss various dilemmas and difficulties that arose in recent assessments.

3. Clinical seminars. These took place for 1 hour fortnightly. In these seminars honorary therapists would present a clinical case and a verbatim transcript. This was followed by a discussion within a large group of psychiatrists and psychotherapists. I presented 3 times in these seminars.

4. Reading seminars. These took place for 1 hour fortnightly. In these seminars, psychoanalytic papers were discussed.

5. Video assessment seminars. These took place for 1 hour 30 minutes on a weekly basis. In these seminars, a detailed analysis of the assessment process was studied and discussed within a small group of psychiatrists and psychotherapists.

This placement offered great opportunities for learning. Thus, I was glad to be accepted to work as an honorary therapist in the clinic during the third year of my studies. During the third year however, I restricted my therapeutic work to one client and attended weekly supervision as my main focus during that time was on my Dialectical Behavioural Therapy (DBT) placement. I also attended the clinical and reading seminars.
Year 3: Tertiary Care Specialist Service

This placement was a tertiary service specialising in treating clients who met criteria for a diagnosis of Borderline Personality Disorder (BPD). It was run by a multi-disciplinary team of clinical and counselling psychologists and a community psychiatric nurse. Clients were referred to the service by their psychiatrist or their Community Mental Health Team. Clients were offered either short-term (6 month) or long-term (between one and three years) contracts depending on the severity of their difficulties. This service was located in an inner city area.

My responsibilities included providing individual therapy that was adherent to the DBT approach (Dialectical behavioural Therapy). DBT was the main therapy offered by this service. DBT is a structured treatment that uses an array of cognitive and behavioural interventions targeting the specific symptoms or difficulties associated with BPD (i.e. suicide and self-harm). I also co-facilitated a weekly psycho-educational group which focused on teaching clients the main DBT skills which are: mindfulness, distress tolerance, emotion regulation and interpersonal effectiveness. Besides this, I ran a skills group by myself and conducted joint assessments with my supervisor. Assessments involved using the structured clinical interview for DSM IV Axis II personality disorders (SCIDD-II) in order to assess if clients met the diagnostic criteria for BPD. Additional responsibilities included liaising with other mental health professionals and attending multidisciplinary team meetings.

I was offered individual supervision for both my individual and group work. In addition to this, I could discuss difficulties arising in the therapeutic work in the weekly consultation meetings held in the service. In these meetings, therapists discussed difficulties that arose in their delivery of the treatment and tried to develop solutions that were based on the synthesis of the views expressed within the team. Moreover, I attended fortnightly business meetings. During these meetings, Trust and Service related issues (i.e. service provision and delivery, service evaluation etc.) were discussed. Similar issues
were also discussed in the annual team away day which I attended. Finally, I attended various DBT training seminars that were conducted within this service.
Final Clinical Paper

On becoming a counselling psychologist:
Setting out for the unknown but never alone

As you set out for Ithaka
hope the voyage is a long one,
full of adventure, full of discovery…

Keep Ithaka always in your mind.
Arriving there is what you are destined for.
But do not hurry the journey at all.
Better if it lasts for years,
so you are old by the time you reach the island,
wealthy with all you have gained on the way,
not expecting Ithaka to make you rich...

Ithaka by C.P. Cavafy (1911) translated by E. Keeley and P. Sherrard

Introduction

In this paper, I am going to present some excerpts from my journey towards becoming a counselling psychologist. I chose to start with an extract from Cavafy’s poem Ithaka because it appropriately represents the experience of my training, and my aspirations for further development as a life-long journey ‘full of adventure’ and ‘full of discovery’. The reader will learn about some of these adventures and the knowledge I have developed as a result of them. This knowledge is not fixed but open to revisiting and re-evaluation in light of new adventures. By the end of this paper, I aim to be able to answer the question ‘who am I as a practitioner at this moment in time’.
The process of developing as a counselling psychologist

I started my training in Counselling Psychology at Roehampton University. I studied there for two years and learned to practise two different therapeutic approaches, person-centred and cognitive behavioural therapy (CBT). Then, I transferred to the second year of the University of Surrey Psychotherapeutic and Counselling Psychology course where I was introduced to the psychodynamic approach and reintroduced to CBT. In this section, I will describe my experience of and views about these therapeutic approaches, as they developed over time. Then, I will present my own synthesis, dialectic or depressive position about different therapeutic modalities and how this influences my therapeutic practice today.

Each phase in my development as a counselling psychologist will be presented as a life-span development stage. Baltes (1987) suggested that human development is a lifelong process that is multidimensional and multidirectional, shows plasticity, involves both gains and losses, is interactive, and is culturally and historically embedded. From my experience, I believe that Baltes’s tenets could also describe my process of becoming a counselling psychologist.

Before embarking upon each developmental stage, I would like to acknowledge the role of supervision as a consistently available ‘parent’ that guided me, validated me and encouraged me to grow.

Infancy

The person-centred approach constituted my first encounter with therapy. When I started my training, my mind was like a blank slate with regards to therapeutic knowledge and I found myself constantly being faced with a plethora of stimuli that I needed to process, memorise, transform and finally use in practice. This was similar to being an infant who is registering the world around her. I was fascinated by the new world I was entering and part of this process involved idealising the founder of the first therapeutic modality to
which I was introduced. Therefore, I put Carl Rogers on a pedestal in an attempt to internalize some of his wisdom and his way of being with clients. Rogers’ (1957, 1959) core conditions (empathy, congruence and unconditional positive regard) provided me with a safe framework as a novice therapist. They took the pressure off me to ‘do’ things for my clients and the only requirement, although challenging, was to be with the client. Whilst seeing clients, I was open and attuned to their experience, my experience of them and the therapeutic relationship. Having minimal theoretical knowledge at the time, I was not distracted by thoughts about linking theory to practice. This way of working with clients offered me some unique experiences that I will present briefly in my work with Mr K.

Mr K was my very first client and ‘teacher’ in counselling psychology. I saw him in a charity organisation that offered support to drug addicts in recovery. The initial information I was given about Mr K was that he was an ex-heroin addict, black British male in his 40s who was unemployed and isolated for most of his life. I was also informed that Mr K was very conscious about his appearance because of his large physique and his scarred face. This information made me doubt as to whether I could display Rogers’ (1957) core conditions. How could I work with someone who was so different (i.e. I am a white Greek female who is a high achiever and was in her late 20’s at the time of seeing the client)? How could I understand his phenomenology without imposing my own value system? Nevertheless, I was resistant to admit this in supervision at the time. I remember my supervisor asking me how I felt about the prospect of working with such a difficult (he did not mention different) client and me replying that I saw this as a challenge.

However, through trusting the therapeutic process and applying the core conditions I increasingly felt closer to Mr K’s experience. Half-way through therapy, I remember forming mental images in which I was sitting next to him on the floor whilst he shared his deepest fears with me. I was taken aback by this experience. Rogers (1980) has talked about similar therapeutic moments during which his ‘inner spirit has reached out and
touched the inner spirit of the other. Our relationship [he continues] transcends itself and
becomes a part of something larger. Profound growth and healing energy are present’
(p.129). Maybe through developing these images, I was responding to Mr K’s need for
closeness and acceptance. As therapy progressed, my experience was one of strong
acceptance of Mr K. Mr K demonstrated that he experienced being accepted through
attending therapy regularly and by becoming progressively more open and trusting. By
the end of our 14 sessions he had made tremendous progress and was able to interact with
other people and make plans consistent with being part of the social world (i.e. register to
a course). By the end of our work together, I had become a trainee counselling
psychologist that acknowledged, respected and named difference. As for working with
inter-racial differences, this was facilitated by me reflecting upon my own white racial
identity, what it meant to me and how it was perceived by others.

Since the first year of my training, I have not experienced such intense transpersonal or
intuitive moments when using other therapeutic modalities. Upon reflection, I believe that
as I increasingly gained theoretical knowledge I tried to theoretically understand and
interpret clients’ experiences. Thus, I stopped just ‘being’ with the client. Theory driven
interpretations may at times be unrelated to clients’ phenomenological experience and as
a result of this they may prevent some clients and therapists from meeting at what person-
centred proponents call relational depth (Mearns, 2003).

Despite my initial commitment to the person-centred approach and the unique
experiences it offered me, I would at times experience some frustration as I felt that it
gave me limited tools to work with complex clients or clients encountering difficulties
that may be best resolved by adopting an evidence-based approach. To this end, I would
often argue that the core conditions (Rogers, 1957) were necessary but not sufficient for
personality growth. For example, when working with very depressed clients, I often
found empathising with their depression counterproductive. This was because what these
clients often required was to be equipped with some skills that would enable them to
regain mastery in certain areas in their lives rather than the therapist to solely empathise
with their depression. My frustration also stemmed from research on evidence-based practice suggesting that CBT and IPT (Interpersonal Therapy) were the most effective therapies for treating depression (Roth & Fonagy, 2005, pp. 66-134). Consideration of and familiarity with evidence-based practice characterise counselling psychologists and have been of prime significance in my practice. This does not mean that I opt to fit the recommended model to my clients’ difficulties in a way that overshadows and diminishes their phenomenology. Clients’ presentation, personal history and therapeutic aims in conjunction with supervision and guidelines of evidence-based practice allow me to make an informed decision in choosing a treatment plan. In this sense, I view the scientist-practitioner and reflective-practitioner models as complementary.

Early childhood
The transition from infancy to early childhood occurred when I was introduced to CBT (Beck, 1967, 1976, 1979) in the second year of my studies. Having developed some therapeutic language and basic therapeutic understanding in the first year of my studies, I was ready to become ‘playful’ and explore therapy further in my CBT year. To this end, I welcomed CBT with excitement as I felt that my counselling psychology trainee toolbox (or toy box) was in urgent need of more therapeutic tools.

I worked using CBT with clients presenting various problems in two different charity organisations. I noticed that different clients responded differently to such structured treatment. For example, some clients were very keen to follow an agenda, doing homework and behavioural experiments whilst others preferred to explore past traumatic issues or other anxieties that troubled them during the session. Following from my humanistic year during which I practised in a non-directive way, I found it extremely difficult to redirect clients’ attention to the tasks agreed. As a result of this, I would often ‘give in’ and allow the clients to explore any issues that concerned them in that moment. Being in my ‘childhood’ phase, I was struggling with myself to stay within boundaries imposed by modality adherence. As I have become more experienced, I believe that I can now facilitate clients to stay focused through demonstrating my own commitment to
being focused. Whilst I believe that any issues ‘troubling’ the client in the present moment are of great importance, I also recognize the importance of attending to structure in time-limited therapy. My views regarding CBT have developed greatly since the second year of my studies and I will present them thoroughly reflecting the current stage of my development (later in this paper) as this coincides with revisiting CBT (in the form of Dialectical Behaviour Therapy) this year.

Middle childhood and adolescence

The period of middle childhood is characterised by major cognitive development as children begin to “develop the capacity to focus on more than one dimension of an object or situation at the same time” (Sugarman, 2001, p. 58). This appeared to be the case for me by the time I completed my CBT year, as I had already started to develop the capacity to distinguish between models through being able to formulate my clients’ difficulties both in CBT and person-centred therapy. But a real cognitive and emotional activation, though, occurred when I was exposed to a plethora of psychodynamic theories in the third year of my studies, having transferred to the University of Surrey course. These theories were very seductive as they had a fairy tale quality at times, and were constructed by very charismatic people. The presence of a charismatic powerful other always had a huge impact upon me. It elicited admiration and idealisation for those figures that was transformed into a passion about the theories they advocated. This process livened up my emotional world and confirmed to me that I had chosen the right career path.

During my psychodynamic year I felt more alive than ever. I believe that this was due to the fact that psychodynamic practice resonated with and integrated both the rational and emotional parts of myself. Up until then, my experience was of being ‘split’, with my intellectual part responding to CBT and my emotional side resonating with person-centred. However, working psychodynamically with clients touched both sides. On the one hand, my rational part would try to unravel clients’ life puzzle with them through identifying links between their past and present experiences. On the other hand, through making my unconscious open to clients’ experience in an attempt to feel, understand and
in some cases transform their aborted feelings, I related to them at an emotional level. This process allowed me to work further towards becoming an integrated person and therapist. At this point, I need to stress that in my view unless I had been in personal therapy myself since the beginning of my training, perhaps I would not have been as able to relate to my clients at an emotional level and therefore develop a strong therapeutic relationship and working alliance with most of them. In this sense, I fully agree with Symington (2006) saying that "knowing myself, to the extent to which I am able to achieve it, is the fundamental yardstick through which I am able to understand the problems of my patients" (p. 20).

My therapy has been extremely important to my growth as a counselling psychologist and as a person. I have been in psychodynamic therapy myself for the last four years. My therapist has never used any particular techniques, set any goals with me, motivated me or stopped me from doing whatever I wished to do at any moment in time. He has been a constant, warm and loving presence that has been beside me along a difficult journey. This therapeutic stance could be described as humanistic. At the same time, he has been like a sensitive scientific instrument that often detects the state of my psyche, especially when my defences stop me from being a relational person. I deeply value his insights with regards to my unconscious processes and his liberating invitation to explore my internal pain or chaos at times. I find empathising with both one’s unconscious and conscious processes to be an advanced form of empathy, and in this sense I regard psychodynamic psychotherapy as an extremely empathic approach when conducted in a relational way. My therapy has allowed me to grow as a person, to become more loving towards myself and other people, especially towards those who are vulnerable and have been deprived of love. In my practice, this love could be translated as agape, a Greek word that has been described by Khan (1991) as "a desire to fulfil the beloved. It demands nothing in return and wants only the growth and fulfilment of the loved one" (p. 37). I have been surprised when I found myself experiencing such loving feelings even when working in very powerful negative transference.
At this point, one might sense my passion for psychodynamic psychotherapy which appeared to grow with time as I practised psychodynamic therapy and gradually moved from the ‘middle childhood’ to ‘adolescence’ phase. How could I not be passionate as an adolescent? This is the time one is desperate to establish a personal identity and this is what happened to me during my psychodynamic year. I conducted my psychodynamic placement at an NHS psychotherapy department where I was very fortunate to receive supervision by, and participate in meetings with, some psychoanalytic psychotherapists who were extremely experienced and pioneering in their field. Despite being in my adolescent phase, rather than seeking greater independence I enjoyed staying at ‘home’ and this was demonstrated by my request to extend my psychodynamic placement for a further year. This was probably due to the fact that this placement represented to me a steady ‘container’ (Bion, 1962) or a ‘secure base’ (Bowlby, 1988) from which I was encouraged to explore the world of therapy and feel accepted, supported and embraced both for my therapeutic successes or impasses. In this environment I was facilitated to grow both as a practitioner and as a person. As a result of this experience I believe that psychodynamic psychotherapy can be a warm and healing experience that promotes personality growth, especially so for individuals whose developmental needs have not been adequately met by their parents. This resonates with my personal experience as my therapy has revealed that I have always craved a paternal figure that would be consistent, reliable and containing, unlike my father who was authoritarian, uncontained and uncontaining. This need has been met by my therapist and on some occasions by other interactions with containing ‘paternal figures’ like my supervisors in my psychodynamic placement.

Judging by the therapeutic outcome of my psychodynamic clients, many of them have experienced psychodynamic therapy in a similar light to mine. Of course at times they would also experience strong transference feelings that indicated that their perception of me was far from warm and loving. In a similar way, I would experience countertransference feelings of anger or dislike that were not consistent with my general agape for my clients. Psychodynamic psychotherapy though, allows the exploration of
such feelings for the benefit of the client. For example, when working with Ms B, a Muslim woman in her 30s who had an extremely traumatic childhood due to her mother’s mental illness, I was experienced both as a warm, stable and emotionally available therapist as well as a cold, critical and abusive person similar to her experience of her mother. Through working on both diverse and different ends of Ms B’s experience, we were able to work through and understand her negative transference towards me and other people. As a result of this, Ms B started to experience me for who I was (person-to-person relationship) rather than whom she had distorted me to be (transferential relationship) (Clarkson, 2003). Such distinction enabled Ms B to develop a new and ‘benign’ relational template (the reparative/developmentally needed relationship). As Paul and Pelham (2000) said “if the work is to have therapeutic value the client needs to experience both the familiar drama and a different outcome” (p. 119) and this is what happened in my work with many of my clients.

Early adulthood
In life-span development, this phase is characterised by achieving intimacy and making career choices (Sugarman, 2001). In my development as a counselling psychologist, this could be translated as making decisions with regards to how intimate or relational I am as a practitioner and making therapeutic model choices. This phase started in the last year of my studies and this is where I predominantly find myself at the moment. Nevertheless, I sometimes revisit previous developmental stages, as the process of developing can be multidimensional and multidirectional (Baltes, 1987).

During the last year of my training I conducted my placement at an NHS outpatient psychology specialist service employing Dialectical Behavioural Therapy (DBT) for treating people with borderline personality disorder (BPD). DBT is a mainly behavioural approach that was developed by Linehan (1993a, 1993b) as a specialised treatment of BPD and suicidal behaviours. Having applied CBT in the second year of my training, I was keen to gain experience in a different yet related approach and to this end I was pleased to be offered a placement where I could also work with a challenging clinical
population. At the same time, I continued to see one client and attend seminars and supervision in my psychodynamic placement.

As a specialised treatment following a medical model, DBT mainly aimed at reducing clients’ ‘symptomatology’. Despite its Eastern philosophical underpinnings reflected in using Mindfulness skills, my experience of working with DBT demonstrated that in practice there was a huge emphasis on shaping clients’ behaviour (stimulus-reaction model). This implied that the therapist would focus on the client’s response to a stimulus rather than the underlying causes of the initial stimulus. To this end, discussions of past traumatic experiences fuelling clients’ present distress were not explored in-session because the model suggested that the clients needed to display sufficient resilience before exploring past traumas. Whilst I believe that this was true for many clients, it may not have been helpful for others. I vividly remember one assessment during which a 40-year-old female client, who was repeatedly sexually abused by her father as a child, was asked what her expectations of therapy were. She replied: ‘I want to talk about all those horrible things that happened in the past. I tried to tell my mother but she doesn’t want to know’. Having empathised with her first, the client was then informed that the first stage of this therapy does not involve exploration of her past experiences. Nevertheless, the client agreed to have DBT as she was desperate for any kind of psychological intervention. Although I acknowledge that this client was probably too vulnerable to explore past traumas, I felt guilty for not having given her the opportunity and trusting her to talk about what was in her mind. In this sense, I probably appeared to her as another person that ‘did not want to know’ about her sexual abuse. I am unsure as to whether this was therapeutic. In this case, I found myself unable to find a dialectical synthesis between the reflective- and scientist-practitioner approaches.

Whilst some clients wish to explore their past experiences, others find it retraumatising and want to avoid it at all costs. If I replace the word ‘analysis’ with ‘psychodynamic psychotherapy’ I agree with Winnicot’s (1962) thesis that ‘analysis is for those who want it, need it and can take it’ (p.169). For example, in my psychodynamic placement I
worked with a bi-polar female client who found psychodynamic psychotherapy extremely persecutory and intolerable; and for this reason she discontinued therapy. On that occasion, my supervisor who was committed to the psychodynamic approach thought that this client was not ready for therapy at that moment in time. However, as a counselling psychology trainee who is not attached to a specific therapeutic approach, I was left thinking that the client might have benefited from a different approach and that her negative experience of psychodynamic therapy might ultimately prevent her from seeking any form of therapy in the future. Furthermore, as she was one of my first psychodynamic clients, I believe that I failed to be relational with her through adopting the blank screen stance (Freud, 1924) that was encouraged by my supervisor at the time (for example it was requested that I would not initiate the session at all costs). As I continued to develop in my psychodynamic work and having also joined a supervision group that was run by a supervisor adhering to a relational (Independent) psychodynamic model, I have felt increasingly more comfortable with developing a more relational style that is in line with my personality and counselling psychology ethos. Thus, today I wonder if this client discontinued therapy because she felt persecuted by my non-relational stance or because she was not well suited for psychodynamic psychotherapy.

Returning to my experience of DBT, as well as being taught a new set of skills (distress tolerance, interpersonal effectiveness, emotion regulation, and mindfulness), DBT helped me improve and consolidate the CBT skills I was introduced to in the second year of my training through gaining further therapeutic experience in a related model. This was facilitated through being restricted to using DBT even if other models appeared to me to be more relevant for the clients’ specific difficulties. As I said earlier in the paper, in my previous experience of CBT I would often allow clients to digress and talk about what was in their mind. Whilst from a psychodynamic and humanistic perspective there is great value in allowing clients to lead a session, when one considers the time constraints imposed for counselling psychologists employed by the NHS or insurances when working in private practice, it becomes imperative that they are able to work in a structured and focused way. I think that this experience has helped me to become more employable and
has enabled me to work towards maintaining a good therapeutic relationship even when using a directive therapeutic approach.

An emphasis on the therapeutic relationship has been highlighted by contemporary proponents of CBT who recommend that 'modern' CBT may be more effective if it encompasses aspects of the therapeutic relationship (Sanders & Wills, 1999; Safran, 1990a, 1990b). As Bannan and Malone (2002) describe “the therapeutic relationship can offer the patient a form of re-parenting, where their schemata can be directly challenged in the relationship with the therapist” (p. 95). I believe that counselling psychologists are well suited to practice various cognitive/behavioural therapies (CAT, Schema Therapy, DBT) due to their training in several therapeutic modalities that enables them to become attuned to intrapersonal and interpersonal processes alongside behaviours and cognitions. This allows interventions to penetrate the superficial levels of negative automatic thoughts and reach core beliefs/schemas that the client might find hard to articulate or access unless he/she is facilitated by a relationally focused therapist.

At this stage of my professional development, my relational stance is mainly demonstrated through trying to use the therapeutic relationship as a ‘secure base’ that facilitates intrapersonal and interpersonal exploration. For example, this year in my psychodynamic placement rather than presenting myself as a blank screen in order to facilitate transference and projections, I try to provide my client with a ‘secure base’ in which repeated and ‘problematic’ relational patterns can be explored in-session and hopefully resolved through a mutual co-constitution of meaning. As Aron (1996) explains “meaning...is not generated by the analyst’s rational (secondary) processing of the analysand’s associations; rather meaning is seen as relative, multiple, and indeterminate, with each interpretation subject to continual and unending interpretation by both analyst and analysand. Meaning is generated relationally and dialogically, which is to say that meaning is negotiated and co-constructed”. This approach in therapy is described as intersubjectivity (Aron, 1996; Mitchell, 1998, 2000) and is strongly influenced by Bowlby’s theory (1969, 1973, 1988) and research on attachment which
suggests that a person’s experience and representation of significant interpersonal relationships influence her attachment patterns. Research has demonstrated that the therapist can function as an attachment figure for the client that may ultimately enable her to construct a secure attachment representation (Mallinckdrodt, Porter & Kivlighan, 2005; Parish & Eagle, 2003).

My work with Mr F, conducted at my psychodynamic placement, was especially influenced by intersubjectivity. Despite Mr F having been referred for moderate to severe depression, our work together revealed a much more complex clinical picture. Mr F was raised in an invalidating environment characterised by severe emotional deprivation and physical abuse. As a result of Mr F’s father presenting himself as some kind of deity that knew everything and could read people’s minds, Mr F developed the belief that there is only one truth and this should be consistent with the truth he had in his own mind (this was especially the case when he was in an anxious or paranoid state of mind). This became particularly evident one session when Mr F experienced a psychotic episode and spoke his mind out without censoring his thoughts. Despite the fact that during that session co-thinking was impossible, I was able to develop better insight into what was going in his mind and how frightening this was, as most of his interpretations about other people’s intentions and behaviours were extremely persecutory. This was probably the most difficult session I have ever encountered, but also the most valuable learning experience I have ever been offered. Despite the difficulties (intense anxiety, anger, confusion, fear) of sitting with and containing a series of accusations towards me, I was able to allow Mr F express his paranoid thoughts without attacking him or becoming defensive. As Mr F was experiencing a psychotic episode at the time, I had to make sure that I would not overstimulate him through providing any interpretations. After the session I felt exhausted and vulnerable. I was also confused and angry. Upon reflection I realised that Mr F gave me a glimpse of what life was like at his home where he had to co-exist with a psychotic father. This increased my empathy for Mr F and helped me process the difficult countertransference feeling he had elicited in me.
In subsequent sessions (during which Mr F appeared much calmer and in touch with reality), I was transparent with Mr F and explained that I respected his views but also introduced the possibility of different people holding different views and how one could tolerate this. Our work enabled Mr F to develop a less rigid and persecutory thinking that was ultimately very liberating for him. This was also achieved through Mr F forming a strong attachment to me that made the ending of therapy extremely painful. In our last session, there was a lot of sadness and through adopting an intersubjective stance I communicated to Mr F that the ending was difficult for me too. Having expressed his feelings for me and about therapy ending, Mr F was very appreciative as my intervention showed him that he had made an impact on me too.

Who am I as a practitioner at this moment in time?

Having presented my latest therapeutic experiences, I will try to give an answer to the question: who am I as a practitioner at this moment in time? One answer comes to mind when I ask myself this question: I am a relational counselling psychologist. My focus on relationships has been reflected both in my research and practice. For example, for my second year research project I explored the impact of individual therapy upon clients’ romantic relationships. My analysis of the data and my experience of therapy have suggested that individual therapy can have systemic effects. To this end, when I practise I try to assess and be sensitive to the impact therapy has upon a client’s relationships. Moving from clients’ extratherapeutic relationships to the therapeutic relationship, my year 3 research project involved a literature review on the impact of therapy upon clients’ attachment patterns. This review stemmed from my interest in further exploring the possible healing effects of the client-therapist relationship. As a result of reading the relevant literature, I became more aware of the therapeutic benefits involved in “enabling the patient to find an image of him- or herself in the mind of the therapist as a thinking and feeling being” (Fonagy, 2007 p. 57). Through such an intersubjective experience the client may realise that two separate entities can exist simultaneously, and acknowledge each other as different without fearing that either of them would be annihilated. The
knowledge I developed as part of conducting my literature review is consistent with my clinical experience, as I have come to realise that the therapeutic models I have employed up to now have proved to be most helpful when used in a relational way. Responding to the needs of our times and with increasing social and self-alienation, most therapeutic approaches appear to be developing in a relational direction.

With relationality being at the core of my practice, I will now present some of the determinants I identified as influencing my choice of therapeutic modality. Based on my experience to date, I believe that such choice needs to take into account a) the client’s phenomenology, b) evidence-based practice, c) the length of time available for therapeutic work (for example, on many occasions I felt that I ended with some of my psychodynamic clients prematurely due to time constraints, although on some occasions huge shifts were revealed in the last session that challenged this view), and d) the client’s goals for therapy. It could be argued that no one approach attends to all these at all times. In response to this, integrative theory and practice has been developing over the last few years (Norcross & Goldfried, 2003). However, as a relatively novice therapist I believe that I am not in a position to create my own integration model before having sufficiently digested and further evaluated each therapeutic approach separately. Besides this, I believe that integration may not be necessary if I use each therapeutic model in a relational way. At the same time, being relational may be considered as some form of integration in its own right and may signify the beginning of my ‘middle adulthood’.

Taking into consideration that relationality characterises the way I practice despite the therapeutic modality employed, I currently adopt a pluralist stance as I aim to work using a single approach with each client (Hollanders, 2003). My choice of therapeutic approach with each client will be based upon a thorough exploration of clients’ presenting problems, phenomenology and goals for therapy during assessment. The treatment plan choice will also be informed by the guidelines for evidence-based practice. This dual approach (ideographic and nomothetic) is consistent with Corrie and Callahan’s (2000) propositions for a reformulation of the scientist-practitioner model as a broader umbrella
of inquiry that could provide a bridge between research and practice. They have argued that such a reformulation is consistent with the core values of counselling psychology.

Adopting a pluralist stance presupposes that the therapist feels competent in practicing at least one therapeutic approach in a pure way (Hollanders, 2003). At present, I feel competent offering both psychodynamic therapy and CBT/DBT but plan to receive further training in both these modalities as well as in Cognitive Analytic Therapy (Ryle & Kerr, 2002) that combines the two. Further training is in line with BPS requirements for Continuous Professional Development (BPS, 2007). As much as I am familiar with and value the person-centred approach, I do not intend to use it in its pure form because I think that the core conditions are necessary but not sufficient for constructive personality change. Even if they were sufficient I would have strong urges to move beyond the core conditions and use other therapeutic skills that I have developed during my training.

**Concluding remarks**

I would like to finish by revisiting the poem I presented at the beginning of this paper. This poem was inspired by the long and strenuous journey of Odysseus to return to his home in Ithaka. The poet suggests that it is not the destination but the journey that enriches somebody’s life. With regards to counselling psychology, I would like to add that the more a therapist is willing to travel in her own and her client’s intrapersonal and interpersonal territories, the more she will develop and facilitate her client’s growth. Of course there is one precondition to this: the client needs to participate in this journey. As client and therapist embark on an adventurous journey together, they are likely to encounter storms (difficult experiences), sirens (id) and punitive Gods (superego) like modern Odysseuses. Despite any adversities, they can rely upon the therapeutic relationship to be their safe haven during this journey. Setting out for the unknown but never alone!

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References


Introduction to Research Dossier

This dossier contains one qualitative research project and one critical literature review undertaken in the second and third year of my studies respectively. This choice was made in accordance with the course requirements outlined when I was accepted to enter Year 2 of the PsychD in Psychotherapeutic and Counselling Psychology at the University of Surrey. The qualitative study examines clients' accounts of how individual therapy affects their close romantic relationships. The critical literature review examines literature relating to the question: ‘Can therapy instigate change in clients’ attachment patterns?’
Title: How does individual therapy influence the heterosexual couple relationship? A grounded theory analysis of the accounts of partnered clients.

ABSTRACT

Previous research conducted with the partners of therapy clients has suggested that individual therapy may have both negative and positive effects upon their couple relationship (CR) or marriage. This study aimed to construct a localised theory of the implications of individual therapy for the CR by examining the experiential accounts of therapy clients. For this purpose, semi-structured interviews were conducted with ten clients who had been in a heterosexual CR prior to and during individual therapy. The interview data were subjected to grounded theory analysis that produced five core theoretical categories, three of which will be presented in this paper. Four of these categories illustrated the process of relationship change, whilst the fifth conveyed participants’ evaluations of the impact of therapy upon their relationships. According to this study’s findings, individual therapy appeared to either accelerate or instigate relationship change. Analysis of the data suggested that, amongst other reasons, partners’ adaptability to participants’ change was the main determinant of therapy functioning either as a catalyst or an instigator of relationship change. Recommendations are offered for therapeutic interventions and future research.

Key words: individual psychotherapy, couple relationship, couple, deterioration hypothesis, therapeutic change

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The impact of individual therapy upon the couple relationship (CR) is a subject frequently discussed amongst therapists. Anecdotal information shared in therapy supervision groups and professional networks indicates that individual therapy has an inevitable impact upon the CR. This view has been supported by empirical research that suggests the CR is affected both positively and negatively by individual therapy (Brody & Farber, 1989; Hunsley & Lee, 1995; Jacobus, 1994; Lawhon, 2004; Lefebvre & Hunsley, 1994; Pomerantz & Seely, 2000; Roberts, 1996).

Previous research into the effects of individual therapy on the CR has focused on examining the views of the partners of individuals who had been in therapy (Brody & Farber, 1989; Lawhon, 2004; Roberts, 1996). Whilst in most cases the focus was on the heterosexual couple, in two studies a small number of non-heterosexual participants was included (Brody & Farber, 1989; Lawhon, 2004). In specific terms, most studies aimed at testing the deterioration hypothesis which emanates from psychodynamic and systemic literature and suggests that therapy has negative repercussions for the partners and the relationships of some clients (Hunsley & Lee, 1995). This hypothesis was formed as early as the 1950s and 60s when empirical research highlighted the negative effect of individual therapy on marriage and suggested that successful treatment in individual therapy was associated with the development of emotional problems in the spouse or deterioration of the marriage in a significant proportion of cases (Heitler, 2001).

Hunsley and Lee's (1995) literature review based on numerous case studies and two surveys of clients' spouses also indicated that individual therapy can have negative effects on the clients' spouse and the marriage. However, they added that in over 20 independent clinical samples, no supportive evidence for the deterioration hypothesis was found. On

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1 In this study, the term 'therapy' refers to psychotherapy, counselling psychology and counselling.

2 In this study, partners of individuals who are in therapy will be referred to as 'partners' and participants will be referred to as 'client-partners'.

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the contrary, treatment-outcome studies indicated that individual therapy may improve marital or spouse functioning (Hunsley & Lee, 1995). These suggested that some partners perceive their significant others who are in therapy as less needy and more open, emotionally available, expressive and communicative than prior to therapy (Brody & Farber, 1989; Lefebvre & Hunsley, 1994). Roberts (1996) suggested that significant others were more likely to be supportive of their partner’s therapy if their partner’s improvement had clear benefits for the significant other. Moreover, Lefebvre and Hunsley (1994) separately interviewed both partners of three couples in which one partner had been in individual therapy and proposed that individual therapy was likely to have a positive impact upon the relationship in cases where the significant other believed that their partner’s problem requiring therapy was a personal problem rather than a relationship one.

By contrast, some partners of therapy clients have reported feeling excluded from their client-partner’s thoughts as well as distressed, blamed, jealous and resentful of their client partner’s therapy and therapist (Brody & Farber, 1989; Pomerantz & Seely, 2000; Roberts, 1996). Roberts (1996) suggested that negative feelings in relation to their partner’s therapy increased in cases where the client-partner appeared to regress. Moreover, significant others who have little knowledge about their partner’s therapy may tend to be ambivalent about the effect of therapy on the relationship (Brody & Farber, 1989; Roberts, 1996).

Lawhon’s (2004) research based on both qualitative and quantitative methods investigated the impact of individual therapy on the client’s significant other. This study did not lend support to the deterioration hypothesis and concluded that therapy had a moderate effect upon the relationship, a major impact on the client-partner and a neutral-mild impact on the significant other. The qualitative analysis demonstrated that significant others felt pressured to change in response to their partners’ therapy related change, but that such change was seen in most cases as relationship enhancing.
Participants also reported "notable therapy-related increases in intimacy, mutual support, understanding, and tolerance of their partners' flaws and limitations, and a therapy related decrease in arguments/fights" (Lawhon, 2004, p. 130).

All apart from one of the aforementioned studies attempted to investigate the impact of individual therapy upon the CR based on significant others’ accounts and reports. Jacobus (1994), though, followed a different route as he researched the impact of therapy upon clients' significant relationships through analysing therapists' clinical reports. Ninety two cases were examined for changes in relationships over the course of treatment. Jacobus (1994) claimed that his study does not support the deterioration hypothesis in relation to marriage "since there were more beginnings than endings of relationships over the course of therapy" (p. 206). Of the 92 cases, only two marriages ended during therapy. However, these clients reported having marital problems and wishing to leave their marriage prior to commencing therapy. Jacobus concluded that therapy possibly accelerated the separation and divorce process. Unlike marriage, a significant number of romantic relationships not involving engagement and/or living together appeared to end during the course of therapy. This led Jacobus (1994) to tentatively suggest that tenuous relationships maybe more at risk when one partner enters therapy.

However, the empirical findings presented in the aforementioned studies can be questioned on sampling and methodological grounds. For example, in Brody and Farber's (1989) study, trainee clinical psychologists' partners were interviewed; thus their partners' clinical training possibly had an impact upon their CR as well as their individual therapy. In some other studies, criteria requiring the relationship to have preceded the therapy were not set (Lawhon, 2004) nor was a minimum duration of the relationship specified prior to therapy (Brody & Farber, 1989; Lawhon, 2004; Roberts, 1996). Finally, Lefebvre and Hunsley's (1994) study included only those couples whose relationship had 'survived' therapy.
Apart from Lefebvre and Hunsley’s (1994) qualitative research during which both partners forming the couple were interviewed, no other study has examined clients’ views regarding the impact of their therapy upon their CR. It could be assumed, based on this observation, that researchers interested in this field may have possibly speculated that any CR changes that are triggered by client-partners’ therapy may negatively affect their partners. Therefore, they attempted to test the deterioration hypothesis through examining partners’ rather than client-partners’ views.

Having as a starting point empirical findings demonstrating that the CR is affected by individual therapy, the present study attempted specifically to examine the process of relationship change from the perspective of the client-partner. As this is not a longitudinal project, this was achieved through examining clients’ retrospective accounts of how their relationships had changed. Moreover, the research aimed to use participants’ accounts to develop a localised theory of the implications of therapy for the CR from the perspectives of those who were therapy clients, as the literature review indicated that such theory had not been previously constructed by other researchers. Despite the fact that systemic and psychodynamic theories have attempted to explain interpersonal processes in general, it is anticipated that a theory stemming from the client-partner’s perspective could allow therapists to assess and to some degree predict the effects of individual therapy on their clients’ CRs. The need for research on the specific topic has been supported by previous studies arguing that using existing psychodynamic theory in order to interpret client-partners CR tensions may not be sufficient or appropriate for all the cases. For example, Brody and Farber (1989) have argued that therapists should consider the possibility that clients’ feelings based on the effects of therapy on their relationship and their partners may be “reality based and not simply indications of resistance or transference” (p. 121). In this respect, a theory stemming from client-partners’ accounts would allow therapists to work more effectively with their partnered clients.
In terms of research, it is hoped that a theory stemming from the client-partner's perspective could provide a framework for future research, through the identification of variables and the possible relationships between these. Finally, the impact of individual therapy upon the CR is a significant area of psychotherapy and counselling psychology inquiry in its own right as it shows that individual therapy influences both clients' experiences of themselves (intrapersonal changes) and clients' relationships with significant others (interpersonal changes).

METHOD

Design
This is a small-scale qualitative study in which data were collected by 10 individual semi-structured interviews, and were subjected to grounded theory analysis. Because this is a small scale study, it was not possible for the researcher to approach theoretical saturation and produce robust theoretical categories. Therefore, an abbreviated rather than a full version of grounded theory was used; with the limitations this might entail (see Willig, 2001, pp. 37-38).

Participants
Participants were required to meet the following criteria in order to be eligible to participate in the study:

1. To have been in individual therapy for a minimum period of six months.
2. To not be in therapy at the time of the interview or if they were, their current therapist should be different to the one they would discuss in their interview (criterion set due to ethical concerns).
3. To have been in a heterosexual CR including marriage for a minimum period of 12 months prior to commencing therapy. The literature describes sufficient differences between non-heterosexual and heterosexual relationships for them to be treated separately (Kitzinger & Coyle, 1995).
4. Participants must not have been therapists or training to become therapists during the specific course of therapy they would be talking about. This is because therapy training may have an impact upon the CR in its own right. The term therapy included all talking therapies.

5. If the relationship they would talk about had ended, it should have ended at least 6 months prior to the day of the research interview. This criterion was set in order to reduce the possibility of restimulating participants' intense emotions in relation to their break-up.

6. Participants who were diagnosed with a psychiatric illness would be excluded from this research, as these were regarded to be vulnerable and at risk of becoming overwhelmed with emotions awakened by the research interview.

7. Participants must not have received the therapy course they would be reflecting upon through the NHS as ethical approval by the NHS was not sought due to time restrictions.

Because a key characteristic of grounded theory is theoretical sampling, an attempt was made to recruit a diverse sample that would provide the analyst with rich data that facilitate theory construction (Charmaz, 1995, 2006). To this end, the emerging theoretical analysis of the first few interviews drove later sampling. For example, having identified the importance of partners' adaptability to client-partners' therapy-related change and having interviewed only one participant whose partner was adaptive (the rest were not adaptive) within the first six interviews, the researcher was interested in interviewing more participants whose partners appeared to be adaptive in later interviews.

In order to recruit participants, posters (Appendix 3) asking people to participate in a study researching the impact of individual therapy on clients' relationships were placed on notice boards of therapy centres (not including NHS therapy departments), health shops and coffee shops. Moreover, an advertisement (Appendix 4) was placed in The Psychologist (2006, vol. 19, p. 238). Finally a flier was e-mailed to professional contacts asking them to circulate it to potential participants (Appendix 5). Those individuals who expressed an interest in participating were sent an information sheet (Appendix 6) including some general information about the research. A telephone screening procedure
(Appendix 7) conducted by the researcher then followed in order to evaluate whether participants met the inclusion/exclusion criteria and if they were emotionally stable to be interviewed on the specific topic. Ultimately, 16 individuals contacted the researcher but only ten met the eligibility criteria and were eventually interviewed at a place that was convenient to them.

**Interview schedule**

Semi-structured interviews were used to collect the rich data required by grounded theory. Attentive and focused listening, that was also facilitated by the researcher's training in counselling psychology, allowed her to explore emergent themes during the interviews and, thus collect rich relevant data (Coyle, 1998).

The development of the interview schedule was based on a literature review, the researcher’s discussions with colleagues and her personal experience as a therapy client who has also been in a CR. The main content areas of the interview were participants’ perceptions and evaluations of the impact of therapy upon themselves, their partner and the relationship (Appendix 8).

The first interview was conducted as a pilot interview and the participant was asked for feedback on the questions, the content and the ethical aspects of the interview. Based on the feedback, no changes were required to the interview schedule. Therefore, the data provided from the first interview were used in the analysis. All participants were asked to give feedback on the interviews conducted. The original interview schedule was followed with all the participants whilst a couple of additions were made at a later stage, as new themes emerged during interviewing and analysis (i.e. participants were asked about their attitudes to couples therapy and to reflect upon how past individual therapy had influenced their subsequent romantic relationships). These additions were consistent with theoretical sampling as this entails interviewing with a focus on emergent theoretical categories (Charmaz, 2006).
Procedure

Ethical approval was obtained from the University of Surrey Ethics Committee (Appendix 1).

The interviews began with the researcher advising participants that their participation in the study involved reflection and re-evaluation of personal experiences which might evoke uncomfortable feelings. To this end, participants were provided with the details of a range of additional support networks that they could access if they needed to (Appendix 9). This was followed by the completion of the consent form stating the details of confidentiality (Appendix 10). Participants then completed a short demographic information questionnaire (Appendix 11). Upon completion of the interview, participants were debriefed.

Interviews lasted approximately one hour. All were audio-recorded and transcribed verbatim (see Appendix 2 for sample interview).

Analytic Strategy

A grounded theory approach (Charmaz, 1995, 2003; Glaser & Strauss, 1967; Pidgeon & Henwood, 1996) was used for data analysis and theory development. Previous counselling psychology and therapy research has used various versions of grounded theory in order to understand and represent the meaning of information about human experience and behaviour (Arthen & Madill, 1999; Frontman & Kunkel, 1994; Rennie, 1994). Apart from meaning, grounded theory is believed to be suitable for studying individual processes because it enables researchers to study the development, maintenance and change of individual and interpersonal processes (Charmaz, 1995). As this research aimed to examine the process of relationship change in relation to individual therapy, the grounded theory approach was believed to be the most appropriate means for data analysis. Moreover, the explicit aim of grounded theory is to generate or discover new theory (Glaser & Strauss, 1967). After conducting a literature review on the topic of
individual therapy and the CR, the researcher concluded that the process of relationship change due to individual therapy has not been investigated and theorised. To this end, grounded theory was chosen over other qualitative methods (e.g. IPA) because the researcher was not only interested in describing client-partners' evaluations of the impact of therapy upon their CRs but also wished to develop theoretical explanations about how client-partners perceived individual therapy to influence their CRs.

A constructivist version of grounded theory was used, as suggested by Charmaz (1995, 2003, 2006). According to this, the researchers' perspective including her values, personal experiences and philosophical stance are understood as contributing to the analysis. By contrast, the original exposition of grounded theory (Glaser and Strauss, 1967) adopts a rather positivist approach to knowledge production by indicating that knowledge is 'out there' to be captured by the researcher (Willig, 2001). I opted for the constructivist approach because I believe that my own values, engagement, and interaction with the data, as a married woman who has been in individual therapy, had an impact upon the theory that was developed or constructed. Despite my conscious efforts not to impose my own values on the data, there is a recognition that, to some degree, my interpretation and collection of the data were also influenced by my own unconscious processes. In turn, the researcher's presence in the interview is likely to influence the participants' accounts. For example, due to the fact that the researcher was a counselling psychology trainee, participants might have felt less able to report negative thoughts and feelings towards therapy.

As a starting point for the analysis, each transcript was thoroughly read a number of times in order for the researcher to become as intimate as possible with the participants' accounts. Each reading resulted in initial coding of the data, being annotated in the left margin of the transcript. These codes were closely grounded in the data and reflected units of meaning that captured actions, processes and any connections or contradictions within each participant's accounts. Then, through comparing the initial codes, focused codes for each interview were developed on a separate sheet (see example in
Appendix 12). These codes allowed the researcher to categorise a large number of initial
codes incisively and completely (Charmaz, 2006). Then, constant comparisons of focused
codes across interviews enabled the identification of possible relationships
(contradictions, similarities, complementarity) between these focused codes. At this
stage, the researcher would re-examine the focused codes and the relationships between
them, through revisiting the original transcripts and allowing unexpected ideas to emerge
as she interacted with the data. This process led to the development of theoretical
categories that specified possible relationships between focused categories (see example
in Appendix 13). Finally, thorough examination and constant comparisons of the
relationships between emergent theoretical categories led to the identification of the core
theoretical categories that were used for theory construction (Figure 1). Throughout the
analytic process, the researcher wrote memos that captured her thoughts, the connections
she made, possible theoretical categories and possible limitations of and solutions for
these i.e. through theoretical sampling (see example in Appendix 14).

Due to the fact that a qualitative method was used in this study, the researcher recognises
that her analysis is characterised by subjectivity, as her main task was to offer her own
interpretations of participants' accounts whilst simultaneously remaining close to the
data. To this end, the researcher's supervisor checked that the emergent themes were
grounded in the data and were not overly idiosyncratic (see Elliott et al., 1999 on
credibility checks). Moreover, extracts from the transcripts are presented in the analysis
section in order for the readers to assess the consistency between the data and the
researchers' interpretation (Elliott et al., 1999). In these quotations, ellipsis points (three
dots) indicate where material has been omitted and material in square brackets is for the
purpose of clarification added by the researcher. Note that the names of the participants,
the people they refer to and location names have been changed to preserve confidentiality
and anonymity of the interviewees.
ANALYSIS

Demographic information

Seven females and three male therapy clients participated in the study (see Table 1). They ranged in age from 29 to 58 years (mean= 39.4; SD=7.8). Nine participants described themselves as White and one described themselves as British Asian. This means that racial diversity was not reflected in the sample.

Participants’ relationship status varied at the time they entered therapy (see Table 1). Five participants were married, four were in a relationship and one was engaged. Four participants separated or divorced whilst they were still in therapy and one participant broke up after completing therapy. The duration of participants’ marriages or relationships varied from 1.5 to 25.5 years (mean=9.3; SD=7.3).

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Education</th>
<th>Duration of relationship</th>
<th>Relationship status before therapy</th>
<th>Relationship status after therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helen</td>
<td>46</td>
<td>Postgraduate degree</td>
<td>4.5 years</td>
<td>Engaged</td>
<td>Engaged</td>
</tr>
<tr>
<td>Lara</td>
<td>35</td>
<td>Postgraduate degree</td>
<td>9 years</td>
<td>Married</td>
<td>Divorced</td>
</tr>
<tr>
<td>John</td>
<td>44</td>
<td>Degree</td>
<td>13 years</td>
<td>Married</td>
<td>Divorced</td>
</tr>
<tr>
<td>Steve</td>
<td>41</td>
<td>Degree</td>
<td>5 years</td>
<td>Married</td>
<td>Married</td>
</tr>
<tr>
<td>Nancy</td>
<td>36</td>
<td>Degree</td>
<td>15 years</td>
<td>Married</td>
<td>Married</td>
</tr>
<tr>
<td>James</td>
<td>34</td>
<td>Postgraduate degree</td>
<td>4.5 years</td>
<td>Relationship</td>
<td>Break-up</td>
</tr>
<tr>
<td>Maria</td>
<td>35</td>
<td>Degree</td>
<td>1.5 years</td>
<td>Relationship</td>
<td>Relationship</td>
</tr>
<tr>
<td>Carla</td>
<td>36</td>
<td>O-levels</td>
<td>12 years</td>
<td>Relationship</td>
<td>Break-up</td>
</tr>
<tr>
<td>Bonnie</td>
<td>58</td>
<td>Degree</td>
<td>25.5 years</td>
<td>Married</td>
<td>Married</td>
</tr>
<tr>
<td>Nikki</td>
<td>29</td>
<td>Postgraduate degree</td>
<td>3 years</td>
<td>Relationship</td>
<td>Break-up</td>
</tr>
</tbody>
</table>
Participants’ duration of therapy varied from 8 months to 6 years (Mean=2.8; SD=2.3). The reasons why participants sought therapy and the type of therapy they received also varied (see Table 2). Five participants reported marital or relationship problems amongst other reasons for commencing therapy. All participants apart from one (Helen) described their relationship as being problematic prior to commencing therapy.

Table 2: Therapy-related characteristics

<table>
<thead>
<tr>
<th>Name</th>
<th>Duration of therapy</th>
<th>Type of therapy</th>
<th>Therapist’s Sex</th>
<th>Reason for starting therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Helen</td>
<td>3 years</td>
<td>Psychosynthesis</td>
<td>Female</td>
<td>Work dissatisfaction, midlife crisis</td>
</tr>
<tr>
<td>Lara</td>
<td>5.5 years</td>
<td>CBT</td>
<td>Female</td>
<td>Work dissatisfaction, self exploration, marital problems</td>
</tr>
<tr>
<td>John</td>
<td>3 years</td>
<td>Not known</td>
<td>Female</td>
<td>Depression, marital problems, self exploration, trauma</td>
</tr>
<tr>
<td>Steve</td>
<td>1 year</td>
<td>Psychodynamic</td>
<td>Male</td>
<td>Marital problems, anger</td>
</tr>
<tr>
<td>Nancy</td>
<td>10 months</td>
<td>Humanistic</td>
<td>Female</td>
<td>Marital problems, self exploration</td>
</tr>
<tr>
<td>James</td>
<td>6 years</td>
<td>Psychoanalysis</td>
<td>Male</td>
<td>Depression</td>
</tr>
<tr>
<td>Maria</td>
<td>1 year</td>
<td>Not known</td>
<td>Female</td>
<td>Personal development, miscarriage</td>
</tr>
<tr>
<td>Carla</td>
<td>1 year</td>
<td>CBT</td>
<td>Female</td>
<td>Depression, self change</td>
</tr>
<tr>
<td>Bonnie</td>
<td>6 years</td>
<td>Psychodynamic</td>
<td>Male</td>
<td>Agoraphobia</td>
</tr>
<tr>
<td>Nikki</td>
<td>8 months</td>
<td>Integrative</td>
<td>Female</td>
<td>Self exploration, relationship problems</td>
</tr>
</tbody>
</table>

Presentation of findings

The analysis of the data produced five core theoretical categories which conceptualised participants’ experiences of the impact of therapy upon their CRs (see Table 3). However, due to space limitations, only three of these categories will be presented in this paper (B1, B3 and B4), although the content of the others will be outlined. The specific three categories were chosen for demonstration because they allow the reader to develop a clear understanding of the theory proposed.
The five core categories (see table 3) were chosen amongst a variety of emergent categories because they were seminal to theory construction. The first category (A) demonstrated participants' personal evaluations of the impact of therapy upon their relationships and was utilised as a point of departure for the investigation of how individual therapy influenced the CR. The main finding associated with this category was that all ten client-partners believed therapy to have had a positive impact upon their relationships. Even in cases where therapy contributed to the termination of the relationship, participants emphasised that their relationship problems were identified, rather than instigated by therapy. Thus therapy was seen as a catalyst rather than an instigator of relationship deterioration. However, some relationships that were portrayed as problematic at the time of entering therapy were said to have shifted and transformed into non-problematic relationships during therapy. Participants attributed relationship progress to their therapy. In these cases, therapy instigated change by transforming the relationship from problematic to non-problematic (instigator). As explained in the analysis and Figure 1, in some cases partners’ reported adaptability to participants’
change often determined the function of therapy either as a catalyst or instigator of change.

The last four categories (B1-4) are inter-linked as analysis demonstrated that the relationship between these contributed to the process of relationship change in relation to therapy. The connections and relationships between them can be identified in Figure 1. In general, the theory constructed suggests that therapy-related enhanced understanding of self and relationships led to client-partners’ increased or reduced relationship expectations, and altered emotional and behavioural expression. These changes instigated the partner’s reaction that determined the impact of individual therapy upon the CR. So, according to this preliminary theory, in cases where the partner is adaptive therapy may work as an instigator of positive outcome, but in cases where the partner is non-adaptive therapy may work as a catalyst of negative outcome. As displayed in Figure 1, at times enhanced understanding of self and relationships, and reduced relationship expectations may instigate change in their own right. This is often dependent upon the client-partner’s specific psychological difficulty.

Figure 1 also presents where each participant is placed within the proposed model so that the reader can become more familiar with each participant’s specific relationship situation. As shown in figure 1, nine out of ten participants described their relationships as problematic prior to commencing therapy. Therefore, the analysis and overview that follow mainly refer to those relationships described as problematic prior to therapy. The one participant who described her relationship as non-problematic has been included in the analysis but there is recognition that the specific view is underrepresented in this study.
Figure 1

THE IMPACT OF INDIVIDUAL THERAPY UPON THE COUPLE RELATIONSHIP

Participants' retrospective evaluation of their relationship prior to commencing therapy

- Problematic
  - Client-partner in therapy
  - Contemplate ending the relationship (John)
  - Enhanced/new understanding of self and relationships
  - Increased relationship expectation → Behavioural/emotional change
  - Reduced relationship expectations (Nancy and Bonnie)
    - Positive: being adaptive (instigator) (Steve, Maria, Nancy)
    - Improved communication
    - Improvement/transformation of relationship

- Non-problematic
  - Client-partner in therapy
  - Enhanced/new understanding of self and relationships
  - Increased/reduced rel. expectations → Behavioural/emotional change
  - Partner's adaptability
    - Positive: being adaptive (catalyst) (Bonnie, Lara, Nikki, James)
    - Good or improved communication
    - Relationship stability/improvement
    - Negative: being non-adaptive (Helen)
      - Conflict: internal/external
      - Being stuck in a problematic relationship
      - Deterioration of relationship

1 Connecting lines indicate non-causative relationships between categories; a line with an arrow indicates a reported directional causative relationship
Enhanced - New understanding of self and relationships

All participants talked about new insights they had developed through therapy. Therapy facilitated them to expand on their understanding of themselves and their partners and in some cases new understandings emerged. As presented in Figure 1, this had an effect upon what they expected from their partner and the relationship and in the way they expressed their emotions and behaved in their CR.

The following themes elaborate on specific aspects of participants’ increased awareness:

**Becoming self-aware**

Becoming more self-aware was frequently reported as a positive outcome of therapy. Participants highly valued developing a better understanding of themselves, as this enabled them to understand the role they adopted in their relationships.

For example, through understanding her own psychological difficulties in relation to her family history, Bonnie was able to stop blaming her husband for her unhappiness:

> I don’t now, I don’t blame my husband... in the end it wasn’t his fault that I was in pieces. That was totally something that was happening to me through my own life history, it wasn’t anything to do with him.

In Bonnie’s case increased self-awareness allowed her to own her problems and stop blaming her husband. Similar findings have been demonstrated in previous studies in which partners suggested that therapy enabled client-partners to become more understanding and accepting of them (Brody & Farber, 1989; Lawhon, 2004).

Whilst Bonnie’s understanding was relationship enhancing and generated subsequent changes in her marriage, in John’s case it led to the termination of his marriage. This is because, through therapy, John was able to explore his sexual identity and realise that his marriage was not fulfilling his sexual needs:
So this is the reason I went there, I wanted to get to the bottom of things… what it was that was holding me back from certain things in my life. Then I went to therapy and then I realised there is another part of myself which likes men perhaps so I wanted to explore that at the time, because I never had any proper relationship with anybody.

As shown in Figure 1, John opted for radical change as therapy enabled him to contemplate divorce.

Other participants’ enhanced self-awareness also appeared to trigger relationship problems. However, this was related to the identification rather than instigation of problems. For example, Nikki, who was in a co-dependent relationship and had relationship problems when she entered therapy, realised that she unconsciously adopted the carer’s role in her relationships.

I think the main thing for me was realising whereas in the past I always wanted to be in relationships with others, and my love, my romantic relationships, by being in a caretaker role it made me feel worthy and valued...and why I did that, was actually for my own needs, so I felt better, I think that was the greatest thing that I went away with about my own awareness, how I am with other people.

This realisation enabled Nikki to consider forming relationships that would be more balanced and equal. This had negative repercussions for her partner as he wanted to remain in the dependent role and have Nikki caring for him. Psychodynamic theory suggests that people in CRs tend to collude with their partners in order to support one another’s defences and enhance each other’s sense of competence (Hunsley & Lee, 1995). In this respect, if we take Nikki’s account as an accurate representation of events, the dissolution of her relationship could be partly explained by psychodynamic theory as she stopped colluding with her partner through becoming aware of the unconscious forces that drove their relationship. However, understanding on its own did not instigate
relationship termination. As explained in Figure 1, it was her partner’s reaction to Nikki behaving differently and having increased relationship expectations that instigated their break-up (see category ‘partner’s adaptability to participant’s change).

**Understanding the impact of transference upon the couple relationship**

Most participants admitted that therapy enabled them to develop a more realistic understanding of their partner by being aware of the impact of transference on their relationship and their partner. Freud called transference a “form of projection in which feelings, thoughts and experiences which belong to another person or situation are displaced onto the figure of the therapist and the relationship between therapist and patient” (Spurling, 2004, p. 97). Projection of feelings and thoughts can also be displaced onto other figures apart from clients’ therapists. In the present category, reference to transference will be limited to the specific projection of thoughts and feelings onto the partners of therapy clients.

Seven out of ten participants described how unresolved paternal/maternal transferences put strain on their relationships or influenced their partner choice. Transference issues were also presented in cases where client-partners repeated earlier problematic relationship patterns as a result of repetition compulsion. According to Freud (1920), people have a tendency to relive and re-enact unpleasant or traumatic situations until a sufficient defence has been built up after the unpleasant or traumatic event. For example, therapy helped James become conscious of his tendency to recreate relationships similar to the one his parents had. Having realised that what he actually wanted was a meaningful relationship including a partnership, he saw that his relationship at the time, if it remained unchanged, was not what he wished for:

> I think one of the big things was understanding the relationship, extraordinarily strong father, extraordinarily weak mother certainly in the relationship between the two of them and me actually having quite strong aspects of both. And that very dysfunctional relationship that they have...I was actually recreating aspects of that
to a point where I was like, okay I have built something which is not a partnership...

As James’ partner appeared resistant to adjust to his new relationship expectations their relationship ended. In his case though, therapy acted as a catalyst rather than an instigator of change as the relationship was problematic prior to commencing therapy. Therapy only allowed James to understand the reasons why his relationship was problematic and form new relationship expectations based on the resolution of his repetition compulsion.

By contrast, Helen’s understanding of the transference enabled her to accept her partner as a whole person with strengths and weaknesses. As her relationship was non-problematic prior to commencing therapy, an understanding of transference appeared to further improve her relationship:

My father left when I was eight so I had a terribly unreasonable view of men. I had this fantasy father who’s perfect. And then as I was going to therapy and seeing my dad as a real person and getting very disillusioned with him, I sort of came about to thinking no he’s not perfect and therefore no man is perfect, and I think that this experience in myself has really made me accept more that my partner is just a wonderful being and, yes, there are things I don’t like about him.

Similarly, through therapy other participants were able to identify the projection of feelings, that were associated with past experiences and relationships, onto their partners. This enabled them to reduce such projections, thus improving their CR. The positive impact of transference resolution upon the CR has also been demonstrated by Lawhon’s (2004) study in which partners identified positive CR changes as a result of the client-partner working through the transference in therapy.
Behavioural and emotional change

In most cases, enhanced understanding of self and relationships resulted in participants acting upon this new awareness, thus behaving differently in their CR (see Figure 1). Participants’ altered behavioural and emotional expression was often consistent with their new relationship expectations. Sometimes this also helped towards the formation of new expectations through testing the boundaries of the relationship and exploring different possibilities of being in their relationship. Emotional and behavioural changes were positive for the relationship when partners were adaptive to change (see next category and Figure 1). However, in the case of ‘rocky’ relationships, where partners were perceived as defensive and rigid, participants’ changes were viewed by partners as threatening to the relationship.

The following themes present some of the most frequently mentioned emotional and behavioural changes.

Feeling assertive and empowered

Participants who had previously felt victimised in their relationships became more empowered to voice their views and needs and felt less persecuted by others as therapy helped them to develop self-respect and improve their self-esteem.

Well I mean those kind of changes, is a broad category of me asking, finding a bit more of a voice, of what I want, and him...responding positively, I think that changed something in me, you know that helped me realise I wasn’t going to be shot down every time I asked for something, or even if something happened, that I could fight for as well, and I had a right to fight for it and this kind of thing.

(Lara)

Through becoming more assertive and less compliant participants were able to express their thoughts and feelings in an attempt to improve their relationship. Relationships appeared to improve when partners were responsive and adjusting to participants’
therapy-related self-expression. However, as indicated in Figure 1, the opposite effects occurred when partners were rigid and non-adaptive as this created relationship disequilibrium. Psychodynamic theory suggests that incomplete individuation (separation from parental control and establishment of autonomy) results “in marital interactions characterised by struggles for dominance and control, with both aggressive independence and passive dependence occurring” (Hunsley & Lee, 1995, p. 2). Therefore, Hunsley and Lee (1995) argued that client’s therapy-related change and new expectations disrupt the fragile power balance of those CRs in which one or both partners’ individuation had been incomplete. Issues of dependence and power dynamics are also displayed in the following theme.

**Becoming independent**

Participants who, prior to commencing therapy, felt vulnerable and dependent upon their partner started to become more independent as therapy progressed. Such a change was experienced as disruptive to the dynamics of the relationship by their partners if the relationship was problematic prior to commencing therapy:

...it [therapy] made me, I know it’s kind of weird to say, but it made me kind of stronger, where I could actually stand on my own two feet, much better. Rather than kind of relying on him so much, and you know, I think I became in one aspect emotionally stronger than him. Where he kind of sort of stayed and I think that’s probably, looking back that’s probably our downfall is that I became much more able to handle certain things and issues and stuff like that.

(Carla)

By contrast, becoming independent did not negatively affect Helen’s relationship, which was a supportive and non-problematic relationship before and during therapy:
...he's very good nurturing sort of person, he does a lot of listening and caring and actually now that I'm much happier I don't need that. So our relationships changed in another way, in that I'm not so dependent on him.

Helen's independence freed up some space for her partner to be vulnerable and thus allowed the relationship to become more equal and balanced:

I think the first time round he didn't have space for his problems because mine were bigger... It's kind of a bit strange really but I think that's also a positive thing in that there's room in the relationship for him to be unhappy.

Again, partners' response to participants' independence appeared to be a determinant of therapy functioning either as an instigator or catalyst of the CR change. In Carla's case, it disrupted the dynamics of her relationship as she shifted from being co-dependent to being independent. For Helen though, becoming independent was relationship enhancing as her partner's self affirmation was not solely gained through him adopting the carer's role.

**Becoming self-absorbed and self-focused**

For those participants who entered therapy whilst being in an emotional and psychological crisis, therapy initially heightened some of their emotional problems, thus accentuating their crisis. In cases where the partner was not understanding and supportive of participants during their crisis, the relationship was negatively affected by participants' regression. As James reported:

I was going through a very much darker time. I mean, generally speaking, people don't think about themselves very much, and certainly don't think about the difficult things in life, of the meaning, of purpose, direction, death and what love actually means. She, if I was talking about any of this stuff, she'd want to stop me from talking about it...I could be regarded as self-indulgent or weak or anything
like that, she’d immediately just want to stop it completely... She couldn’t accommodate me.

James, like another three participants, experienced moderate to severe psychological difficulties when he entered therapy. Addressing and working through these difficulties in therapy initially led to the accentuation of participants’ psychological problems. However, as therapy continued they were able to work through their difficulties and improve their emotional well-being. Partners’ adjustment to client-partners’ initial deterioration was a significant determinant of relationship continuation or dissolution. As seen above, James’ break-up followed his girlfriend’s difficulty to accommodate him when he was regressing. This is consistent with Roberts’s (1996) study according to which partners claimed feeling angry and disappointed in cases where the client-partner regressed. However, according to the same study, when the client-partner improved with clear benefits to the CR, partners became supportive of therapy. In this respect, previous studies and the presented categories highlight the importance of partners being consistently adaptive to participants’ change in order for the relationship to improve rather than deteriorate. This will be further explored in the next category.

**Partner’s adaptability to change**

**Non adaptive partners**

Partners’ reactions to participants’ self-change, therapy and therapist varied. Partners who appeared to be in problematic relationships prior to commencing therapy displayed different degrees of adaptability to participants’ behavioural and emotional changes. In some cases, partners were described as suspicious of the client-partner’s therapy and unwilling to accommodate any changes that altered the dynamics or threatened the *status quo* of their relationship. Partners’ rigid and negative responses often resulted in the termination of those relationships. As these relationships were perceived as problematic, prior to commencing therapy, therapy appeared to function as a catalyst of change. As Nikki explained:
He was only seeing it [therapy] from his perspective and he couldn’t see it in terms of everything. In terms of the bigger picture and that, in a sense, if he had given me more space to grow and deal with whatever I had to deal with, which meant part of that was the relationship. I think if he’d have adapted to me changing, there might have been some hope for the relationship but he wanted to keep me where I used to be. He wanted things to stay the same, but in order for me to be happier I needed to change. But he wasn’t willing to adapt to that change.

One of the reasons why partners appeared to resist adjusting to CR changes was being jealous of the client partners’ therapist. Four participants argued that their partners’ feelings of jealousy and exclusion were counterproductive to their efforts to overcome their psychological difficulties, and caused further relationship problems. For example, James said:

She hated the fact that I was speaking to someone else about everything. I mean probably in retrospect because of the level of intimacy that that would imply and the fact that all of a sudden there was a third party in our relationship. Because… there is a very intimate bond with the analyst even if my analyst…this means that there is something to be jealous of and I think that made her very angry… because the communication had broken down between us and here I was going off to speak to someone else.

Partners’ feeling excluded or left out by their partners’ therapy has also been demonstrated in Roberts’ s (1996) study that suggested these feelings were accentuated in cases where client-partners did not share the content and the process of therapy with their partners. Indeed, James and another three participants in the present study identified this as having occurred in their cases.
Sometimes partners' personal emotional and psychological difficulties obstructed them from being adaptive to participants' change. Participants' accounts suggested that this was because some partners were unable to contain both their personal problems and the uncertainty of a relationship that was being transformed and requiring them to alter their own way of being in it:

And it came out that his father had abused him from the age of 6 to the age of 13, which, kind of...explained his total inability to deal with somebody who was opening up completely, so we were like the opposite.

(Bonnie)

The reaction of Bonnie’s husband could be explained by general systems theory according to which changes in one partner are likely to elicit changes in the other partner and cause disequilibrium to the couple system (Bowen, 1978). In this sense, in cases where partners were emotionally vulnerable, they felt threatened by relationship changes and attempted to avoid them at all costs.

**Adaptive partners**

In contrast to those negative experiences, some relationships that were described as problematic prior to commencing therapy (see Figure 1) appeared to improve due to partners being responsive and accepting of participants’ emotional and behavioural change (therapy as an instigator of change). This was the case for Nancy who appeared very emotional when recounting her husband’s reaction to her discussing therapy with him:

He would listen and if I had anything particularly poignant to say you know at the end of the day, you know, I’d say...therapy today was particularly intense because I spoke about, you know whatever it was we spoke about. He would just take it in, he wouldn’t try to counter it or operate an opinion about it, he would just very much take it in.
Unlike Nancy, John felt guilty as his wife appeared to be supportive of him even when he was detached and abusive towards her. John was the only reported case where his wife’s positive response was not sufficient for his marriage to survive. This was because through therapy, John discovered that he was a gay man; thus he felt entrapped in a heterosexual marriage:

I was feeling guilty because, really, yes she was changing so... to make that relationship work, but I couldn’t accept that because subconsciously I had decided what I wanted to do. So I was feeling worse... It [therapy] improved our relationship as two human beings. But the marriage was dead. It helped to bury it, that’s it.

Leaving John’s unusual case aside and extrapolating from the remaining nine participants’ accounts, it appeared that partner’s reported adaptability to participants’ change was a significant determinant of therapy functioning either a catalyst or instigator of change. This finding does not corroborate Brody and Farber’s (1989) conclusion that partners’ strong reaction to client-partners’ therapy is a natural response that is not a predictor of negative relationship outcome.

OVERVIEW

This research aimed to employ the experiences of therapy clients who had been in a CR prior to commencing individual therapy in order to begin the process of creating a localised theory of the implications of individual therapy for the CR from this sample’s perspective. Moreover, this study attempted to specifically examine the process of relationship change from the viewpoint of the partner who had been in therapy.

Analysis of ten interviews conducted with a diverse sample identified four core theoretical categories associated with relationship change and one category related to
participants’ evaluations of the impact of therapy upon their CR (see Table 3). The interrelations between the four core categories suggested that therapy is conducive to relationship change. According to this study’s substantive findings, therapy appeared to work either as a catalyst or an instigator of relationship change. More specifically, some relationships that were described as problematic prior to commencing therapy deteriorated further during therapy and one relationship that was characterised as non-problematic improved further in its quality. In this sense, therapy appeared to accelerate processes already inherent in the relationship (that is, it acted as a catalyst). However, some relationships that were portrayed as problematic at the time of entering therapy shifted and transformed into non-problematic relationships during therapy (that is, therapy acted as an instigator). Therefore, it could be concluded that this study’s substantive findings did not lend support to the deterioration hypothesis.

The data indicated under which conditions therapy worked either as a catalyst or an instigator of change. As displayed in Figure 1, for some relationships that were previously described as problematic, termination appeared to be accelerated by therapy (catalyst). Participants’ accounts suggested that therapy facilitated them to become self-aware, be in touch with personal needs and wishes, set new relationship boundaries, develop new relationship expectations and feel empowered to communicate these. In cases where partners were not adaptive to participants’ emotional-behavioural change and relationship expectations, participants felt empowered and supported through therapy to end an unfulfilling relationship (Nikki, Carla, James, Lara). In one case, the participant’s decision to end his marriage was based on discovering an aspect of his sexual identity that he was not previously aware of. In this instance, participant’s decision to end the relationship was not influenced by his partner adaptability (John).

On a positive note, some relationships that were characterised as problematic prior to commencing therapy appeared to transform into non-problematic and such transformation was to a large extent attributed to therapy (instigator). Participants’ accounts suggested that relationship progress was achieved as a result of a) therapy facilitating clients to
decrease their expectations through realising and accepting that their partner cannot fulfil all their needs (Nancy, Bonnie); b) therapy enabling them to work on and resolve personal issues that appeared previously to put strain on their relationships (Steve, Maria, Bonnie); c) their partners being adaptive to change (Steve, Maria, Nancy). This last point is consistent with Lawhon’s (2004) research findings suggesting that, despite partners feeling pressurised to change as result of client-partners’ therapy, they ultimately experienced any changes as relationship enhancing. In general, analysis of the data suggested that partner’s adaptability to participants’ change was the main determinant of therapy functioning either a catalyst or instigator of change.

The process and conditions of relationship change, described in this study, allow the reader to understand why participants expressed the view that therapy had a positive effect upon their relationships, even if their relationships failed. This is because, in cases where there was relationship deterioration, therapy was perceived as a catalyst, rather than an instigator, of change (not an instigator of negative change). However, in cases where there was relationship improvement, participants attributed such change to therapy (instigator of positive change).

One of the limitations of this study is that only one individual was interviewed who described her relationship as non problematic prior to therapy. Therefore, this view is under-represented. The fact that most participants appeared to have relationship problems prior to commencing therapy may suggest that most clients seeking individual therapy encounter relationship problems that are either instigated by their personal emotional difficulties or that relationship problems trigger their emotional difficulties. This view has been empirically supported in research on marital discord and depression (Denton, Golden, & Walsh, 2003). Another reason why only one participant from the specific population was recruited may be that people, who had encountered relationship problems prior to commencing therapy, were more interested in participating in this research. Future research should focus on recruiting individuals who claim to have a good relationship prior to commencing therapy so that the process of relationship change of the
specific population is examined. Another limitation of this study is that the process of change was examined through participants’ retrospective accounts that were subjected to reconstruction of their perceptions of reality at any given time. This limitation could be overcome by employing a longitudinal research design so that data gathered prior to commencing, during and upon completion of therapy could be compared and contrasted in order to ascertain change over time with confidence.

Finally, the main limitation of this study is that due to time constriction, an abbreviated rather than a full version of grounded theory was employed. As a result of this, theoretical saturation could only be implemented within the interviews that were analysed (Willig, 2001). Therefore, the theory constructed mainly reflects the ten participants’ experiences of CR change in relation to therapy and the conclusions drawn must be viewed as limited to the sample interviewed. Lack of theoretical saturation in conjunction with having recruited a diverse sample as required by grounded theory, further indicate that generalisability of this study’s findings cannot be supported. However, despite the heterogeneity of the sample with regards to the type and duration of therapy, and relationship duration and status, the sample was homogeneous in terms of education, socioeconomic status and racial background. Homogeneity was also reflected in participants’ evaluations of their relationships as problematic prior to commencing therapy (nine out of ten participants). Therefore, it could be proposed that the theory constructed may be indicative to some degree of the experiences of white highly educated professionals who enter individual therapy whilst being in a CR that they describe as problematic. Future research employing the full version of grounded theory by interviewing a larger sample that would produce saturated theoretical categories, could expand, modify or reject the theory suggested in the present study.

Moreover, further development and refinement of the proposed theory could be achieved by a quantitative testing of this model. For example, researchers employing quantitative research designs could examine if any associations suggested by the proposed theory are
statistically significant and, if so, to create an instrument measuring partners’ adaptability. Such an instrument could enable therapists to conduct assessments to predict the effect of individual therapy upon partnered clients’ relationships.

Despite these limitations, it is hoped that this study will enhance counselling psychologists’, psychotherapists’, and counsellors’ understanding of the effects of individual therapy on their clients’ CRs so that facilitative interventions might be made when individual therapy appears to trigger relationship tensions. In addition to this, it could alert therapists during the assessment process to client, partner and relationship characteristics that could be indicative predictors of potential relationship vulnerability (i.e. partners’ adaptability, unrealistic expectations, problematic relationships etc.). If therapists suspect that their clients’ relationships may be at risk, they could discuss the possibility of referring their clients for couples therapy or encourage them, as Heitler (2001) suggested, to bring their partner along to the first session where potential effects of individual therapy upon the couple could be explored and assessed. Moreover, in line with previous research suggesting that therapists should discuss with partnered clients possible effects of individual therapy upon the CR (Lefebvre & Hunsley, 1994; Phillips, 1983), the findings of this study could be informative to all those clients who are in a CR and wish to undertake individual therapy. It is also hoped that this study will alert therapists to consider clients as part of a wider system and attend to their interpersonal as well as intrapersonal-intrapsychic processes.

Finally, this study demonstrates that therapy helps individuals develop fulfilling relationship through transforming problematic relationships to non-problematic ones or through terminating relationships that do not fulfil their needs so that they form new fulfilling relationships. This finding could be further pursued in future research evaluating the outcome of therapy beyond symptomatology.
References


Personal Reflections

Research topic
Interpersonal relationships have always been my main research focus. For example, in the past, as part of my MSc studies in social psychology, I explored the relationship dynamics between gay men and their heterosexual female friends. Moreover, when I worked as a researcher in a UK university, I examined young people's romantic relationships in Britain. It, therefore, came as no surprise to me, that my interest in exploring dyadic relationships drove me on this occasion to investigate the impact of individual therapy upon the couple relationship (CR).

Having been in a close and committed relationship myself before entering individual psychodynamic psychotherapy, I had noticed significant changes in my relationship that often related to my therapy and subsequent personal growth. As voiced by some participants, it may be difficult to determine whether relationship changes occur as a result of therapy or life. However, I am pretty certain that my therapy-related personal development contributed to or accelerated relationship movement. Relationship progress happened gradually and often stemmed from productive resolution of conflict that allowed the relationship to accommodate the changes in me and the impact those changes had upon my partner. Having reflected upon the process of change in my relationship, I was really curious to explore other people's experience of the effect of therapy upon their relationships. Moreover, in conversations with colleagues and in supervision, I noticed that the impact of therapy upon the CR varied from improving some relationships to further deteriorating others. This observation raised my curiosity to explore how change occurred and identify some of the conditions under which therapy promoted relationship improvement or dissolution.
Interviews

Regarding the interview process, I believe that I had initially underestimated the intensity of emotions and awakening of long forgotten memories that my research topic would trigger for some participants. Participants often became emotional during the interview and some participants attempted to use the interview as a therapy session. I was aware of the potential risks this entailed for them, as most participants were not currently in therapy where they could further explore any emerging feelings related to the research topic. As a result of this, when appropriate, I avoided asking them to expand or stopped them from elaborating on areas that appeared painful for them. Whilst in a therapeutic context I would have stayed with clients’ emotions, during the interviews I diverted from them. This created some guilt and dissonance in me because as a therapist I deeply invest in emotional expression but during the interview my behaviour suggested that emotions were not acceptable and this was contrary to my training and my therapeutic values. However, in cases where strong emotions emerged, my training in counselling psychology allowed me to contain most of them and ensure during debriefing that participants were emotionally stable.

Moreover, I believe that as a result of my training in counselling psychology I was able to empathise with participants and be sensitive to their experiences without misinterpreting or underestimating the emotional value these carried. Such therapeutic skills as empathising, reflecting and summarising allowed participants to give detailed and deeply reflective accounts that facilitated the collection of rich data. Moreover, reflections enabled me to check if I understood the described phenomena from the participant’s perspective, thus these reflections were also used as a validity check during the analysis.

Apart from the interviewees, the interview process had a major impact on the interviewer, as I was exposed to many traumatic life stories that I had to contain without the support of therapeutic supervision. In one case, a participant talked about having been sexually abused as a child and how this had influenced his CR. When recounting his story, he said that I was the only other person apart from his therapist to whom he had disclosed this. As
he was talking, I had a very strong countertransference reaction of emotional pain. This was the only interview that lasted for 35 minutes. Upon reflection, I believe that unconsciously I cut the interview short as I felt unable to contain the painful feelings projected into me for much longer (projective identification). In terms of psychological self-safety, I believe that my personal therapy helped me discuss and finally contain any uncomfortable feeling triggered by the interviews.

Analysis
Regarding the analysis, I was pleased to discover that participants’ views varied and diverted from the stereotypical view expressed in therapists’ informal conversations that suggests relationships deteriorate because the ‘client moves on and the partner stays behind’. Whilst this might have been the case for some participants, analysis of the interviews highlighted the complexity of the phenomenon under investigation. Due to the fact that this is a sensitive topic and my anonymity is not protected I would not like to give a detailed account of my personal experience of CR change. I can admit though, that whilst I was able to identify with some interviewees’ experiences, others sounded completely new and alien to me. In turn, some of my views were not voiced by any participant and therefore were not included in the constructed theory e.g. I believe that the therapist’s theoretical orientation and personal values influence the therapy-related CR changes. This demonstrates that, as far as I was consciously aware, I did not impose my idiosyncratic views on the theory. Moreover, as some of my experiences were not shared by other participants, it could be postulated that theoretical saturation was not achieved.

Personal learning
As a result of my engagement with the specific topic I have become more attuned to my clients, as being part of a system and I am more aware of the impact of therapy upon themselves and their significant others. I am also more alert to the facilitative and non-facilitative interventions made by my therapist and I have started to think about the ethical commitment therapists have not only to their clients but also to those closely
connected to them. These are some thoughts that now influence my practice and are likely to inform my future research interests.
9 February 2006

Ms Stamatia Grigoriou
Department of Psychology
School of Human Sciences

Dear Ms Grigoriou

**How does individual psychotherapy influence the couple relationship? Accounts of clients who are in a close couple relationship (EC/2005/141/Psych)**

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: **09 February 2006**

The list of documents reviewed and approved by the Committee is as follows:-

- **Document Type:** Application
  - Dated: 13/12/05
  - Received: 14/12/05

- **Document Type:** Summary of Project
  - Received: 14/12/05

- **Document Type:** Research Proposal
  - Received: 14/12/05

- **Document Type:** Appendix 1 – Poster
  - Received: 14/12/05

- **Document Type:** Appendix 2 – Flier
  - Received: 14/12/05

- **Document Type:** Appendix 3 – Information Sheet
  - Received: 14/12/05

- **Document Type:** Appendix 4 – Telephone Screening/Assessment Procedure
  - Received: 14/12/05

- **Document Type:** Appendix 5 – Consent Form
  - Received: 14/12/05

- **Document Type:** Appendix 6 – Interview Schedule
  - Received: 14/12/05
This opinion is given on the understanding that you will comply with the University’s Ethical Guidelines for Teaching and Research, and with the conditions set out below:

- That you amend the Method Section on page 3 of the Protocol as this still states that participants ‘who have previously been or still are in personal psychotherapy ...’. This contradicts with point 2 of your letter dated 22 January 2006.
- That you amend the Eligibility Criteria. Page 3, point 2, currently states “They must have completed the course of psychotherapy related to the relationship they will be talking about” – Does this mean they could still be in therapy, but associated with a different relationship? The Committee feel that the participant should not currently be in therapy – even if it’s not the same relationship, the interview could change the dynamic between the (current) therapist and the participant.
- That you amend the Information Sheet, fourth paragraph, to say ‘I am seeking individuals who were in psychotherapy ….’, rather than ‘who have been’ as this will make it clear that the therapy is complete.

The Committee should be notified of any amendments to the protocol, any adverse reactions suffered by research participants, and if the study is terminated earlier than expected, with reasons.

I would be grateful if you would confirm, in writing, your acceptance of the conditions above, enclosing the amended documents for the Committee’s record.

You are asked to note that a further submission to the Ethics Committee will be required in the event that the study is not completed within five years of the above date.

Please inform me when the research has been completed.

Yours sincerely

Catherine Ashbee (Mrs)
Secretary, University Ethics Committee
Registry

cc: Professor T Desombre, Chairman, Ethic Committee
Dr A Coyle, Supervisor, Department of Psychology
APPENDIX 2
Interview 1: Lara

R= Researcher
I=Interviewee

Three question marks (???) reflect inaudible remarks.

R So for how long were you in the relationship before you started therapy?

I I was in the relationship for about 4 years before... oh no sorry actually I was in the relationship, I was married for 4 years, but I'd known him, for 5.5 years that I'd been in the relationship.

R Would you like to tell me a bit about... what your relationship was like before you started therapy?

I Well... at that point it wasn't very good, er... it was very difficult at that point, I was, we use to fight a lot usually, you know out to dinner with alcohol involved, and I felt I was going mad because we had the same arguments again and again and I didn’t quite understand where they were coming from. I mean they seemed to focus around, I'd listen to him a lot about his job and I would try and support him and did support him a lot, but sometimes I just, I’d disagree with what he was saying and when I did he’d get kind of annoyed and ask why are you contradicting me, and I didn’t quite understand, it would just seem to shoot off somewhere and then it would just go somewhere, where you just couldn’t capture any balance afterwards and I’d get annoyed because he wouldn’t listen to me, er... so at that point we were both working, we’d see each other in the evenings, er... you know we’d either come, have microwave meals at home or we’d kind of go out to dinner and money wasn’t a problem so we could do that. We had a nice place to live although it was small for two people, er... and I did love him, but I don’t know,
I'm not too what else to say, I was getting quite annoyed with him but also just feeling very confused about the arguments and things, its kind of hard to sum up 5 years.

R Yeah. Cause there would be ups and downs.

I Yeah I mean we got married, very happy, very happy to be married, there was something about that, I think there was a kind of dependent, kind of security in it and I knew that he would never leave me bizarrely,...but I think when I look back at what was happening we...he wanted me to be around more I think, he always liked the independence side of me which I always said was there and after on and had a job of my own, but he couldn’t handle the fact that I had my stress from my job and he couldn’t be there for me. And he’d get angry when I’d be upset because he felt er...he was doing, he wasn’t being a good husband, if I was unhappy then he wasn’t doing his job right, he felt his job was that I should be happy, which left no room for me to be sad because then it made him upset and then suddenly everything, you know I was there helping him and I was the one upset to begin with. Em...so those kind of dilemmas were going on. And so I didn’t feel supported and he kind of didn’t understand why I was unhappy. He wanted to do things together all the time...I didn’t like roller-blading, I’d encourage him to go out and do it on his own he did, and that was fine, you know and that was really good but...and then the other stuff too. I’d hit walls, I hit him once, I kind of pounded on his chest out of confusion and just said go away I don’t understand, I don’t understand what’s going on and felt I was going mad. And these fights were just ...I think they would happen and I couldn’t control them, and he couldn’t control them so I just started feeling less and less.

R Is this why you started therapy?
Yeah it wasn’t just that I mean, I think there was a parallel process happening in my job, you know I was kind of I’d been happy in it, and suddenly I wasn’t as happy, in it… and in fact preceding going in to therapy I was trying to change that first. You know kind of, that was more clear that I was unhappy in my job and I could, I could… articulate that and say well what’s wrong here and was working on it and you know was looking for other jobs and was trying to figure out more about myself so there was a little bit of self discovery process that went on before I went in to therapy and I kind of got books and all these things like what colour is your parachute? And a book I found, cause I was quite unhappy, for a long time before that…and this book about business career interest, I did career counselling, I paid money to talk to these people in America over the phone and they did an interest inventory and I filled this thing out and all of my interests kind of came towards counselling and mentoring from a business perspective even. And I was like god…it said just put your interests down, not what you’re qualified to do, not what you’re training to do, but what sounds most interesting. And that was a real revelation for me, so that was all going on and I was applying for kind of people type jobs and not likening them, you know recruitment consultancy, it wasn’t appropriate and that’s why I was doing that. It sounds good to kind of get some movement, you know oh at least I’m going to try this but I wasn’t getting any satisfaction out of it, I was… everything kept pointing to me wanting to change my career to get on to counselling in a way, and I didn’t understand that I didn’t know anything about it and I think, I think so partially I got to the point, not too long before I went in to therapy, or even after, I can’t pinpoint at it, it was a process that was happening of me wanting to change my job but it was in to such a completely different direction that I, I think that was completely scary. That was going to change everything so I wasn’t really acknowledging it, I didn’t see it clearly. But there was certainly a feeling of a big change has to happen there. And I don’t think I could have handled dealing with it, with Mario but then also I was incredibly unhappy in my marriage and I knew that, my best friend knew that, I’d call her and I’d always be crying I didn’t know what to tell her, I didn’t have
anything to say, I think I just shut down, I stopped talking to anybody about it, I
didn’t think anybody could understand. I didn’t even understand, I didn’t even
know what to say to them. And I think it was, I actually kind of more at that side
knowing that I just felt, utterly and completely lost. I didn’t know where to go...
emotionally. And I knew someone who saw a therapist, there was a bizarre entity
out there in the world that I didn’t know, so...I didn’t really know about, you kind
of knew that they were out there, and there was that funny feeling inside that
someone was willing to get to know you in a different way.

R  To help you to get to know yourself.

I  Yeah and someone was going to help you look at that side of you. I mean that’s all
of kind I know was that ??? and it felt really exciting to be honest, I thought god
that’s really interesting, er...so I went...

R  During the first few months you were in therapy did you notice any changes in
your relationship? What was your relationship like then?

I  Well, my relationship at that point was very difficult. I kind of felt that I was the
one going, saying it was so difficult, and he would just stick his head in the sand
and say everything is going to be better, everything is going to be okay. And so
when I went, just the fact that I went, cause I told him I didn’t hide it,
er...changed something, he kind of...he was a bit curious, he was a bit intrigued,
defensive and a bit scared and he didn’t quite know what to do, so suddenly there
was a little bit of a birth around me, you know he kind of...he’d ask and I
wouldn’t say, because ultimately I was just going to her and collapsing.
And...seeing how unhappy I was, I didn’t quite say it to him in that way and ..I
think a lot of the changes that were happening, my experience of it was that they
were more in me, I was learning to look at the relationship differently. Er...and
that was just starting to create a fog a little bit, it was like we were, I couldn’t
separate myself from it, the therapy helped me to start to separate and to see that...perhaps he was being difficult in a certain way because I think I thought it was all me, I just didn’t know. Er...I don’t remember how, what other things changed, I think I was very self focussed you know because a lot of it was my own depression you know, I just needed that and he just kind of, very ...went through the motions of what was going on, so in the very beginning things didn’t change, I was getting a little bit...I can remember the process now because I’d go out and I’d have to have these fights again, cause then I could come in and talk to her about it and I would just be sobbing, not knowing you know, the pain that I would be in during, I just wouldn’t understand them and she’d help me kind of try to start to separate from them a little bit, so I think that had to happen in me before I could actually then do something.

R What happened when you did something about it?

I I can’t quite remember, ...I think, I can’t remember what happened when... I think my time line is a bit messed up it was so confusing. I remember trying to sit down with him, and gosh it must have seemed quite difficult, I kind of told him all the things that I thought were wrong, with him, and the relationship, which was really a bit mean but I didn’t know what else to do, I thought I had to voice what I thought and that was the only way I knew how to do it. And...then I think he told me stuff about me, which was quite painful. Wasn’t that helpful really. It was all, it was all kind of on a functional level we weren’t really talking on an emotional level, everything we did we just wanted time when we got home and we were just kind of stuck, not understanding each other and...so I tried to think like that and I remember trying to accept some of the things he said and try and find a compromise so we’d try and change things ...so when he came home from work not bug him about something, not start talking about dinner or something, or leave him sleep for a bit or things like that, er...
R Were these changes related to your therapy in anyway?

I I know that somewhere, because I would start to, you know and he’d er... and we kind of just went on and continued for a while, we were both happy to kind of ignore it, and I was feeling happier in myself and just learning to take a bit more distance from the relationship, and that in itself just helped because then I didn’t, I didn’t get so wrapped up in the fights, I think what would happen is then I could stop, where as before I couldn’t stop you know, and... and I’d be like Hmm and then I’d go back and we just went in circulars, we had the same fits over and over again it was just mind boggling. And...I think one thing that happened was that I did start to change and I would disengage from the fight, but it was very difficult because he’d continue, and I’d just have to stop. And...er...go to bed. Just go to bed, I wouldn’t...you couldn’t talk to him you had to wait until the next day and he’d always kind of say something nice, I think that always made it feel like oh it was okay, at least he kind of recognise it but er...he use to kind of, he’d be supportive and then he wouldn’t be, and he’d kind of put me down in a way, it certainly felt like that. So...again I was just trying to learn to not take it up so personally and that helped.

R And did your therapy help you?

I Yeah that helped me in that way.

R And you said that one of the self changes that started to occur after you started therapy, was that you became a bit more self focussed? And you mentioned some other changes as well, had your partner, ex husband, ever expressed an opinion about you changing at the time?
To be honest I can’t really...I’m sure he did. But I mean I, what I remember, if I remember anything its kind of er...this isn’t doing you any good. Kind of...you know, what’s this doing to you? This isn’t helping us.

You changing or the therapy?

Well I think he meant me changing because I’d been on therapy you still need to see her? Those kind of things...are you sure? Aren’t you okay now? You know those kind of comments. We tried...as a result of my therapy we actually tried marital therapy, and that wasn’t very successful. Er...but I do think, I remember him kind of accusing me of changing. Made it like a bad thing. I’m not the person he knew, and I wasn’t. But I didn’t think it was a bad thing and I think he did. Yeah...

So in this sense, would you say that your self-change affected your relationship?

Very much so, very much. Although I just felt that most of the change was happening on my side. That’s unfair I mean he did change, he was, I must admit I find it hard to kind of say how, but things evened out a lot and I think I did a lot of the work, but you know he would try and listen and try and understand. Er...what was the question?

Did your self change affect your relationship in anyway?

Yeah, it was affecting both, there was the relationship, I felt my interaction with the relationship was ...I didn’t feel that he kind of grasped as much of what was going on, he did on a functional level, in trying to explain himself and that was fine but I just never felt that still there was room enough for me...he couldn’t give me the support that I wanted and I was learning that, while I was trying to use what I learned from therapy to make changes in our relationship by interacting
with him differently. By trying not get involved with the fights, by kind of trying, suggesting that we could er…and also just kind of going on with life as well, we couldn’t just, we weren’t sitting around doing this everyday, kind of discussing our relationship. You just kind of wanted, I wanted to stick my head in the sand to a certain degree, I wanted to get on because it was much too painful to have to deal with it at the time. But but it did definitely affect, it did start to affect our relationship.

R And whilst you were in therapy did you notice any changes in the expectations you had about your relationship?

I Yeah. Em…it was funny I mean I think some went up and some went down, I mean realising perhaps that I was asking more of him than he could give, or perhaps I was being unreasonable in some ways and thinking well maybe do I really need that or can I get that elsewhere, do I always need to get it from him. Is there not some other way of doing this. And…er…I’ve forgotten..

R …changes in your expectations about the relationship

I Expectations of it, yeah so that was kind of something that perhaps releasing a bit of pressure on him but on the other hand…er…I think I tried to have expectations of him, interacting with our relationship, having more, giving more to me. I think in expecting less from men, having more balanced expectations from men. Later it then changed, I then realised that I wanted more than that, I wanted more than what was in that relationship. It was like I had to realise, I had to come to terms with what I could get from Mario first and then see, work with that and see how that was and then realise, later realise that that wasn’t enough. That I had changed and I knew something different. So…

R Was that near the end of your marriage?
Yeah. That was the end. That was very difficult actually. That was horrible...
Liberating but horrible in a way. That was much longer, it took about...well it
took 3 years, we lived for 3 years like that, we made some changes as well, you
know in our lives, er...and my goodness I even, I even felt, I was kind of thinking
well we've worked on this a bit things are a bit better, but they're not quite there
yet but I never know when they will be and it was too soon, kind of quick, and so
we even tried to have kids and er...thank god that didn’t, that just didn’t happen.
And I remember it was that panic that kind of, when I realised that I wanted to
leave the relationship. It was a real kind of action, push to realise that oh my
goodness you have to do this now?

So would you go through these thought processes and feelings with your
therapist? Would you talk about these things?

Yes I did definitely, I mean I remember, one of the things that I remember really
clearly was, you know for a long time, the thought that this marriage may end I
just couldn’t contemplate it was too er...important, on an emotional level for me.
And the fact of actually leaving somebody I just found incredibly difficult, I loved
him, and I knew how much it would hurt him but I couldn’t bear to be that person
to do that. But I remember, quite clearly, breaking down in to tears with my
therapist and saying, it was almost like I had to say it now, I had to say the
unspeakable which was: what if it doesn’t work out. I just couldn’t actually think
about before it was too hard to go there. And er...so I definitely, that became a
place where I could talk about these things. But I was never really encouraged
either way which was really good. It was like when I said that she took me
through it. She said well... what would happen if you did? And so rationally I
could look at it more as a possibility, you know and when I'd decide not to she
was supportive kind of either way and I never felt pushed to do one thing or the
other with her. But I'd always thought that. A lot of when I talked about in my
therapy was about the relationship and trying to sort that out. Mostly me, definitely mostly me, but for a while it was really mostly about the relationship.

R And I guess...so whilst you were in therapy you’ve mentioned that you started to be different in your relationship, you started to change things, er...would you like to say a bit more about it or if you can think a bit more about it in terms of how your thoughts were any different or your feelings? Or how your behaviour towards your ex husband changed, if it did? If you could give me any examples at all.

I Er...let me think. It’s a long time ago now. I mean I would certainly hate doing fights if it started up I kind of got this thing from her about saying well he’s difficult in that way, he takes this personally or whatever, and I use to kind of go through that in my head, it would be like a mantra, while the fight was going on because he’d still be sitting there having a go at me and I’d just have to sit there and I’d kind of nod my head but I wouldn’t engage, I wouldn’t engage with it, I would just kind of...it is difficult like this, this is his problem, you know, just not to take what he said personally er...

R So in a sense your thoughts were different and your behaviour because you would not engage ...in a sense they were different.

I Yeah and I think I tried to say things more and talk about how I felt about...what I’d have liked to do. Er...I would always seem to go along with what he wanted to do but we’d...er...like we went on a skiing trip and I’d try to become less uptight about things, money he spent loads of money, he earned loads of money so...but you know sometimes I just felt it was a bit extravagant and I think maybe I felt it was unfair, he’d spend lots of money and stuff but I wouldn’t do it on me, well I didn’t earn half as much as he...er...and I remember once trying to be a bit more relaxed about it, and he ended up buying me a holiday to go to this, he had this
connection in this big hotel so, it was X he booked this I think it was a one week
holiday, maybe it was two weeks I don’t remember, one or the other, makes a big
difference between it was 2000 or something, what? You can’t spend so much
money on tarararara sorry, it was something he had a choice and in the end he just
went for it, he said because this is what it was and I did it, some luxury holiday, it
was for me too you know but I kind of got angry, cause I felt he was irresponsible,
and then I thought, ...I was trying to be a bit less rigid and so I said
no...afterwards wait a minute well why can’t you just enjoy it, just go and enjoy
it? why not? and also while being there, though I didn’t want to go downhill
skiing because I just fell down al the time and its no fun anymore and I hit my
head and I was, I really don’t want to do this so I went cross country. So that
changed, so he went downhill skiing, and I’d go cross country skiing and before
he would have just blown a fit, not wanting to do that, so I must have kind of
talked that through with him. And say okay but I’d like to do it this way, I want to
do it differently to you. And he came one day and did some cross country skiing
with me, so he did, he would try and do things.

R  And would you say that this change that you noticed in yourself in terms of saying
what you wanted or...trying to understand your feelings, is this related to you
having therapy?

I  Completely related. All of this stuff is stuff I’ve talked through in therapy, it really
was, in my mind it was almost like a triangular relationship. Perhaps in his mind
too sometimes, but for me it was a huge crutch to talk through these situations, I
was learning things, it was like I was a little kid and just learning ways of dealing
with and finding my own rights in the relationship and I’d go back and I’d tell her
what happened and you know she’d be encouraging or whatever, and...so I mean
I’d say most of what happened was to do with that therapy, it was actually a big
part of it, I mean it did help. I think things got better because if I could start that
cycle then he could start and we could perhaps have er...try and talk about things
the next day in a way and I'd try and find a way to say things to him that wouldn't upset him. I was a bit resentful that I was doing all the work, but then he would, I felt that way, he would respond to a certain degree I think it was just...I wanted him to get up here near me...he couldn’t go as far as that, but I think he did change, and I believe it was this therapy, and I think in a way after a while he was quite happy about Amanda.

R Your therapist?

I Yeah I mean she was the third person in our relationship (laughing), and he’d be like oh are you going to see Amanda and, but then after a while he’d have a go at it, I couldn’t quite deal with that, with him, this back and forth stuff and that was a big pattern in this relationship he’d be supportive and then he’d get angry and he’d have a go and then he’d take it on, the things that were my weak point where I’d worry, and I did worry that I didn’t have the right to kind of ??? all the time. Er...so sometimes he’d be quite supportive but then often he’d get angry about something, he’d blame her. Although I never really talk about it...I'd give him little bits to keep him happy that were very neutral.

R About what happened during the session?

I yeah.

R And what you talked about?

I Yeah.

R Was he curious? Did he ask you?
I think he was curious but he didn’t really want to know, you know he’d ask in that kind of way of so... yeah, so what... did happen today? And... I think, he was curious but he did respect the boundary I think. I did.

R And you said at some stage you had some marital therapy together?

I Yeah.

R Had he ever expressed an interest in having er... personal therapy himself?

I No. I think he did as a threat. I’m going to get someone myself then you know, but it wouldn’t be anymore than that, so to me that expressed some desire perhaps somewhere in him and then after we’d split up, he didn’t do one on one therapy he did something else that was a bit bizarre but he did kind of seek some help. Er... but no he never, it was always, I think he was quite happy to keep er... that sort of blame on me... you know I was the one in therapy I have to carry that. I carried the sickness in the relationship in a way. I mean I wasn’t, he wasn’t pretending that I was the one causing all the problems, I think to a certain degree he would acknowledged that he was difficult but he would just say, well I’m an Italian man and I’m fiery and in a way, you shouldn’t take things so personally and to a certain degree he was right but you know when he blows up he kind of has a go at my soft spots and I didn’t take that very well I found that very hurtful, and I found it very difficult. But even the marital therapy I had to threaten to leave him to get him to go.

R And you said that as you started changing, at some stage you would notice that he would do things a bit differently as well, he would come cross country skiing with you for example..

I Yeah.
R Did you notice any other changes in him that you think might be related to your therapy and self change?

I Other changes in him?

R Mm...related to your therapy.

I Well I mean those kind of changes, is a broad category of me asking, finding a bit more of a voice, of what I want, and him...responding positively, I think that changed something in me, you know that helped me realise I wasn’t going to be shot down every time I asked for something, or even if something happened that I could fight for as well and I had a right to fight for it and this kind of thing, I think I just really...and I think I could run the show and I did and I didn’t. Em...what else can I add...

R Did his behaviour towards you change?

I (Silence) I think something changed. Don’t know. Not sure to be honest. Maybe a little bit, just inline with kind of...but...not that much. That was the problem. He didn’t change enough, it all just calmed down a bit er...

R Would you say that there were any changes in the opposite direction? Not only you know...

I That he got worse?

R Yeah.

I No I got worse.
R You didn’t notice many positive changes but something negative or what?

I No I saw positive changes, there was a positive change from it. Er...but I think in the end again it wasn’t enough. It did change but then I realised we kind of hit a plateau and we were on different grass but I don’t, I think he was, a bit...for all his childish antics he was quite respectful. In a way he was in other ways he...I think he was respectful, I don’t think he was supportive. And I think that respect bit came out you know when I was actually being able to go and see somebody and get help and go through this and it was quite a hard thing to do and I think he respected that I was doing it, but when it felt threatening to him he would then attack.

R So can you say a bit more about when it started to feel threatening for him, what was it that actually threatened him?

I He didn’t say, and don’t know from him, I can kind of...I think it threatened the relationship because I think he would see that it would change me and any change in me would threaten the relationship. I think it was more in the beginning where by he, you know there is a foreign element going on and he didn’t know what was going to happen here, the whole unpredictability of what could then happen...what are you talking about? Are you talking about me? Feeling insecure about that, feeling exposed in that way, er...and I think I tried to reassure him and say well I do talk about you, of course I do, things have been really difficult between us, I think you know that. But you know we don’t...oh is she telling you to leave me? And I'd say no she never said that. Its not about that, when she talks to me...and so I think that calmed his fears down a bit because I think he thought...and then I'd get upset, what do you think I'm going to just sit there and have someone tell me what to do, but then...you know...I think that's what he thought was happening, and I was going to go and be brainwashed and told what
to do and of course all the women get together and tell them to leave their husbands, that’s what it felt like for him. But I think it really was about me changing and what does that mean for our relationship so ultimately it was threatening to our relationship.

R If you take a moment, can you recall any therapy sessions or session during which your understanding about him changed or enhanced?

I Em...about him?

R Mm.

I Yeah well I mean I think the things that I...funny I don’t...remember specific details but there was definitely a feel...well it’s difficult in this way, he gets upset in this way, and maybe he was just getting angry and he’s just saying, and people say things when they’re angry and that kind of line of understanding was something that she took, so it was very ??? in this way and that I can connect with. It was reaffirming that someone else was saying that he was difficult, because I kind of thought he will blame me and I just didn’t know, who’s fault it was. But then also you know she kind of say well maybe he does say these things but he’s angry and...maybe it’s not that personal, so it helps me in that way. Er..those are the biggest things I remember.

R And if you take a moment can you recall any therapy sessions or session during which your understanding about yourself in your relationship changed or enhanced? Maybe you thought oh this is what I’m like in my relationship, I see...I didn’t know...

I [long pause thinking] I guess there was different things about...realising, you see I’d want things from him and like, its kind of well do you ask? And I wanted him
just to know I wouldn’t want to have to say anything and I had to learn that I could say to him... and after I didn’t think that I had any right which was kind of linked up to that as well. That I didn’t have the right to... which is why I get angry because I think I wouldn’t have the right and then I'd be angry at him for stepping on my rights but I didn’t... I'd get angry with him for stepping on my rights but I wouldn’t defend them I wouldn’t actually. I have rights to change my mind, its okay I’m not some evil woman. Er...

R So is this something that you found out about yourself?

I Yeah, that I had to be... more assertive. If I did want to get... and I was just really afraid, because he’d get angry, but I think also because at that stage, he’d get angry... and then I couldn’t handle it. Er... but also I just felt that I’d be rejected if I actually had and in that rejection was the rejection of me as a person not as a rejection of my request. Some people asked me and I was quite focussed, but I had to learn to separate that in my head.

R And did your therapy help?

I Yeah, yeah. It was quite you know a cognitive behavioural therapist, so I didn’t kind of... so we stayed on that more of a functional level but I think with that came an emotional understanding, you know ???. I don’t have to ask...[END SIDE]

R You mentioned the big shift in your understanding about your... on the one hand in trying to improve your relationship and then realising that maybe the best way is to end it as it would never become the relationship you would have liked it to be... Was their a specific session, is there a session that stands out in terms of, you know, understanding er... again, you gaining a better understanding of your relationship?
I don’t, the session I remember is the one I said before, where I kind of had this realisation that it maybe possible that I would go, there was actually a possibility and that was frightening, that I remember. I don’t think I remember, I remember when it happened in my life, but I don’t remember a therapy session. Which I was quite happy about in a way that it happened outside the therapy, it wasn’t a session that kind of, wasn’t ‘a’ session er…it wasn’t a therapy session actually, it was in my memory that was pivotal in terms of me leaving…doesn’t mean there wasn’t one but er…let me have a think…(silence) No because it was different, it was all the learning that I had done before about how the relationship, how we were in this relationship and working on that, and seeing improvement but then seeing it kind of stagnate I suppose, er…and leaving was more than kind of felt sense f it, actually it just popped one day, actually two things happened I can remember on two separate days. That it was, it made me realise that I couldn’t continue like this, it wasn’t…that inner self saying I can’t do this, I’ll die, I’ll have to die to do this, inside…and I’m not, I can’t do it. But that wasn’t in therapy, I brought it to therapy and therapy is instrumental in helping me remain sane and handle that process, which was very difficult. But the decision to leave didn’t happen in therapy.

R So it was something that …was discussed and gradually progressed to what you described.

I At that point therapy definitely supported me through the decision and my decision to leave was as a result of a lot of learning about me in therapy. And it was like I kind of taken that learning in my relationship and going off and doing it, doing it in the relationship and letting that kind of, move along and see how that went. But in parallel you know I was working on myself in therapy then, cause I continued in therapy for those years, so it became more focused on me in therapy and less on the couple, me in the couple, and him in the couple whatever. Em..but yeah no it definitely influenced.
We’re coming near the end. I was wondering what was your overall feeling about personal therapy, do you think that it might have caused any problems in your relationship?

Well yeah it caused some problems, but I don’t see them as bad things, I think they kind of caused immediate shake-ups, I think it gave me the strength to address things I hadn’t. That needed addressing you know for both of us in a way. Er...so in sense it did cause problems but it also helped it and like I say they weren’t wrong problems, they were things that needed to happen.

And what did you find helpful in dealing with these problems?

Therapy. Yeah it was mostly therapy because I found the people around me didn’t quite understand the kind of stuff I was talking about in therapy. Cause the way it was helping me conceptualise things differently. You know that didn’t, people didn’t quite, well my best friend didn’t quite get it, she was always supportive of me, and she’d remind me of the good things with Mario which is nice er...but er...you know it was kind of like, she was also a bit of a coach, I kind of felt like I was okay, okay lets look at it this way and I’d go away and I’d try things and I’d bring them back and I say oh my god this happened, I did really well and then...and then something happened that I couldn’t handle it, and I would blow up and I’d bring in the situations back in to therapy, this was the place that I could discuss what was going on and how he reacted, and how I reacted and what I said and what he said, and it helped me kind of pick it apart. Em...so the therapy was you know the place I brought all my marital problems.

And I know the marriage you’re talking about has ended, but have you ever you know, did you ever think that the personal therapy improved your relationship in anyway?
Yeah no it definitely did, it did get better. Its hard to kind of think that now, because in the end it kind of had to be bad to go, so there were other things that still happened, but...you know it did get better...certain things in it got better and...I always wondered whether it would have been even better if he was in therapy. But...he wasn’t, I don’t know, I don’t think it would have made that much of a difference anyway. But I...I think it, that it was good for a while, it did me a lot of good and it did help the relationship, even though it caused problems this thing that we had to work through to make things a bit better.

So can you give me a couple of examples?

Well like these fights and things, you know like having to, whenever I kind of stand up for myself a little bit there’d be a bit of a fight about it as well, so those were problems. Em...the stuff about him feeling threatened about therapy, I didn’t handle it well I just kind of brushed it off I just didn’t make a big deal out of it, I just felt well...no its not that, I understand that you may feel insecure about it, but its not that that’s bugging me and I think we’d see...we both saw that it was happening. Like I said he sometimes recognised that.

And what about your relationship then, when the marriage ended... did he express any views about...the end of the marriage in relation to yourself?

Funnily enough I don’t think he did, but I’m not sure...I don’t remember. It wasn’t a huge thing, he was very nasty but it wasn’t, it was all very well directed straight at me er...he may very well have I don’t remember, cause I think I blocked, just let it go over my head because I had to handle it that way because there’d be such a stream of stuff coming at me, he may very well have said something about it, but I don’t...
R Overall would you say that therapy had a positive or negative impact upon your relationship?

I That's a hard one to answer. From the relationship itself...I thought it had positive effects.

R But I know it sounds like a paradox but I understand from what you've told me because there was an end...

I Yeah although it ended, it ended and that was that. In the sense that it was painful but we wouldn't have made each other happy anymore, and you know I may still see that more than he does but I don't, I can't take responsibility for it, for him in his life and I made a decision but certainly I knew that I wasn't going to be happy and if I wasn't going to be happy then it certainly wasn't going to make him happy even if it felt safer just to stay in this relationship. So off I went, but in the mean time I think things did improve a bit. Em...but I think there were just some fundamental things that didn't change and had to do with...giving reasons for it, and understanding what I was doing, and I just thought I deserve that and for whatever reason he can't get better but yeah, it was difficult

R Is there anything else you would like to add?

I No I don't think so. Em...[long pause] no.

R Thank you.

END INTERVIEW
APPENDIX 3
Poster

RESEARCH INTO THE IMPACT OF INDIVIDUAL
PSYCHOTHERAPY UPON THE COUPLE RELATIONSHIP

Have you ever been in personal psychotherapy/counselling for at least 6 months?
Were you in a couple/romantic relationship or marriage prior to commencing and
during psychotherapy or counselling?

Would you like to talk about how your experience of the specific course of therapy
has influenced your romantic relationship or marriage?

My name is Tina Grigoriou and I am a trainee Counselling Psychologist at the University
of Surrey, conducting a research study which looks into how individual psychotherapy
might influence close couple relationships including marriage. I would like to hear your
views on how having been in therapy has influenced a present or past relationship of
yours. You can also talk about relationships that ended whilst you were in therapy. The
course of therapy you will be talking about must have been completed and must not have
been provided through the NHS

Interviews will last approximately an hour and will be arranged at an agreed time and
place. All information will be handled in accordance with the Data Protection Act 1998.

If you would like to participate, please E-mail Tina on:
S.Grigoriou@surrey.ac.uk or call on: 01483 689176

Department of Psychology, School of Human Sciences, University of Surrey,
Guildford, GU2 7XH
PARTICIPANTS WANTED FOR RESEARCH STUDY

Have you ever been in personal psychotherapy or counselling for a period of at least 6 months?

Were you in a romantic relationship or married prior to commencing and during therapy?

My name is Tina Grigoriou and I am a trainee Counselling Psychologist at the University of Surrey, conducting a research study which explores how psychotherapy might influence close couple relationships.

Would you like to talk about how your experience of personal therapy has influenced your romantic/couple relationship or marriage?

Interviews will last approximately an hour and will be arranged at an agreed time and place to suit you.

All information will be confidential and will be handled in accordance with the Data Protection Act 1998

If you would like to participate, please E-mail Tina at:
S.Grigoriou@surrey.ac.uk
Or call on: 07900 890969 (Tina), 01483 689176 (Course Secretary)
Department of Psychology, School of Human Sciences, University of Surrey, Guildford
APPENDIX 5

Flier

RESEARCH INTO THE IMPACT OF COUNSELLING OR PSYCHOTHERAPY
UPON CLOSE ROMANTIC RELATIONSHIPS OR MARRIAGE

Have you ever been in personal psychotherapy or counselling for a period of at least 6 months?
Were you in a romantic/couple relationship or married prior to commencing and during psychotherapy or counselling?

Would you like to talk about how your experience of the specific course of therapy has influenced your romantic relationship or marriage?

My name is Tina Grigoriou and I am a trainee Counselling Psychologist at the University of Surrey, conducting a research study which looks into how psychotherapy or counselling might influence close romantic/couple relationships including marriage. I would like to hear your views on how having been in therapy might have influenced a present or past relationship of yours. You can also talk about relationships that ended whilst you were in therapy. The course of therapy you will be talking about must have been completed and must not have been provided through the NHS.

Interviews will last approximately an hour and will be arranged at an agreed time and place to suit you. All information will be handled in accordance with the Data Protection Act 1998.

If you would like to participate, please E-mail Tina on:
S.Grigoriou@ac.uk or call on: 01483 689176

Department of Psychology, School of Human Sciences
University of Surrey, Guildford, GU2 7XH.

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Dear Participant,

My name is Tina Grigoriou and I am a trainee Counselling Psychologist at the University of Surrey, conducting a research study which looks into how individual psychotherapy/counselling may influence close couple/romantic relationships including marriage. I would like to hear your views on how having been in therapy has influenced a present or past relationship of yours.

Previous research into the effects of individual therapy on the couple relationship focused on examining the views of those individuals whose partner had been in therapy. However, there has been very little research done to investigate psychotherapy clients’ views on how therapy affects their close couple relationships and how they manage any relationship shifts and changes related to psychotherapy. The reason why I am undertaking this research is because I am particularly interested in exploring the views and experiences of therapy clients.

I hope that this research will help individuals who are in a relationship and seek therapy to consider the possible impact of individual psychotherapy upon their relationship and how this could be managed. Moreover, this research could enhance therapist’s understanding of the impact of therapy on their clients’ relationships so that possible relationship problems are worked through within therapy and -when necessary- other forms of therapy such us couples therapy are recommended.

In order to conduct this study I am seeking individuals who were in psychotherapy or counselling for a minimum period of six months and had a close heterosexual relationship or were married for at least 12 months prior to commencing therapy. Participants can talk about relationships that have ended, however a period of 6 months should have elapsed between their relationship break-up and the date of the interview. Participants must not
have been (or have been in training to become) psychotherapists, counselling psychologists or counsellors at the time that they were receiving the course of therapy that they will be asked to reflect upon. It should also be noted that participants may only talk about a course of therapy that has been completed or will have been completed by the date of the interview. The specific course of therapy must not have been provided through the NHS.

If this applies to you and you would like to volunteer for the research then I would like to speak to you over the phone just to make sure we both think it’s the right time for you to do this. If we agree to proceed then we can arrange a face-to-face interview which should last approximately one hour. The interviews will be audio recorded, and then verbatim transcribed and analysed. Participants’ identity and those of whom they speak will remain confidential and all information will be handled in accordance with the Data Protection Act 1998. I would also like to inform you that participants have the right to withdraw at any time from the study without having to give any reason, as their participation is strictly within a voluntary capacity.

Finally, I would like to bring to your attention that your participation in this study may involve the reflection and re-evaluation of personal experiences, which could potentially evoke negative feelings. To this end, at the end of the interview you will be advised of a broad range of additional support networks that you can access if you wish to talk further.

I suggest that you think carefully about your feelings in regard to taking part in this study and possibly discuss it with close friends/relatives. If you decide you want to take part, find out more about it, or arrange a meeting in which we can discuss the research further then please ring me on 01483 689176 or e-mail me at S.Grigoriou@surrey.ac.uk.

Kind Regards,

Tina Grigoriou, Counselling Psychologist in training.
APPENDIX 7
Telephone Screening/Assessment Procedure⁶

(Offer to ring participants back so that they are not paying for the call)

_Broad areas to cover (in conversational tone, this is NOT an interview)._ 

_Introduce myself and the research_; My name is Tina Grigoriou and I am a trainee Counselling Psychologist at the University of Surrey, conducting a research study which looks at how individual psychotherapy might influence close couple relationships, including marriage. I would like to hear your views of how your experience of psychotherapy has influenced a present or past relationship of yours.

_Explain the commitment that interviewees have to make_; you should be willing to attend an interview in the next x weeks that will last approximately an hour, although the length of the interview will really depend on how long you need.

_Exclusion criteria_; Unfortunately, I cannot involve anyone who has been diagnosed with a psychiatric illness or who feels vulnerable and in crisis at the moment. I would also like to inform you that you can talk about relationships that have ended. However, a period of 6 months should have elapsed between any relationship break-up and the date of the interview. Moreover, the course of therapy you intend to talk about must have been completed. You don’t need to tell me more about it if you are not comfortable with it but perhaps one of these criteria apply to you?

_If yes:_ Explain that unfortunately I cannot invite them to take part. Thank them for their time and interest. Mention that I am aware that they have taken the trouble to make contact and might feel disappointed not to be offered an opportunity to tell their story.

⁶This telephone screening procedure that was originally devised by Dr Olivia Thrift (as part of her research project for her PsychD in Psychotherapeutic and Counselling Psychology at the University of Surrey) has been adjusted by this researcher so that it could be applicable to the present study.
Ask if they would like me to give them some information on services they can get in touch with. Take some time over this so that they do not feel ‘brushed off’.

*If no:* Just so we can make sure that this is the right thing for you to get involved with, do you mind if I ask you a few questions? Do you have some privacy now for us to talk for a bit? If not arrange a time to call her back.

**Questions**

Maybe you can start off by telling me something about why you’ve responded to my letter?

Is there anything in particular you are hoping to get out of taking part?

*Watch for signs of wanting therapy*

*Research not therapy:* It is imperative that you are clear that what I’m inviting you to be involved in here is a piece of research and not therapy. That means that whilst I’ll be taking care to ensure the well being of interviewees, I’m not offering anything long-term, and being interviewed might not be the right thing for you to get involved in at this time.

Do you have friends and other supportive people in your life that you feel comfortable in talking to and leaning on in times of need?

*Note caution if the answer is no or there are covert signs that support is not all it could be*

Could you talk to him/her/them after the interview if you needed to?

*Note caution if there is hesitancy, deliberation or the answer is no*
Are you in therapy or counselling at the moment? 
*If yes:* That’s great in that if you do take part you have somewhere to take any upsetting or traumatic feelings that might be raised.

How do you feel about taking part in research like this? Do you have any reservations or worries?

The interview will be conducted sensitively and will be pretty flexible in terms of letting interviewees decide what and how much they want to say. I hope they might be of some benefit to those taking part. However, there is a possibility that talking about an experience like this could trigger unexpectedly powerful emotions. *(Do they seem able to hear that?)*

If you did decide to take part and you became upset, how would you like me to respond?

**Concluding the call if deemed suitable:** I won’t be starting interviews for about another x weeks. However I think it’s important that you have a few days to think about the things we have talked about just to make sure that you are comfortable with taking part or you may decide that you want to give it a miss. So if it’s ok with you, can I give you a call in a couple of days?

**Concluding the call if deemed unsuitable:** Thank them for getting in touch and for showing an interest. Say that on reflection I’m wondering if this might not really be the best thing for them to get involved in at present. Mention that I am aware that they have taken the trouble to make contact and might feel disappointed not to be offered an opportunity to tell their story. Ask if they would like me to give them some information on services they can get in touch with. Take some time over this so they do not feel ‘brushed off’.

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Changes and developments in the relationship

So you started therapy x (information in the questionnaire) years ago, could you describe what your relationship was like before you started therapy?

What was your relationship like during the first few months of therapy? (If participants report any relationship changes or developments explore how they are linked to therapy).

What was your relationship like as you approached a year in therapy? (If participants report any relationship changes or developments explore how they are linked to therapy)

Whilst in therapy, was there a specific moment when you thought that your relationship might be changing? (If yes) Could you describe what happened?

If the participant noticed any changes: What would you attribute these changes to?

How do you understand these changes?

Participant’s change

So you had been in therapy for x years/months. Did you notice any changes within yourself during that time? (Don’t encourage them to talk in detail about the specific changes at this stage)

(If yes) Had your partner ever expressed an opinion about you changing? (If yes) What was it?

Did your self-change affect your relationship in any way? (If yes) How?

Whilst you were in therapy, did your expectations about your relationship change? (If yes) How?

Whilst you were in therapy, did you notice being any different in your relationship?

(If yes) In what way were you different? (explore whether their thoughts of, feelings for and behaviour towards their partner changed/ask for examples)

Was he/she aware of these changes (in your feelings/thoughts/behaviour)?
(If yes) Did he/she react to these changes? (If so, how? Ask for an example)
How did you deal with these reactions?

**Partner’s change**

Whilst in therapy, did you notice any changes in your partner that you think might be related to your therapy and self change?
(If yes) Would you like to talk about these changes? *(encourage to talk about partner’s observed or perceived change/look for links with therapy/ask for examples)*
How did these changes in your partner affect you?

**Partner’s views on participant’s therapy**

Has your partner expressed an opinion about your therapy? (If so, what was it?)
Has your partner expressed an opinion about your therapist? (If so, what was it?)
Did you use to discuss what went on in therapy with him/her?
Was he/she interested to know more about your therapy?
Had he/she ever expressed an interest of having therapy himself/herself?

**Significant moments in therapy that had an impact upon the relationship**

If you take a minute, can you recall any therapy sessions during which your understanding about your partner changed or enhanced? (If yes) Can you say a bit more?
If you take a minute, can you recall any therapy sessions during which your understanding about yourself in your relationship changed or enhanced? (If yes) Can you say a bit more?
If you take a minute, can you recall any therapy sessions during which your understanding about your relationship changed or enhanced? (If yes) Can you say a bit more?
Evaluation of the impact of therapy on the relationship and exploration of coping strategies for dealing with any negative impact

Has your personal therapy caused any problems in your relationship?
(If yes) Can you talk about them?
What did you find helpful in dealing with these problems?
Has your personal therapy improved your relationship in any way?
Overall did therapy have a positive or negative impact upon your relationship?

Is there anything else you would like to add?
Prompts:
What makes you say that?
Can you think of an example?
APPENDIX 9
Therapy contacts: list of supportive resources for participants

Below is a list of supportive resources (telephone help-lines and counselling services) in case you experience any distress by taking part in this interview and you feel that you need help.

**Telephone help lines:**

Samaritans: 0845 790 9090
Sane Line: 0845 767 8000

**Counselling Services:**

Mind (voluntary organisation):
0845 766 0163

London Centre for Psychotherapy:
020 7482 2002

British Association for Counselling and Psychotherapy:
0870 443 5252

You can also contact your GP and ask him/her for a referral to your local counsellor or psychotherapist.
APPENDIX 10
Consent Form

I understand that this is a qualitative study being conducted by a trainee counselling psychologist, Tina Grigoriou, as part of her studies for a Practitioner Doctorate in Psychotherapeutic and Counselling Psychology. This study examines psychotherapy clients' perceptions of the impact of individual therapy upon their couple relationship. I have been informed that the study involves a one hour semi-structured interview, during which time I will be interviewed on an individual basis.

I have been informed that the interviews will be audio recorded, and then transcribed verbatim. I understand that the resulting content of the tapes will be analysed and reported and that the tapes will be kept in a secure place and erased when the Practitioner Doctorate is complete in September 2007. I further understand that these findings will be presented in a written report that will be submitted in partial fulfilment of the course requirements and that this report may be published in an academic journal. It has been made explicit to me that extracts of these transcripts will be presented within the report but that all identifying features will be removed to protect my confidentiality.

I have been assured that my identity and those of whom I speak about shall remain confidential and all information will be handled in accordance with the Data Protection Act 1998. I understand that I need to be responsible for ensuring the confidentiality of third parties and should not reveal information, which could potentially lead to their identification. I fully understand the limits of confidentiality, in that the disclosure of information about a serious risk of harm to myself, or others will result in the need for the researcher to inform appropriate others.

I have been advised that my participation in this study involves the reflection and re-evaluation of personal experiences, which could potentially evoke negative feelings. In
response, I confirm that I have been advised of a range of additional support networks that I can access and have been provided with relevant information and literature.

I understand that at any time during the study I have the right to withdraw, as my participation is strictly within a voluntary capacity.

I give my informed consent in relation to all above aforementioned and to be interviewed by Tina Grigoriou.

Participant’s Name .................................

Signature........................................... Date..............................................

Researcher’s Name.................................

Signature........................................... Date..............................................
APPENDIX 11
Background Information Questionnaire

Thank you for participating in this research study. I would greatly appreciate it if you could complete this questionnaire as I would like to get some basic information about you (such as your age, education and occupation). The reason I would like this information is so that I can show those who read my research report that I managed to obtain the views of a cross-section of people. The information that you give will never be used to identify you in any way because this research is entirely confidential. However, if you don’t want to answer some of these questions, please don’t feel that you have to.

1. Are you (tick the appropriate answer)

   Male __   Female __

2. How old are you?  [ ] years

3. How would you describe your ethnic origins?7

   (a) White

   British ___

   Irish ___

   Any other White background, please write in below

   ________________________________________________________________

7 The format of this question is taken from the 2001 UK census.
(b) Mixed

White and Black Caribbean  
White and Black African  
White and Asian  
Any other mixed background, please write in below

(c) Asian or Asian British

Indian  
Pakistani  
Bangladeshi  
Any other Asian background, please write in below

(d) Black or Black British

Caribbean  
African  
Any other Black background, please write in below

(e) Chinese or other ethnic group

Chinese  
Any other, please write in below

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4. What is your highest educational qualification?  
(tick the appropriate answer)

None __________
GCSE(s)/O-levels/CSE(s) __________
A-level(s)/AS-level(s) __________
Diploma (HND, SRN, etc.) __________
Degree __________
Postgraduate degree/diploma __________

5. What is your current occupation (or if you are no longer working, what was your last occupation)?

6. What is your current legal marital status  
(tick the appropriate answer)

Single __________
Married __________
Divorced/separated __________
Widowed __________

7. a) Do you have any children?  
(tick the appropriate answer)

Yes ___ (go to part b)  No ___ (go to question number 8)

b) How many children do you have?  [   ]

Thank you
APPENDIX 12
Example of initial coding: Lara’s interview

Factual info

Both working (25-26).
Spent time together every evening, eating in, going out (26-31).
Well off (28-29).
5.5 years in the relationship/ 4 years married (4-7).
Power differences (money) (362-366).

Relationship prior to therapy

Initial Phase of the relationship

Happiness (37-38).
Feelings of dependence (39).
Security (39).

Triggers of marital problems

Changes in work status (participant started work) (40-45).
Stress-Not feeling supported (45-46), (52-54).
Partner feeling responsible for participant’s unhappiness (46-49).
No containment (47-51). Feeling unhappy (49-51).
Cultural differences (465-471).
The above resulted in having **FIGHTS**

Fights/not making sense/fear of going mad (not making sense)/repetitive arguments/no control (12-17), (57-63).

**Process of arguing:**
Not knowing where the arguments come from. For example: disagreement (trigger of argument)/emotional response (annoyance of partner)/behavioural response (aggressive questioning)/no control over the argument/feeling not listened to resulted in annoyance/anger/disappointment/confusion (17-33).

**Relationship after commencing therapy**

**Reasons for starting therapy**
Dissatisfaction with work (67-102).
Self-discovery (72-76).
Career change (77-102).
Unhappy in marriage (103-105).
Feeling lonely and unsupported (105-109).
Feeling desperate (107-112).
Looking for support and understanding (112-124).

**Partner’s reactions to participant’s therapy**
Curiosity (135-136), (442-444).
Defensiveness (136).
Fear, feeling threatened (136), (455-460), (532-539), (553-555 about participant’s change), (718-723).
Unpredictability (538).
Paranoia. Are you talking about me? Is she telling you to leave me? (partner needed reassurance) (538-543).
Insecurity (539-541).
Feeling exposed (540).
Feeling ganged up on (542-552).
Happy about therapist when there was some improvement (414-415) but also ambivalent angry and accusatory, blaming therapist when things went wrong (419-430).
Disapproval (218-221).
Therapy is not helpful (221).
You are not the person I knew (different view: she thought it was a good thing but he didn’t) (231-232).
Curious about therapy but respecting the boundaries (44-445).
The one in therapy carries the sickness in the relationship (460-463).
When their marriage ended he possibly expressed anger towards therapist but the participant had no recollection (729-735).

**Sharing information with partner**
Not sharing how unhappy she felt at the beginning of therapy (137-144).
Careful disclosure about therapy content (429-430).

**Effect of therapy upon the participant**
Self-change (652-657).
Looking at relationship differently (142-144).
Start making sense by separating self from the problem (157-160).
Acknowledging partner’s responsibilities and faults (571-577).
Not engaging in fights (186-192), (406-409).
Not taking things personally (204-206), (576-577).
Realised partner’s lack of support (252).
Expressing own wishes (358-389).
Keeping an open mind (361-366).
Contemplate divorce (311-322).
Having a space to explore possibilities without being encouraged either way (therapist’s neutrality) (311-333).
Not feeling persecuted (565-577).
Becoming assertive and feeling empowered (585-596).
Acknowledgment of fears of rejection as a person (600-607).
Finding her own voice without fearing rejection (488-495).

Effect of therapy upon partner
Tried to listen to her (242).
Tried to understand her (243).
Responding positively at times to her (488-490).
Behavioural changes (i.e. went cross country skiing with her) (378-389).
He became respectful of her efforts to seek help (522-527).
He felt threatened by therapy and then became attacking (425-427).
Acknowledgment of own responsibilities (465-471).
BUT
He changed but not enough (411-415), (500-503), (517-520).

Changes in expectations as a result of therapy
Having more realistic expectations (268-270).
Considering other resources (271-273).
Realisation of own needs and adjusting the expectations accordingly (278-289).
Self change leading to different expectations (that were not met) leading to the end of marriage (285-289).

Relationship Shifts/Process

No shifts at the beginning of therapy/fights continued (150-160), (192-196).
Participant recognising difficulties (130-131) BUT
Partner sticking his head in the sand (131-133).
THEN

Explicit communication about relationship problems (164-177).
Voicing own views about the partner and the relationship (164-177).
Exchanging views but on a functional level AND trying to find solutions-practical changes (176-182).
Interacting with him differently so that she doesn’t get involved in fights (247-255), (406-409).
Not getting wrapped up in the fights through not taking things personally (186-192), (343-352).
Not thinking about the problems all the time (255-263).
Expressing own wishes and partner being responsive to some degree (358-389).

BUT

Relationship improved because participant felt happier in herself through making sense of the problem-separate herself from problem-not taking things personally-not getting wrapped up in the fights/disengage from fights (196-206) (change in the process of arguing described above). She found different ways of saying things so that she would not upset him (406-409). Finding her own voice in the relationship, becoming more assertive (488-495). This period was only seen as a calming down period (502-503).

EVEN IF

There was some positive change, it was not sufficient for sustaining the marriage (297-305), (500-503), (517-520), (634-639), (746-758). Participant felt resentful for doing all the work on her own (406-409) [Probably she implies she would have liked him to start therapy too /they tried marital therapy but it was not effective]. New expectations related to therapy were not met (285-289). His changes were not sufficient (411-415).
Participant realised that she wanted to leave the relationship (293-305). Working in therapy on contemplating divorce (311-322) [here, therapist’s neutrality was highly valued 322-326]. Therapy facilitated exploring other possibilities i.e. divorce (324-329). Therapy enabled understanding about self and helped managing separation (645-647). In therapy she felt supported when she made the decision to separate (652-654). Therapy gave her strength to address things (677-673).

FINALLY

Wondering if the relationship would have survived if partner was in therapy too (700-706).
Therapy seen as having contributed positively to the relationship and to separation (729-758).

**Participant’s explicit views of the impact of therapy upon her relationship**

Therapy as the main support (396-406) (678-694).


Acknowledging that “I’d say most of what happened (in the relationship) was to do with that therapy” (404-406).
APPENDIX 13
Example of constructing a theoretical category

Improved Communication

Therapy improved communication through:

- Talking things through

Therapy allowed more space for talking/discussing problems and finding solutions:

Yeah I think by trying out different ways of communicating through talking about things in my therapy, it then became obvious to both of us that that really worked, cos I’m...I’m half X nationality blood in me makes me very very, I get angry very quickly and I calm down very quickly. And in the past I’ve often just got angry and calmed down and I apologise quickly but this has helped me to kind of understand it and its helped him to see that it really works if I’m angry its always for reason, and he’s very analytical and so he’s seen that, and so he’s learnt that its really good if we talk about it. So its,...it really is, it’s a systemic thing, that both of us have been learning together. (Helen)

Changes is very subtle, its almost like you can look back and say what’s changed, and if I look back now I think I get angry a lot less than I use to, we communicate better, I don’t know how much that’s to do with therapy, I think probably a lot of it is, because we were together 3 years before. (Helen)

- Using new concepts increased understanding of each other

...one day I was having a slight argument with him, quite early on in therapy and he didn’t answer me, and I said to him why do you have to spend so much, why can’t you

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8 The particular category is offered as an example because it was not presented in the research paper due to word limit restrictions.
just answer me, why have you got to spend so long before you can even answer a question, he said its because I've got this sub personality who's like Alistair Campbell and he had to vet what all the other ones, he had to look at what each of them said and then has to decide which is the best answer to give. And of course I just roared with laughter, and this dispelled all the anger that was around and also its really helped me now because I understand him so when he has these long silences, I think he is really going through a process, sort of vetting things and it was just wonderful how, he's not studied it, he's not been in therapy and there's him talking about his sub personality so that...really lovely. (Helen)

- Finding new ways (more productive ways) of communicating

...so I mean I'd say most of what happened was to do with that therapy, it was actually a big part of it, I mean it did help. I think things got better because if I could start that cycle then he could start and we could perhaps have er...try and talk about things the next day in a way and I'd try and find a way to say things to him that wouldn't upset him. (Lara)

- BUT when there is not a relationship to begin with and there are issues involving shame and early unresolved conflict it may stop communication. For example John became self-focused and saw any communication as disruptive:
  Yes I just didn’t have time for anybody else, er...rather than me and I was going to be the only person I had to concentrate on and I did. (John)

- Expressing needs clearly and not impulsively

...rights and my wishes...it did, that's another...you know more general sort of benefit it had for me, which had a good affect on the relationship was that I felt stronger and more clear about what I wanted and what I didn't want, able to express that more clearly without the anger and the emotion. (Steve)
• Becoming a better listener through being less defensive and willing to hear and process information

Less opinionated I would say, definitely, yes less opinionated and working towards being less defensive and you know listening, had a lot to do with it, because I think I spend so much time in therapy talking, I didn't need talk quite so much and I could actually listen. Er...and then take it in and process it a little more...more time for thinking. (Nancy)

Yes er communicating more, just by the fact that I think he knew that I was working towards listening and not being defensive, it would give him an opportunity to express himself. Yeah.

R Em...and how were you affected by him changing?

A Very well, it was good because it was just sort of...a softening of our communication in general and an admittance that you know, we're vulnerable so that was very good. It was weepy, a bit of a weepy time (laughing). But it was good. (Nancy)

...so I would say it softened our communication quite a bit and there was also an admission on my part that I didn’t have all of the answers, or necessarily know everything. And I did possibly prior to that, we were two very strong wills and we were two strong wills together often but then if it ever came that we were opposing each other er...there was a lot of flexibility, so therapy allowed flexibility for me to look at maybe some of my own issues, in how I may be projecting this on to our relationship. (Nancy)

• James attributed the decline in his relationship to poor communication prior to his therapy. There was a sense that the damage was irreparable:

Getting greater understanding of what was going on inside me. And also exposing some of those gaps in the relationship you know we need to talk about the abortion and what
that meant to me, the fact that children were very important here and I had destroyed them, but pretend it was a very insignificant thing. (James)

- **Improved communication generates increase in mutual understanding**

I wouldn’t say it was much much more better because I...because it was quite difficult to communicate with my partner, but we did, and it would work but...I mean we work on it and it was very difficult to really understand each other, so we talk, so I’m not saying that at the end of this therapy it was like everything was fantastic no, it was better because we tried to understand more each other, but...it’s slightly better yeah. (Maria)

- **Therapy facilitated the understanding of unhelpful behavioural patterns impeding communication, understanding instigated change:**

I was thinking when I have a problem I run away and I mentioned to my partner and he said, yeah, actually you leave me like er, you make a decision to finish the argument and that’s it and so helpful for me and for you and for both just to stay and try to be more er...communicative...(Maria)

- **Being more open and self aware (trusting) increased opportunities for communication and cements trust:**

I mean I thought about it the way that we communicate, the difficult way, that’s...a very very, it was very-very difficult for us to communicate and I don’t say that after that it was easy, because it’s a process anyway but after that I felt that er...I thought that inside him, in his heart this guy is good, this guy is a good person and maybe we have er...problems to manage our feelings but inside, deep inside, this guy if he listened to me about these that he wanted to help me, this is a good man. (Maria)
Through feeling in control Bonnie could react differently in fights; thus the patterns of fights changed and more verbal communication took place instead:

Em...in a way it was good because ...I think he realised then what he was doing which was to, cause that was always his way, was to shout and ...louder and louder sort of intimidate, push-push-push, and I would just go I don’t care, you can shout as long as you like. And in fact that kind of helped, us being able to start to talk to each other in a better way. (Bonnie)
MEMO on Relationship with own Self/ Self-change/ Self actualisation
(Ultimately, this memo informed the theoretical category of behavioural and emotional change)

Things to bear in mind in the analysis: Can self-change be tolerated in a relationship? Under what circumstances does it have a positive or negative impact upon the relationship? Note: a positive impact is not always associated with maintaining the relationship. Ending of unfulfilling relationships was seen as a positive effect of therapy. Think about self-change with a specific focus on its impact upon the relationship.

Analysis of the interviews showed that participants appeared to develop a better relationship with their own self as a result of therapy (i.e.increase in self esteem). They felt more empowered to voice their views and needs and felt less persecuted by others through not taking things personally. For Lara, this would reduce arguing with her husband. However, this was not enough to sustain the relationship as a change in her self brought some changes in her expectations of her marriage. These expectations were never met. For Lara though, being attuned to her inner self was regarded as more important rather than sustaining an unfulfilling relationship:

It was like I had to realise, I had to come to terms with what I could get from Mario first and then see, work with that and see how that was and then realise, later realise that that wasn’t enough. That I had changed and I knew something different. (Lara)

At that point therapy definitely supported me through the decision and my decision to leave was as a result of a lot of learning about me in therapy. And it was like I kind of taken that learning in my relationship and going off and doing
it, doing it in the relationship and letting that kind of, move along and see how that went. But in parallel you know I was working on myself in therapy then, cause I continued in therapy for those years, so it became more focused on me in therapy and less on the couple, me in the couple, and him in the couple whatever. (Lara)

Therapy helped Helen to get more in touch with her self and realise that she is a worthy person. This increased her self-esteem and generated positive changes in her relationship. As her relationship was good prior to commencing therapy there was a fear that self change could drive her and her partner apart. This fear was expressed many times throughout her interview.

For John, a victim of childhood sexual abuse, therapy helped him to explore his sexual identity and to develop a better relationship with himself. Through understanding where his problems stemmed from and through acknowledging his needs and desires he felt empowered to voice his views and become his own person without trying to please others as means of avoiding rejection. This led him to end his marriage. The divorce was seen as a positive outcome of therapy as John felt trapped in that marriage through being in a non-loving relationship. In addition to this, therapy opened a window for exploration and acceptance of his sexual identity as a gay man.

Participants valued being in touch with themselves and developing a good relationship with themselves. For Helen though, there was a fear that an internal change through therapy could have a negative impact upon her relationship:

...things I mean, that I couldn’t, I worried a lot as well in the middle of the therapy, maybe I still worry about it now, I don’t think I do actually, but I worried that I would change through the therapy and that I wouldn’t love him any more, and I was very worried about that because actually here I’ve gone in to therapy at a time when I feel my relationship is really strong and we’re getting married and what would happen if that suddenly I found deep in myself a different side and I
started questioning my relationship with him, which obviously isn’t perfect and I thought …so I was quite worried about. (Helen)

Having split up during therapy, Nikki was worried about the impact of self-awareness on her future relationships:

That therapy might bring up things that are relevant to the relationship or things that are relevant to me personally which means the way I view our relationship may change, because my view of self or the world changes, so I had to be honest with him and say this is a risk for both of us, but I knew I wanted to do it and had to do it. (Nikki)

The following quotations demonstrate some of the above points.

**Becoming assertive and feeling empowered**

I guess there was different things about…realising, you see I’d want things from him and like, its kind of well do you ask? And I wanted him just to know I wouldn’t want to have to say anything and I had to learn that I could say to him…and after I didn’t think that I had any right which was kind of linked up to that as well. That I didn’t have the right to…which is why I get angry because I think I wouldn’t have the right and then I’d be angry at him for stepping on my rights but I didn’t…I’d get angry with him for stepping on my rights but I wouldn’t defend them I wouldn’t actually. I have rights to change my mind, its okay I’m not some evil woman. Er… (Lara)

Em…and yeah I probably wouldn’t have the courage to do that so the counselling, and that generally not just from this suggesting but generally the counselling was helping me deal with my issues of feeling like a victim and feeling like I didn’t have the right to stand up for what my rights and my…wishes… (Steve)
Well, yeah er...I think to a lesser extent to the things I’ve just been talking about but certainly getting my ideas on the practical level sorted out and also the, being clearer about what I want, er...more resolute and steadfast basically and er, expressing that better and also being able to say no more, which has always been a bit of a difficulty for me, I find myself trying to say yes to everyone and everything that I was expected to do by my wife but also in life outside generally I was able to start saying no, and...simplifying my life both outside the home and in the relationship and er, which meant I was not spreading myself so thin and I was able to meet more of her expectations. (Steve)

Finding one’s own voice without fearing rejection

Well I mean those kind of changes, is a broad category of me asking, finding a bit more of a voice, of what I want, and him...responding positively, I think that changed something in me, you know that helped me realise I wasn’t going to be shot down every time I asked for something, or even if something happened that I could fight for as well and I had a right to fight for it and this kind of thing, I think I just really...and I think I could run the show and I did and I didn’t. (Lara)

I don’t want to disappoint people, now I don’t need to do that because I know even if I say no...it's not going to make me a bad person where as before...

R So this is something you noticed.

A ...yeah...I lost a lot of my self esteem completely because of this abuse thing that happened when I was a child but...so everything was my fault that’s how I felt. Especially subconsciously so...therapy helped me to be like this...I don’t feel that...(John)
Self acceptance

Yeah, sort of learning about how you relate to other people in the groups group, so I kept thinking well I’ve got to be quieter I’ve got to be calmer, and one day my therapist I was talking to her about it and she said in my experience these groups, what you do you go along you be yourself and you see what happens, and somehow that just realised something in me to stop worrying about changing myself so I went to the group and I just was myself. I cried and I was angry and I talked too much, and I wasn’t calm and I suddenly realised that it was fine and that sometimes I talked too much because I had really useful things to say, I was older than these people in the group and its been absolutely life changing for me because I suddenly realised that I’m okay, I’m not only okay, I’m just fantastic just as I am and that’s been completely astoundingly real life changing for me. And I don’t think that would have happened without the two things together so…(Helen)

Yes I don’t, looking back I think therapy was enormously important for me, er…my understanding of myself, of my own needs, and my weaknesses, of being kind to myself and acknowledging that you know, that I’ve done okay, through all these different sort of episodes. I don’t now, I don’t blame my husband but its…that was good from the therapy point of view that in the end it wasn’t, it wasn’t my husband’s fault that I was in pieces that was totally something that er…was happening to me through my own life history, it wasn’t anything to do with him. (Bonnie)
Becoming one's own person

Do you think your self change has affected your relationship in any other way?

A Mm... (long silence) not sure it has, but its hard to say... its difficult to answer this question without actually being cruel to someone because its not just me in therapy, but the course I'm on its in a group and we meet in a group regularly and I felt that it's a combination of the two, that that... the biggest effect. This is also very difficult to extract. I think the most powerful affect I've had in therapy hasn't been to do with my relationship with my partner its been to do with my relationship with myself and this came about putting the two things together. I was in the group and I was sort of finding it... I was thinking I'm never quite sure what I'm supposed to be doing in this group, I think I'm supposed to be talking and I'm terrible with silence. (Helen)

Discovering identity

So this is the reason I went there, I wanted to get to the bottom of things, what it was all these... what it was that was holding me back of certain things in my life. Then I went to therapy and then I realise there is another part of myself which likes men perhaps so... wanted to explore at the time, because I never had any proper relationship with anybody. (John)

Understanding own self/ becoming self aware (this is also linked with importance of family background. For Carla it is clearly linked with setting the boundaries)

Yeah er... yeah again I would say just I noticed within myself, primarily er... my need for approval which I think I think subconsciously got stuffed away at the back but it was what I needed, but therapy sort of brought that to light, how important the opinions were of other people in my life, my husband, my family
growing up... so that was a really interesting thing that came up. That’s something that clearly to this day, this concept of well how much of what I decide to do or say or dress is because I’m looking for approval of the outside world or because I choose it because I like it, or this is what I really think. So yeah I wouldn’t say that I’ve solved all of that, or sorted it all out bit it really showed me how sociability is really important to me and good acceptance. (Nancy)

I think she ... it improved my performance in that respect in her expectations. And it wasn’t you know, it might sound like I was trying to be something that I’m not but it wasn’t it fitted, I was actually expressing what I wanted better em... I understood myself a bit more and that had a good effect. (Steve)

Er.. it changed when ... when one of the sessions er... I didn’t know how to get let’s see... I use one of the art material, oh its difficult to express that, I used one of their materials to express er... my... things in the part that I didn’t like from me and that I used. And then I used other materials that mingled together, related to my partner helping me to cope with that, so it was like other materials I was asking er... for help and er... and I created this sculpture and I still keep it because it work, I don’t know it work, ...just since that moment I know that, I didn’t ask after that I talk to him about my experience about his sculpture he asked me asking him help about you know, and I could talk to him about this problem and I asked for help verbally? (Maria)

... the plus side of things it made me look at myself more and made me er... understand me much more and begin and certain things would kind of slot in to place, I wouldn’t say everything but certain things would slot in to place. (Carla)
I think er...yeah, in one sense because therapy made me understand you know, because it made me understand me much more it makes you then decide you know that you’re not going to put up with certain things and that you’re not going to, you know and that you are stronger than what you thought you were and that’s what I was, I’m much stronger than I thought I was and I think therapy helped me in that sense, that I am much stronger er...and that er...you know I am able to cope. (Carla)

Yeah I think looking back and now yeah. I think er...it has, you know I think the combination of being in therapy and also er...my son has made me much stronger and er...just knowing that what I want and what I don’t want it does give you that kind of er...understanding and makes things much more clearer, the combination of those two it really does. You know and what you won’t put up with and that’s another thing, so yeah. (Carla)

Yes yes, definitely. Em...I think that’s more to do with the understanding of who I was as a person, and the most positive thing that came from therapy was an understanding of this scared child that I was. And...this child who’d never really had a voice and I think, where as my husband use to be able to bully because he’d shout at me, because that was the only way he could deal with me. (Bonnie)

Mm...yeah I think...er...I realised that I was very in my head, very intellectual and rational and sometimes didn’t really allow myself to feel what I was actually saying so that was one thing, I realised why I did that. And er...I think what else? Er...I think the main thing for me was realising that i didn’t, where as in the past I always wanted to be in relationships with others and my love, my romantic relationships, by being in a caretaker role it made me feel worthy and valued and I think the main thing that came out of those 8 months was do I still want to, is that what I really still want, do I still want to be always the one that people are dependent on and...that always give the advice and information and why I did
that, was actually for my own needs, so I felt better, I think that was the greatest thing that I went away with about my own awareness, how I am with other people. (Nikki)

So Nikki adjusted her expectations accordingly:

Oh yes expectations, yah, so with regard to that well...not expectation but what I learnt was this was not the relationship for me and I was able to verbalize that and admit it to myself and to him actually but also realising what is it that I want in a relationship and its someone who's not dependent on me, I don't want to go back in to that role where I've always been within my family of origin and with my friends which is the caretaker role, I'll make things better, but then there's no space for me. (Nikki)

**Becoming emotionally stronger**

I think in one sense, even though we didn't communicate, it made me, I know its kind of weird to say, but it made me kind of stronger where I could actually stand on my own two feet, much better. Rather than kind of er...er...relying on him so much, and you know...yeah, I think ...I became er...in one aspect emotionally stronger than him. (Carla)
APPENDIX 15

Theoretical category B2: Increased/reduced relationship expectations

B2. Increased/reduced relationship expectations

• Increased expectations

Some participants' enhanced or changed understanding of themselves enabled them to become more attuned to their own needs and wishes. This resulted in them forming new expectations of their partners and their relationship so that their newly discovered needs were fulfilled. This was especially the case for those relationships in which the client-partner felt victimised and disempowered.

Therapy encouraged Carla to set some boundaries in her relationship and ultimately empowered her to terminate the relationship when those boundaries were not respected. Besides setting the boundaries, therapy also empowered Carla to break up:

I wouldn’t put up with his behaviour. I wouldn’t put up with a lot of things. I mean he’s changed, and the reason why we’ve split up is because he has an addiction, and if I was younger and hadn’t gone to therapy, I would have just stuck, you kind of just get stuck… I think therapy kind of helped me and it made me see enough is enough and you back away, it makes you feel emotionally stronger, so you’ve got the strength to say okay this is what’s important and this is what I need to do.

Nikki’s enhanced understanding of self was reflected in her wish to develop an equal, rather than dependent, relationship. Her partner, though, could not adjust to her new expectations of him and the relationship:

...what I learnt was this was not the relationship for me and I was able to verbalize that and admit it to myself and to him actually, but also realising what is it that I
want in a relationship and it’s someone who’s not dependent on me, I don’t want to go back into that role where I’ve always been within my family of origin and with my friends, which is the caretaker role.

Lara’s self change and attunement with herself empowered her to terminate a marriage that could not fulfil some of her fundamental needs:

I then realised that I wanted more than that, I wanted more than what was in that relationship...I had to come to terms with what I could get from Mario first and then see, work with that, and see how that was, and then realise, later realise that that wasn’t enough. That I had changed and I knew something different.

- **Reduced expectations**
Two participants reported having set very high and unrealistic expectations of their partners. As their partners were unable to meet such extreme expectations, participants felt unhappy and dissatisfied in their relationships. However, therapy enabled them to set more pragmatic and feasible expectations of their partners and their relationships; thus alleviating any tensions caused when their partners could not fulfil their needs.

Nancy’s self and relationship awareness had a positive impact upon her marriage (therapy as an instigator of change). Through therapy, she was able to understand and accept that it was impossible for her husband and her marriage to fulfil all her needs:

In the sense that I would say at the beginning of marriage when, you know, I’d partnered with someone naively, the thinking may have been everything you could possibly ever need is in this one person, and I would say that what therapy did for me, at the time was show me that, you’re not going to get everything you need from one person. That...I may need to talk to different people about different things that my husband may or may not be able to relate to. So it took a lot of
pressure off of our relationship, I think, to be perfect. It could be as good as it
could be, but not be 100% of all the social interaction I would ever have.
Instructions to Authors

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Title: Can therapy instigate change in clients’ attachment patterns? A critical literature review

Abstract

Purpose: This paper reviews literature relevant to the question: ‘can therapy instigate change in clients’ attachment patterns’? To date, there has been scant research exploring changes in clients’ attachment patterns in relation to therapy. However, new advancements in adult attachment measurement and a growing interest in the clinical application of attachment theory point to the beginning of a promising new era of attachment research that may provide evidence for effective clinical practice.

Method: Critical evaluation of relevant articles obtained through computer-based literature review searches and cross-referencing.

Results and Conclusion: Through an extensive review of studies exploring adult attachment stability and change, the function of therapists as attachment figures, and changes in clients’ attachments in relation to therapy, this paper demonstrates that therapy may shift clients’ attachment patterns from insecure to secure. Future research investigating further this proposition is recommended at the end of the paper. Moreover, implications for therapeutic practice are discussed.

Key Concepts: adult attachment, (psycho)therapy, client attachment, treatment, attachment stability

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Introduction

John Bowlby’s (1969, 1973, 1980) attachment theory is one of the most researched and comprehensive theories designed to explain individuals’ psychosocial development. Having integrated principles from psychoanalysis, ethology, developmental and cognitive psychology, Bowlby suggested that cognitive, emotional and social development occurs primarily within the context of close relationships that are generally referred to as attachment relationships. In one of his last writings, Bowlby (1988) proposed that the therapeutic relationship shared many similarities with individuals’ early attachment relationships and that the therapist could serve the function of an attachment figure. This paper will focus and expand on this proposition by reviewing relevant literature.

Bowlby (1969) suggested that relationships between infants and their primary caregivers result in the development of Internal Working Models (IWM) that serve the function of interpreting, regulating and predicting attachment related behaviour, thoughts and feelings. These models are mental representations encompassing information about infants’ formative relationships with significant others and are used as ‘cognitive maps’ that guide future dyadic relationships (Cassidy, 2000). Moreover, IWMs include representations of one’s self, with self either being regarded as valued and worthy of care or unworthy and undeserving of love. Self-representations are thought to be dependent upon the emotional availability and responsiveness of significant attachment figures during individuals’ formative years (for an extensive review of IWMs see Bretherton, 2005; Pietromonaco & Barrett, 2000).

Although Bowlby’s attachment theory was inspired from his work with children, he believed that human attachments play a “vital role ... from the cradle to the grave” (Bowlby, 1969, p. 208). During the last two decades, research on adult attachment has shown that the attachment patterns identified in infancy correspond to attachment patterns displayed in adulthood. For example, Mary Ainsworth et al.’s (1978) experimental study with one-year-olds identified three attachment styles: secure, avoidant and
anxious/ambivalent. These were replicated by Main, Kaplan and Cassidy’s (1985) study with adults. Specifically, the Adult Attachment Interview was developed (AAI; George, Kaplan, & Main, 1985 cited in Hesse, 1999, pp. 395-433) in order to explore how patterns of early relationships manifested themselves in adult relationships. Their analysis of parents’ narratives of their own childhood suggested that adult attachment displayed analogous patterns to early attachment: autonomous (secure), dismissing (avoidant), preoccupied (ambivalent). In 1990, Main and Hesse suggested that there was a fourth pattern of attachment which they called unresolved/disorganised. Since then Bartholomew and Horowitz (1991) proposed a four-category (secure, preoccupied, dismissive, fearful) and two dimensional model (working models of the self and other) of attachment representations. Further research by Brennan, Clark and Shaver (1998) supported that attachment patterns may be better measured as dimensions rather than categories (see Figure 1).

Figure 1: Brennan, Clark and Shaver’s (1998) dimensional model of adult attachment adapted from Fraley (2004, http://www.psych.uiuc.edu/~rcfraley/attachment.htm).
The development of the AAI and other self-report attachment measures (Experiences in Close Relationships; Brennan, Clark, & Shaver, 1998, and Experiences in Close Relationships-Revised; Fraley, Waller, & Brennan, 2000) expanded the focus of research from childhood attachments to adult attachments; and from research in developmental psychology to psychotherapy, clinical and counselling psychology research. If Bowlby were alive today, he would be particularly pleased with these advancements, as in 1988 he expressed his disappointment that

"Whereas attachment theory was formulated by a clinician for the use in diagnosis and treatment of emotionally disturbed patients and family, its usage hitherto has been to mainly promote research in developmental psychology. Whilst I welcome findings of this research...it has none the less been disappointing that clinicians have been so slow to test the theory's uses"

(pp. ix-x).

Recent research on the clinical implications of attachment theory has mainly focused on the impact of each attachment organisation upon the therapeutic relationship, and therapeutic process (i.e. Eames & Roth, 2000; Hardy et al., 1999; Mallinckrodt, Porter, & Kivlighan, 2005; Slade, 1999; Strauss, 2000; Woodhouse et al., 2003). Despite the gradual flourishing of this research field, there is minimal research investigating the impact of therapy upon clients' attachment patterns and how this might relate to therapeutic outcome. In a recent special section on attachment theory and psychotherapy in the Journal of Consulting and Clinical Psychology, Davila and Levy (2006) noted that most relevant research has been conceptual and case study based, with only very few empirical studies using attachment measures pre and post treatment in order to assess any attachment related outcome. Fonagy (2001) has explained that a reason why there is limited research into attachment theory and therapeutic outcome is due to the fact that in the past there was "'bad blood'' (p. 1) between attachment theory and psychoanalysis. However, with intersubjective approaches gradually gaining popularity in psychodynamic therapy (i.e. Aron, 1996; Mitchell, 1988, 2000), as well as other psychodynamically
inspired treatments that focus on modifying clients’ attachment representations (i.e. Mentalization Based Therapy; Bateman and Fonagy, 2006; Transference Focused Psychotherapy; Clarkin, Yeomans, & Kernberg, 2006) it is hoped that there will be an increasing interest in investigating the impact of therapy upon clients’ attachment patterns. Any changes in clients’ attachment patterns could be then explored in relation to the alleviation of their psychological symptoms, as a growing number of clinical studies has demonstrated a positive relationship between insecure attachment and psychopathology (Fonagy et al., 1996; Sable, 1997; Sroufe et al., 1999; Travis et al., 2001).

Having identified a relevant gap in attachment literature and hoping to generate further research interest in this field in the future, the present paper will attempt to critically review empirical studies that are related to Bowlby’s (1988) proposition of the therapeutic relationship as an attachment relationship that has the potential to alter clients’ pre-therapy attachment representations. For this purpose, studies exploring whether the therapist serves the function of an attachment figure will be reviewed first. Then, research investigating stability and change in adult attachment patterns will be discussed in order to determine whether attachment changes in adulthood are possible. Since there is scant research exploring change in relation to therapy, the findings of wider literature on stability and change will be discussed in an attempt to identify their possible relevance to adult attachment changes in relation to therapy. This will be followed by a review of the few available studies investigating the impact of therapy upon clients’ attachment styles. Finally, areas for future research will be recommended.

Therapists as attachment figures

Apart from the attachment relationships identified between infants and their primary caregivers, other relationships created in adulthood have also been shown to serve attachment needs and expectations. This has been specifically the case for romantic relationships (for an extensive review, see Feeney, 1999). Another relationship, which has been frequently
referred to as an attachment relationship but has rarely been investigated as such is the client-therapist relationship (Borelli & David, 2004). This view stems from Bowlby’s (1988) proposition that one of the main functions of the therapist:

“...is to provide the patient with a secure base from which he can explore the various unhappy and painful aspects of his life, past, and present, many of which he finds it difficult or perhaps impossible to think about and reconsider without a trusted companion to provide support, encouragement, sympathy, and, on occasion guidance.” (p. 138)

In other words, Bowlby proposed that the main attachment characteristics of ‘secure base’ and ‘safe haven’ describing a secure parent-infant attachment relationship could also characterise clients’ attachment to their therapists. This is also facilitated by the fact that most individuals seeking help are often in a state of distress that is likely to activate attachment behaviour (Farber, Lippert, & Nevas, 1995).

The first study examining the specific client-therapist attachment aimed to develop a valid and reliable scale that could measure the clients’ attachment to their therapists (Client Attachment to Therapist Scale, CATS; Mallinckrodt, Gantt, & Coble, 1995). Factor analysis of 100 items generated by a panel of expert therapists suggested that 36 items loaded on 3 subscales (Secure, Avoidant-Fearful, and Preoccupied Merger). The findings suggested that clients who scored high on the CATS Secure subscale perceived their therapists as promoting a secure base from which they could explore difficult emotional experiences. On the other hand, clients who scored high on the Avoidant-Fearful and Preoccupied-Merger subscales displayed characteristics similar to those that would be expected by an avoidantly or fearfully attached individual (i.e. distrust in the former and compulsive preoccupation with the other in the latter).

In 2005, Mallinckdrodt, Porter and Kivlighan conducted another study that compared clients’ attachments to their therapist (CATS scale) and clients’ attachment with their...
partners (Experiences in Close Relationships Scale, ECRS; Brennan, Clark, & Shaver 1998) but found a non-significant association. The non-significance was attributed to small sample size (N=38) and to this end further research with bigger samples was recommended. It is also possible however, that difference between these two attachment relationships may indicate that individuals hold simultaneously a number of relationship representations. Moreover, as this research recruited participants who had been in therapy for a short period of time (4-8 sessions), it is possible that there may not have been sufficient time in order for them to revise and update their predominant IWM.

Parish and Eagle (2003) also attempted to explore the same hypothesis by using different measurements to the previous study. They calculated correlations between data obtained by the Components of Attachment Questionnaire (CAQ; Parish 2000 cited in Parish & Eagle, 2003, p. 273) and by the Relationship Questionnaire (RQ; Bartholomew & Horowitz, 1991). Unlike Mallinckrodt, Gantt and Coble, (1995) who recruited participants who had completed 5 sessions or more of either brief or long-term (unspecified modality) therapy, Parish and Eagle’s (2003) study recruited participants who had been in psychodynamic therapy for at least 6 months. Analysis of the data suggested that long term psychodynamic psychotherapy shares many similarities with attachment relationships. These similarities were: proximity seeking, secure base, safe haven, stronger/wiser (this is how the attachment figure may be perceived), the attachment figure’s availability, strong feelings towards the attachment figure and particularity (the attachment figure is a particular other person). Separation protest was the only attachment component that did not appear to characterise participants’ relationships with their therapists.

In reviewing the above studies, some interesting research questions emerge. For example, as noted by Farber, Lippert and Nevas’s (1995), it may be interesting for future studies to explore whether temporal, financial, structural and ethical boundaries characterising the client-therapist relationship differentiate the nature of the client-therapist attachment from other attachments.
Furthermore, it may be useful to explore whether therapists' use of specific treatment modalities impacts upon them being perceived as attachment figures. To date, limited evidence from Parish and Eagle's (2003) research has shown that the level of attachment to the therapist is related to the frequency of the sessions and the duration of the therapy. This could lead to the hypothesis that shorter-term therapies (i.e. Cognitive Behavioural Therapy) may not allow sufficient time for clients' attachment to therapist to be activated. On a related note, based on Mallinckrodt, Gantt and Coble's (1995) findings which suggest that insecure individuals who enter therapy display behaviour and expectations in line with their insecure attachment representations, it could be speculated that insecurely attached clients may need longer time in therapy before they begin to view their therapists as secure attachment figures.

Nevertheless, other research has shown that aspects of clients' early insecure attachment relationships are projected onto the client-therapist relationship after one year of treatment (Diamond et al., 2003a). This could be interpreted though, as clients' attempt to explore and resolve previous insecure attachment relationships within the secure base of the therapeutic relationship that evolves over time. This interpretation would be consistent with research demonstrating that a secure client-therapist relationship facilitates the emergence of negative transference as the client feels safe-enough to explore negative representations of self and other through trusting the therapist to be a secure base from which one can explore distressing issues (Woodhouse et al., 2003). Bowlby (1973) had conceptualised transference in terms of "forecasts" (p. 206) that clients make about their therapists based on previous IWMs that were developed during infancy but that do not reflect the clients' current relationship with the therapist. Resolution of transference and updating of existing IWMs or development of new secure ones have major implications for therapy process and outcome. For example, when an early insecure attachment with a significant other is activated in therapy and demonstrated through transference, the therapist's IWM incongruent behaviour (as one would hope) may enable the adaptation of the existing insecure IWM over time (altering prototype attachment representations). Such change could be facilitated through the therapist offering the core conditions
(Rogers, 1957) that are conducive to the 'safe haven' and 'secure base' ideas. Moreover, in case of clients' transference-related distortions of the therapist, exploration of transference in therapy may contribute to clients' understanding of their unconscious processes, and thus allow them to ultimately build a new secure attachment relationship with their therapist based on the actual lived experience during therapy.

Stability and change in adult attachment patterns

In the previous section, literature proposing that the therapist-client relationship can be conceptualised as an attachment relationship was reviewed. However, even if this unique relationship qualifies as an attachment relationship, one might wonder if it merely replicates previous attachment relationships through transference (Brumbaugh & Fraley, 2006; Mallinckrodt, Gantt, & Coble, 1995) or whether it has the potential to positively affect previous insecure or disorganised attachments; the opposite might also be possible indeed in the case of ineffective therapy. In an attempt to answer this question, the possibility of change in attachment patterns during adulthood needs to be examined.

Research into attachment stability and change over the life-span has provided evidence that under certain conditions attachment relationships developed during the critical period of infancy can change post-infancy, and that the attachment figure can be any adult who facilitates developmental change. According to Davila and Cobb's (2004) literature review these findings have been demonstrated by three different sets of research: i) longitudinal studies examining the correspondence between attachment classification in infancy and early adulthood (i.e. Hamilton, 2000; Lewis, Feiring, & Rosenthal, 2000; Waters, Merrick et al., 2000; Weinfield, Sroufe, & Egeland, 2000), ii) research demonstrating changes in adult attachment security in relation to romantic relationships (i.e. Kilpatrick & Hazan, 1994) and iii) research exploring changes in attachment security over a short period of time during late adolescence and adulthood (i.e. Crowell, Treboux, & Waters, 2002; Davila & Sargent, 2003; Scharfe & Cole, 2006).
Different research measures have been employed by each set of studies. For example, research across the life-span identified attachment styles in infancy using observational methods (Ainsworth’s Strange Situation paradigm; Ainsworth et al., 1978) and compared them to adult attachment classifications as determined by the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985 cited in Hesse, 1999, pp. 395-433). Studies investigating attachment changes in relation to romantic relationships mainly used self-report questionnaires, whilst research on attachment change over a short period of time used a variety of methods (AAI, a variety of self-reports and interview assessments), either in combination or separately. Self-report questionnaires have been criticised for lacking construct validity due to the fact that they fail to measure unconscious processes that are inherent to attachment representations (Davila & Cobb, 2004). Nevertheless, Shaver and Mikulincer (2004), through conducting an extensive literature review, have argued that such criticisms “are exaggerated, if not completely invalid” (p. 44). In an attempt to synthesise the two opposing views, Davila and Cobb (2004) have suggested that different measures may assess different aspects of the attachment system, as well as different types of change (i.e. short term vs. long term change).

Despite using different measures, these different sets of research have consistently demonstrated that adult attachment presents approximately 60-70% stability between infancy and early adulthood, and between two short term periods in adulthood (Scharfe, 2003). This moderate stability demonstrated by a variety of attachment measures suggests that stability is not a product of measurement error and that approximately 30-40% of people exhibit changes in their attachment patterns. Furthermore, when different measures are employed within the same study, a stability coefficient close to or within this range is produced by each measure, although there can be some slight differences between measures. For example, Scharfe and Bartholomew’s (1994) findings showed that interviews produced a 77% stability, self-reports a 59% stability whilst partner-reports a 70% stability. Extrapolating from the above, the important point for this review is that a large number of studies (i.e. Baldwin & Fehr, 1995; Scharfe & Bartholomew, 1994; Scharfe & Cole, 2006) and a meta-analysis of 24 studies (Fraley, 2002) have suggested
that attachment styles in adulthood are moderately stable and to this end it could be argued that attachment change in adulthood is possible for some people.

How do attachment patterns change? Stability and change of internal working models

Bowlby (1969) hypothesised that IWMs are fairly stable. However, he suggested that they could be adapted in light of new information that could challenge existing relational experiences. In Bowlby’s (1969) words:

"To be useful...working models must be kept up to date. As a rule this requires only a continuous feeding in of small modifications, usually a process so gradual that it is hardly noticeable. Occasionally, however, some major change in environment or organism occurs: we get married...At those times, radical changes of models are called for” (p. 82).

Therefore, Bowlby suggested that both accommodation and assimilation processes take place within IWMs that appear to share similar properties with cognitive schemas (although they also have distinct properties: for more information see Collins & Allard, 2001). For example, schema congruent information is assimilated and thus reinforces the existing IWM, whilst in some cases schema incongruent information may lead to the adaptation and change of the IWM. Apart from these two mechanisms, a third possibility might be a distortion or segregation of objective experience so that it corresponds with existing IWM information (Prior & Glaser, 2006). In this case, the individual may employ an array of defence mechanisms which ensure the stability of the IWM. Bowlby (1980, 1988) identified two main defence strategies: defensive exclusion (formation of two inconsistent models but only one being consciously available) and segregation of principal systems (two distinct and segregated selves corresponding to distinct IWMs each). It could be argued that therapy may enable clients to integrate or become aware of the influence of IWMs that are split off consciousness, and to this end facilitate stability of attachment security in case of fluctuations between security and insecurity.
Through reviewing the literature, it became apparent that researchers coming from different theoretical traditions have emphasised either the stability of IWMs or their potential to be revised and updated in light of new experiences. The first view has been highlighted mainly by research in psychodynamic and developmental psychology traditions, and argues that relationships in infancy constitute the prototype for future relationships (i.e. Hamilton, 2000; Waters, Merrick et al., 2000). Without excluding the possibility of adaptation and change within IWMs, it is proposed that representations developed during the early years remain stable through individuals forming relationships that provide IWM congruent information or at least these relationships are interpreted as such either consciously or unconsciously. On the contrary, social-cognitive psychology researchers have mainly focused on the adaptation properties of the IWM demonstrating that IWMs are revised and updated in light of new experiences that are incompatible with previous information contained in the IWM; and thus may change from infancy to adulthood or between two periods of time in adulthood (Baldwin & Fehr, 1995; Baldwin et al., 1996; Lewis, Feiring, & Rosenthal, 2000; Pierce & Lydon, 2001; Pietromonaco & Barrett, 2000). Fraley’s (2002) meta-analysis of longitudinal studies investigating change in attachment representations suggested that two models of stability and change have been reflected in the literature; the prototype model emphasising continuity of attachment representations over the life-course and the revisionist model emphasising change. Research corresponding with each model will be outlined in the following paragraphs.

**Prototype model**

- Continuity of attachment patterns from infancy to adulthood

The prototype model suggests that attachment representations during infancy remain relatively unchanged and continue to influence relationships across the lifespan. This is "because procedural, nonlinguistic forms of representation are more difficult to modify once sophisticated forms of cognition emerge" (Fraley, 2002, p. 126). Moreover, as Thomson (1999) explained, IWMs "provide implicit rules for relating to others that may,
for better or worse, help to confirm and maintain intuitive expectations about others and oneself. These internal representations are self-perpetuating, both because of confirmation biases inherent in their functioning and because they cause young children to elicit complementary responses from partners that are consistent with their relational expectations” (p. 267). However at the same time the prototype model acknowledges that IWMs are dynamic constructs accounting for both stability and change. This is consistent with Bowlby’s (1969) proposition that major change in the environment or the organism might instigate a radical revision of one’s IWM.

Bowlby’s (1969) proposition was tested by a number of studies looking at changes as a result of either negative life events or due to life transitions i.e. becoming a parent, getting married, graduating from the university etc. In 2000, three longitudinal studies examining the continuity of attachment representations from infancy to adulthood were published in *Child Development* (Waters, Weinfield, & Hamilton, 2000). These studies were the first to test Bowlby’s proposition of moderate stability through conducting measurements at two different points in time rather than relying on individuals’ reports of their childhood experiences, as previous studies did (i.e. Hazan & Shaver, 1987). In specific terms, these studies focused on how such negative events as death of a parent, foster care, parental divorce, chronic and severe illness, single parenthood, parental psychopathology, addictions and childhood experience of physical or sexual abuse might influence existing IWMs. The researchers stressed that the purpose of their research was to demonstrate that changes in attachment styles occur in relation to changes in attachment figure’s availability and responsiveness.

For this purpose, Hamilton (2000), when exploring attachment stability in an alternative life-style sample and a conventional family sample, found that attachment styles at 12 months (assessed according to Ainsworth’s Strange Situation paradigm; Ainsworth et al., 1978) remained 77% stable in adolescence (according to the Adolescent Attachment Interview; George, Kaplan, & Main, 1984 cited in Hamilton, 2000, p. 692), and that changes in attachment classification did not relate to negative life events. Overall though,
there was a moderate rate of attachment style changes in relation to negative life events in both samples \[x^2(3, n=30)=10.70, p<.05\]. Similarly, Waters, Merrick et al. (2000) found 72% continuity of attachment classification from infancy to early adulthood. In line with their hypothesis, 44% of the infants whose mother reported negative life events presented changes in their attachment style as opposed to 22% whose attachment changes were not related to any reported negative events.

In contrast to these findings, the third study of the *Child Development* issue (Weinfield, Sroufe, & Egeland, 2000) investigated negative events (i.e. poverty) of greater frequency and duration and demonstrated discontinuity (38.6% continuity) in attachment representations from infancy to early adulthood. This suggested that attachment representations are vulnerable to difficult and chaotic experiences (i.e. child maltreatment, maternal depression and family dysfunction in early adolescence). Discontinuity in attachment patterns from infancy to adulthood was also found in Lewis, Feiring and Rosenthal (2000) study of 84 middle class participants. Their evidence suggested that a one-year-old attachment is not related to an 18-year-old attachment and that there is no relationship between infant attachment status and adolescent maladjustment. However, their study lent support for the change due to life-events hypothesis as they found that divorce was related to discontinuity between attachment behaviours in infancy and attachment representations in adolescence.

To sum up, despite revealing different percentages of change in adult attachment patterns, the aforementioned studies demonstrate that prototype attachment patterns may change in adulthood.

- Change of attachment patterns within adulthood

Studies measuring stability and change of attachment representations at different times in adulthood have also provided evidence for the prototype model (Kilpatrick & Hazan, 1994; Klohen & Bera, 1998; Treboux, Crowel, & Waters, 2004). For example, Klohen
and Bera's (1998) 31-year longitudinal study measuring female participants' attachment changes at the ages of 21, 27, 43 and 52 showed that age 52 attachment style did not simply stem from recent relationship experiences in adulthood and that early attachment patterns have potentially long-lasting and powerful influences on subsequent attachment functioning. Changes in attachment patterns were related to the loss of a parent, and a young adult's goals and expectations, such as interest in marriage, predicted midlife attachment. However, it was also stressed that whilst some individuals displayed stability in attachment representations, others showed marked change within a 25 year period.

Treboux, Crowel and Waters (2004) conducted a 6-year multimethod longitudinal study investigating correspondence between adults' generalised representation (prototype) and the specific representation of marital relationships. The generalised representation was assessed with the AAI and the specific representation with the Current Relationship Interview (CRI; Crowel & Owens, 1996 cited in Treboux, Crowell, & Waters, 2004, p. 299). It was hypothesised that specific representations are referenced against the generalised representation. The findings suggested that during participants' premarital stage there was 58% correspondence (k=.35, p≤.01) when the most distressed individuals (i.e. those experiencing separations or divorce) were omitted. The specific study also focused on the implications of discrepancy between the generalised and specific models. For example, those individuals who had an insecure generalised attachment but a secure attachment to their partner at the first year of the study (prior to getting married) "reported a drop in their positive feelings about the relationship that was associated with stress" (p. 310). However, the group that was at greatest risk of marital dissolution was the one in which the partner had a secure generalised attachment but an insecure specific one. Both these results provide evidence for the enduring effect of the prototype representation on other subsequent attachment relationships.

Studies conducted over a shorter period of time in adulthood have also provided evidence for the prototype model (Scharfe & Bartholomew, 1994; Scharfe & Cole, 2006). Scharfe and Cole (2006) explored stability and change of attachment representations in a sample
of young adults experiencing the transition from university and examined reasons for change (seven months interval between T1 and T2). Their findings suggested that attachment was moderately stable (60-70%). The authors concluded that attachments in adulthood are well-developed and thus they are shown to be resistant to change. Scharfe and Bartholomew’s (1994) research measuring changes over a period of 8 months has also demonstrated high stability (r values ranging from .72 to .96) in attachment patterns especially in the absence of major life events.

The aforementioned studies, being consistent with Bowlby’s attachment theory, suggested that an individual’s primary or default model is moderately stable (from infancy to early adulthood and at various points in adulthood) but may be adapted as a result of negative or major life events that challenge the existing content of one’s IWM. In a similar way, it could be argued that therapy can be conceptualised as a major event, a unique interaction that primarily focuses on the relationship between the client and the therapist (this is especially the case for relational approaches i.e. psychodynamic and humanistic) and as such has the potential to challenge and ultimately change clients’ existing IWMs through providing them with IWM incongruent information (Eagle, 2003).

Revisionist model

Unlike the prototype model, the revisionist model adopts a social cognitive perspective on attachment change through emphasising the state-like (as opposed to trait-like) properties of attachment representations (Baldwin & Fehr, 1995; Baldwin et al., 1996). For example, rather than assuming that there is a predominant attachment representation that may be adapted in relation to major IWM incongruent events, it proposes that different representations might be displayed by the same person in relation to changes in his/her state of mind. Moreover, this model assumes that each person has multiple relational schemas that are relationship specific and that each relational schema has similar qualities to the IWM concept proposed by Bowlby (1969). For example, Baldwin (1992) defined relational schemas as “cognitive structures representing regularities in patterns of
interpersonal relatedness [that] include images of self and other, along with a script for an expected pattern of interaction derived via generalisations from repeated similar interpersonal experiences” (p. 461).

The main difference between IWMs and relational schemas lies in the fact that, unlike IWMs that are viewed as containing information about a person’s generalised/prototype attachment style, relational schemas include both attachment and non-attachment relationships (Trinke & Bartholomew, 1997), and thus encompass multiple representations of the self and others. According to Baldwin and Fehr (1995), each person holds numerous relational schemas that may even reflect multiple and contradictory attachment styles. Extrapolating from this, it could be argued that such multiplicity might create chaos to an individual’s sense of self and relating with others. In response to this, it has been suggested that individuals tend to employ a preferred or chronically most accessible schema but may also access less strong relational schemas that may correspond better to specific relationship partners, context and goals (Baldwin & Fehr, 1995). This thesis does not disagree significantly with Bowlby’s (1969) notions of one principal attachment-figure followed by other subsidiary attachment-figures, although it moves beyond attachment relationships.

Another related issue is the assumed ‘monotropy’, or in other words the child’s propensity to attach especially to the primary attachment figure (Bowlby, 1969). The notion of monotropy has been challenged during the last decade, and research has focused on exploring whether various attachment relationships exist simultaneously and how these might be stored in memory. In reviewing the findings of various studies, Prior and Glasser (2006) explained that the literature suggests that multiple attachments may be represented in a hierarchical, integrative or independent structure and that empirical support was found for all three structures. Bretherton (2005) though, suggested that it “remains to be discovered about whether, when, and how a child constructs an integrated self-model while participating in two (or more) qualitatively different attachments” (p.17). Growing social-cognitive literature reviewed in the following paragraphs appears
to address questions around monotropy and multiplicity of attachment patterns. These studies may offer some information about how the therapeutic relationship, as a relationship-specific representation, may be integrated within the generalised attachment relationship in a way that will induce adaptation of the IWMs towards security.

The first systematic study suggesting multiplicity of attachment representations came from Baldwin and Fehr (1995) who proposed that "for attachment theory to integrate findings of meaningful variability there will need to be a shift in emphasis away from trait-based, individual differences approach to a more thoroughgoing social-cognitive conceptualisation" (p. 257). This proposition was followed by three social-cognitive theory driven studies that lend support to the hypothesis that most people hold a variety of relational schemas corresponding to a range of attachment representations (Baldwin et al., 1996). In specific terms, 88% of participants (N=178) reported that they had experienced more than one attachment pattern in their ten most significant relationships. However, it should be acknowledged that the researchers focused on significant rather than solely attachment relationships, and that they used self-report measures that did not account for unconscious representations. Through priming of specific attachment orientations, the researchers were able to demonstrate that participants’ current state of mind determined the attachment style they reported and thus it was argued that individuals may approach new relationships influenced by their current state of mind rather than their generalised or else ‘chronic’ style of attachment. This could also lend support to the variability displayed in attachment stability coefficients as relationship-specific schemas rather than global models may be active during the time of measurement (Overall, Fletcher, & Friesen, 2003).

Following Baldwin et al.’s (1996) study that empirically supported multiple representations of relationships, the next wave of social-cognitive research focused on how relationship-specific and generalised (or else global) models of attachment are related. Pierce and Lydon (2001) conducted two studies that further explored Collins and Read’s (1994) and Crittenden’s (1990) attachment metastructure frameworks which
proposed that relationship-specific models and generalised models are distinct yet integrated into a hierarchy of interconnected models. Their findings suggested that global relational models (generalised attachment representations) "at least partially account for specific relational models... Yet results do not suggest that a person’s global relational models strongly overlap with specific models..." (p. 627). Regression analysis of self-report questionnaires completed at the beginning of the study and then approximately 4 months later (M=3.77 months, SD=0.34 months) demonstrated that relationship-specific models at T1 were generalised and integrated into self-reported global models over time. Similarly, Davila and Sargent’s (2003) 8-week daily diary study showed fluctuations in attachment styles and these were related to the meaning individuals assigned to events indicating interpersonal loss. However, this author wonders whether the meaning assigned to such events was consistent with individuals’ prototype/general attachment representations of which the full extent could not be explored due to the data collection methods (i.e. diaries as opposed to the AAI).

Research by Overall, Fletcher and Friesen (2003) provided further evidence for a hierarchical organisation of attachment and relational organisations (Collins & Read, 1994). They conducted three studies that attempted to test three different models of attachment and relational representations. The first model proposed that attachment representations consist of a single global working model. The second model suggested that there are three independent working models for the relationship domains of family, friends and romantic partners. The third model postulated that specific relationship models (i.e. my friend X) are nested under relationship domain representations (i.e. friends, partners, parents) that are nested under an overarching global working model (attachment style developed over time). Confirmatory analysis of the data lent support to the third model. It was suggested that relationship-specific and general attachment representations reciprocally influence each other (Overall, Fletcher, & Friesen, 2003). Therefore, it could be assumed that the therapeutic relationship may influence a client’s generalised models and be influenced by them.
It may be interesting in the future for researchers to explore whether certain specific relationships (i.e., therapeutic relationship) are more likely to influence individuals' global models than others. Moreover, further research could investigate the conditions under which relationships stored in lower levels of the hierarchy (i.e., the specific client-therapist relationship) become integrated to an overarching global working model (i.e., secure attachment representation).

**Changes in clients' attachment patterns in relation to therapy**

Despite the fact that research on attachment stability and change has not produced any conclusive evidence as to whether changes in adult attachment classifications reflect a change in prototype representations or shifts between different levels of a hypothetical relational-attachment hierarchy, the above studies showed that infant attachment representations are open to revision as proposed by Bowlby (1969). Therefore, if change in prototype and subsequent attachment patterns is possible then clients' close relationship with their therapist may also lead to a revision and updating of their existing IWM, and consequently in shifts in their attachment classifications.

In relation to this, Travis et al. (2001) conducted a systematic clinical study that compared pre-treatment (T1) and post-treatment (T2) attachment classifications by using both categorical and dimensional ratings (Bartholomew Attachment Rating Scale; Bartholomew & Horowitz, 1991). The attachment styles of 29 participants who were classified as insecure at T1 were measured again once they had completed 25 sessions (minimum amount of sessions was 5) of time-limited dynamic psychotherapy (TLDP; Strupp & Binder, 1984). Analysis of the data showed that 7 (24%) out of the 29 clients were classified as secure at T2, and that in general only 34% of the participants retained the same attachment classification at T2. This percentage is much lower than the stability co-efficient produced by the studies discussed in the previous section, and possibly indicates that interventions targeting change in clients' attachment patterns may have a greater impact on attachment stability than other environmental and interpersonal events.
Whilst one would hope that all changes would indicate movement from insecurity to security, this did not happen. Other factors like time of therapy, and individual client and therapist characteristics (i.e. attachment styles as suggested by Diamond et al., 2003a) may also influence the type of attachment developed post-therapy. Nevertheless, dimensional ratings of attachment suggested that ‘there was significant movement for the group of clients toward secure attachment’ (Travis et al., 2001, p. 154). Finally, Travis et al.’s (2001) findings showed that clients who developed secure attachment patterns demonstrated a significant decrease in measures of anxiety, depression, interpersonal sensitivity and hostility for others. These findings were consistent with other research demonstrating that high Global Assessment of Functioning (GAF; American Psychiatric Association, 1987) scores were associated with individuals classified as secure (Dolan, 1992 cited in Travis et al., 2001, p. 150; Fonagy et al., 1996). In relation to these findings, Travis et al. (2001) suggested that shifts from insecure to secure attachment patterns could potentially constitute evidence supporting the effectiveness of time-limited dynamic therapy.

Whilst Travis et al. (2001) recruited a clinical population that met criteria for an Axis I or Axis II diagnosis (DSM IV; APA, 1994), subsequent studies on attachment change in relation to therapy have solely recruited participants who met criteria for a diagnosis of Borderline Personality Disorder (BPD). This may be due to the fact that recent developments in research regarding attachment theory and personality disorders have shown that BPD is associated with insecure attachment classifications (mainly disorganised) that are based on multiple and contradictory IWMs developed in infancy and childhood (Bateman & Fonagy, 2004; Bateman & Fonagy, 2006; Slade, 1999). Most papers regarding changes in attachment patterns of clients diagnosed with BPD are based on a longitudinal study (N=23) investigating the patient-therapist attachment in the treatment of borderline personality disorder; this study has been conducted by the Personality Disorders Institute (PDI) at New York Presbyterian Hospital (Diamond et al., 1999, 2003a, 2003b). According to one of these papers reporting on 5 clients out of a total sample of 23, two out of the five clients who were classified as insecure prior to receiving
Transference-Focused Psychotherapy (TFP; Clarkin, Yeomans, & Kernberg, 2006) appeared to have developed a secure attachment within one year of therapy (Diamond et al., 2003a). The researchers were surprised with this finding as they did not expect such a rapid change to security given the severity of these clients’ pathology. However, it was suggested that their subsequent secure attachment classification was not “necessarily synonymous with secure attachment overall” (p. 167) but it indicated clients’ capacity to verbalise impulses and affects rather than acting out their psychic reality through self-harming behaviours. The remaining three clients in this report also displayed changes in their attachment patterns but these changes reflected a mixture of dismissing and preoccupied states of mind rather than attachment security. This was interpreted as a possible process of attachment reorganisation.

Further evidence regarding clients’ attachment change in relation to therapy was recently reported by Levy et al. (2006) who took part in a randomised controlled trial exploring shifts in 90 BPD clients’ attachment patterns in relation to three different treatment modalities: Dialectical Behavioural Therapy (DBT; Linehan, 1993), Supportive Psychotherapy (SPT; Appelbaum, 2005) and Transference-Focused Psychotherapy (TFP; Clarkin, Yeomans, & Kernberg, 2006). One of the most significant findings of this study was that within one year of TFP, DBT and SPT there was a threefold increase (from 5% to 15%) in clients’ attachment security. The greatest changes were reported in relation to TFP, as 31.8% of the clients who received TFP shifted from an insecure attachment style to a secure one. Although the classification was based on clients’ increased narrative coherence (according to the AAI; George, Kaplan, & Main, 1985 cited in Hesse, 1999, pp. 395-433), the researchers suggested that only further research could determine if there would be any significant changes in participants’ self-harming behaviours (Levy et al., 2006). Eagle (2006) has also argued that achieving narrative coherence indicates that the individual may access and communicate his/her attachment state of mind rather than changes in his/her attachment patterns. It was suggested that in order to assess changes in attachment representations, ecologically valid measures assessing security beyond narrative characteristics need to be developed (Eagle, 2006).
Conclusions and Future Directions

The main aim of this literature review was to explore literature related to the question: Can therapy instigate change in clients’ attachment patterns? This is believed to be a question of major clinical significance as research has demonstrated a positive relationship between attachment security and psychological well-being (Fonagy et al., 1996; Travis et al., 2001). The studies examined in this paper suggest that change in attachment patterns during adulthood is possible and may be instigated within the context of the therapeutic relationship. This conclusion has been drawn through discussing and evaluating wider literature regarding the stability and change of adult attachment representations as well as specific literature suggesting that the client-therapist relationship can be conceptualised as an attachment relationship that could challenge and ultimately change clients’ pre-therapy attachment representations (Diamond et al., 1999, 2003a, 2003b; Levy et al., 2006; Travis et al., 2001). Extrapolating from the studies reviewed, the last few paragraphs will address some relevant questions in relation to our topic of investigation.

Do all therapeutic modalities promote change in clients’ attachment representations?

The clinical studies reviewed in this paper mainly stem from the psychodynamic/psychoanalytic psychotherapy tradition and have demonstrated that psychodynamically oriented therapies can instigate change in clients’ attachment styles. Therefore, it is not possible to answer this question before research including other therapeutic modalities (i.e. cognitive, behavioural, and humanistic) explores change in clients’ attachment patterns in relation to therapy. From a theoretical perspective, it is reasonable to say that psychodynamic therapies may instigate change in clients’ attachments as these therapies focus both on the deconstruction of established but unsatisfactory ways of relating and on the construction of new and satisfactory ways of relating (Lyons-Ruth, 2005). With regards to other therapeutic modalities, it could be expected that therapies that focus on the therapeutic relationship (and at this point it should be stressed that many therapeutic
models are increasingly taking relational factors into account) may equally promote change in clients' attachment patterns. For example, even within the cognitive behavioural tradition that is generally regarded as less relational, there has been a movement towards paying special emphasis on the therapeutic relationship (this movement was initiated by Safran, 1990a, 1990b). Coming from a cognitive-behavioural perspective, Bannan and Malone (2002) suggested that “the therapeutic relationship can offer the patient a form of re-parenting, where their schemata can be directly challenged in the relationship with the therapist” (p. 95). Further research could reveal if specific therapeutic modalities promote change in clients’ attachment representations.

*Is there an association between the duration of therapy and clients' attachment style change?*

The studies reviewed suggest that longer-term therapies (lasting at least 6 months) are more likely to promote change, as they allow sufficient time for the client-therapist relationship to develop as an attachment relationship, which in turn enables some clients to move from insecure to secure attachment patterns (Diamond et al., 1999, 2003a, 2003b; Levy et al., 2006; Parish & Eagle, 2003; Travis et al., 2001). Slade (1999) argued, from an attachment theory perspective, that “today clinicians are under increasing pressure to administer short, cost-effective, problem-centred treatments... the brief psychotherapies are unlikely to result in the ‘reworking’ of representational models, or in changing the quality of attachment representations. They are also unlikely to allow for the development of healthy and curative attachment processes between patient and therapist” (p. 590). The development of more secure attachment patterns moves beyond symptom reduction to symptom prevention, as attachment security has been associated with psychological resilience (Weinfield et al., 1999), which may contribute towards the prevention of further psychological difficulties.
Are the secure attachment patterns developed in relation to therapy durable?

Evidence stemming from longitudinal studies is required before this question could be answered. To date, it could be argued that some supportive evidence exists, regarding the durability of secure attachments developed in adulthood, from studies on ‘earned security’ (insecure infant attachment but secure adult attachment). For example, by demonstrating that under stressful situations earned secure parents responded similarly to their children as continuous secure parents, Phelps, Belsky and Crnic’s (1998) study showed that “emotionally confronting and working through a harsh child-rearing experience results in durable shift in how attachment information is processed” (p. 36). Besides this study, further evidence stems from Wzontek, Geller and Farber's (1995) research demonstrating that clients who have effective therapy “form an enduring relationship with their therapists, in the form of internalised representations” (p. 409).

Further research into the specific attachment relationship between client and therapist could investigate if the therapist as a secondary or supplementary attachment figure is influential for a limited period of time (i.e. the duration of the therapy) or lasts over time (d’Elia, 2001).

Is the attachment representation of the client-therapist relationship a generalised (global) representation or a relationship-specific one?

In reviewing the relevant literature, it was suggested that the client-therapist relationship can have an impact upon clients’ attachment or relationship representations in two ways: i) by facilitating the update of clients’ prototype (generalised) IWMs through providing IWM incongruent information (i.e. Bowlby, 1969; Fraley, 2002) or ii) by offering them a new relationship-specific experience that could ultimately be integrated in their relational hierarchy and thus inform further interactions (Overall, Fletcher, & Friesen, 2003; Pierce & Lydon, 2001). Whilst both possibilities may be equally valid, only further research could explore how specific treatment modalities could address either or both possibilities. It could be speculated that the type and duration of therapy may determine whether the
client-therapist relationship becomes integrated in clients’ general attachment representation or if it remains a specific-relationship experience and therefore is subordinate in the relational hierarchy. To this end, research could explore whether longer-term and more relationally-focused therapies are more likely to affect clients’ prototype representations and thus promote lasting change in clients’ attachment patterns.

To conclude, growing literature in adult attachment stability and change, in combination with Bowlby’s (1988) wish for attachment theory to be tested with clinical populations, have only recently generated a research interest in exploring shifts in clients’ attachment patterns in relation to therapy. As most relevant research to date, apart from one (Travis et al., 2001), comes from the field of personality disorders, it is hoped that future studies will recruit clients who also meet criteria for other Axis I and Axis II diagnoses (DSM IV; APA, 1994). Further research into attachment stability and change will be facilitated by the development of a fast and reliable questionnaire that is currently being constructed by Fonagy and his colleagues who plan to conduct further research investigating shifts in attachment states of mind in relation to therapy (Fonagy’s interview to White & Schwartz, 2007). As White and Schwartz (2007) highlighted, “in the current climate of evidence-based work, to have a tool that we could use that would be convincing to our funders of the efficacy of an attachment-based intervention would be such an asset” (p. 61). It is believed that similar enthusiasm could also be demonstrated by proponents of other relationally-focused therapies.
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Personal reflections on conducting the literature review

Ever since I was introduced to attachment theory, it resonated with me and inspired me to further explore my attachment pattern, the patterns of my clients and of those people who are closely related to me. Whilst in the review paper, I critically evaluated the literature using a positivist framework, in my personal reflections section I would like to evaluate the literature in relation to my experience of personal therapy and other close relationships and to this end I will adopt a phenomenological stance.

Based on my experience of personal therapy and other close relationship experiences, I have formed the impression that prototype attachment patterns have lasting effects and are predominantly activated in times of distress. So, whilst research supporting the revisionist model demonstrated a multiplicity of attachment patterns held by the same individual, I would like to argue that this might not be the case when individuals experience distress that may trigger in them prototype related feelings and views about themselves, others and relationships. For example, I am aware that on most occasions I do not display similar attachment expectations and behaviour to all individuals I relate to and that I may feel more or less secure around different people. However, I have noticed that in times of distress I adopt a more generalised view about the availability of others. Whilst I would classify my self as ‘fairly secure’ with regards to being able to verbalise my attachment experiences, I am aware that as a result of some earlier life experiences (i.e. my mother started work when I was 6 months old; at the age of three I was left home alone to look after my one-year old sister whilst my parents were at work) I may oscillate between security and avoidance at times of distress. Whilst avoidance was an adaptive behaviour ensuring my survival and reduction of psychic pain when I was an infant/child, these days it can cause unnecessary pain and suffering, especially when I misinterpret others’ behaviours and intentions.

I became particularly aware of avoidant-attachment related thoughts and feelings during the final year of my studies which is when I felt both physically and emotionally drained
due to the heavy work load. During that time, I was struck by an experience I had whilst watching the London marathon and seeing the crowd cheering the athletes in order to encourage them. I became tearful and I begun to think that nobody would cheer me and encourage me through the end of my studies. Was this true? Whilst there was a lot to be validated in this thought, having reflected upon this experience in my personal therapy and after significant self-reflection, I came to realise that this view was overgeneralised. I also became aware that I would often not ask for support because there was an expectation that this would not be genuinely offered. Following this insight, I permitted my self to ask for help in order to challenge and ultimately disconfirm these views (or else update my internal working model, IWM). Were my distorted views disconfirmed? Yes to some degree (depressive position). However, new thoughts emerged in relation to this newly acquired insight. We live our lives repeating patterns over and over again and we form attachments with individuals who display similar characteristics to earlier attachment figures. Thus, our prototype attachment is perpetuated unless it is challenged by a new attachment figure that could offer us a different relational experience: the therapist!

In relation to this, I would like to agree with literature suggesting that therapy could challenge some of clients’ established ways of relating by providing them with insight (making the unconscious conscious) as well as offering them a different emotional experience. From my experience of personal therapy, I would like to say that it has taken a long time for me to relate to my therapist as an attachment figure. Apart from my avoidant attachment related tendencies, this could also be related to a course of ‘unsuccessful’ therapy with a previous therapist. However, I have been progressively forming a secure attachment to my current therapist. The most rapid progression in becoming more attached to him has coincided with one of the most distressing times in my life and as theory and research suggests this is when the attachment system is particularly activated. During those times, therapy became my secure base and safe haven. I would also like to acknowledge that I was able to trust my therapist with time,
and therefore I agree with literature suggesting that longer-term therapies facilitate attachment to the therapist

As I have now been in therapy for almost 4 years, one might wonder if my prototype attachment pattern has changed. Unfortunately, I did not complete an attachment measure prior to commencing therapy, thus I would not be able to give an empirically validated answer to this question. My view is that my oscillation between avoidance and security has now become a conscious process of which I am able to have some control, through having developed insight. This does not necessarily mean that the core synthesis of my prototype representation is altered but I am less likely to act out unconscious impulses and interpret others’ behaviours in a way that confirms and strengthens my existing avoidant IWM. So, if I was to be administered a questionnaire measuring attachment styles as dimensions pre and post-therapy, I suspect that this would demonstrate that therapy has helped me to move nearer security.

Through comparing my personal experience of therapy to the wider literature, I became aware that my idiosyncratic experience of therapy as an attachment relationship shares similarities and differences with the evidence suggested by quantitative research. This realisation strengthens my belief that both qualitative and quantitative research can be valuable within the field of counselling psychology and complement each other in order for psychologists to develop an understanding of both nomothetic and idiographic phenomena.

Finally, I would like to highlight that this literature review contributed greatly to my development as a counselling psychologist by increasing my understanding of the development of self in relation to others. This is believed to be one of the main tasks therapy attempts to achieve: the development of the client within the context of the therapeutic relationship.
Computer-Based Literature Review Searches undertaken:

Below are details of three of the most fruitful computer-based searches I undertook for this review.

Search 1:

Electronic Database – Ovid: PsycArticles

Search Criteria – Key words ‘attachment’ and ‘change’ in title.

Results – 6 articles found.

Significance of search – finding two seminal papers:

1) A recent article regarding the impact of therapy upon clients’ attachment representations:


2) A recent article investigating stability and change in adult attachment patterns:

Search 2:

Electronic Database – Ovid: PsycINFO

Search Criteria – Key words ‘attachment’ (title) and ‘psychotherapy’ (key concept).

Results – 202 articles found.

Significance of search – several important articles found including:

1) Two articles from a special section in the Journal of Consulting and Clinical Psychology including articles on attachment theory and psychotherapy:


2) One article demonstrating clients’ attachment changes in relation to therapy:


3) One book chapter about the patient-therapist attachment:

4) One article exploring the client attachment to therapist:


**Search 3:**

Electronic Database – Google Scholar

Search Criteria – Key words ‘attachment’ (title) and ‘stability’ (title). Search only in Social Sciences, Arts and Humanities.

Results – 124 articles found.

Significance of search – several important articles found including:

1) An article introducing a special section in *Child Development* that presented three longitudinal studies on attachment stability and change:


2) An article including a Meta-analysis of attachment stability data:

APPENDIX 2

Notes for Contributors

_Psychology and Psychotherapy: Theory Research and Practice_ (formerly _The British Journal of Medical Psychology_) is an international scientific journal with a focus on the psychological aspects of mental health difficulties and well-being; and psychological problems and their psychological treatments. We welcome submissions from mental health professionals and researchers from all relevant professional backgrounds. The Journal welcomes submissions of original high quality empirical research and rigorous theoretical papers of any theoretical provenance provided they have a bearing upon vulnerability to, adjustment to, assessment of, and recovery (assisted or otherwise) from psychological disorders. Submission of systematic reviews and other research reports which support evidence-based practice are also welcomed, as are relevant high quality analogue studies. The Journal thus aims to promote theoretical and research developments in the understanding of cognitive and emotional factors in psychological disorders, interpersonal attitudes, behaviour and relationships, and psychological therapies (including both process and outcome research) where mental health is concerned. Clinical or case studies will not normally be considered except where they illustrate particularly unusual forms of psychopathology or innovative forms of therapy and meet scientific criteria through appropriate use of single case experimental designs.

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

Papers should normally be no more than 5000 words, although the Editor retains discretion to publish papers beyond this length in cases where the clear and concise expression of the scientific content requires greater length.
3. Reviewing

The journal operates a policy of anonymous peer review. Papers will normally be scrutinised and commented on by at least two independent expert referees (in addition to the Editor) although the Editor may process a paper at his or her discretion. The referees will not be aware of the identity of the author. All information about authorship including personal acknowledgements and institutional affiliations should be confined to the title page (and the text should be free of such clues as identifiable self-citations e.g. 'In our earlier work...').

4. Online submission process

1) All manuscripts must be submitted online at http://paptrap.edmgr.com.

First-time users: Click the REGISTER button from the menu and enter in your details as instructed. On successful registration, an email will be sent informing you of your user name and password. Please keep this email for future reference and proceed to LOGIN. (You do not need to re-register if your status changes e.g. author, reviewer or editor).

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